

End of Project Evaluation Report

Challenging AIDS Related Poverty:

**Interventions with ownership, diversity, reach and innovation
for poor and marginalised communities
in South India
(IN 033 A07)**

Co-financed by HIVOS and the European Union

28 September 2009

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Evaluation Summary

The project, Challenging AIDS Related Poverty: Interventions with ownership, diversity, reach and innovation for poor and marginalised communities in South India (IN 033 A07), co-financed by HIVOS and the European Union, was signed on 3rd February 2006.

The **overall objective of the project** is:

To reduce poverty and improve quality of life of poor and traditionally marginalised communities, disproportionately affected by or vulnerable to HIV & AIDS; and empower civil society organisations to check the spread of HIV and reduce the impact of AIDS, in the highest prevalence states of Maharashtra, Tamil Nadu, Andhra Pradesh, and Karnataka, and the contiguous state of Kerala.

The **specific objective of the project** is:

To reduce stigma and discrimination and increase equitable access to HIV & AIDS prevention, treatment delivery, care and support for people in sex work (PSW), gay, bisexual, transgender and transsexual people (GBT), people living with HIV & AIDS and their families (PLHAs) and the people in the immediate environment of the target communities (PIE), through establishing community-based voluntary counselling, testing, support and care centres (CVCTC+) and promoting self-help groups of members of target communities to address the sociological, psychological and medical factors that increase their vulnerability to HIV & AIDS.

The objectively verifiable indicators of achievement of the project, contained in the Log Frame, are:

- Seven replicable models of CVCTC+ established and operational across project areas.
- Sixteen representative and functional groups of PSW, PLHA and GBT across functional areas.
- Government agencies and other civil society organisations around the project area start/add to initiatives based on learning from CVCTC+ model and network processes.
- A functional consortium of civil society organisations working to reduce stigma and discrimination and increase equitable access to HIV & AIDS prevention, treatment delivery, care and support, among PSW, GBT, PLHA and PIE.

Key findings of the Evaluation

Overall

Throughout the life of the initiative, there has been a tension between the project as a vehicle for service delivery and action, and the coalition as a facilitator of voice.

The project has been successfully implemented. The coalition has made significant progress towards achieving the outcomes that it aspired to at its inception.

Specific Expected Results

Expected Result No. 1

Improved quality of life of PSW, GBT, PLHA and PIE through improved health seeking behaviour and equitable access to services through community-based voluntary counselling, testing, support and care services (CVCTC+).

This outcome has been achieved. More than seven community-based voluntary counselling, testing, support and care centres (CVCTC+) centres have been established.

The Sarvojana members who have established CVCTC+ have built and operated good practice programmes where counselling and testing is integral to providing access and avenues to the care, support and treatment needed by community members.

Care and support are provided at the CVCTC+s. Treatment referral is primarily to government providers and facilities. Quality assurance and follow-up of referrals can be a challenge.

The establishment of the CVCTC+s has fostered community feeling, community formation, community self organizing, and community organisational development.

The CVCTC+ create safe spaces and promote solidarity and a sense of purpose. These generate self esteem and self-worth whereby positive living takes centre stage.

Expected Result No. 2

An effective alliance of 16 groups of target communities of PSW, GBT, PLHA and coalition members engaged in community mobilisation and advocacy at government, private and community levels to reduce stigma and discrimination.

This outcome has been achieved. More than sixteen self-help and community groups have been established, meet regularly and have met together.

The project has created self-help and community groups with a sense of purpose and allowed them to grow organically rather than programmatically.

Sarvojana needs to become clearer on the roles it wishes these groups to play in dealing with individual cases of ill-treatment, injustice and the violation of rights, in educating the public on these matters, on creating a social justice based response to the HIV epidemic, and in advocacy at all levels.

Expected Result No. 3

The expected results of the project are:

Improved quality of services available at government, private and community facilities for a continuum of care for HIV and AIDS prevention, treatment delivery, care and support for target communities.

This outcome has been achieved but this is an unfinished agenda.

It was not clear that the importance of Expected Result 3 in improving the quality of life and well-being of the communities of interest has been reflected in project implementation. It may have been overshadowed by the focus on the CVCTC+s.

Nevertheless change in the immediate social environment is palpable and the persons in the immediate environment have demonstrated support to a great extent.

All of the partners reported the training of health-care personnel, including laboratory technicians, counsellors, buddies and peers.

The project moved beyond the sensitisation of government providers to working with them towards improving the nature of service delivery, notwithstanding the day to day challenges.

The project has demonstrated community capacity in health promotion and the achievement of social justice.

Expected Result No. 4

Effective functioning of an umbrella organisation, established with the objective to build capacity of coalition members to cooperate and manage future projects in this area.

This outcome has been achieved. The Project Management Committee fulfils this function and fulfils it effectively.

There are some issues of continuing concern in the quest for good governance that will need to be addressed:

- the need for a conflict resolution mechanism outside of the regular PMC meetings, perhaps a sub-committee of the PMC, to ensure that other agenda items for the PMC are adequately addressed
- the need for continuity of representation on the PMC and representation at senior level, and
- the inadequacy of the transfer of the vision of the coalition and of project approaches and components to new PMC members.

The tools and indicators used to capture outcomes, in particular, the Project Logframe and its associated Management Information System, have not been adequate to capture the way the coalition works and its achievements.

The log frame approach needs to be combined with other approaches more able to capture and measure subtlety in complexity and to contribute to a deeper understanding of how to bring about lasting social change in complex and ethically problematical situations.

Issues of interest in project implementation

Community ownership: On indicators used to measure increased community ownership, the project has succeeded: increased usage of services by community members, increased trust of the centres and staff, community members trained as staff, participation by community members in decision making relating to the centres, community members consulted and involved in centre activities, community members on the governance structures.

Community empowerment: The basis of project success in the area of community empowerment has been practices of giving respect and dignity to marginalized populations.

HIV objectives relating to coverage, distribution of condoms, access to services, and others, can be achieved and exceeded in spaces where respect and empowerment are the objective and the practice.

Replicability: The project has been successful to a certain extent in influencing the nature of services in the local environment to their communities of interest but this is an unfinished agenda. It has also been successful in influencing the nature of HIV-related services in the country in general but this too is an unfinished agenda.

The CVCTC+ centres are a valuable addition to the topography of health-care provision to poor and marginalised communities and they have increased and improved access to needed services by the members of these communities. Their continuation depends as much on the continuing passion and commitment of those involved as on funding. There is a continuing need to ensure that services sought by

community members are provided with care and without stigma and discrimination, wherever these services be provided.

Sustainability: The project has contributed significantly to bringing about changes in the ways members of poor and marginalised groups are viewed by their communities. These changes will need on-going support if they are to be sustained.

Gender: Gender sensitivity and competency are defining qualities of Sarvojana, stronger in some members than in others.

The understanding and acceptance of gendered fluidity and diversity does not stretch to the statistics. Data are still disaggregated into binary categories and it is unclear, for example, where data on transgender people are categorised.

Recommendations

That Sarvojana continue as a values-based coalition of like-minded civil society organisations concerned for the human rights, dignity and well-being of their communities of interest.

That the work of Sarvojana continue to be supported on the bases of relevance and need, and of effectiveness.

That the work of the Sarvojana member organisations be better theorised, documented and disseminated so that their very real achievements can contribute to the development of communities of effective HIV practice in India and elsewhere.

That Sarvojana members base their future work plans on on-going processes of reflection on the needs of their communities of interest, on their vision as a coalition, and of the value added that they individually and together bring to this work. This may necessitate rolling work plans, budgets and log frames.

That Sarvojana continue its partnership with HIVOS and that this partnership be itself considered as a partnership of like-minded organisations.

That, within this partnership, HIVOS continue its financial and moral support to Sarvojana, to assist the coalition to access funds sufficient for its needs, and to work closely with it to achieve its purpose.

That the differing governance needs of the coalition and the project be clarified and an appropriate governance structure be developed for the coalition.

That, if the PMC is redrawn as the governance structure for both, the agenda of the PMC on a regular basis contain items relevant to the coalition.

That Sarvojana create a programme position to support its programme of action and advocacy as a coalition of organisations speaking with a unified voice concerning the practices, ethics and effectiveness of HIV work in India.

That ways be found to ensure that Sarvojana's vision and purpose be transferred to in-coming participants.

That the coalition reflect on whether it would be beneficial to gain new members, either individual or organisational, and if so how they will balance the value of familiarity in processes of joint project management with the authority that could be gained from a larger group speaking with one voice.

That the coalition, in partnerships with its communities of interest and its donors, become clearer on what would be successful outcomes of their efforts and develop ways of monitoring, documenting and reporting on the pathways to these outcomes in keeping with their understanding of how the desired social changes come about.

Evaluation Report

Introduction

In 2003, eight community-based organisations and community partnership organisations in South India came together to seek strength in unity.

What first struck the outsider, and in particular HIVOS when they were approached for support, was the diversity of the member organisations. Some were organisations that were born within their communities, communities of fluid and diverse sexualities and identities, communities of women and men engaged in sex work to earn their livelihoods, communities of the poor, often exploited and abused, who come together on the margins of society. Others were organisations in partnership with these communities.

There was diversity in geography and reach. Some were small organisations; others larger. They were dotted across the high-HIV-prevalence landscape of South India. They were at different junctures in organisational maturity.

However, whilst valuing diversity, the founding organisations had many features in common. Each was an experienced and technically sophisticated organisation with a proven track record of effective HIV work. Each was marked by a commitment to give voice and agency to its communities and by a concern for the dignity and well-being of community members. Each was committed to ethical practices of respect and integrity. Each was already involved in responding effectively and respectfully to community needs and building on community strengths.

The organisations came together to protect their organisational way of being in the world, their way of doing HIV work, of practicing development. They wanted to shield, and expand, the community spaces that they had created that were characterised by these commitments. They wanted to connect with each other in networks of solidarity and conscientisation.

To do this at the time they did, in 2003, was an act of resistance. Much of the funding then available for work with their communities of interest, for 'targeted interventions', came with an ethos of social engineering, an emphasis on HIV technology and a requirement for conformity to externally designed programmes¹.

These organisations came together to resist tendencies to dehumanise and instrumentalise HIV work, to resist the imposition of external models when their

¹ For a critique of the approach and focus of the Gates Foundation, see Editorial and papers in *The Lancet*, Vol 373, No. 9675, May 9, 2009, pages 1577, 1584-1585 and 1645-1653.

own 'local' work had already born rich fruit², and to safeguard spaces for diversity and endogeny in approaches.

Most of the founding organisations were structured around a committed and charismatic individual. Many were already actors in local and national arenas. All were people of courage and vision. The coalition was seen as a platform to give voice to their shared aspirations and unease.

The catalyst for their coming together was Shyamala Nataraj, the founding Programme Director of SIAAP, the South India AIDS Action Programme. SIAAP approached HIVOS, its long-standing partner, with the idea.

A project began to take shape and, since projects have their own logic, in particular that clearly definable results flow logically from pre-planned activities and outputs in limited and identifiable time frames, this mode of HIV work was inevitably to affect and shape what was undertaken by the coalition and how it was undertaken.

The project was intended to be a vehicle for action in each of their communities of interest and a vehicle for a united voice as a coalition.

² HIV infection rates among women in sex work and at ante-natal centres in Tamil Nadu had fallen significantly before the large donors such as the Gates Foundation began to fund projects in South India.

The project objectives, anticipated results and indicators of achievement

The project, Challenging AIDS Related Poverty: Interventions with ownership, diversity, reach and innovation for poor and marginalised communities in South India (IN 033 A07), co-financed by HIVOS and the European Union, was signed into existence on 3rd February 2006.

The **overall objective of the project** is:

To reduce poverty and improve quality of life of poor and traditionally marginalised communities, disproportionately affected by or vulnerable to HIV & AIDS; and empower civil society organisations to check the spread of HIV and reduce the impact of AIDS, in the highest prevalence states of Maharashtra, Tamil Nadu, Andhra Pradesh, and Karnataka, and the contiguous state of Kerala.

This makes clear that the focus of the project was the quality of life of its communities of interest, the poor and traditionally marginalised. Its concern was with the forms of impoverishment caused by the HIV epidemic: the loss of physical health and well-being, the financial impacts of HIV infection, the loss of rights suffered, and the undermining of people's dignity and social well-being by the isolation, stigma and discrimination the epidemic brings in its wake.

One of the programmatic innovations of the project was its understanding that to improve the quality and length of life of its communities of interest, it needed also to work with People in their Immediate Environment (PIE). Many of the types of impoverishment identified in the project document³ are relational. They arise in the context of the everyday, the social and interpersonal interactions that those touched by the epidemic and those close to them experience in their daily lives.

The **specific objective of the project** is:

To reduce stigma and discrimination and increase equitable access to HIV & AIDS prevention, treatment delivery, care and support for people in sex work (PSW), gay, bisexual, transgender and transsexual people (GBT), people living with HIV & AIDS and their families (PLHAs) and the people in the immediate environment of the target communities (PIE), through establishing community-based voluntary counselling, testing, support and care centres (CVCTC+) and promoting self-help groups of members of target communities to address the sociological, psychological and medical factors that increase their vulnerability to HIV & AIDS.

³ The phrase 'project document' is used in the evaluation report to refer to the Grant Application Form submitted by HIVOS to the European Commission.

The project designers framed the project around the practices of capacity building, participation, and self-help. These practices were to lead to the ownership of the work by those involved, to the empowerment of the communities of interest to 'set and enforce agendas relevant to their well-being' and to networks of solidarity amongst them.

The objectively verifiable indicators of achievement of the specific objective of the project, contained in the Log Frame are:

- Seven replicable models of CVCTC+ established and operational across project areas.
- Sixteen representative and functional groups of PSW, PLHA and GBT across functional areas.
- Government agencies and other civil society organisations around the project area start/add to initiatives based on learning from CVCTC+ model and network processes.
- A functional consortium of civil society organisations working to reduce stigma and discrimination and increase equitable access to HIV & AIDS prevention, treatment delivery, care and support, among PSW, GBT, PLHA and PIE.

The expected results of the project are:

1. Improved quality of life of PSW, GBT, PLHA and PIE through improved health seeking behaviour and equitable access to services through community-based voluntary counselling, testing, support and care services (CVCTC+).
2. An effective alliance of 16 groups of target communities of PSW, GBT, PLHA and coalition members engaged in community mobilisation and advocacy at government, private and community levels to reduce stigma and discrimination.
3. Improved quality of services available at government, private and community facilities for a continuum of care for HIV and AIDS prevention, treatment delivery, care and support for target communities.
4. Effective functioning of an umbrella organisation, established with the objective to build capacity of coalition members to cooperate and manage future projects in this area.

Evaluation methodology

The evaluation team was led by Dr. Sundar Sundararaman, who was joined by Dr. Elizabeth Reid for two of the field visits (SWAM and WINS) and for the evaluation of the Sarvojana Coalition. Dr. Reid also visited INP+ and SIAAP.

Dr. Sundararaman is a medical practitioner who has been actively involved in the struggle for a rights based and effective response to the HIV epidemic in India since the start of the epidemic, and in conceptualising the response as a development practice. He has extensive experience in working in respectful partnerships with affected marginalised groups.

Dr. Elizabeth Reid is an experienced development practitioner and a Visiting Fellow at the Gender Relations Centre at the Australian National University, Canberra. She began visiting in India in the mid-70s, working first on women and development and later on HIV and development. Her work as a development practitioner, mentor and adviser has also taken her to many developing countries and countries in transition. She had worked with or was aware of the work of a number of the coalition members prior to the evaluation.

In preparation for the evaluation mission, the team undertook desk reviews of the key documents since the inception of the Coalition and relating to the Project, including the report of the 2003 Planning Workshop, the 2004 project document, the HIVOS contract, the minutes of the Programme Management Committee 2006-2008, the PMC Policy and Code of Conduct, the 2007 baseline study of Stigma, Discrimination and Violence, the annual technical reports, the European Union monitoring visit reports, the MOU with partner organisations, the 2007 conflict mediation report, and the 2008 Mid-Term Self Evaluation Report. The team defined the data requirements for the evaluation and worked with the Programme Director to collect the required data.

On the basis of the document review, the team mapped out the activities undertaken within the Project in order to identify main lines of action. The team reviewed the findings and recommendations of the Report of the Sarvojana Mid-Term Self Evaluation 2008. The Mid-Term Self Evaluation designed, managed and written by Sashi Rajagopalan, was of invaluable assistance to the team.

The evaluation process and methodology distinguished between project implementation and the role of the coalition. It is acknowledged that to a certain extent this is not an absolute dichotomy. The founding visionaries saw the *project* as a vehicle for action, for service delivery, service improvement, for the claiming of rights and respect and for the validation of their work. The *coalition* was conceived as a vehicle for voice and activism for change. Each can influence and contribute to the other.

However, it was felt that, for the purposes of the evaluation, there would be value in distinguishing between the two and, given the difference in their *modus operandi*, two different evaluation methodologies were developed. The evaluation report refers to Sarvojana when both aspects of the work are being discussed. Otherwise it uses the referents 'the project' or 'the coalition'.

Dr. Sundararaman led the evaluation of the activities undertaken within the Project and of Project management and implementation. The Project review used a community-centred consultative review methodology. This included visits to each project site, where the evaluation team began by discussing with the community members the value of the project activities to their lives and concerns and the nature of the relationships established with and by project staff and outreach workers.

Project staff and management and, wherever possible, Board members, were also asked about the value of the project in their lives and their reflections on its practices, procedures and impact.

All but two of these field visits were undertaken before the workshop in March and April 2009. Dr. Reid accompanied the team leader on two of the field visits (SWAM and WINS) and met herself with two other of the member organisations (INP+ and SIAAP).

