# ACTION PLAN FOR HIV/AIDS PREVENTION

## 1.1 BACKGROUND

Andhra Pradesh Road Development Corporation (APRDC) of Road and Building Department, Government of Andhra Pradesh (GoAP), through Government of India has requested for loan assistance from World Bank towards the cost of construction, maintenance of core road networks in the State under APRSP. APRDC, GoAP, has identified about 900 km of State Roads (mainly State Highways) for improvement under APRSP phase-I. The present road improvement proposal includes widening, strengthening and maintenance of various State Highways as well as important District roads. APRSP Phase I has identified about 230 kilometers of roads as follow:

**Table 1 APRSP Phase I Roads under up gradation**

| Sl. No. | Name of Road | SH/MDR | Length (km) |
|---|---|---|---|
| 1 | Kandi- Shadnagar | MDR | 65.60 |
| 2 | Chittoor- Putttur | MDR | 60.60 |
| 3 | Kurnool-Devanakonda | SH-50 | 60.60 |
| 4 | Mydukuru-Jammalamadugu | SH-57 | 41.00 |
| | | **TOTAL** | **228.00** |

Detailed project report has been prepared for above mentioned phase I roads. It also includes preparation of a comprehensive environmental and social management plan. The Social Management Plan addresses issue related to resettlement and rehabilitation, communication strategies with people in general and with vulnerable groups (women, Schedule population, resource scarce person etc) in particular. The SMP has also dealt with the other emerging social issues inherent with the improvement of roads like issue related to road safety and HIV/AIDS prevention. These emerging social issues have been addressed as an interrelated but independent social management plan.

The present report has been prepared to addresses strategy and action required to for prevention HIV/AIDS emerging from road improvement and these issues. The HIV/AIDS Action Plan is prepared following status of HIV/AIDS issues in the State, strategies adopted to address these issue, gap identified in the strategies pertaining to road construction vi-vis nature and characteristics of transmission/proliferation of AIDS epidemic and important activities being undertaken under the project. The action plan is prepared by involving important stakeholders like APRDC,local people,NGOs , APSACS and District Health department.

## 1.2 NEEDS FOR HIV/AIDS ACTION PLAN IN ROAD SECTOR PROJECT

Based on findings of recent studies about nature and cause of transmission (especially in transport sector) of HIV/AIDS, it is learnt that there are linkages between improvement of transport and prevalence of HIV/AIDS. These linkages can be summarized in following points.

- 67% of HIV/AIDS is caused by migration and movement
- Transport workers are twice as likely to acquire HIV/AIDS than that of normal population
- Transport worker are mostly unskilled, less educated and more vulnerable towards epidemic
- Further, the improved roads contributes to increased movement of people and goods which could open once closed communities to mobile populations and these interactions could increase vulnerability to HIV among both the groups.

Thus transport sector is one of the key sectors that needs to be proactive in managing HIV/AIDS as the workforce of the transport sector is not only at high risk for HIV/AIDS, but also serves as a social vector in the transmission of the disease. Keeping above mentioned point in view APRDC has put prevention of HIV/AIDS transmission in high priority. Accordingly, when APRSP was being planned, the prevention of HIV/AIDS became part and parcel of planning. This document is prepared(HIV/AIDS Action Plan) for up gradation and improvement component(About 430km,World Bank Funded)) of APRSP.

**Objectives:**

1. **Strategize to achieve comprehensive and effective coverage with messages and services**
2. **Evolve workable guidelines from experiences for adoption in new interventions within each target group**
3. **Capacity enhancement of service providers (Contractors and Package Level) to deliver services as per accepted minimum standards within one year of commencement of the intervention**
4. **To implement behavior change intervention among the different audiences**

## 1.3 PRELIMINARY ASSESSMENT OF STATUS OF HIV/AIDS IN THE STATE

Andhra Pradesh is the one of the sixth high prevalence districts in the Country with a median urban prevalence of 2% in urban areas and 1% in semi-urban areas. The HIV

prevalence in STD clinics is 22.8%. 93 % of all infections are through sexual contact with 92% occurrence in the age group of 15-49 years. Specific factors fuel HIV in the state are high non regular sexual partners, low condom usage (25%), high rates of trafficking, migration and sterilizations,..

From the information collected through BSE survey it is revealed that about 50.60% people know methods,

HIV positivity in pregnant women is more than 1% in all 17 districts except Srikalulam, Adilabad, Visakhapatnam, Kunool, Mahboobnagar and Khammam. The mean value of HIV prevalence in STD cases is 22.99% and median value is 30.40%. The District wise data of VCTCs for the period April - December, 2006 reveals that the positivity among VCTC attendants is around 12-13 % among those tested.

**Vulnerable Populations in Andhra Pradesh**

The mapping study undertaken in 2002, by APSACS to locate vulnerable groups in order to effectively reach them with prevention, care, and treatment programmes and additional studies of CSW and MSM populations were conducted in 2003 and 2004 by the AVAHAN programme of the Bill & Melinda Gates Foundation (BMGF) shows presence of vulnerable populations across the state. The table below shows the concentration of high-risk and bridge populations across the state as drawn from studies.

**Table 2 Distribution of Vulnerable population among high risk groups in Andhra Pradesh**

| CSW | MSM | Truckers | Migrant Labour | Street Children | Construction Workers | Mining /Quarry Workers |
|---|---|---|---|---|---|---|
| **82,244** | **39,312** | **84,725** | **106,711** | **8,973** | **58,408** | **70,500** |

The Mapping study also shows that there are 6.64 lakh vulnerable populations who need to be addressed on priority. Of these the core groups of vulnerable population like sex workers and MSM are estimated to be 82,244 and 39,312 respectively. Among the bridge population 70,500 persons work in mines and quarries, nearly 84,725 are truckers, 58,408 are construction workers and over 106,711 are migrant laborers. There are also nearly 2 lakh fishermen and 38,000 women working in tobacco grading units (majority in Prakasam followed by Guntur) who are also found to be vulnerable due to special circumstances in which they work.

## 1.4 GOVERNMENT INITIATIVES FOR HIV/AIDS PREVENTION

Taking vulnerability of State towards HIV/AIDS into account, the GoAP has undertaken a number of initiatives; some of these initiatives have really produced results. Following

section describes strategies adopted by the State and other partners to combat HIV/AIDS from the State.

**i) Be Bold Campaign:** The "Be-Bold Campaign" was launched in Andhra Pradesh by the AP State AIDS Control Society (APSACS) on December 1st, 2006, covering all areas- villages and cities- and involving all sections of people- The campaign, urging people to be bold to come out and test to know their HIV status and to fight against the sigma and discrimination.

| **Duration** | **Got tested** | **ART Use** | **Number of calls to help line** | **Remarks** |
|---|---|---|---|---|
| For 12 months | 5.9 lakhs in last 12 months | 3075 | 13824 | Chief Minister of AP came forward to initiate testing during be bold campaign |
| During 9 months of the campaign | 11.34 lakhs in 9 monthd | 18333 | 21315 | |

As inferred from the table above the "Be-Bold" campaign is aimed to "**translate the awareness into action**". The Be-Bold campaign is a complete package addressing all these issues and has general as well as targeted messages, which are non-judgmental and are positive in nature.

**General messages**

*Be Bold* to talk about HIV/AIDS;

*Be Bold* to get tested;

*Be Bold* to accept the result of the testing;

*Be Bold* to change the life style accordingly-

*Be Bold* to call 1097 the toll free number to know more about HIV/AIDS.

The **targeted messages**

*Be Bold* to take care of HIV +ve family member

Doctors to *Be Bold* to treat HIV +ve patients;

Teachers to *Be Bold* to admit HIV +ve children to their classes;

Youth to *Be Bold* to accept HIV +ve peers as friends;

Youth to *Be Bold* to say NO to negative peer pressures.

The Be bold messages can grow on and on like crystals suiting to various occasions like Women to *BeBold* to say NO to sex without condoms or girls to *Be Bold* to ask for the HIV status of their suitors/ bride-grooms etc …..

A directory of services containing detailed lists and addresses of the testing centres, care and support centres, STD clinics etc. for HIV/AIDS, the vulnerability assessment questionnaire, Involvement of Police Department, issuance of identity cards to the peer educators of sex workers, the **'Hyderabad Declaration'** as a pledge of the positive network persons have pledged to ensure curtailing of the spread the virus through responsible behaviour, Unda me Degera campaign for condom promotion, Zero by Seven Campaign, 15,000 red ribbon club formations, Bold Doctors club, mainstreaming of HIV into Governmental and non Governmental programs, etc. are some of the significant.