In the course of the evaluation Dr. Sundararaman fell ill and could not visit the remaining two coalition partners as planned: the Foundation for Integrated Research in Mental Health (FIRM), Trivandrum, and the Indian Network of People Living with HIV/AIDs (INP+), Chennai. This part of the evaluation was carried out by Ms. Rajamma G. who visited the two organizations between 22nd and 25th June 2009.

The second part of the evaluation consisted of a reflective forward looking assessment of the work of the Coalition, looking backwards over the time since its inception and, on the basis of this appraisal, looking forward to what its future might be.

This reflective evaluation took place during a three day workshop, held in Chennai, Tamil Nadu, 6 to 8 April 2009. The coalition members participating are listed in the Annexe.

The final evaluation report was prepared by Dr. Elizabeth Reid using as guidance the valuable presentation made at the workshop by Dr. Sundararaman. Dr. Reid prepared the report of the evaluation of the Coalition.

Methodology for the evaluation of the coalition

The methodology for the evaluation of the coalition, as distinct from the project, was based on learning for the future: a forward-looking assessment. It involved critical reflection on past and present work in order to determine future pathways.

The review was undertaken by the coalition members themselves, facilitated and contributed to by the evaluation team. It was decided that the HIVOS staff present at the workshop should participate fully as partners in the reflection.

A flow sheet was prepared for the workshop by the evaluation team and agreed to by the coalition members at the start of the workshop. The backward-looking assessment was structured around a set of key questions identified during the document review, in discussion with the HIVOS programme officer prior to the mission, and arising in discussion with member organisations.

These questions were:

- What is the coalition? How would you describe its purpose?
- How has the coalition used its combined strength since its inception?
- What lessons have you learnt about working together?
- What are the governance structures and practices of the coalition (as distinct from the Project)?
- To what extent has the coalition developed a learning culture?
- To what extent has the coalition communicated its vision to others?

These questions also provided a reference point for the forward-looking part of the assessment although other questions also emerged from the discussions, especially relating to membership of the coalition and to the identification of issues that could be addressed as a coalition.

Before the forward-looking reflection, Dr. Sundararaman presented his observations and insights on the Project gathered during the field visits and document reviews undertaken before the workshop. These were then able to be taken into consideration during the forward-looking reflection.

The members present decided to participate in the evaluation process as involved individuals, rather than seeking to find an organisational stance or response on an issue.

The methodologies used to review these questions included individual reflections, group discussion, mediated brainstorming, identification of burning issues, identification of lessons learned, and, to determine the value added by the coalition, a version of the Most Significant Change (MSC) methodology was designed for the workshop.

This latter methodology was chosen in order to give coalition members experience of a non-quantitative methodology that can be used to manage processes of change and to monitor outcomes. The methodology is suited to the review and evaluation of complex situations with many players and levels and is particularly suited to monitoring a programme where the focus is on learning rather than just accountability. It is also suitable for use in and by communities, including marginalised communities, where story telling and the learning of lessons from stories is part of their traditions.

The methodology is a story-based practice. It involves the collection of stories of change which are then analysed, discussed and verified. The stories capture changes in the lives of those involved, both beneficiaries and stakeholders, changes in the character of their participation, changes in their interrelations, changes in attitudes, beliefs, norms and practices. The method can also help to identify why and how change happens.

The workshop exercise showed that there is an art in writing/telling such stories of change, as well as in reading and analysing them. Often well written stories have more immediate appeal; often the stores are read as stories, rather than as stories of change. The process of analysis is time consuming. The analysis requires in-depth discussions about the value of the reported changes.

The MSC methodology does, however, help in understanding complex impacts and in capturing unintended outcomes. It can also help all involved understand the different points of view and values of the various players in a complex, multi player initiative. Used in conjunction with more quantitative measures, methodologies such as these can create a richer tapestry of change.

In the afternoon of the third day, a facilitated discussion took place to determine the importance of the work of the coalition to its members, their dedication to its continuation, to gauge the commitment of each organisation to participate in the coalition, and to determine how to proceed.

The theory of social change which shapes the work of the coalition

The original individual members of the coalition were known for their courage in speaking out, for their practices of respect and integrity, by their activism, and as visionaries. They were speaking out before the coalition was established but as individuals. The coalition was to give them strength in unity, a space for the expression of outrage, grounds for collective bargaining, and a platform to talk about the larger issues of HIV work.

However, there was no formal statement of vision or purpose of the coalition, as distinct from the project, drawn up in the Planning Workshop in 2003 nor contained in the 2006 Project document.

The Planning Workshop in December 2003 recognised that the coalition “could ensure two things:

- a) build a critical mass of interventions across high prevalence regions that could demonstrate validity and models for scale-up, and
- b) build effective networks for sustained policy advocacy at national and state levels”.

This was the initial and tentative essay of the members to articulate the theory of social change which shapes their work:

Effective local HIV work, often small scale work, is possible and these local initiatives can synergistically form a mass sufficient for significant social change to occur. However, social change must be stimulated and enabled through the development of advocacy networks. These networks contribute to the creation of the enabling environments for sustained collages of social change.

The planning workshop began the process which eventuated in the development of the project document/grant application form signed on 3rd February 2006. These insights from the planning workshop into the processes which enable social change were to a certain extent further elaborated in the project document. However, by then, the project and the coalition were being constantly elided.

The project document contains as one of its objectives the establishment and effective functioning of “an umbrella organisation with the objective to build capacity of coalition members to cooperate and manage future projects in this area” (p.12).

In this imaginary, the purpose of the coming together is inward turning. The coalition becomes a joint project management mechanism whose role is to facilitate the members of the coalition to respectfully provide needed services to and with their communities of interest. It is outward turning only in so far as it recognises the

decisive importance of building synergies and linkages between communities, civil society organisations, health-care and other government institutions, law, policy and the private sector (p.14).

However the project document also talks of the members of the coalition having reviewed existing HIV programmes and found a “set of components universally held as critical to effective HIV & AIDS prevention and care were missing in programmes across India” (p.14).

In this imaginary, the coalition is outward turning, its canvas the whole of India. Issues of sexuality and gender, respect for human rights, process of community voice and ownership, concern for the social and economic well-being of marginalised communities and the refusal of blame and prejudice are to be promoted and challenged nation-wide (p.14).

This is a clearer articulation of the coalition’s theory of social change. In most social change work, the problems are complex and often not well defined. Addressing them involves changing perceptions, attitudes, habitual behaviours, relationships, capacities, and conditions.

The complex and interdependent processes of social change take time, often unforeseeable amounts of it. Individual organisations can seldom achieve the required changes on their own. Social change involves developing networks of relationships with a range of actors, organisations, institutions and individuals, some like-minded, some not. These webs of relationships can be conceptualised as systems of forces and actors that influence, positively or negatively, the possibility of change in the context of the intervention.

It also involves creating a supportive eco-system or enabling environment by evidence building, by advocacy and by activism through which issues of concern can be “promoted and challenged nation-wide”⁴.

However, the coalition has tended to see itself in terms of its vision rather than in terms of its theory of social change. The processes of articulating and developing a theory of social change helps organisations see beyond the familiar in order to understand the full complexity of the changes they wish to see and to imagine new pathways to change in dialogue with others.

During the April 2007 PMC meeting, the phrases used to re-capture the vision included: ‘community agenda’, ‘mutual support’, ‘synergy’, ‘influence the Indian agenda’, ‘decide together how to take the work ahead’, ‘learn from best practices of each organisation’, ‘address gaps in the care continuum’, ‘resist the imposition of donor agendas’, ‘code of conduct’ and others. These phrases attempt to capture the

⁴ Words used by a participant in the evaluation workshop.

‘the philosophical spirit’ or ethical practice which shaped the formation of the coalition was to see if it was still accepted as a *raison d’etre* by coalition members.

There is a radical difference between seeing oneself in terms of one’s vision or *raison d’etre*, and understanding what would constitute success and how to bring it about. The former relates to values and perceptions of identity. The latter would be a narrative of how that vision can be brought about, and be seen by others to have happened.

The development of a theory of social change is often initiated by asking the core constituencies to write a brief obituary or epitaph for their organisation: what would they like to have been left behind once the organisation ceases to exist? What is the core transformation they would like to have contributed to? This then is followed by reflections on how that can be brought about.

There are usually three core constituencies in processes of social change: those who have the vision and the desire for change to occur, those who provide the resources and the support to realise the vision, and those whom the change is designed to benefit.

The articulation and re-articulation of a theory of change requires a grounded understanding of how change comes about and enables the pathways to the desired outcomes to be mapped, acted on, monitored and documented.

These pathways and outcomes provide ways of measuring success in complex systems of change. If these pathways had been mapped, the impact of the coalition could have been measured against them during this evaluation.

More critically, the coalition constituents could be measuring themselves against their own theory of change. At present, the Project Logframe, which is an inventory of objectives and activities unframed by a theory of change, provides the only benchmark for the measurement of success.

The coalition and the project

Evaluation finding: Throughout the life of the initiative, there has been a tension between the project as a vehicle for action, for service delivery, and the coalition as a facilitator of voice.

The self-perception of the coalition in terms of its vision rather than in terms of an on-going constituent dialogue on the desired social changes and the pathways to change has exacerbated this tension.

In the absence of an articulated theory of change, projects take on a life of their own: project documents to be signed, project management mechanisms to be established, project log frames to be prepared, project financial systems to be established, indicators of project results to be developed and agreed, project documentation, monitoring and review systems to be established. These are the bread and butter of project work but they can drain energy away from the aspirational and focus attention on the mundane.

The Sarvojana Mid-term Internal Evaluation Report (2008) recognises the inevitability of this: “Any coalition of the complexity that Sarvojana has, will initially use its energy to establish itself for smooth collaboration around project management” (p.25). This was verified in the Evaluation Workshop: “We have not been able to give enough time to the coalition due to these other commitments”⁵.

There has not been confusion in members’ minds over the difference between the project and the coalition. The project was understood as a “vehicle to nurture the coalition”, a means by which community voices could be heard and community issues addressed. The coalition was to give solidarity, affirmation and audience to these voices, insights and issues.

It was proposed that the project and the coalition have come together: “in the growing shared understanding of the different communities of interest, of the issues that span these diverse communities and affect their members, in the involvement in their different geographies”. Coalition members have been interacting with each other and learning from each other: “It has not been a formal group but a group based on friendship and growing respect.”

However, it is acknowledged that, to a certain extent, “because of the project, we have lost sight of the coalition”. The procedures, systems and mechanisms put in place were predominantly for the governance of the project; the agendas of the meetings of the Project Management Committee (PMC) responded mainly to the

⁵ All quotes in this section and following sections of the report are from Sarvojana members who attended the Evaluation Workshop, Chennai, 6 to 8 April 2009.

exigencies of jointly managing a project or of the project cycle; the name, Sarvojana, has been used to refer to either the project or the coalition, sometimes to both.

Despite all this and because of this, the coalition has made significant progress towards achieving the outcomes that it aspired to at its inception.

The project implementing organisations

The project grew out of a loose alliance of like-minded organisations drawn together by shared concerns and relations of friendship and respect for each organisation's approach to their work.

The eight participating organisations are all not-for-profit organisations. They are:

- The South India Aids Action Programme (SIAAP), based in Chennai, Tamil Nadu, and working in the field of HIV since 1989
- The Foundation for Integrated Research in Mental Health (FIRM), based in Trivandrum, Kerala, and working in the field of HIV since 1997
- The Humsafar Trust, based in Mumbai, Maharashtra, and working in the field of HIV since 1992
- The Indian Network of People Living with HIV & AIDS (INP+), and working in the field of HIV since 1997
- Sangama, based in Bangalore, Karnataka, and working in the field of HIV since 1999
- Samraksha, based in Bangalore, Karnataka, and working in the field of HIV since 1993
- The Social Welfare Association for Men (SWAM), based in Chennai, Tamil Nadu, and working in the field of HIV since 1997, and
- Women's Initiatives (WINS), based in Thirupathi, Andhra Pradesh, and working in the field of HIV since 1994.

These organisations had in common a pervasive unease about the high rates of HIV infection in South India and a deep apprehension about the way this might impact on the lives of their communities of interest, and on the poor and marginalised in general. They also had in common a track record of activism and advocacy, footprints of their commitment to change. Some of this is outlined in the project document in section 1.8 (f).

The vision which brought these disparate organisations together reflected beyond all else a determination to maintain and improve the effectiveness and reach of their work. The form of their association, a service delivery and advocacy coalition, was unusual, the project document refers to it as 'pioneering in nature' (section 1.8 (e)).

At the time, much emphasis was being placed by the donor community and internationally on 'scaling-up' the response to the HIV epidemic. This was

understood, in this context, as increasing the coverage of the response by taking an existing organisation and expanding it, often beyond its mission and capacity.

The crafters of the coalition had a different vision, a quilt-like concept of scaling up: take the squares formed by a number of organisations and stitch them together into a larger quilt-like whole, a coalition, and in so doing increase their voice, effectiveness and reach.

This understanding of scaling-up brought with it an important principle of project implementation: diversity in unity, that is, the balancing of respect for the autonomy and identity of the participating organisations with the practices of collaboration and joint programming.

Each organisation has implemented the project within the framework of the project document based on its own founding mission and values. Thus, the Indian Network of Positive People, INP+, is a networking organisation which has as its mission the support of people living with HIV and the advocacy of their concerns. It decided not to establish a community-based voluntary counselling, testing, support and care centre (CVCTC+) but rather to work within the other objectives of the project. This was agreed at the start of the project.

During the evaluation mission, the need for an adequate language for the work was constantly raised. Sarvojana members, members of the communities of interest and others commented on the fluidity and diversity of identities, sexualities, gender expression, community-formation and religious and social practices amongst the poor and marginalised, and the difficulty in finding respectful and accurate ways of referring to them. Unease was expressed at many of the referring expressions, phrases and acronyms used and, in particular, of 'MSM'.

Sarvojana's commitment to respect and recognise those they work with commits it to struggle to find a vocabulary and discourse of respect and recognition. The phrases 'women in sex work' or 'people in sex work', which do respect people's humanity, have emerged from this struggle.

Phrases such as 'sexual minorities' have also emerged, although this still defines people by their sexualities and demographic status, rather than their humanity. It is a distancing phrase. The phrase 'males who have sex with males' is used by some members to indicate that young men and boys, not just men, are attracted to and sexually active with males. The phrase 'men who are sexually active with men' captures what is of interest to those using a medical or interventionist paradigm in HIV work. It fits less well into a social transformation approach.

In this struggle, there is a need to resist a discourse of identities based on sexual behaviours, which may reinforce beliefs that sexuality is fixed and can be fitted into mutually exclusive categories (sex worker, homosexual, bisexual, gay, transgender, double decker, hijra, kothi, and more). At the same time, there is a need to recognise the importance of a sense of belonging to a community, particularly in

contexts of pervasive stigma and discrimination. However, sexuality, sexual practices or sex work constitute only one aspect of the person. The language of this work needs to create non-hierarchical, intersectional and open spaces for conversations (Sharma 2008, CREA 2006).

In recognition of this, the evaluation report uses 'communities of interest', rather than 'target groups' or 'targeted communities, to refer to the communities with whom the project works. It uses the phrases 'same-sex-desiring men', 'transgender people', 'women/people in sex work' and 'people living with HIV'.

The implementation sites and communities of interest for the project are as follows:

- SIAAP works with women in sex work, same-sex-desiring men and people living with HIV in Theni plus two other districts in Tamil Nadu.
- FIRM works women in sex work, same-sex-desiring men and people living with HIV in Trivandrum, Calicut and Trichur in Kerala.
- Humsafar works same-sex-desiring men, transgender people, men in sex work and people living with HIV in Kalyan on the outskirts of Greater Mumbai, Maharashtra.
- INP+ worked with people living with HIV in Chennai, Thiruvallur and Kancheepuram in the first years of the project, adding the Family Counselling Centre at GHTM Tambaram in the second , and moving to Trivandrum and Villapuram Ariyalar in the third year, districts in Tamil Nadu.
- Sangama works with same-sex-desiring men, transgender people and people living with HIV in Bangalore, Karnataka.
- Samraksha works with women and men in sex work, same-sex-desiring men, communities and people living with HIV in Karnataka. The community of interest for the CVCTC+, in Raichur District, Karnataka, is people with self risk perception in the immediate environment.
- SWAM works with same-sex-desiring men, transgender people and people living with HIV in Chennai, Tamil Nadu.
- WINS works with women in Thirupathi, Andhra Pradesh.

The programme of work of each organisation falls within the project framework but grows from the realities of its communities of interest and the contexts of their lives. Communities of practice have emerged from within rather than being imposed.

Progress made towards achieving project outcomes

Project Expected Result No. 1

The expected result within the Project Document is:

Improved quality of life of people in sex work (PSW), gay, bisexual, transgender and transsexual people (GBT), people living with HIV & AIDS and their families (PLHAs) and the people in the immediate environment of the target communities (PIE), through improved health seeking behaviour and equitable access to services through community-based voluntary counselling, testing, support and care services (CVCTC+).

The relevant objectively verifiable indicator of achievement of the specific objective of the project contained in the Log Frame was:

- Seven replicable models of CVCTC+ established and operational across project areas

This was one of the key strategies of the project. The centres were to be accessible to the communities of interest, managed by the coalition member in partnership with the target communities, and to operate according to agreed ethical guidelines relating to confidentiality, standards of care, the principles of respect, recognition and reliance, and preferential access for the communities of interest (section 1.7, 1.1).

Evaluation finding: This indicator of achievement has been realized. More than seven CVCTC+ centres have been established and are operational. The report will return to the issue of the replicability of the centres.

It is important to note what has been achieved, that is, to honour the '+' in CVCTC+. At the time when the project document was signed, and since then, there has been tension between the funding of HIV-dedicated or HIV-focused responses and support to initiatives which have a philosophy of social transformation within which HIV-related objectives can be met. The project document states:

To prepare the plan of action, the local partner and member organizations from the different target regions and communities reviewed existing programmes in these regions. They found that a set of components universally held as critical to effective HIV & AIDS prevention and care were missing in programmes across India.