**ii) Targeted Interventions**: Targeted Interventions in the State for sex workers and men who have sex with men are carried out through 31 NGOs in the State/ Truckers' interventions are being carried out by NGOs at locations where truck drivers halt for sufficient duration while the migrant interventions were carried out at trans-shipment and conglomeration points . The Truckers' interventions are mainly along highway stretches, relaxation and refreshment points, business activity areas while the migrants were predominantly at the labour pick up points or worksite. These interventions are supported with funds from NACO-APSACS grants. There were 20 truckers and 8 migrant interventions through NACO-APSACS-DFID grant (which have been closed effectively from October 31, 2007), two truckers through Transport Corporation of India Federation-BMGF and Bhoruka Trust-BMGF.

**iii) Initiative of Workplace interventions:** In the State of Andhra Pradesh, under the Initiative of Workplace interventions, APSACS and HLFPPT initiated a series of efforts for mainstreaming HIV interventions through the Transport Sector. Furthermore, APSACS and HLFPPT initiated negotiations with the Transport Department to incorporating HIV related questions in the Driving License Test. A battery of FAQ along with a reference module on HIV/AIDS was developed by HLFPPT and key drop questions and coded keys for the same. "**Unda Mee Degara"** stickers were printed for sticking them on the trucks, to spread awareness, act as reminders, encourage discussions about HIV/AIDS, raise curiosity, etc. Two MAST Information Centres, exclusively for the truckers, were initiated in collaboration with ITC and Singareni, These centres have recived very good response from hih risk groups including trukers.. It is planned to set up such centres in different locations across the state.

**iv)NACP II:**The NACP II evaluation of the Targeted Interventions among Truckers and migrants intervention under NACP II has identified the following key lessons learnt after working for over a decade on this intervention are:

(a) Sex worker interventions would have to exclusively carried out through leadership and ownership from the community of sex workers

(b) Saturated coverage is essential for programs to make a difference

(c) Local community's involvement is critical, as peer educators, participation in local events, sponsoring some events for truckers etc. ;

(d) Selection of "peer" educators from within the community. These peer educators have been able to provide services to the sex workers, truckers / helpers and migrant population with a measure of success.

(e) Highway sex workers are best reached through Truckers Interventions. The high mobility makes it difficult for other interventions to reach to them on a regular basis.

(f) The multiple sexual relations that occur in the migrant population most often than not does not get considered as sex work and hence may be required to be reached within a general population strategy with increased attention to people with multiple relationships.

(g) Need for focus on providing access to STI treatment, an issue that continues to be a challenge. Truckers and migrants either self medicate, or go to local RMPs and private practitioners.

(h) Social Franchising or branded STI Clinics have been explored on the highways for greater visibility, enhancing the recall factor of the name/services, better access and availability of services. The traditional service package within the 9 to 5 standard practice may not cater to them.

(i) VCTC services are generally referred from the halt points to the nearby government clinics, but the number of truckers seeking free services at public facilities is low because the travel distance and the time required act as disincentives. In the case of migrants, loss a day's wage becomes a major deterrent to accessing timely health services. Physical proximity of services encourages better service utilisation.

**v) Strategies under NACP-III(currently in operation):**The goal of NACP III is to halt and reverse the epidemic in India over the next 5 years by integrating program for prevention and care, support & treatment. To achieve this goal, NACP III will pursue, with main objectives being:

(j) Prevention of new infections in high-risk groups and general population

(k) Increasing the proportion of people living with HIV/AIDS who receive care, support and treatment

(l) Strengthening the infrastructure, systems and human resources in prevention and treatment programmes at the district, state and national levels

The major thrust areas for bridge population under the NACP-III are:

- Mainstreaming HIV Prevention through respective departments
- Partnerships with workplaces through Public Private partnership State and District Transport Agency
- Focus on one stop branded service points closest to points of activity
- Evidence based planning and program implementation

The approach and the strategy to be adopted for interventions through the new road construction activity will be guided by the experiences and innovative practices evolved during NACP-II and guiding principles of NACP-III.

However the data projects conservative estimates as there are limitations of sampling methodology imposed by cost and time constraints, especially in estimation of mobile populations. In case of sex workers and MSM estimates of PSA studies and subsequent validation studies by BMGF partners are underway which are expected to give more authentic data.

In the NACP III the APSACS would directly be working through NGO's to reach out the core groups of sex workers, MSM and IDU's. In addition, the bridge population of truck crew and in-migrants (at the destination places) would be reached by a revised strategy of working with truckers associations, dept. of transport and roads.

## 1.5 GAP IDENTIFIED IN GOVERNMENT INITIATIVES

Above mentioned initiatives are either for targeted population in general or targeted intervention covering a few section or stretches in the state. These strategies have not covered the issues which are emerging from road improvement under APRSP especially the roads so selected for improvement. Therefore following section has mentioned those aspects which have not been covered under HIV/AIDS prevention program run by the state and strategies required for APRSP.