These included issues of sexuality and gender that are fundamentally linked to HIV & AIDS; human rights violations that help to accelerate the spread of infection, processes of community mobilization and ownership that can lead to a sustainable response, social and economic well-being of vulnerable

communities that is essential help them protect themselves against infection; and stigma and discrimination that drive people underground.

Thus the founding organisations, both philosophically and from their own prior experience in responding to the HIV epidemic, committed themselves to responding to the needs as human and social beings of their communities of interest, rather than just using them instrumentally to reduce HIV transmission. They were committed to improving their quality of life and health through practices of empowerment, respect and encouragement.

This commitment can be seen in the wide range of services provided by the CVCTC+ (Table 1 & Table 2): general health, reproductive and sexual health counselling and treatment, psychological support, TB treatment, nutritional supplements, as well as a range of HIV-related services. The centres encouraged the creation of support groups and established drop in centres, both of which are safe spaces for gathering and talking and gaining and giving support. They are also space which facilitate problem solving, activism and advocacy.

Evaluation finding: The Sarvojana members who have established CVCTC+ have built and operated good practice programmes where counselling and testing is integral to providing access and avenues to the care, support and treatment needed by community members.

Other outcome indicators:

- 12,000 members of the target population seek CVTCT+ services by the end of the third year

The experience of the founding organisations had taught them that, especially when working with marginalised and oppressed groups, the establishment of CVCTC+ centres has to be complemented by programmes which reach out into these communities and encourage and motivate them to attend ((section 1.7, 1.2).

INP+ joined the other partner organisations in this. It did not establish a CVCTC+. However, it worked closely with its members through its district networks in Tiruvallur, Kancheepuram and Chennai in the first two years of the project and then at Vizhupuram and Ariyalur encouraging and motivating positive people to access public health and support services from government hospitals.

The result of the synergy created by the combined service delivery and outreach strategies was a significant coverage of the communities of interest in terms of their access to the services provided by the project. When those reached by INP+ are added to the figures for the CVCTC+ centres, in 2008 over 101,000 people were either reached by outreach workers and/or sought out the services provided in the CVCTC+ centres.

Table 1: Services offered by the CVCTC+

	Services offered	FIR M	Hum safar	Samr aksha	Sanga ma	SIA AP	SWA M	WI NS	Total
1	Pre-test counselling	Y	Y	Y	Y	Y	Y	Y	7
2	Post-test counselling	Y	Y	Y	Y	Y	Y	Y	7
3	Testing	Y	Y	Y	Y	Y	Y	Y	7
4	ART referral	Y	Y	Y	Y	Y	Y	Y	7
5	Nutritional supplements	Y	-	Y	Y	Y	Y	Y	6
6	STI testing/ treatment	-	Y	-	Y		Y	-	3
7	DOTS (TB)	Y	Y	Y	Y	Y	Y	Y	7
8	General illness treatment	Y	Y	Y	Y	Y	Y	Y	7
9	Drop in centre	Y	Y	Y	Y	Y (2)	Y	Y	8
10	IEC materials, education	-	Y	Y	Y	Y	Y	Y	5
11	Condom supply	-	Y	Y	Y	Y	Y	Y	5
12	Support group meetings	Y	Y	Y	Y	Y	Y	Y	6
13	Hepatitis B vaccination	-	-	-	Y	-	-	-	1
14	Life skill education for infected and affected children	-	-	-	-	-	-	Y	1

This far exceeds the planned figure of 12,000 members of the target populations and provides strong evidence for the effectiveness of the two-pronged strategy in the project design.

Table 2 shows the usage of the services of the CVCTC+ in 2008. Over 86,000 people were reached by the outreach workers from the CVCTC+ either in one to one interactions or in group interactions. When the people reached by INP+ outreach workers is added (15,347), this brings the total reached to over 101,000. Attendance at self-help groups at the centres was high, especially at those organised by WINS and Samraksha.

Figures for the first half of 2009 for outreach and for self-help group attendance have not remained at this high level. This needs to be followed.

Almost 16,700 people had access to various services at the centres in 2008. Of these 7,145 came with referrals from the centre's outreach workers; 9,555 were walk in clients. Again, this is a significant figure and anecdotal evidence indicates that the reputation of the centres had spread by word of mouth.

Of the almost 16,7000 people using the CVCTC+ services in 2008, 566 were referred to the ART centre which are now available in each CVCTC+ area, 1118 were referred to services for prophylaxis and treatment of HIV-related opportunistic infections and 236 for TB DOTS treatment. CVCTC+ staff refer and accompany clients to and assist at local government centres. They follow-up on treatment adherence for ART and TB and link community members to other services.

More than one third of people attending the CVCTC+s decide to go through the process towards an HIV test. However it is not clear from these figures whether the centres are attracting people for testing early in the course of HIV infection.

Similarly high levels of usage of the services of the CVCTC+ centre continued into the first half of 2009, with approximately 8,500 attending.

These are impressive figures of the reach of the outreach workers, of people attending self-help groups and of people accessing the services of the CVCTC+s. They indicate significant health seeking behaviour and access to services amongst the communities of interest.

However, the evaluation team was informed that the advent of ART services in the vicinity of the centres has had an impact on the centres. The field visits indicated that the follow-up of the centres on aspects of community support and care is significant. However, follow-up after referral to another health-care facility, especially for ART, is variable. This is particularly so because after referral, the person becomes a patient of the health-care facility, often only returning to the CVCTC+ to attend support group meetings.

Table 2: Usage of the services and programmes of the CVCTC+ in 2008

Sarvojana Data - Jan to Dec-2008									
Heads	Siaap	SWAM	Samraksha	Sangama	HST	WINS	FIRM	Total	INP+
One to one ORW	4070	3039	9915	23546	6927	5508	456	53461	8994
One to group ORW	2843	3038	21564	421	1331	3148	279	32624	6353
SHGs etc	1438	1196	17419	883	4191	23825	814	49766	3825
Total contacts (1-1 + 1-grp)	6913	6077	31479	23967	8258	8656	735	86085	15347
Visitors from ORW	961	793	1605	1160	1272	506	848	7145	
Total clients visited centre	2108	2281	2062	1576	5660	1384	1617	16688	
Pre test	646	846	862	1576	1331	466	881	6608	
Tested	385	842	837	1563	1289	434	620	5970	
Post test	357	808	837	1133	876	421	592	5024	
Positive	17	56	60	177	163	69	3	545	
Negative	368	786	777	1386	1126	365	617	5425	
ART ref	16	18	83	9	73	364	3	566	
STI/RTI	174	18	88	243	178	601	25	1327	
GI	243	7	435	336	724	1319	3	3067	
TB treatment	6	1	62	22	11	134	0	236	
OI treatment	7	0	233	312	75	491	0	1118	

Key: ORW: outreach worker; SHG: self-help group; GI: treatment for general illnesses; OI: treatment and prophylaxis of HIV-related opportunistic infections.

Evaluation finding: Care and support are provided at the CVCTC+s. Treatment referral is primarily to government providers and facilities. Quality assurance and follow-up of referrals can be a challenge.

Other outcome indicators:

- 60 per cent of people testing positive for HIV receive social support

Table 1 and 2 indicate the range and usage of social support services, including for people testing positive for HIV. During 2008, 545 people tested positive for HIV, of these over 60 per cent received social support.

This indicator moves the monitoring from coverage in terms of numbers reached and served to a more person centred form of accountability. The interest is in the type and extent of support a person with HIV might receive in the centres.

The centres provided extensive psychosocial support including on-going counselling, self-help and support groups, and nutritional support. Other forms of support included assistance with preparation of bodies for burial, and provide emotional and financial support, including funeral costs (see Story 7 in Annexe Two: Most significant change stories) and life skills training for children of women living with HIV, especially female children.

Tables 2 and 3 also provides an indication of the quality of the interventions and the extent to which the ethical practices of respect, recognition and reliance have been honoured in service provision and in the interactive spaces created by the project.

Table 3 shows the percentage of clients who were counselled and tested who returned for post test counselling and to receive their test results. This rises steadily from an already impressive 76 per cent in 2007, to 84 per cent in 2008, to 94 per cent in the first half of 2009.

Table 3: Percentage of clients tested who returned for their test results 2007-9

	FIRM	HST	Samraksha	Sangama	SIAAP	SWAM	WINS	Total
2007	88	69	>100	54	78	91	92	76
2008	95	68	100	72	92	96	97	84
2009	94	80	100	69.5	>100	100	83	94

These figures indicate a high degree of comfort and confidence in the centres and a high level of trust and faith in the service location and provider.

The field visits to each CVCTC+ provided support for this interpretation of the figures. The CVCTC+s promote safe spaces, solidarity and a sense of purpose. Each of the centres provides spaces and support for self-help groups. Each CVCTC+ has a drop-in centre. These create and strengthen self-esteem and a sense of self-worth and through this positive living takes centre stage. In the words of a community member: 'This is the place I know that I can be myself. I know it gives me confidence and strength to not only survive but to live a life.'

The project sought to be guided in carrying out this work by the principles of empowerment, participation, solidarity and capacity building. The practices arising from these principles are incompatible with abuses of power. They strengthen forms of power within and power together which are the forms of power required by the poor and marginalised in their daily lives, as well as to hold the HIV epidemic at bay. They challenge the fears that come from powerlessness and instil confidence.

Evaluation finding: The CVCTC+ create safe spaces and promote solidarity and a sense of purpose. These generate self esteem and self-worth whereby positive living takes centre stage.

Project Expected Result No. 2

The expected result within the Project Document is:

An effective alliance of 16 groups of target communities of PSW, GBT, PLHA and coalition members engaged in community mobilisation and advocacy at government, private and community levels to reduce stigma and discrimination.

The relevant objectively verifiable indicator of achievement of the specific objective of the project contained in the Log Frame was:

- Sixteen representative and functional groups of PSW, PLHA and GBT across project areas

The project document states: *Each member organization will facilitate the establishment of at least two networks/institutions of target communities in their own project areas.*

This benchmark needs to be understood in light of the founding principle of diversity in unity discussed above (section on the project implementing organisations). Each of the partner organisations of Sarvojana had a history of working with one or more groups of people impoverished or marginalised. But they did, and do, this in different ways.

Some have helped establish support groups: Sangama helped establish Sadane, a registered self-help group for people living with HIV, SWAM has helped two groups for MSM living with HIV be established, WINS a group for women living with HIV, Humsafar has formed three groups, a Safe Sailor Club of positive MSM and TG, Ashiyana of MSM and Asmita of TG, SIAAP two groups, one of women in sex work and the other of people living with HIV. FIRM has reported the promotion of 7 groups, three registered and four unregistered.

These groups provide a setting for sharing feelings, concerns and challenges and for mutual support. They accompany their members for treatment and care services in hostile environments, work to ensure responsive care in government hospitals and help mobilise communities.

Samraksha works closely with the people living with HIV in its programmes but its approach has been community-based. Rather than forming self-help groups, it works with entire villages, creating circles of shared confidentiality and involving them in improving the living conditions for people living with HIV.

INP+ is a community owned network of networks of positive people. In the districts in which it has worked under the project, it has worked towards building capacities

of network leaders particularly in advocacy areas. In one district this has led to establishment of ART centre in the district (Story 4 in the Most significant change stories Annexe). The networks encourage ART adherence, assists in issues of school admission for children of positive parents, and liaise with government hospitals for responsive treatment.

Thus formally the indicator of achievement has been met.

However the indicator itself is an inadequate measure of the expected result. The objective of the project went beyond the establishment of self-help groups. It was to strengthen the capacity of the self-help groups 'to set and enforce agendas that are relevant to their well-being' and to 'mainstream government support to these groups' (Section 1.5, Specific Objective). It was anticipated that these groups would form an 'effective alliance ... engaged in community mobilisation and advocacy ... to reduce stigma and discrimination' (Section 1.7, Ad. Result 2).

Evaluation finding: The project has created support and self-help groups with a sense of purpose and allowed them to grow organically rather than programmatically.

The three activities under this result in the project document relate to the stigma and discrimination so pervasively experienced by the communities of interest:

- A baseline survey to quantify the levels of stigma and discrimination experience by the communities of interest.
- Meetings of self-help groups to address cases of stigma and discrimination, educate the public and seek legal redress when necessary, and
- Advocating with government, private and community agencies for action against the stigma and discrimination experienced by the communities of interest.

These activities have been carried out. The baseline survey was carried out in 2006 and its findings were translated into local languages and were disseminated in workshops for government, private and community agencies in 2007.

Self-help and support groups for people living with HIV were established at each CVCTC+ and meet regularly. Community groups have also been established. These groups have been involved in addressing discrimination in the neighbourhood, engaging with the police and courts for protection of their rights, addressing stigma and discrimination in health-care settings and advocacy for change in policy and legislation. However it was reported to the evaluation team that there was a need to strengthen their capacities to undertake more concerted advocacy initiatives against stigma and discrimination.

The first combined network meeting, foreshadowed in the project document, was held in Chennai in 2008. Nineteen groups or people from differing poor and marginalised backgrounds met to discuss the things that they had in common. The

Report of the network meeting identified these issues as 'health, discrimination in hospital and other social setting, police violence, livelihood problems, concerns about their children'. The major decision taken at the meeting was to collect further evidence and to document specific cases of violations of human rights. These could then form the basis of an advocacy strategy to address stigma and discrimination.

The value of such meetings is captured in Story 3 in the Most significant change stories annexe:

Last year, [Durga] attended a meeting held by people from these 7 centers. She learnt that she was not alone. The meeting had brought together women like her, women from the mainstream community who were also positive, men who have sex with men. They sat together to discuss issues and the common thread was the stigma and discrimination they all faced in the health-care set up. They did not talk about the virus or transmission of the virus between individuals. But spoke about it in the context of people's lives.

This is a story of the importance of networks of solidarity and of how they can strengthen self esteem, conscientise and empower. It is a story of the claiming back of the right to life with dignity, the founding vision of Sarvojana (Story 8 in Annexe Two).

This Expected Result area addresses the ever-present stigma and discrimination experienced by the poor and marginalized, especially the HIV-affected poor and marginalized. In addition to the empowering of community members and groups to promote, demand and act for the rights and services they need, it also seeks, through advocacy at all levels, to 'mainstream the concerns' of the communities.

There have been advocacy successes in the area of stigma and discrimination at the national level. One of these has been the development of the HIV Bill which guarantees the legal rights of people living with HIV and other marginalized communities in India. Sarvojana, through its designated lead agency, INP+, assisted in the development of the Bill, organized public discussions and consultations on the Bill, and helped create the Tamil Nadu State Steering Committee (SSC) for the HIV Bill (See Story 8 in Annexe Three: Stories of change told during the Evaluation workshop).

Also at the national level, the sexual minorities' partners of the Sarvojana coalition, along with the member organisation of the The Integrated Network For Sexual Minorities (INFOSEM), Naz Foundation International and community leaders, developed a national strategy document titled "Evidence to Action". This document was submitted to NACO as part of an advocacy strategy for a rapid start up and scaling up of targeted interventions with MSM and TG (particularly Hijras) under NACP - Phase III.

The submitted document became the basis of the operational guidelines for MSM and TG in the NACP-III. Of particular importance is the adoption in the guidelines of the criteria developed by Humsafar to determine high risk behaviour among MSM community, namely:

- Percentage of consistent condom usage
- Number of partners in one month period
- Health seeking behaviour of the community
- Percentage of penetrative anal sex being practised in the community.

This means that, when seeking health services around STIs and HIV, same-sex-desiring men will not be questioned about their identity as gay, kothi, panthi, hijra, double decker etc., identities which are fluid rather than fixed in nature. Their risk will be assessed on the basis of their behaviour as defined by the criteria (See Stories 3 and 6 in Annexe Three: Stories of change told during the Evaluation workshop).

However, a number of the coalition partners felt that Sarvojana had been less successful in the area of stigma and discrimination at the local and State levels.

It is difficult to determine the accuracy of a claim such as this. The Report of the first combined network meeting states that, as foreseen in the project document: 'When the issues are of nature which needs appropriate actions, as in the case of violence by police, discrimination by neighbor or landlord, children are sent out of school, then action plan is drawn and where the support is required from other sources then they coordinate with the project officer who in turn advises about further course of action'. Story 5 in the Most significant change stories annexe is a story of the resort to the law to protect a group of women in sex work evicted from their homes in Calicut and Story 7 is a catalogue of local activism, advocacy and determination.

However, as the Mid-Term Internal Evaluation points out: 'The project appears not to be monitoring the promotion and functioning of these [self-help] groups as numbers of members, work done by the groups promoted, etc, were not readily available, even though in some areas, the groups appeared to be doing some remarkable work.' (p.13).

The Report goes on to recommend: 'The PMC may consider incorporating in its regular agenda a review of the functioning of the groups promoted, as these groups may have a major role to play in the continuation of the CVCTC services, either in the present form, or through adoption by governmental agencies of the services.'

The evaluation team supports this recommendation.

Evaluation finding: Sarvojana needs to become clearer on the roles it wishes these groups to play in dealing with individual cases of ill-treatment, injustice and the violation of rights, in educating the public on these matters, on creating a social justice based response to the HIV epidemic, and in advocacy at all levels.

Project Expected Result No. 3

The expected result within the Project Document is:

Improved quality of services available at government, private and community facilities for a continuum of care for HIV and AIDS prevention, treatment delivery, care and support for target communities.

The relevant objectively verifiable indicator of achievement of the specific objective of the project contained in the Log Frame was:

- Government agencies and other civil society organisations around the project area start/add to initiatives based on learning from CVCTC+ model and network processes.

Evaluation finding: It was not clear that the importance of this project area in improving the quality of life and well-being of the communities of interest has been reflected in project implementation. It may have been overshadowed by the focus on the CVCTC+s.

The Mid-Term Evaluation states: 'From the self-assessment reports, it was not clear whether each coalition partner had in place a set of identified local institutions that it wanted to influence, and a strategy in place to influence these, using the CVCTC and the local community organisations as change agents.' The evaluation team remained unclear about whether a network analysis had been undertaken to identify the key institutions on which each CVCTC+ wished to focus. Nor was it clear whether strategies to influence change had been developed. What was clear however was that change had occurred.

The project document introduces the concept of people living in the immediate environment of their communities of interest (PIE). It does not, however, specify the members of this group or elaborate on its importance. The concept refers to those in the immediate environment of the communities of interest whose attitudes and behaviours, norms and practices directly influence the quality of life and well-being of community members.

The people in the immediate environment (PIE) that project implementation focuses on are healthcare workers and other care providers. Stories abound of the intrusive, abusive and discriminatory treatment of the poor and marginalised in health-care settings. Most of the stories of significant change in Annexe Two relate to these forms of neglect and humiliation in care settings: stories 3, 4, 5, 7, 8, 9, and 10, for example.

However, many of the stories and reports also refer to a group of people in the immediate environment referred to in the literature as gatekeepers, a group usually in local positions of power and privilege which facilitate abuse (Jenkins 2003: 38-9).

The term is used to refer particularly to the police, but also to security men, thugs, gurus, politicians, religious leaders, and venue owners and staff where people work. The project document does not place particular emphasis on this group although its members are often responsible for acts of violence, extortion, harassment and other forms of abuse against community members.

Another group in the immediate environment of community members are their neighbours, local shopkeepers and traders, workmates, friends and families. The attitudes and behaviour of these social networks can affect community members' daily lives in ways that are a constant source of indignity and pain. The women in Story 9 talk of 'the pain caused by words, gestures or actions', and of how 'the world outside is unsympathetic and horrifying' (Annexe Two: Most significant change stories). The evaluation team heard many stories of community members, often men, estranged from their families, another source of pain and regret.

There are stories of good practice. Samraksha works with the local communities within which community members live, helping to strengthen bonds of respect and support. Story 8 (Annexe Two: Most significant change stories) tells of the engagement of whole communities in the struggles for right treatment, for compassion, to provide support and mobilise resources for those touched by the epidemic. SWAM carries out slum sensitisation programmes to reduce violence towards their members (Story 7). INP+ worked with village leaders on the personal and social impact of discriminating against people living with HIV (Story 4). There is much that can be learnt from this work.

One source of concern has been the question of how to reach out to the wives and women partners of the men who are sexually active with men. Community-based work in the areas where these men live could assist here.

Evaluation finding: Change in the immediate social environment is palpable and the persons in the immediate environment have demonstrated support to a great extent.

To improve the quality of HIV services in health-care facilities and other care settings requires a range of interventions. The project document states that 'past experience has shown that the best way to help care givers change discriminatory attitudes is to provide them with personal support, build professional skills, and deal concretely with their fears of acquiring HIV infection during work' (Section 1.6, (g) 3.1).

This requires the strengthening of practices of interrogating often deep seated beliefs and prejudices about poor and marginalised people which drive stigma and discrimination and which health-care workers share with others. It requires addressing the fear peculiar to HIV care settings, the fear, both irrational and rational, of iatrogenic transmission. It requires strengthening the care and treatment knowledge and practices of health-care workers and carers. Most of this applies also other people in the immediate environment, to gatekeepers, neighbours and families: the addressing of fear, of prejudice and stereotyping, knowledge about

protection from infection and about how to physically interact with people living with HIV. Each of these requires different approaches. Training courses and the development of training materials assist particularly where there are knowledge deficits relating to care and treatment.

Evaluation finding: All of the partners reported the training of health-care personnel, including laboratory technicians, counsellors, buddies and peers.

The mid-term evaluation found that tasks to be undertaken under the project in this regard appear to have been completed, although record keeping with respect to training content, participants and coverage has been less than adequate. Interestingly, however, most partners rated themselves poorly or modestly on this activity.

Data is not available on the venues of the training but the project document envisages that training would be more effective, not just in the transfer of information but in the processes of conscientisation, if these trainings were carried out in the CVCTC+s (Section 1.7, 3.1). It states:

Each member organization will conduct 8 training courses for care providers from other agencies, using the CVCTC+ as the hub for such training. ... The exposure to a center actively used by disadvantaged and hitherto marginalized communities is expected to add value to theoretical training usually provided. The huge numbers of people accessing services, the high levels of participation by local communities, and the supportive attitudes of CVCTC+ staff will help influence other agencies to change to more effective approaches.

Data required to verify this hypothesis have not been collected.

Addressing fear of transmission requires more than training. This is evidenced by the lack of compliance to Universal Infection Control Procedures in health-care facilities in general: protocols exist and staff are trained in their application. Safety in HIV care settings requires little more than the standard infection control procedures. Fear in HIV settings can lead to the refusal of services and to inadequate care of people living with HIV and to increased likelihood of infection amongst health-care workers.

The vignettes in Story 4 (Annexe Two: Most significant change stories), however, are stories of significant success in addressing such fears: of medical officers, of laboratory technicians, of their managers and others. It is important to note that it is possible that this impact came about because people living with HIV were involved in or carried out this training. Other stories testify to this also. It should also be noted that the equipment and supplies necessary to follow the infection control procedures were supplied as a result of the conscientisation of managers and staff in the training.

Evaluation finding: The project moved beyond the sensitisation of government providers to working with them towards improving the nature of service delivery, not withstanding the day to day challenges.

Data are not available on the role of the project in increasing access to post-exposure prophylaxis for health-care workers, nor on the monitoring of infection control in government hospitals in project areas, as envisaged in the project document (Section 1.7, 3.2).

The project document gives a central role to the self-help and community groups in achieving this project outcome. The members of these groups accompany people living with HIV for treatment and care services and work hard to ensure respectful and responsive behaviour in government hospitals.

Evaluation finding: The project has demonstrated community capacity in health promotion and the achievement of social justice.

The story, Attendant care for women, (Annexe Three), shows the complexity of the HIV care situation. It is a story at one level of individual courage, of how a woman, understanding from her own situation how often people were unable to access care because they did not have anyone to come with them to hospital to provide attendant care, was prepared to do this for others. It shows a self-help group prepared to be attendant carers for each other. It illustrates the important role of the partner organisations in helping people think through and find ways through their problems. But beyond compassion and solidarity, it shows the insidiousness of poverty in people's daily lives and how it affects HIV care.

Evaluation finding: The establishment of the CVCTC+s has fostered community feeling, community formation, community self organizing, and community organisational development.

An area of good practice that emerged in the course of the evaluation was the insistence of the partners on ethical principles and practices in HIV testing, treatment, care and support and their willingness to act to defend these principles.

Two stories provide important testimony to this although there are others: the story on ethical testing practices and the story of resisting presumptive STI treatment for poor and marginalised groups (Annex Three). The first is a story of violations of national guidelines for HIV counselling and testing, of the ways that evidence was collected and of the action and advocacy taken in response. The second is a story of resisting the imposition of strategies that deny understanding and agency to the poor and marginalised in pursuit of a medical objective for which the evidence is disputable.

Issues arising in the course of Project implementation

Community ownership, sustainability and replicability

The phrase 'replicable models of CVCTC+' does not appear in the project document/Grant Application Form. The words occur in the 2004 Log Frame. The project document describes as the reason for the selection of this project activity (section 1.6 (g) 1.1):

This activity was chosen in order to encourage community ownership of project activities and increase access of target communities to equitable HIV & AIDS prevention and care resources. Currently all counselling, testing and care services are based at government hospitals, where caregivers are often prejudiced against target communities and discriminate against them. Also, the hospitals are usually in urban towns or cities and difficult to access by many people because of distance, time and cost factors.

Thus, in the project document, rather than being established as replicable models, CVCTC+s were established to encourage community ownership and to increase the access of community members to HIV services.

Evaluation finding: On indicators used to measure increased community ownership the project has succeeded: increased usage of services by community members, increased trust of the centres and staff, community members trained as staff, participation by community members in decision making relating to the centres, community members consulted and involved in centre activities, community members on the governance structures.

Some of the Sarvojana partners are engaged in a process of building the capacity of the community members to staff and manage the CVCTC+. Some are involved in building a partnership within which the community and the organisation together run the centre and its services. Some are involved in working closely with communities of interest. All of these can be empowering process for the communities involved. Each of these approaches has led to community empowerment.

Evaluation finding: The basis of project success in the area of community empowerment has been practices of giving respect and dignity to marginalized populations.

This is an important finding which is backed up by the literature from India and elsewhere on social transformation and HIV (Cornish 2009, Campbell and Gibbs 2009, Jenkins 2000, Jana and Banerjee 1999). The Sonagachi project, run by the sex workers' collective Durbar Mahila Samanwaya Committee (DMSC), in Kolkata, is well documented. DMSC base their work on the 3Rs: Respect, Recognition and Reliance. That is, respect of, in this case, women in sex work and their profession; recognising

their profession and their rights; and reliance on their understanding and capacities. By basing their work on the 3Rs, they address the empowerment and priorities of the women.

Sangram, the NGO which supports the Maharashtra-based sex worker collective, VAMP, uses the question: 'Does this activity further women's empowerment?' as a guide to decision making (Cornish 2009: 129).

Such practices lead to different processes, activities and outcomes from an intervention based on HIV-related medical or interventionist paradigms. Although these organisations have been funded to do HIV prevention, their fundamental commitment and programme focus, as with Sarvojana members, is to the empowerment of their communities of interest.

This understanding has led to different measurements of success, different programme strategies, from more interventionist HIV models.

Priority has been given to the challenging of internalised stigma and discrimination as a first step in addressing injustice. Extensive training is undertaken to stimulate processes of conscientisation and to strengthen self esteem and solidarity (Sangram 2007). Empowerment is understood to be unachievable for as long as community members internalised society's view of them and their profession.

Secondly, empowerment is built into organisational development. Participatory, inclusive, and transparent processes are used in the development of peer outreach programs, advocacy strategies and in the involvement of community members in decision making and programme management. These processes posit community members as active and competent agents, capable not only of taking control of their lives but also of being involved in and running their groups and organisations.

Similar practices of respect and recognition have been implemented by Sarvojana members. The evaluation team was struck by the range of respectful practices that it saw as standard procedures in its field visits: habits of constant translation to ensure that community members could follow and contribute to discussions, seating arrangements, discussions and presentations led by community members, the refusal of hierarchies and other expressions of power, privilege and status, practices of praising, and many more.

Evaluation finding: HIV objectives relating to coverage, distribution of condoms, access to services, and others, can be achieved and exceeded in spaces where respect and empowerment are the objective and the practice.

Replicability and sustainability

The questions of the replicability and sustainability of the CVCTC+s have been raised throughout project implementation and seen as a design flaw in the project.

Both concepts, replicability and sustainability, may be interpreted in a number of ways. Replicability has sometimes seemed to be interpreted in a turn-key project manner: Has the project created a model that can be set up elsewhere?

The project document, however, talks of the centres 'influencing' others health-care providers and facilities to provide effective and courteous care and treatment to poor and marginalised populations. This is another meaning of replicability where it is not the model/structure but the approach to care and treatment which is to be replicated.

Replicability in the first sense underestimates the extent to which such centres are built on traditions of service and solidarity with the poor and marginalised and on the passionate commitment to social justice of those involved. These traditions and passions cannot be replicated within a project framework.

It is in the second sense of replicability that the project has shown itself to be replicable. This is the sense of replicability used in the indicator of achievement for Expected Result 3 of the project. The evaluation has found that the project has shown that this is a viable approach.

Evaluation finding: The project has been successful to a certain extent in influencing the nature of services in the local environment to their communities of interest but this is an unfinished agenda. It has also been successful in influencing the nature of HIV-related services in the country in general but this too is an unfinished agenda.

Sustainability also has a number of interpretations in the life of the project. One has been that the centres are to be taken over by government after the life of the project. The sustainability of the CVCTC+ centres might be assured if government were to take them over and run them. There is a good discussion of the implications of this in the EU Mission Report of 30 August 2007. It is rightly pointed out that, if so, this should have been negotiated in the project design. The tensions inherent in transferring centres committed to community participation, holistic service provision and social support to a bureaucratically based system would probably undermine the possibility of sustainability of the centres as developed under the project.

Another sense of sustainability is that the access of community members in a respectful environment to the services needed is sustained after the life of the project. This could be achieved through 'finding a new home' for the services provided, or some of them, or by ensuring that the services needed are provided by other facilities in the neighbourhood. The EU Mission Report of 27 January 2009 provides a helpful case study of Humsafar's partnership strategy in which it has established close working relationships with a network of service-providing organisations, public, private, faith-based and voluntary. This has increased access for Humsafar's communities of interest to a larger and varied complex of service providers.

Another possibility is that the centres generate revenue for their continuance after the project funding ceases through fund raising campaigns and activities. The Report of the Sarvojana first network meeting (2008) states:

In one centre two income generating programmes are organized. One is chocolate condom machine, secondly by offering STI screening at lesser rate than commercial labs. When they buy the kits at wholesale and due to availability of lab technician's services they are able to generate good income.

Whilst small scale, the example shows that some thought has been given to revenue generation for the centre.

User-pay fees have been canvassed as a possibility. However, the literature on user-pay fees indicates the inherent problems of introducing them in situations of deprivation and economic impoverishment.

The evaluation team has also questioned an imperative of sustainability, in the sense of requiring the continued existence of the CVCTC+s. The longer term strategy inherent in the project design seems to be that the centres show the possibility of appropriate and empowering service provision to poor and marginalised populations whilst at the same time strengthening the capacity of other facilities to provide similar care. If successful, the continuation of the centres themselves may be desirable but is not essential.

Evaluation finding: The centres are a valuable addition to the topography of health-care provision to poor and marginalised communities and that they have increased and improved access to needed services by the members of these communities. Their continuation depends as much on the continuing passion and commitment of those involved as on funding. There is a continuing need to ensure that services sought by community members are provided with care and without stigma and discrimination, wherever these services be provided.

Another sense of sustainability that has developed is in terms of the sustainability of the changes the community groups have experienced, in the way the larger community perceives them, reacts to them and views their participation in the social and political life of the community. In this sense of sustainability, it is the sustainability of these changes that is involved and the continued existence of the centres one way of supporting this.

Evaluation finding: The project has contributed significantly to bringing about changes in the ways members of poor and marginalised groups are viewed by their communities.

However, lessons learned, from social change in this area and with respect to gender, are that recidivism is a constant companion. These changes become sites of continuing struggle and contestation.

Gender

Evaluation finding: Gender sensitivity and competency are defining qualities of Sarvojana, stronger in some members than in others.

Gender is often theorised as a marker of difference in which the masculine is privileged. Working with poor and marginalised communities, however, has led Sarvojana members to challenge binary approaches to theorising gender, and sexuality. Gender expression in the communities of interest is diverse and fluid, changing in space and time. SWAM has created safe boundary-crossing spaces, spaces into which people may come with one gendered identity, as men, and stay or leave as women, changing back to return to their families or to go to other spaces.

Gender sensitivity in Sarvojana members shows itself in practices of respect and of resistance to abusive forms of power. WINS has created a safe space where widows can wear brightly coloured saris and put flowers in their hair and laugh with each other, a space from which they can go out into the world with confidence and self esteem. This is a repudiation of forms of social coercion.

Evaluation finding: The understanding and acceptance of gendered fluidity and diversity does not stretch to its statistics. Data are still disaggregated into binary categories and it is unclear, for example, where data on transgendered people are categorised.

Some interesting gendered insights have been gained from project implementation. Women often feel at ease in spaces created for marginalised groups, especially same-sex-desiring men and transgender people. This references the different power dynamics of these spaces and throws light on how women experience spaces where the sexual and gender dynamics are abusive or carry the threat of abuse.

Samraksha has shown that women tend to seek services close to their homes while men may often travel to more distant facilities, particularly if they feel shame or estrangement.

Both of these gendered insights have programme ramifications.

Women in management positions of networks of people living with HIV experience the same forms of discrimination and silencing as women in other organisational structures. This is well documented in the conflict mediation reports. It may also occur in other settings and meetings and in representation and participation. Operating guidelines need to be developed to minimise its occurrence.

Where Sarvojana members work with gender and sexual diversity, strong bonds of friendship and of solidarity have sprung up across these lines: men teaching women how to dance and to make themselves up; each protecting the other from threats of abuse or violence; small acts of kindness, shopping or running errands, for example.

Again these are spaces where power dynamics flow, form, re-form and emerge in differently gendered and sexualised ways and patterns.

Sangama and Samraksha both work with these diversities bringing their various communities' members into the same space and time and so strengthening bonding social capital amongst the various groups.

Project Expected Result No. 4

The relevant expected result within the Project Document is:

- The effective functioning of an umbrella organisation established with the objective to build capacity of coalition members to cooperate and manage future projects in this area.

Evaluation finding: This outcome has been achieved. The Project Management Committee fulfils this function and fulfils it effectively.

The Project Management Committee consists of senior representatives of each of the 8 collaborating agencies. The secretariat for the project is hosted by SIAAP, Chennai, which is where the Project Coordinator and accounts team are based.

The Sarvojana Mid-term Internal Evaluation Report notes that the PMC has “conducted itself with dignity despite facing some very challenging issues of coalition. Some of the PMC representatives are person of extraordinary skill, commitment, and repute, and have years of experience in governance and management issues”.

The principle of balancing respect for the autonomy and identity of the participating organisations with the practices of collaboration and joint programming placed significant responsibility on the Project Management Committee to manage these disparate but yet unified organisations and posed challenges to the Project Implementation System. These responsibilities and challenges have been well met.

The commitment of the coalition members can be seen in their willingness to invest significant time from demanding schedules to project management and oversight: PMC meetings of two to three days, organisational exchanges, joint visits to each other’s organisations, joint campaigns and more.

PMC meetings have been held regularly: 4 in 2006, 5 in 2007, 3 in 2008. The agendas of the meetings are circulated in advance and each member organisation can contribute further items. The meeting minutes are prepared and circulated in draft form for comments. Management information systems are in place. Financial and programme reporting is done in a timely manner.

Within the coalition, each member has strengths and weaknesses, be it with respect to good governance, good connections with government, good connections with community, strengths in conceptualising, in proposal writing, good reality checks. It was felt that the whole had become greater than its parts: “As a coalition, we gain in these strengths”.

Evaluation finding: The processes put in place to manage the conflicts that have arisen within the coalition have been based on an understanding of good practice in conflict negotiation and resolution. They have been effective and have strengthened the mutual respect of coalition members and their ability to cooperate.

Evaluation finding: The Sarvojana Mid-term Internal Evaluation Report and the Evaluation Workshop identify some issues of continuing concern in the quest for good governance:

- the need for a conflict resolution mechanism outside of the regular PMC meetings, perhaps a sub-committee of the PMC, to ensure that other agenda items for the PMC are adequately addressed
- the need for continuity of representation on the PMC and representation at senior level, and
- the inadequacy of the transfer of the vision of the coalition and of project approaches and components to new PMC members.

These will need to be addressed.

Evaluation finding: The tools and indicators used to capture outcomes, in particular the Project Logframe and its associated Management Information System, have not been adequate to capture the way the coalition works and its achievements.

Quantitative indicators have a place in project management. However, the question must be asked of each one proposed: What does it tell us? This practice does not seem to have been followed.

The predominance of quantitative tools in systems established by NACO and by the donor community leads to an inability to capture and record the richness of diversity, the frailty and vibrancy of human interactions, the ethical predicaments, the practical exigencies of living on the margins of a society and the intersecting disadvantages of gender, HIV, poverty and violence. Subtlety and nuance is lost; stories are not collected and mined for insights; life beyond the indicator categories is not valued.

It is important to establish systems of documentation, reflection, monitoring, and review/evaluation for the coalition and its activities that better reflect its values and practices. Where a theory of change guides social change work, the documentation of complex changes and outcomes is shaped by the understanding of how change comes about which is contained in the theory.

Coalition Identified Outcomes: The aspirational domains of change

An extensive discussion of the purpose of the coalition, as distinct from the project, identified six core domains of change for the coalition:

- Ways of working together with respect and integrity
- Shared learning and mutual support
- Giving voice and agency to community
- Advocating issues of marginalised communities
- Creating spaces of diversity and courage in action
- Politics and ethics of HIV work.

These domains were considered to reflect the vision of the coalition and to capture the purpose for which the member organisations come together. They therefore constituted a set of agreed outcome areas through which the coalition reflected on progress made as a coalition in the context of the evaluation.

Each member present was asked, in advance of the meeting, to identify the most significant change that they considered the coalition had contributed to bringing about. The stories were written before the coalition members had reflected on the difference between the coalition and the project. Consequently some of the stories relate to project outcomes rather than coalition outcomes. The stories of change are in Annexe Two.

During the Workshop, the coalition members were asked to read the stories and to assign each story to one of the above six core domains of change for the coalition. After reflection and discussion, the stories were assigned as follows:

Core domains	Stories
Coalition	
A. Shared learning and mutual support	9, 12
B. Ways of working with respect and integrity	1, 2, 6, 11
C. Giving voice to community and agency to community	3, 8, 10
D. Advocating issues of marginalized communities	
E. Creating spaces of diversity and courage in action	5
F. Politics and ethics of funding	
Project	
G. Other / change brought about by the project (for report on project)	4, 7

Four of the stories were thought to be about ways of working as a coalition with respect and integrity (1, 2, 6 & 11), three about giving voice and agency to

community (3, 8 & 10), two about shared learning and mutual support within the coalition (9 & 12) and one about creating spaces of diversity and courage in action (5). Two other stories (4 & 7) were considered to be stories of change brought about by the project rather than the coalition.

The coalition members were also asked to choose the four stories of change brought about by the coalition that they considered to be the most significant of the set of ten stories. Their choices were as follows:

Stories	1	2	3	5	6	8	9	10	11	12
Choices	--	3	11	7	4	6	2	3	6	--

The stories ranked in order of significance to the coalition members were 3, 5, and 8 and 11. The first was a story of personal empowerment and growth through association with the service values of the project. This drew the woman into the centre and, through her engagement with the centre, she was chosen to attend a meeting of people drawn from all the communities of interest covered by the project.

This meeting came about through the commitment of the coalition members to giving voice and agency to their communities and led to the establishment of networks of solidarity and mutual learning. The insight and courage of the coalition in bringing together people from different marginalised communities to sit together and gather strength from each other led to significant cross-community empowerment.

The second ranked story was of a situation in which the moral and financial help of the coalition gave a member organisation the courage to fight two cases of stigma and discrimination, one concerning a group of women in sex work illegally ejected from their homes, the other a person living with HIV refused medical care. In this way the coalition had created space for courage in action.

The third story was of processes of community empowerment through discussion, advocacy and activism, in one case the community of people living with HIV, in the other, a village community. The valuing of the exchange of stories of such changes amongst consortium members in turn led to the deepening of insights and understanding in the coalition.

The fourth story was about the coalition itself, its history and its core values. It is a story of the aspirations that brought the coalition into existence, of the growing in maturity of the coalition, of learning to work together for a common cause and of learning to see things from the points of view of others and, hence, of strength in diversity.

The discussion of these stories and the general discussion in the workshop elicited further stories of significant change for which the coalition had been a lead agency or to which it had significantly contributed. Many of these stories and other stories of activism and change were written up during the workshop and are in Annexe Three.

Some of these were stories about the politics and ethics of HIV work:

- The lead role of a coalition member in preparation of a national advocacy strategy and strategy document for sexual minorities entitled “Evidence to Action” which was adopted in the operational guidelines for MSM and TG in the NACP Phase III. This work was in response to a perceived lack of understanding of sexual minorities and their communities and the resultant intrusive, disrespectful and undignified practices of government figures and other figures of power (story 3).
- Evidence-informed advocacy against unethical and ineffective policies and practices of presumptive STI treatment of marginalised communities (story 4)
- Joint action and evidence based advocacy against unethical HIV testing practices, especially in marginalised groups (story 2).

Some were stories of advocating issues faced by marginalised communities:

- The action campaign developed nationally and in Tamil Nadu to create awareness about the draft HIV bill which guarantees the legal rights of people living with HIV and other marginalised communities across India (story 8).
- Stories of the development of local-level linkages to increase access to HIV and related services, through the training and equipping of service personnel, and through the strengthening of processes of community ownership (story 7).

There were stories of giving voice and agency to communities:

- Through addressing power relations in Hijra communities: “My house is going to be a care centre for all Hijras living with HIV thrown out by their guru. But I can take in only 30 people. I want to motivate other gurus to also take Hijras living with HIV.”
- Of how the insights of an illiterate HIV infected widow when supported by a member organisation became the basis of an attendant care programme for income poor but altruism rich women (story 1).

What became clear during the discussion was that stories such as these were often not captured and recorded by the coalition. They were not being documented, shared, analysed, used in advocacy and research, used in results based or other reporting systems, or used to understand how change comes about and how it can be brought about in more effective and timely ways. The stories told and captured during the workshop shows what a loss this is.

Lessons learned as a member of the coalition

In preparation for the workshop, Coalition members were asked what they thought were some of the more important lessons that they had learnt since becoming a member of the coalition. The answers highlighted lessons relating to conflict resolution, the need to nurture the coalition, coalition governance, local and national constituency building, evidence building and advocacy.

The theme of exploring lessons learned was continued in the Evaluation Workshop with discussion of the following more specific questions:

- What lessons were learned about working together, about being a coalition?
- What practices, ways of working together could be further strengthened?
and
- Has the coalition developed a learning culture, developed as a learning organisation?

Lessons learned about working together

Most of the lessons identified related to the coalition's ways of working together, lessons about coming together across differences to work as a coalition. The constant themes included the following.

Coalitions give rise to tensions and conflicts and need the ability to talk things through: Many of the lessons identified related to the handling and resolution of conflict amongst coalition members.

The mature ways in which the coalition worked through differences, tensions and conflicts were evidenced in the space and time given to listening, reflecting and responding with tolerance and patience. One lesson clearly learned was: "Differences should be addressed right in the beginning, lest they sap the energy and time of all concerned." The importance of having an agreed Code of Conduct and a PMC policy in creating a respectful space for dialogue was noted.

The "patience and processes" in the coalition for addressing differences and conflicts amongst partner organisations were considered to have been effective and sources of learning for its members.

The need to nurture the coalition: The cohesiveness of the coalition across differences was felt to arise from the reserves of mutual respect and trust that it had built up along with a sense of a common purpose or vision. These qualities meant that there was not a competitive spirit among the coalition members or between

them and their communities. It was acknowledged that these qualities need to be cared for and cultivated: a coalition “of this stature needs a lot of nurturing”.

In particular, its visionary and aspirational core needs to be nourished and passed on to others, especially project staff: “The PMC is a passionate and committed set of individuals. However, the follow-up of PMC decision was rather a slow and tedious process and thus the project outputs that could be stronger got a little diluted and lost in translation from the visionaries to the project officers.” The coalition needs to give thought to how all involved, including project implementers and their partners, can be imbued with the vision and principles of the work.

For the PMC members, this nurturing has been contributed to in many ways: through joint technical activities, such as the development of a joint Management Information System against which their individual and collective performance can be measured, through an openness to learn from each other and to seek advice from each other, an example given was the giving out of test results on the same day as the test, and through the recognition of the importance of spending time together.

It was acknowledged that when the coalition works well together, its collective voice is much stronger: “Mutual support leads to concerted resistance to unethical practices and bold advocacy.” It also increases the collective strength of its community members.

The importance of governance mechanisms and procedures for the coalition: A number of lessons relating to the governance of the coalition were identified: the need for a proper structure to govern the coalition, the need for formal leadership, meeting agendas which provide time for discussion of coalition matters, continuity and seniority of participation, rotation of meetings, transparency and accountability, and a shared understanding of their vision.

The importance to the good functioning of the coalition of the nomination of a lead agency was emphasised and the competency and courtesy with which SIAAP played this role was much appreciated.

It was felt that the coalition functioned as the “keeper of conscience for all of its members.” There is a need for a mechanism to deal with situations in which there is point of departure from shared values or where coalition decisions differ from those taken by the Board of a member organisation. However it needs to do this in ways that safeguard the autonomy of individual members.

The power of respectful partnerships between donors and recipient organisations: One of the important lessons identified was how a respectful, flexible and facilitating stance in donor agencies can increase effectiveness and bring about pride in a collective achievement. HIVOS and the European Union were praised for their supportive role in working with the coalition to achieve its goals, for their willingness

to talk things through and to listen to different points of view, for their understanding of capacity building and of activism.

For a coalition which was stimulated into existence in part at least through concern about the imposition of external, donor-driven agendas, through perceived unethical practices and behaviours on the part of some donors, and the lack of respectful dialogue and trust between donors and their recipient organisations, this was an important learning experience.

For HIVOS also, it was a learning experience. From the start, they recognised the importance of different actors and organisations working together but they had no experience of similar coalitions of diversity. The journey together had demonstrated that it was not easy but it was possible and enriching for all involved. With continuing dialogue, reflection, the honouring of principles of respect, mutual support and learning from each other, such coalitions can come out much stronger.

Areas for further strengthening as a coalition

Activism: It was acknowledged that the coalition had an activist role and that this helped to strengthen and unify the coalition and at the same time increased the bargaining capacity of communities and helped address their issues. It was stated that even if the Project were not there, the coalition should be.

However, some members consider that not enough has been done to address local-level issues of stigma and discrimination, of indignities, violence and neglect, some examples of which are outlined in Story 7 of the Most Significant Change stories in the Annexe. Some feel the coalition has dealt more in words than action: “The PMC talks but nothing gets done. Perhaps we need a rapid deployment force/response. The story of Sarvojana could be a story of little actions”.

It was felt by some that the findings of the Stigma and Discrimination Study had not been used to develop an advocacy and action agenda and that procedures were needed to ensure that future advocacy and activism agendas were grounded in the realities being experienced by their communities of interest.

The Stigma and Discrimination Study looked largely at local situations of stigma and discrimination and most coalition members have addressed this at a local-level, and done so in a fairly effective manner. This had included local action in the area of refusal to treat in public health services, segregation within families or communities, exclusion from social participation and discrimination at the workplace.

At the systems level in health-care and amongst public servants, however, prejudices and bureaucratic habits have proven to be deep rooted and may need to be addressed on a more continuous basis. At the national level especially related to interpretation of programme into policy more may need to be done.

Creating strength through solidarity: The work of the coalition has shown that “marginalized groups can come together to address their issues together”. However, at least one member felt that the developing sensitivity and understanding of strength in diversity within its organisation had not been transferred to the communities it worked with: women in sex work, sexuality minorities, people living with HIV and women vulnerable to HIV. “Membership in the coalition has brought an understanding of the [importance of the] coming together of these communities not only on advocacy issues but in everyday life” but this coming together, it felt, was still to be strengthened amongst its communities of interest.

However, it was clear that the recent workshop that brought together different communities created and strengthened these bonds of solidarity and support, as Story 3 shows.

Evidence building: It was agreed that the coalition needed to build its evidence base, a base that not only sought to identify problems and transgressions but also recorded effective responses, acts of goodness, stories of change. Time and time again members mentioned: “the need for evidence building: documentation, documentation, documentation! Not there yet, though!”

Documentation and evidence building requires communication: email lists, a Sarvojana web site, blogs, discussion groups, can all contribute to the strengthening of communication and the sharing of insights and innovations.

A commitment was made to the collection of stories of change and their discussion at coalition meetings.

Advocacy: There is consensus that not enough has been done to develop a strategic advocacy agenda: “While some [of the PMC representatives] have extraordinary skills and experience in advocacy, and were applying these in their own organisational work, there did not appear to be any concerted joint advocacy action by the coalition, as anticipated during project formulation.” (Report of the Sarvojana Mid-term Evaluation 2008: 25). During the workshop, it was agreed that advocacy at all levels needed “much more strategic concerted thinking and action” by the coalition.

There needs to be a deeper understanding of what advocacy is. Often in documents of the coalition, advocacy is defined as influencing legislation and policies yet, as stated in the workshop, “Advocacy does not just have one face. There are different styles, different needs, different responses”.

The coalition has approached its advocacy work in different ways: assigning lead agency to INP+ with respect to the HIV Bill; joint advocacy of interested members on the rights of sexual minorities; and, coalition backed advocacy when it is agreed that one member will speak in the voice of the coalition. The advocacy has been at many levels: local, state and national. Where it has been least organised is in speaking with one voice on issues of deep concern to it.

There is a wide variety of different advocacy definitions, approaches and strategies: policy advocacy, social justice advocacy, feminist advocacy, people-centred advocacy. Advocacy strategies concerned with empowerment, citizenship, rights and ethical practices differ from those that focus on policy or legislative reform. Different advocacy strategies embody different values, political views and goals. They reflect different assumptions about how politics and power operate and how change happens.

The coalition needs to reflect on what advocacy is for them, its links to activism, and reach a common understanding to guide its advocacy and activism planning.

Visibility: Related to this is the feeling amongst coalition members that the coalition has lacked visibility. Visibility, it was felt, not only helps achieve advocacy and evidence sharing ends but is also protective for coalition members and their communities of interest. It provides transactional power, the power of collective bargaining, and creates influence. It reinforces the values and vision that gave rise to the coalition.

Some ways of achieving visibility were suggested, for example, the convening of workshops under the Sarvojana banner for disseminating good practices, for discussing ethical issues, and similar.

Understanding the relationship between poverty and the work of the coalition:

Time and time again in the stories of change and the stories told during the workshop, the impact of the work of the coalition on challenging HIV-related poverty was touched on. However, these insights and achievements have not been drawn together into a narrative. Ownership, diversity, reach and innovation were recurring themes, in the workshop and in the documentation, but not poverty.

Yet many of the stories written and told through the workshop were stories of the safeguarding of the incomes of the income-poor and improving the quality of their lives. This was achieved through lessening the time away for treatment, through making testing and treatment more accessible and thereby lessening the loss of wages and money spent on travel, food, accommodation, etc., through simple payment schemes for attendant care, through protecting community members rights to shelter and livelihood, through lessening violence and its social, psychological and economic costs.

The contribution of the work of the coalition to challenging poverty becomes even more significant when poverty is understood in terms of lack of opportunities, capabilities and freedoms. Such understanding includes how violence and discrimination around sexuality can intensify poverty, how sexual autonomy and the expression of sexuality can contribute to well-being, how respect and dignity can motivate people to protect themselves from HIV.

It could strengthen the work of the coalition to reflect more deeply on how poverty, HIV and sexuality intersect, not only in terms of sexual exploitation, violence and ill health, but also in the norms, social rules, economic and legal structures that regulate people's lives, mainstreaming and rewarding some people, marginalising others.

This would help it to see patterns and structures upon which it could build to develop a theoretical basis for its work. Recent publications in this area could be of help (Boesten 2009, Correa and Jolly 2008).

The learning culture of the coalition

The coalition was deemed to have a collegial learning culture, a culture in which members had been able to learn what not to do as well as what to do. There was a depth of acceptance of each other that made possible the discussion of mistakes as well as successes.

The coalition was an important forum for learning from each other and sharing innovative ideas and strategies. Many examples were given where organisations had learnt from each other, where good practices had been shared, where counsel had been sought about how to handle difficult experiences and troubling problems. When difficulties had arisen at field level, members had called each other and asked for advice. Cross-organisational visits and peer reviews had affirmed and strengthened this learning culture: “Sharing of knowledge has percolated and the exchange of technical resources among partners has strengthened individual resource bases”.

It was felt that it was important to continue to create opportunities when members could learn from each other, times of reflection and free-flowing discussion in which linkages could be made, understandings deepened.

One example of such a space being created was drawn from the context of the Evaluation Workshop. It arose when the Humsafar participant expressed concern about the number of suicides amongst transgender persons in their community. When reflecting aloud on why this might be, the point was made that many of those who committed suicide were in abusive relationships, relationships in which they had been beaten, betrayed and used.

This reflection led to a discussion of possible parallels with work that Samraksha is planning on reducing violence against women within marriage. The oppressive nature of violence against women in marriage is one of the key factors in women’s risk of contracting HIV. It systematically strips women of dignity, destroys their confidence, and agency to take control of their lives. Similar forces are at work in the lives of transgender people.

Samraksha is developing a strategy to engage men and women in constructive as well as confrontational processes to build perspectives on marital relations, gender power inequities and violence. This was shared in the workshop and its possible relevance to the situation of transgendered people discussed. Future insights and strategies could contribute to cross organisational learning.

The strength of the learning culture was evident during the Evaluation Workshop. The facilitators were repeatedly impressed by how intensely thoughtful the meeting was, by how, even when differences ran deep, members continued to listen respectfully to each other, despite differences, by how members supported each

other to understand points made, to move through blockages and by the depth of the commitment of each member to their communities of interest. These are striking reflective practices and practices of respect without which a learning culture cannot thrive.

In this respect also, the coalition showed itself to be values based and values driven. It showed itself to be, in the words of a member, “a coalition of like minded organisations upholding principles of respect, dignity, openness to others, compassion and ethical practice”. These are the pre-conditions for a learning culture.

Sarvojana and the Paris Declaration on Aid Effectiveness

The coalition and its 'non-negotiables'

It was suggested during the evaluation workshop that the coalition should give thought to what it considered to be non-negotiable in its dealings with donors, governments and others, what for it were basic principles that needed to be honoured.

A valuable and spontaneous discussion identified a number of areas for consideration. These are listed in the order of the discussion rather than of importance or logic:

- That the interests of their communities of interest are paramount and must not be overridden by external impositions.
- That members must have the freedom to implement their own agenda.
- That there must be partnerships of equals with donor agencies and others, based on mutual trust and respect and allowing space for consensus building and negotiation.
- That procurement restrictions which are not cost effective or ethical should not be imposed (travel, drugs, etc.).
- The intellectual property of members should not be appropriated; there should be joint intellectual property ownership. Overriding this is the requirement that the urgency of developing effective responses to the HIV epidemic requires that all HIV documents should be in the public domain.
- Disbursements must be made in a timely fashion.
- There should be a single reporting system for all donors.
- Reporting requirements and other paper work should not be unnecessarily and unethically burdensome. It was pointed out often data collection was a form of covert or disguised research and often hinders the interpersonal dynamics essential for effective interactions.
- Ethical guidelines for social research need to be further developed along with ethical guidelines for project visits and missions by partners, government officials and others. Guidelines prepared elsewhere (for example by the Poro Sapot Project of Save the Children in PNG) could serve as a reference.
- The integrity of proposals submitted for funding needs to be honoured. Cherry picking of proposals/the selecting of some parts only for funding is unacceptable.
- Reporting systems appropriate to the project should be developed. In particular, for complex social change, documenting and reporting systems should include qualitative accounts as well as quantitative measures.

Further work is needed to refine these principles. Most of them fall within the spirit of the Paris Declaration on Aid Effectiveness although some of them might need to be argued.

The 2005 Paris Declaration on Aid Effectiveness

The 2005 Paris Declaration on Aid Effectiveness laid out a number of donor and recipient partnership commitments which should govern how aid is designed, delivered and managed and accounted for:

- Ownership: recipient partners take the lead in setting the agenda
- Alignment: donor partners base their support on recipient partners' strategies and systems
- Harmonisation: donor partners coordinate their activities and ensure they are transparent and effective
- Managing for results: partners manage the resources and improve decision making to achieve results, and
- Mutual accountability: partners are accountable to each other for progress and achieving results.

Whilst this was not a focus of the evaluation and was not referenced in its terms of reference, it is clear that every attempt has been made to honour these commitments in the partnership between Sarvojana, HIVOS and the European Union.

However a number of tensions or contradictions have arisen which it could be productive to consider.

Ownership: The EU has Visibility Guidelines on the basis of which its staff have required Sarvojana members to ensure the visibility of the EU funding, even to the extent of requiring the acknowledgement to be made in local languages.

However, in the aid partnership, all involved bring experience and capacities to the common endeavour. Some members feel that these visibility requirements favour the funders over the implementers in attributing provenance or success.

Humsafar, for example, have as an organisational priority the desire to have all staff feel that they are a part of Humsafar rather than in some vertically funded donor programme or another. They promote the Humsafar identity, discourage staff from referring to themselves as working in a particular project funded by a particular donor. This is true also of other Sarvojana members. They are aware that donors are uncomfortable with this but work from their own principles.

Ownership and alignment: Sarvojana members have a long history of reflective practice and effective responses to the HIV epidemic and extensive experience working with their communities of interest.

For donors to work in partnership with such organisations requires an openness to learning and humility. The Paris Declaration sites ownership with the recipient organisation and requires alignment of the donor organisation to the recipient agenda and strategies.

This makes proper reporting by the recipient organisations an imperative. This has been honoured by Sarvojana in their annual technical reports and in other reporting documents and interactions.

It also places the onus on the donor to eschew the role of expert in favour of a more reflective, interactive and exploratory discourse. This is a difficult task but important to do well if a partnership of equals is to be maintained.

Managing for results: The Paris Declaration places responsibility with both donor and recipient to ensure that the resources are used transparently and effectively and that the agreed outcomes are achieved. Most donors use a Logical Framework Approach for managing for results.

This approach is characterised by a logic of direct causality and attribution in which four levels – activities, outputs, outcomes and results – are linked by direct causal relations.

There is no agreed approach which provides an alternative to log frames for measuring the effectiveness of development assistance. Unfortunately the simple linear causality of this approach is less relevant to the management of complex projects in complex social systems, such as Sarvojana. Further this framework favours quantitative indicators of success. Again, such indicators are often inadequate to adequately capture outcomes or impact or to improve decision making in complex situations.

Evaluation finding: A log-frame approach needs to be combined with other approaches more able to capture and measure subtlety in complexity and to contribute to a deeper understanding how to bring about lasting social change in complex and ethically problematical situations.

Mutual accountability: There is a need for flexibility in the implementation of complex projects which are values based and guided by principles of respect, inclusion, participation and empowerment. These projects grow out of on-going processes of reflection, consultation, and learning. This cannot be captured in frameworks that determine indicators and outcomes at the onset of a project.

It is important to find ways of bringing such flexibility into the relationship. This may necessitate rolling work plans, budgets and log frames.

Developing a theory of social change

Evaluation finding: It could be of benefit to Sarvojana to think through and articulate its theory of social change.

This could involve bringing together the core constituents to go through a process that might include:

- Imagining a vision of success, a picture in words of the sort of world the coalition members wish, together with others, to help bring about
- Exploring the question: what needs to happen for this to come about?
- Taking the question backwards: Then what needs to happen for that to happen? And then: What needs to happen for that to happen? Leading the exploration down consequential and causal flow and pathways identifying the prior changes that are necessary if the outcomes are to be achieved, not just what the coalition can do on its own
- Arranging these preconditions of success into pathways to outcomes
- Mapping how the coalition can get from where it is now to where it wants to be and with whom it will travel the pathways.⁶

These pathways provide a framework for planning activities and for reflecting on performance. Any theory of social change with respect to the HIV epidemic needs to take into account the broader driving forces of the epidemic.

The development of a theory of change provides ways of recognising and documenting changes, successes and mistakes, and of learning. Some of these changes will be measurable quantitatively; some will only be able to be captured in narrative forms, written or visual.

Approaches to the collection of these narratives include:

- Encouraging staff and volunteers to write down changes that they notice or that they hear talked about in change journals, to put letters of praise or complaint, articles in the paper, etc. into a folder, etc.
- Using methodologies for collecting and analysing stories of change, such as the Most Significant Change methodology
- Developing and training staff in simple methodologies for textual/narrative analysis, for example, content analysis

⁶ For a discussion of approaches to understanding how a theory of change emerges or unfolds through a facilitated process of open enquiry and dialogue, see www.keystoneaccountability.org.

- Using structured dialogue techniques such as focus group discussions, world café (www.theworldcafe.com) and other ways of capturing what people think the coalition is achieving
- Surveys and studies.

In these approaches to change, reporting moves towards reflective processes, inclusive of all the core constituencies, which aim to understand the difference the coalition is making and as such becomes an integral part of learning and improving.

Such open inclusive reflective processes provide a framework for constituency-wide accountability, accountability/reporting not only to donors but to communities of interest, as well as to service providers and regulators, to networks, alliances and others in the linkages, and through them to people at large. A shared sense of what is needed and involved in bringing about the desired changes emerges.

By bringing reporting into the public arena, the integrity of the insights and claims for success of the coalition can be scrutinised, debated, validated or refuted, and can contribute to wider learning processes.

Theories of social change enable groups to understand not only what has or has not happened, but under what conditions, how and why, and so how such changes might be achieved in other places and times.

Decisions taken with respect to the coalition

It was decided that the coalition embodied the original dream of its founding members; the project was one means of helping to bring that dream about. As such, it was important for the coalition to continue and to grow in effectiveness.

It was also decided that the founding dream, a dream of ethical HIV and development practices, of respectful and responsive partnerships with marginalised communities, of a world of equity and integrity, continued to be relevant and that this vision should remain at the core of the work of the coalition.

It was felt important to capture that dream on paper so that it can be understood and passed on, within and beyond the coalition. A part of that dream is the fundamental principles of the coalition, its non-negotiables, which it wishes to govern its interactions with others, including its donors, the different levels of government with which it deals and other partners.

All members of the coalition present indicated a strong desire and commitment to continue as members of the coalition.

A commitment was made to being a coalition that dares, in the way that its founding members were people who dared, a coalition courageous enough to take principled stands, to give voice to the voices of the marginalised, to be heroic in its actions. The coalition exists because change is needed.

It was accepted that the coalition needed to find a balance between its work as a coalition and the design, management, monitoring and implementation of the projects of the coalition.

This balance could create a tension with respect to the membership strategy of the coalition. The current members have struggled to develop a collegial management team for the oversight of their shared project. In this they have succeeded. Future project management would require the same level of understanding, trust and respect as has been achieved among the current members. The coalition on the other hand might benefit from being the collective voice of a larger group of like minded organisations. The expansion of the coalition might require anew the struggle for cohesion as a project management team as well as as a coalition..

It was established that there was a need to re-think the governance mechanisms for the coalition, as distinct from its project work. In particular, a commitment is needed by member organisations to the continuity and seniority of representation on its governing body and to the time required to nurture and advance a coalition of diverse membership. Basic documents such as the Code of Conduct and the PMC policy need to be re-visited to ensure that they capture the coalition as well as its projects.

It was recognised that there is a need to develop mechanisms and procedures for grounding the work of the coalition in the reality of the daily lives of their communities of interest, for the collection and documentation of the situations within which they worked and the changes that they were contributing to bringing about.

It was recognised that the needs of the communities with which coalition members worked and their contexts had changed in the intervening years and that there was a need to stand back and re-assess the strategic entry points for change for the work of the coalition.

It was decided that to reflect on how best the members of the coalition might now support, serve, give voice to and empower their communities of interest and to design an initiative by which they might contribute to achieving such outcomes.

It was also decided to strengthen the other means by which the coalition could contribute to realising its dream. In particular, it was felt that key areas for the coalition as it moved forward were advocacy and activism as a coalition, the values based visibility and influence of the coalition, and the strengthening of the evidence base for and the documenting of its work.

It was agreed that the coalition would seek to work with donor agencies who understand and value the *raison d'être* of the coalition and the rationale of its work, and who would enter into learning and capacity building partnerships with the coalition in order to bring about these changes. It was decided to begin this dialogue with HIVOS and the European Union because of the respectful and principled partnership already established.

Recommendations

That Sarvojana continue as a values-based coalition of like-minded civil society organisations concerned for the human rights, dignity and well-being of their communities of interest.

That the work of Sarvojana continue to be supported on the bases of relevance and need, and of effectiveness.

That the work of the Sarvojana member organisations be better theorised, documented and disseminated so that their very real achievements can contribute to the development of communities of effective HIV practice in India and elsewhere.

That Sarvojana members base their future work plans on on-going processes of reflection on the needs of their communities of interest, on their vision as a coalition, and of the value added that they individually and together bring to this work. This may necessitate rolling work plans, budgets and log frames.

That Sarvojana continue its partnership with HIVOS and that this partnership be itself considered as a partnership of like-minded organisations.

That, within this partnership, HIVOS continue its financial and moral support to Sarvojana, to assist the coalition to access funds sufficient for its needs, and to work closely with it to achieve its purpose.

That the differing governance needs of the coalition and the project be clarified and an appropriate governance structure be developed for the coalition.

That, if the PMC is redrawn as the governance structure for both, the agenda of the PMC on a regular basis contain items relevant to the coalition.

That Sarvojana create a programme position to support its programme of action and advocacy as a coalition of organisations speaking with a unified voice concerning the practices, ethics and effectiveness of HIV work in India.

That ways be found to ensure that Sarvojana's vision and purpose be transferred to in-coming participants.

That the coalition reflect on whether it would be beneficial to gain new members, either individual or organisational, and if so how they will balance the value of familiarity in processes of joint project management with the authority that could be gained from a larger group speaking with one voice.

That the coalition, in partnerships with its communities of interest and its donors, become clearer on what would be successful outcomes of their efforts and develop

ways of monitoring, documenting and reporting on the pathways to these outcomes in keeping with their understanding of how the desired social changes come about.

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Annexes

List of Evaluation Workshop participants

Most significant change stories

Stories of change from the workshop

Annexe One: List of participants at the Sarvojana Evaluation Workshop

Sl. No.	Name	Organisation	Position	E-mail	Phone
1	Lallu Joseph	FIRM	Chairperson	lallujoseph@gmail.com	0 98478 35566
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4	S. Revathy	Sangama	Director	sangama@sangama.org	0 99452 31491
5	Reginald Watts	Sangama	Consultant	sangama@sangama.org	0 96111 44901
6	B. Sekar	SWAM	Director	Sekar_swam@rediffmail.com	0 98404 37686
7	R. Meera	WINS	Director	Rmeera102@gmail.com	0 98492 04711
8	Sulekha. K	Samraksha	Regional Coordinator	sulekha@samraksha.org	0 94484 58301
9	Sanghamithra Iyengar	Samraksha	Director	Sanghamitra.iyengar@gmail.com	0 94484 77426
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16	Jamuna	HIVOS	Director		080 2221 0514
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19	Lavanya Keshavraj	Siaap	Advocacy Officer	lavanyakeshavraj@rediffmail.com	0 98842 35188
20	Anu.S	Siaap	Training Coordinator	anu@siaapindia.org	0 99403 04546

Annexe Two: Most significant change stories

What do you think is the most significant change that has come about because the coalition came into existence? Write a story.

Story 1

Key Change

Nature of coalition showed strength in diversity and that marginalized groups can come together under one umbrella to address their issues together. It also highlighted that though Proposal goal and outcomes can be common but design and strategies to achieve the same may differ in each region and cross learning between partners shared at PMC meetings and trainings of staff led to strengthened capacities and better understanding of marginalized communities. The PMC has managed to stay together despite differences that were addressed through arbitration. The funds management by the lead agency has been transparent and efforts have been made to track funds effectively with all partners. However the alignment between the funds allotted and activities designed could have been better planned for effective delivery of all outputs.

Lost in translation

The PMC is a passionate and committed set of individuals.. However the follow-up of PMC decisions was rather a slow and tedious process and thus the project outputs that could be stronger got a little diluted and lost in translation from the visionaries to the implementing project officers. The continuous debates and questions on the design of the project and its interpretation by partners at times led to a feeling that this was more of eight independent partners managing independent projects rather a consortium managing one cohesive project.

Story 2

In the initial stage of the consortium meetings we were not clear what this partnership would lead to. We had to think how we could contribute to the consortium because most of the partners were concentrating on testing and counseling. We had few conflicts in the beginning with the some of the partners and the district level network. It took some time for us to understand where the conflict began and what could be the best way to sort out the same, during our interaction with all the partners in the meeting, we came to know that there was lot to learn from each partner because of their competency and expertise. All the partners were working with the different community and this helped us to understand each of the community and how could we contribute to the problem and supplement to the work We started thinking how could we link our district level network with the consortium partners, discussions and views of the partners helped us to form a partnership with all the district level network and link them to the consortium partners, At this juncture the conflicts in the district were called for discussion with the partners and this was solved. As the relationship strengthened, INP+ could advocate issues with the support of the partners. The partners also felt that INP+ should have a larger presence in the consortium and opportunity was provided for INP+ to take the lead in advocating issues with NACO. This helped in strengthening the chord. Now we feel that the presence of the partners in each state is an anchor to our movement

Story 3

Durga, a sex worker and positive wanted to get treated for severe diarrhea and continuous fever. But she was fed up of going to the government hospital. She was not treated with respect and had to wait for a long time to see the doctor.

One day she came back home, very hurt at the attitude of the health-care workers. Her friend who worked in a close by center which did testing took her to the center. Not only Durga was treated at this center, she was also treated with much respect. This encouraged her to visit the center more frequently. She also learnt that this center was run as part of a project and there were 7 such center in 5 States.

Last year, she attended a meeting held by people from these 7 centers. She learnt that she was not alone. The meeting had brought together women like her, women from the mainstream community who were also positive, men who have sex with men. They sat together to discuss issues and the common thread was stigma and discrimination they all faced in the health-care set up. There were many more such issues which they decided to discuss at the next meeting.

Projects that are target focused normally have such meetings within the target communities. The consortium had brought together the different community people together who discussed issues with great responsibility. They did not talk about the virus or transmission of the virus between individuals. But spoke about it in the context of peoples lives.

This was made possible because of the consortium.

Story 4

Sarvojana – a consortium has paved the way for INP+ to take up grass root advocacy in improving the access to health-care and social support to provide quality services to PLHIV. INP+ has taken up several initiatives to reduce Stigma & Discrimination at the health-care settings, schools and in the villages. All these initiatives have brought in quite successful outcomes. The following are the perceivable changes realized under the consortium support.

Increased PLHIV friendly environment at Govt. hospitals in the project districts of Kanchipuram and Tiruvallur

The advocacy program on the need to address the issues behind treating PLHIV at the Govt. hospitals held for the medical officers have had a telling impact in treatment settings at these Govt. hospitals. PLHIV have now better and increased attention to their complaints and adequate and appropriate care has been given to the patients.

One of the Medical Officers trained has been transferred to another district of our project and she has established a greater goodwill among PLHIV in her new place. Such has been the impact of the advocacy.

Increased practices of Universal Precautions by the lab tech in the districts of Chennai, Kanchipuram & Tiruvallur.

Sarvojana has given intensive training to lab tech in the districts of Chennai, Kanchipuram & Tiruvallur. The training has removed many of misconception of the technicians in respect of spread of HIV and it has also improved their knowledge to a greater extent on the needs and significance of practicing universal access. As a result, now there have been safer practices at all these labs in waste management.

Resolutions on anti discrimination

Another significant change brought about by the consortium, now among the village leaders has been their determination to fight against discrimination against PLHIV and their families. Nearly 27 Panchayat leaders from Ariyalur district have been sensitized and they have been fully convinced on the ill effects of Discrimination against PLHIV. These leaders have come forward to pass Panchayat resolutions in their Gram Sabha.

Education support by Faith Based Organisation

After our initiatives on inter faith consultation, one of the churches has decided to support CIA for their education. They are now providing full scholarship for the CIA from the next academic year.

Workplace advocacy

At Ariyalur district, following the Sarvojana's initiatives to address the workplace issues, a local work place advocacy committee has been formed to take up issues at the district level on a regular basis.

Of these changes the most significant has been the increased practices of Universal precautions by the lab techs.

Earlier, before our training, there was complete absence of any safer practices in handling the lab wastes. The technicians used to dispose the wastes everywhere and kept the patients and themselves prone to danger. There were no bins to collect them. The technicians were also having fear of contracting infections.

INP+ through the sarvojana had given intensive one day training on UP at the instance of District Project Manager, Tiruvallur district. There were many doubts and clarifications in the course of the training and each one of them was cleared.

The DPM who was present at the present at the training had made immediate arrangements to get the kits and utilities to make the lab tech to provide a fool proof services. 3 color dust bins, aprons, gloves, appropriate materials, prophylaxis have been regularly given to the lab techs.

The lab techs report that now they have no fear and there is no feeling of insecurity. The lab and its surroundings now wear a hygienic look.

Story 5

FIRM was basically an activist NGO, without much discipline in pursuing a case or an issue for a long period, even when the situation demanded that. The consortium, thanks to the project mode it demands (though to give the best expression to the activist attitudes) has effected a positive change in FIRM so as to address an issue from both the activist mode and the project mode.

The consortium has helped FIRM morally and financially to fight two blatant cases of stigma and discrimination towards the sex workers and an HIV +ve for over two years.

a) 39 female sex workers were illegally thrown out of their legally occupied homes in Calicut by the moral police with the tacit support of the local police. When the prudish society and an equally prudish media turned a blind eye towards the incident, FIRM, thanks to the financial and moral assistance of the consortium, moved the High Court of Kerala, which gave an order directing the DGP to provide police protection to the sex workers to re-enter their homes, and to conscientize the police force not to harass the sex workers, who are doing nothing illegal. After taking various strategy to undermine the spirit of the court order , the police, after FIRM initiated contempt of court proceedings against the DGP, has initiated steps to find out a locally acceptable social leader to conscientize the local people so that re-entry of the sex workers to their homes would be a smooth affair. The re entry has started in a phased manner.

b) An HIV +ve, who met with an accident was bundled out of a hospital in Trivandrum when he revealed his HIV status. The issue was discussed in detail by the media. FIRM, thanks to the moral and financial support from the consortium, moved the NHRC. The NHRC, sought a report from the KSACS, but KSACS gave a factually wrong report saying that there was no case of discrimination. NHRC, totally relying on the report of KSACS , and not bothering to give a hearing to the victim of discrimination, even after he launched a fresh affidavit questioning the report of KSACS, closed the case. FIRM has now moved the High Court of Kerala challenging the order of NHRC and the report of KSACS.

These protracted legal battles would not have been possible without the consortium giving a free hand to FIRM to fight the cases to their legally logical conclusions as part of advocacy, and FIRM becoming disciplined in its effort to pursue a case even when there are set backs.

Story 6

From the beginning of the project in 2006 in every PMC meeting the key discussions would focus on project implementation, budgets, reaching target numbers and challenges to manage with in constrained budgets, turnover of staff, conflicts to unite with existing networks etc were the issues which would be taken up. Of course the burning issues like photo I cards for MSM and other happenings at the national and international level would be discussed which would at the end make members feel helpless and exasperated. However, in the last PMC meeting Sarvojana consortium identified role for itself as that one of “watchdog” in the implementations of NACPIII. It discussed in great detail about various issues concerning violation of rights and confidentiality and somewhat arrived at the mechanism through which these would be addressed or taken up. The discussions resulted in formulation of detailed advocacy plans for this year.

Story 7

First of all I am proud to be a member in the consortium. We are having cheers and also drawbacks.

The double decker, transgender doing their HIV test here without any hesitation.

If we will send them to GH they won't go there because they are hiding their problems of faces from outside.

But the same time Kothis are going to GH to make themselves for HIV test.

The high risk group will come here to do their HIV test three months once.

The pathetic sex workers having fear to receive their test report.

The counselling to MSM, PLHIV persons is not that much successful.

The positive sex workers taking alcohol and the Kothis won't take the ART properly.

If they will go to GH to get ART half day will be swallowed in GH.

The usage condom is 70%.

We are providing the nutrition for positive people also.

It is acting as one of the ways to improve their CD4 count.

We are functioning another one MSM positive centre in Tambaram.

MSM, PLHIV persons don't like to go for other networks to take their treatment.

We reduced the violence in slums by slum sensitization programme.

By this programme, panthis also using condoms and they are visiting to SWAM VCTC centre with their life partners to do HIV test.

In MSM, PLHIV persons we are giving the special attention and care for STD.

MSM, PLHIV persons having fear to share their problems.

We are reducing the SRS operation by counselling for their bright future without problems.

We are doing the last rites for MSM, TG without any expectation.

Nowadays 12 – 15 years old Kothis are coming here. We are giving the counselling to them to make their mind for a right decision.

Nowadays the government giving a little support to TGs.

Story 8

The most significant change that has occurred is the transformation of advocacy issues from a distant “it just does not work, somebody should do something” or ‘let us galvanise others to do something” to “I can do something” and “ I will do something”.

Across the partners, even before the consortium, there have been different sets of actions by communities, by CBOs or the NGOs, which have sought to claim back the right to life with dignity. In fact this is what brought the members together. The partners have all been engaged in various forms of advocacy; through public protests and demonstrations, through policy , programme or service advocacy; through public hearings and legal processes at district, state or national levels.

The change that is taking place is a questioning at a very local and individual level, with people rallying around them. One story is that of the ART centre doctor in Raichur asking people living with HIV, coming in for ART to go out to private labs to get investigations done at a high cost when these were available in the government hospital at no cost. People spoke about it in local meetings, mobilised the positive network and Samraksha, and pressurised the doctor to stop this practice. In another situation, when both parents died of HIV-related causes, the grandparents caring for the two children wanted to send away the children. Community members spent time with them, clearing misconceptions, providing confidence and mobilising resources to continue to care for them in the same setting.

Similar stories have been heard from Theni , Chittoor, Chennai, Bangalore. The change that I see happening is the courage and wish to claim the right to services, to dignity, being transferred from organisations whether NGO or CBO to individuals. The presence of the organisation to support or handle backlash may still be sought, but action has begun to be taken at an individual level.

The formalisation of the information and resource exchange between partners of the Consortium, has led to insights on changes such as these.

Story 9

Multiple interaction with consortium members has widen the understanding of marginalised community

My understanding of the marginalised community was more in the context of counselling. Interaction with multiple partners in the consortium and visiting to the partner organisation who had wider understanding and directly working in the area of prevention and care gave me an good opportunity to broaden my understanding beyond counselling. These learning's were taken back to the project and state level in the form of discussion, trainings and some changes in the policy level.

People from the marginalised community accessing services in CVCTC as well as in the ICTC is an major issue. Samraksha in the state is involved in training of ICTC counsellor and lab technicians for the past 4 years. State and organisation counsellors had an intensive induction training for 12 days on different issues in counselling including marginalised communities. To sensitise the counsellors used consortium members and people from positive network and members from the community as resource persons. Their input and experience has made some changes in the professionals in their settings.

Changes among individuals were also documented in several interactions with the counsellors and in the recent refresher training of ICTC and ART counsellors. Some changes were also recorded from the community who have accessed services.

Story 10

Women build access to quality testing and treatment services

Community members who have never stepped out of home had to go in for treatment for a strange disease. They had grief, fear and concerns. There was no one, and they had no way to get out of these, after they learnt they are HIV positive. Slowly when they met women who are also like them, they realized they can be together and share their lived experience. They spoke sharply about pain caused by words or gesture or action. This helped the victim. It gave them relief and got their energy renewed. On the other hand, their colleague listening to their story of pain is able to offer suggestions, by standing beside her, taking sides with her, presenting her point of arguments, analyzing issues in a focused manner and addressing set backs layer after layer, getting at the roots of the problem and defining individual's roles in a positive manner help her tide over the crisis.

Increasingly HIV positive women have to fight against their dreaded fear that their 'days are counted'. Some where, in life they are aware of their limitation. They are trying hard to pick up information and skill at the same time for their common good. But the world outside is unsympathetic and horrifying. This upsets them. And it is polarized: One for the rich and one for the poor. They are frustrated and tired and some are of the opinion that it is easy and comfortable to follow the oppressors and fight it out, when it is less strenuous. Coalition had helped them figure out who they are and how they can dream.

Story 11

A few years ago a few friends got together. They had become friends by meeting each other in various forums over a period of time. They respected one quality in each other – that they were articulate and often voiced an opinion quite different from that of the majority of the people in any given forum.

None of them were very complete individuals or had built very complete organizations. They valued their independence – making a choice when it came to the type of work they did.

They thought that they could work together on some common issues, and gave voice to a project proposal where they could work independently, yet in concert with each other.

What happened next? During the implementation of the project, the various organizations interacted with each other. Bonds were established between quite a few people in each of the organizations with individuals in the other organizations.

People got to understand the mindset of people from communities that they were not familiar with. They learnt to see things from another point of view.

Are all the constituents of the coalition equal in terms of their maturity or capability? Like in any group of individuals they are not. Some are better at one thing and some are better at another. It is only when they learn to respect these differences that the coalition will be more effective.

Working in a coalition involves working together for a common cause, while continuing to pursue one's own interests. This calls for a great deal of maturity. Using the membership of the coalition to score points against another who is seen as a rival in a different context is counter-productive. Hopefully, the coalition has learnt this lesson from the experience of working together over the last few years.

What of the original bunch of friends? They remain in touch but some of them have clearly moved on as individuals. Just as any organization learns to deal with people in key positions leaving it, the coalition too should be able to cope. However, some of the founding members did not help with this transition, and in many ways left their baby in the lurch. However, the babies have learnt to cope with this abandonment and are finding their own feet.

This is early days yet for the coalition. But this is an idea that needs to work if communities are to get back their voice from the ones who control the money flows.

Story 12

Earlier we give the report after 3 days. but due to this there was a huge gap between pre test and post test this was the universal problem of project the partner NGO s this issue put forward in the partner meet and finally we decided to give report on the same day this helped us increasing the post test numbers.

From this consortium team helped us in the Capacity need assessment program and they helped us in building capacity of the NGO in project implementation and project management etc..

It helped us in developing Net work and linkage with us partner NGO s and other CBO s.

And this is one of the Important Forum for inter learning and sharing of innovative ideas and strategies.

It helped us to discuss about common challenges of the project.
And to find possible solutions.

Consortium Joining each other in Project officer meeting and pmc and we Discuss each other how to go our organization and discuss Issues, linkages programs support, and Training programs,

After the formation of the consortium the number of referral phiv community members for ART Treatment, Care and support, has increased No 261.

Annexe Three: Stories of change told during the Evaluation workshop

Stories

1. Attendant Care for women
2. Advocacy towards ethical testing practices in HIV/AIDS
3. National Strategy Document for NACO to support NACP – III and Capacity building of MSM and TG groups to help upscale interventions
4. Resisting Presumptive treatment for Women in Sex Work, MSM and TG
5. Making HIV testing accessible and affordable
6. Operational Guidelines for MSM and TG in NACP-III: high risk behaviours rather than high risk groups
7. Establishing an ART center at Tiruvallur
8. Case study on HIV BILL

Attendant Care for women

A is an illiterate infected widow. She lost her husband to AIDS when she was 32. When she died, this year she was 42. Her husband was a stone cutter. They migrated to Tirupathi soon after their marriage. Her grown up children a son and a daughter are married. They are construction laborers on daily wage. A has grandchildren from both her son and daughter. She has had the need for hospitalization thrice in the time we have known her. Each time she was not very willing to get herself admitted. But our coaxing and motivation helped her make the decision to get admitted. But it was a difficult decision for her to make considering that there is simply no person to spare for accompanying her to the hospital or to attend on her.

But all hospitals including care and support centers require the inpatient to bring along an attendant. This is not possible when every member of the family has to bring home the daily wage and loss of income for a single person even for a single day could adversely impact the family finances. In fact many PLHAs in need of hospitalization do not get admitted simply because they cannot get an attendant to come along. For wage earners and women tending to their families it is not possible to spare a person whole time to attend upon the in patient.

A understood that timely admission into a hospital might make the difference between life and death. She suggested that if infected and affected persons could be motivated to attend upon inpatients if only they could be sure of not losing their daily wage. So we suggested to her that she could make an example of herself if she would undertake the first experiment. So it happened that when another infected woman was in need of hospitalization, A accompanied the woman and stayed with her for the duration of admission.

It caught on and she proved that if community members could ensure the reimbursement of the daily wage, it is possible to locate another community member to attend upon the inpatient.

Today we have a system where we reimburse the daily wage for PLHAs who are willing to attend upon other community members In need of hospitalization.

Joint Action Committee

Advocacy towards ethical testing practices in HIV/AIDS

Background:

South India AIDS Action Programme (SIAAP) received reports that large numbers of women in sex work and Men who have Sex with Men (MSM) populations have been tested for HIV in Theni, Namakkal, Madurai, Tanjore, and Coimbatore in Tamil Nadu in the last few days in complete violation of all national guidelines for counselling and testing.

Participants have reported that close to 500 people have been made to stand in line at these camps to wait their turn for getting tested. The participants have reportedly received a bottle of Horlicks and some money as an incentive. The camps have been organised by the Tamil Nadu AIDS Initiative project. Many participants that we have spoken to also claim that they did not know they were being tested for HIV, either before the camp started or when the blood was collected.

The matter was reported to the Tamil Nadu State AIDS Control Society (TANSACS) on 12.12.07 by a small group of NGOs and CBOs including **SWAM**, Sahodaran, **INP+**, Samuthram, and **Siaap**. The Project Director has instructed that ***all such mass testing activity be stopped immediately***. However we now hear that the field workers in these organisations continue to bring women to the ICTCs in these districts. Though the number has reduced drastically, we are still not clear if proper norms are followed.

Many CBOs and NGOs in Tamil Nadu, Karnataka, and Andhra Pradesh also report similar violation of national testing policy guidelines as well as the rights of vulnerable communities by large Indian and international NGOs in terms of intervention, research and testing activity.

Action taken

Narrations collected from participants:

- Women in sex work from the Periyulam Magalir Munetram Matrum AIDS Thaduppu Sangam participated in the camp on December 11, 2007 they reported that 400-500 women were tested; there was lot of commotion due to heavy **crowd**
- **There was only one person to draw blood from women; and only one lab technician to perform tests.**
- First women were asked to come in line and were registered and provided a token (registration card) and two forms namely consent form and a pre test counseling format; they had stapled the registration card on the consent form, on such a way that it concealed off the printed text reading "HIV-TEST"; thereby **women who were to undergo the test were not aware that they were to be tested for HIV**

- Women were expected to have a registration number with Tamil Nadu AIDS Initiative. However other women were found to be using these numbers to make up for absence.
- Then they were sent to counselor for counseling; but the counselor had asked the women to sign the consent form without any due information or counseling; few women shared that they were not aware that it was Blood test for HIV; there was neither any group education nor any video played in this regard
- Many had presumed that they had come for the routine VDRL test, which they undergo every month.
- Women who came for testing were **provided a 1/2 Kg Horlicks Bottle**. (Peer Jeevan provided Lunch and travel allowance for their respective peers).
- All results (both Positive and Negative) were disclosed by the Project Coordinator (PCO), without any post test counseling; this was done in front of other staff and women waiting to collect their results in the queue. A volunteer shared that the PCO asked a women to come the following Friday to collect her result; when she refused to go without the result, the PCO had immediately questioned about the purpose of her testing, and had said that "...you are infected by HIV, so we need to test your CD4; so come back on Friday, we have made further arrangements for the same..."
- Fair number of women on the age group of 60 years and above had undergone testing merely to take home the Horlicks bottle; a girl (probably less 15 yrs old) was tested among other sex workers. On further enquiry, her mother shared that she gets frequent epileptic fits and so she had brought her to test.
- Nearly 40% women from general community were brought for testing by the peer Jeevan (to meet out their targets and to avail their incentives from TAI); **these women were informed by the peer Jeevans to report as sex workers.**
- On an average each women had to wait for 6 – 7 hrs, without water / food, to get tested and walk out with their results.

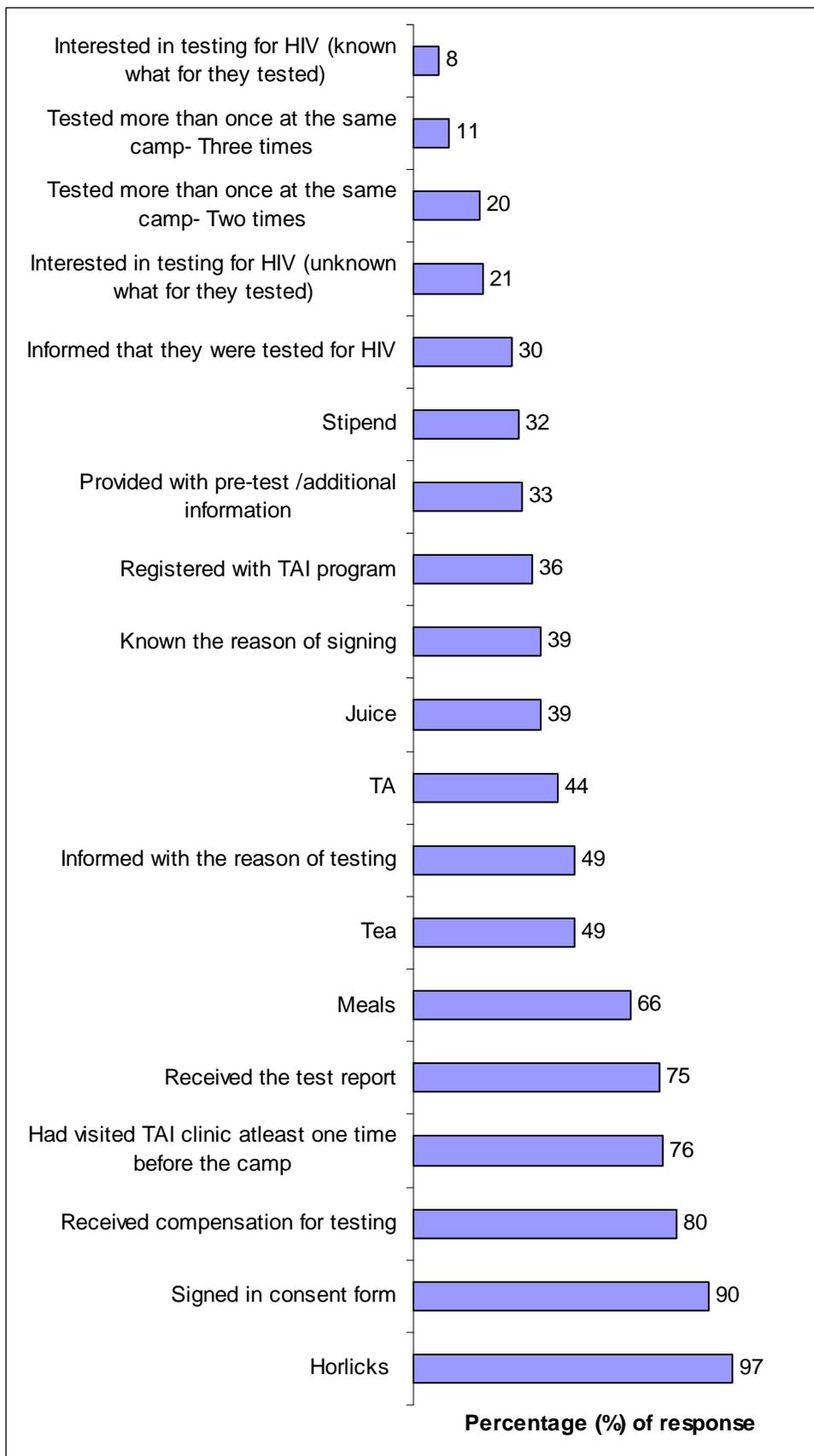
Meeting with TANSACS:

On 12th December 2007, A team comprising **Siaap**, SWAM, Sahodharan, Samuthiram, and INP+, met PD, TANSACS and produced the evidence based report. PD thoughtfully discussed and gave orders to withdraw technicians from the site and to stop the mass testing with immediate effect. Later this evening TNSACS reported that the women who showed up for testing the next few days would be asked to go to the ICTC in the area for appropriate counseling and testing. This has since continued. However, reports from the ICTCs suggest gross improprieties.

Results of field research on HIV testing drive in four districts of Tamilnadu

An initiative of JAC (Joint Action Committee)

	Tanjavore	Theni	Namakkal	Madurai	Total	%
Total respondents	25	6	27	31	89	100.00
Registered with TAI program	6	6	9	11	32	35.96
Had visited TAI clinic at least one time before the camp	13	6	21	28	68	76.40
Informed with the reason of testing	15	5	13	11	44	49.44
Informed that they were tested for HIV	9	1	8	9	27	30.34
Provided with pre-test /additional information	7	3	14	5	29	32.58
Interested in testing for HIV (known what for they tested)	7				7	7.87
Interested in testing for HIV (unknown what for they tested)	8	1	6	4	19	21.35
Signed in consent form	18	6	26	30	80	89.89
Known the reason of signing	17		14	4	35	39.33
Received compensation for testing	24	6	22	19	71	79.78
Horlicks	24	6	25	31	86	96.63
Tea	2	3	24	15	44	49.44
Juice	7		24	4	35	39.33
TA	9	2	1	27	39	43.82
Meals	18	4	19	18	59	66.29
Stipend	11			18	29	32.58
Tested more than once at the same camp- Two times	2	1		15	18	20.22
Three times		1	1	8	10	11.24
Received the test report	18	3	19	27	67	75.28



National Strategy Document for NACO to support NACP – III and Capacity building of MSM and TG groups to help upscale interventions.

The sexual minorities partners (LGBT) of the SARVOJANA coalition in South India and the member organisation of the The Integrated Network For Sexual Minorities (INFOSEM) Naz Foundation International and community leaders in India developed a national advocacy strategy and a national strategy document titled “Evidence to Action” and submitted to NACO for rapid start up and scaling up of targeted interventions with MSM and TG (particularly Hijras) under NACP - Phase III. The national strategy document was adopted in the operational guidelines for MSM and TG in the NACP-III.

To provide support to NACO in NACP – III to upscale interventions with MSM and TG , implemented a yearlong capacity building and advocacy project in 2006-07. It was a national level capacity building and advocacy project, and focussed on strengthening the capacities of community-based organisations (CBOs) of men who have sex with men (MSM) and male-to-female transgender (TG) people spread across India. This was in keeping with the objectives of NACP – Phase III, which recognizes that CBOs have enormous potential to effectively contribute to the national responses to HIV epidemic.

The beneficiary organisations were based in: Mumbai, Sangli, Pune and Nagpur in Maharashtra; Baroda and Rajkot in Gujarat; Kolkata / Dumdum and Chandannagar in West Bengal; Bhadrak in Orissa; Imphal in Manipur; Chennai, Kancheepuram and Tiruchirappalli in Tamil Nadu; South Goa district in Goa; Bangalore in Karnataka; and Pondicherry.

The Humsafar Trust (consultants), Sarvojana Coalition MSM and TG partners, Solidarity and Action Against The HIV Infection in India (SAATHII) and other INFOSEM members with experience and expertise in conducting interventions among MSM conducted several need-based training workshops to strengthen the capacities of INFOSEM member organizations. The key training areas included advocacy, BCC development, program and organizational development. The project that promised to build capacities of 20 MSM / TG CBOs, eventually provided support to 25 organisations. Besides, an organizational structure and business plan was created for INFOSEM and the process of registration of the network as a Society was started in New Delhi in March 2007.

Resisting Presumptive treatment for Women in Sex Work, MSM and TG:

Three years ago, the Avahan initiative proposed presumptive treatment of sexually transmitted infections (STIs) for different populations which were seen as being at repeated risk for them.

This meant that women in sex work, MSM or hijras accessing an STI clinic would be presumed to have STIs and mandatorily provided treatment for them on every monthly visit., irrespective of whether they had an infection or not.

This practice was questioned by Samraksha and Humsafar Trust independently with the state lead partners in Karnataka and Maharashtra on two counts: ethical practice and public health hazard.

On ethical grounds, presumptive treatment denies the understanding and agency of marginalised communities to seek treatment when required. It was a practice that was not found in literature to have been used anywhere except with marginalised groups in developing countries. The risk of drug resistance was not denied. Drug resistance not just related to the STI but also loss of the drug to treat any other infection in the individual. Transmission of Drug resistant STIs would be another public health problem.

Although other partners in the two states accepted presumptive treatment, Samraksha and Humsafar Trust refused to give in. Several discussions were held and literature reviewed. However, neither organisation was convinced of the need for presumptive treatment. When discussions did not yield positive results, both organisations took expert advice. Humsafar Trust took the matter to its International Health Advisory Board (IHAB) that consists of 8 national and 4 international medical experts working in the field of HIV, Mental Health and Nutrition. Samraksha took it to its Institutional Ethics Committee (IEC).After reviewing the matter, the Ethics Committee called for the opinion of three independent technical experts

The Professor of Skin and Venereal Diseases at a major government teaching Hospital; a public health expert and a leading STI specialist in private practice were consulted and their opinions considered.

Both the IHAB and the IEC carefully considered the issue and recommended motivating community members to seek regular health check ups but advised against presumptive treatment.

These recommendations were taken up with the donor agency and their state lead partner and this was accepted . This is an example of how evidence-based advocacy pays off.

The story however has a sequel. In NACP-III it has now become mandatory that presumptive treatment should be provided to all women in sex work, MSM and hijras accessing services from STI clinics that are being supported through NACO funding . Our earlier advocacy has given us a space to argue the point.

Humsafar has started a dialogue with Mumbai District AIDS Control Society on the recommendations of the IHAB and CAB; and Samraksha has started a similar one with the Karnataka State AIDs Prevention Society and hope that we will be successful in getting our point of view and our protocols accepted in the national programme.

Making HIV testing accessible and affordable

The Humsafar project has a STI clinic but did not have provision for HIV testing as the mandate of AVAHAN did not allow HIV testing in the clinic. The male sex workers accessing services at Humsafar who desired an HIV test had to be referred to Humsafar ICTC which was located 4 miles away from the project clinic.

The IHAB (International Health Advisory Board) of Humsafar recommended the following:

Though the Avahan initiative did not support HIV testing in the STI clinics there was no need for community people to travel to two clinics (one for STI examination and another for HIV testing) so it was decided that the Avahan STI clinic would also do pre test for HIV/ blood collection and then post test at report collection. However the actual testing would take place in the Humsafar ICTC and adequate arrangements need to be made to send samples to the ICTC for HIV test and sending reports to the project STI clinic. This would help community members in saving time and resources of travelling to two different clinics and also respect the mandate of the project requirement.

Meeting was organised with the community advisory board (CAB) and FGDs were conducted. A new process of dialogue with FHI and FPAI (implementing partners for AVAHAN in Mumbai) to negotiate on the issue and concerns were discussed. The point of view of the IHAB and minutes of meetings with CAB and FGD reports were discussed. Finally the recommendation was accepted. The meetings and discussions were held in a positive spirit and it was an example that how positive dialogue can bring about a positive change and the donor agency is also willing to see reason and accept ground level reality.

Operational Guidelines for MSM and TG in NACP-III: high risk behaviours rather than high risk groups

The Humsafar Trust works with various sub groups of MSM. It has developed four criteria that determine high risk behaviour among MSM community.

- a) Percentage of consistent condom usage
- b) Number of partners in one month period
- c) Health seeking behaviour of the community
- d) Percentage of penetrative anal sex being practised in the community.

There is a policy decision that while providing health services around STIs and HIV to MSM, we will not question about the identity of the person whether he identifies as gay, kothi, panthi, hijra, double decker, etc. The outreach team is trained to assess high risk behaviour and if the person is in any of the four criteria developed should be motivated to access clinical services from Humsafar. If the issues of the person are not unsafe sex but more of sexuality, workplace harassment or rights issues than the person can visit humsafar counsellors, lawyers or just visit the space to be himself.

The operational guidelines introduced that STI and HIV services should be aimed at the Kothi community (effeminate gay men) as they are highest at risk. The groups do not form part of core group though can be addressed.

This was in direct clash with the organisational policy on provision of health services to high at risk MSM. It became evident when one of the programme officers from the Technical support unit (TSU) visited a health camp and pointed out that the health camp should focus on Kothi's and mainly kothi's should be registered as clients. The matter was reported to the Project Management Unit (PMU) of Humsafar and concern was expressed.

It was discussed at the local District AIDS Control Society and State AIDS Control Society and though Humsafar enjoys very good working relationship with both they expressed their inability to help as it was being done as part of national operational guidelines.

The matter was then brought to the notice of Ashok Row Kavi who heads MSM and TG Desk in UNAIDS and Dr. Samarjit Jana who worked with NACO who intervened and got the definition of MSM cleared and shared in a MSM and TG consultation held in Delhi on 25th October 2008 that high risk behaviour of MSM and TG depend on certain criteria's and not identities and labels which are very fluid in nature. The operational definition of MSM and high risk was read out to the audience and later shared with all State and District AIDS Control Societies in the country thus confirming that high risk behaviour of MSM will be based on criteria's of high risk and not identities or labels that people may give themselves.

Establishing an ART center at TIRUVALLUR

The People Living with HIV /AIDS who belong to Tiruvallur District till 2007 were receiving their ART from GHTM Tambaram. The people who live near the Andhra state boarder which is nearly 150 Kms from Tambaram found it very difficult to get the medicine, they have to come on the previous day of their turn and stay in the hospital to get the medicine. Most of the people belong to the poverty line and are depending on their daily wages, on ART days they may have to loose two days wages and have to spend a lot on their travel and food, Some PLHAS go to Tambaram with their children

From 2006 on wards under the SARVOJANA Project INP+ has given lot of Capacity trainings to the Tiruallur District Network. The Network realized the need for an ART center for Tiruvallur, even though DLN office functions just opposite to the Thiruvallur hospital it was not useful to the PLHAS even for OI treatment. Under the sarvojana the Medical officers were sensitized on HIV , Stigma and Discrimination, this has motivated some of the doctors to become PLHA friendly

The President of the Network along the PLHAs met the District collector and the district Health officials and submitted memorandums requesting for an ART center, they even represented their case with TNSACS.

The Network has a very good rapport with the District Project Manager who has realized the need for the ART center in Tiruvallur and recommended for it to TNSACS.

The ART center was inaugurated on the 2007 world AIDS day in Tiruvallur celebration and now people are receiving ART, the quality of health service has improved and the people are accessing OI treatment, the district collector monthly once visits the ART center and reviews the facilities

Case study on HIV BILL

Joint effort by Lawyers Collective and INP+ along with APCASO and Sarvojana

1. About HIV Bill: In 2002 Lawyers Collective was commissioned by National AIDS Control Organization (NACO) to draft legislation for HIV (HIV Bill). The bill guarantees legal rights of PLHA and other marginalized communities in India. The main focus of the bill is on Discrimination, Treatment Access, Informed consent, Confidentiality, Disclosure. The Bill in short is an Anti-Discrimination Law. Preparation of this Bill involved extensive consultations with civil society organizations in India. The final draft of the Bill was submitted to NACO in the year 2005 but it is yet to be tabled in the Indian parliament.

2. In the Year 2007, INP+ along with lawyers collective has conducted a signature campaign (among the INP+ state and district level network members). A total of 20,000 signatures were collected in support of HIV Bill and were submitted to Prime Ministers Office in Feb 2008. Signatures were also collected from the SARVOJANA project areas

4. In March 2008, INP+/APCASO with technical assistance from Lawyers Collective Organized for a One-day State level consultation meeting on HIV Bill in Tamil Nadu. This Meeting was attended by representatives from PLHA networks and civil society organizations in Tamil Nadu. This consultation not only provided an opportunity for creating broad-based awareness about the Bill to Civil society organizations in Tamil Nadu but also provoked the need and thought for the established of a State Steering Committee for HIV Bill.

5. As a result of the State Consultation Meet, Key civil society organizations in Tamil Nadu have come together and established the State Steering Committee (SSC) for HIV Bill. The SSC comprises of representatives from the following agencies INP+/APCASO, SARVOJANA ,Tamil Nadu Networking People with HIV/AIDS (TNNP+), World Vision, South India AIDS Action Program (SIAAP), Actionaid, Professional Social Workers Association (PSWA), Lawyers Collective.

8. Realizing the need for creating awareness through field action, the SSC for HIV Bill have organized for an Advocacy rally (In support of tabling HIV Bill in the Indian parliament) on May 18, 2008 in Chennai. Over 500 people from PLHA networks, Civil society organizations participated in this rally. We have also collected supportive signatures from General Public (1000 people have signed) for HIV Bill. The rally has very good media coverage (Both in Print and Electronic Media).

In connection with the HIV Bill we met Dr. Ramadoss, Local Politician (Dr. Ramadoss was the father of Dr. Anbumani Ramaodoss, Hon'ble Minister of Health and Family Welfare, Govt. of India) and explained to him about the bill and requested him to lobby for this bill

In connection with the bill we have developed a poster jointly with APCASO

With all this efforts the bill was sent to Law ministry but the ministry has removed three important chapters which safe guard the rights of the people with regard to the access to treatment and blood testing and forwarded to the health ministry and NACO is ready to place the revised bill for tabling, due to election it is not able to do so ,

Now Lawyers collective and INP+ is again campaigning to include the deleted chapters and wants to table it before the parliament after the elections.