(a). Information collected during BSE and Census Survey along the project corridor, it is revealed that I-E-C materials dissemination has not been done along the proposed road(APRSP) adequately.

(b). During consultation with NGOs and CBOs it is established that APSACS partner NGOs networking requires strengthening and communication with high risk groups of transport sector requires specific targeted intervention.

(c). **Targeted interventions** under truckers project has been done along NH-5,NH-7 and NH-9 but state highways have not been covered. None of the truckers project conducted by APSACS and its partner has targeted project roads under proposed improvement.

(d). **Be bold massages** have aimed to cover targeted population of entire state(large geographical area) But actually have feeble coverage in rural areas along the project road.

(e). The project (primarily a road up gradation project) will have '**cause and effect'** relationship with improvement of roads and proliferation of HIV/AIDS within a project influence area which needs to be addresses within the planning part of the APRSP.

These gaps need to be addressed during preparation of prevention of HIV/Action Plan for the proposed road. For this purpose following section outlines socio-economic characteristics of the project area, important intervention program along the settlement and need of HIV/Action Plan.

## 1.6 CHARACTERISTICS OF INTERVENTION AREA

**A brief socio-economic characteristic of the project affected area (Intervention area) is presented below**.

District level pattern

Most of the people in the Districts are dependent on the agricultural activities. The table below indicates that the project area has poor development indices.

Proportion of non-workers is 53.20% for CP Road, 55.20% for MJ Road,53.17% for KS Road and 50.55% for KD Road. Likewise literacy rate is 66.80%,62.8%,54.10% and 53.20% for CP,MJ,KS and KD road respectively. Female work participation rate varies from 32.71% to 42.36% for these Districts. (Table 3)

**Table 3: Social and Economic Indicators of the Project Districts**

| Project Districts | Economic | | | | Social& Demographic | |
|---|---|---|---|---|---|---|
| | Per capita Income | % of land put to non agricultural land Use | % Non-Workers | Female work participation in % | Literacy | Decadal Growth Rate |
| Chittoor | 18874 | 9.51 | 53.20 | 35.37 | 66.80 | 14.86 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Cuddapah | 17682 | 11.27 | 55.20 | 32.71 | 62.8 | 14.73 |
| Ranga Reddy | 24346 | 11.64 | 59.8 | 26.29 | 66.2 | 40.9 |
| Medak | 24490 | 7.71 | 51.6 | 41.38 | 51.6 | 17.64 |
| Mahbubnagar | 15830 | 4.33 | 48.1 | 47.41 | 44.4 | 14.2 |
| **Kurnool** | **15125** | **7.69** | **50.55** | **42.36** | **53.20** | **18.72** |

**Settlement level analysis**

Following section outlines some of the social indicators of the settlement abutting project road.

For CP Road the percentage of ST and SC groups is more in Annur village (81%) and as low as in Venkatapuram (0%) and Nallepallimitta (0%). The non-workers percentage is more in Kattapaligota (68%). The literacy rate varies from 29% (Nallepallimitta) to 85% (Venkatapuram).

For MJ Road percentage of ST and SC groups is more in Devagudi village (24.82) and is low in Rameshwaram village (7.12). The non-workers percentage is more in Rameshwaram (57.53). The literacy rate varies from 28.19% (Chowduru) to 37.97% (Goriganur) but still lower than state average.

The percentage of SC groups is more in Sankarpalli village (74.88) and is low in Chevella village (18.64). The non-workers percentage is more in Sankarpalli (55.92). The literacy rate varies from 16.81% (Chevella) to 36.02% (Sankarpalli) but still lower than state average.

The percentage of ST and SC groups is more in Peddapadu village (33.31%) and is low in Salkapuram village (5.99%). The non-workers percentage is more in Kodumuru (57.69%). The literacy rate varies from 12.08% (Peddapadu) to 36.43% (Kodumuru) but still lower than state average. The characteristics of settlements are presented below in **Table 4.**

**Table 4 : Settlement along the Project Road**

| Name of the Village | Chainage | | Total Population | % of SC+ST | % Of Non-Workers | Literacy Rate |
|---|---|---|---|---|---|---|
| | From | To | | | | |
| Chittor-Puttur Road | | | | | | |
| Venkatapuram | 3.000 | 5.500 | 139 | 0.00 | 55.4 | 85.61 |
| Peddakalwa | 5.500 | 6.300 | 2067 | 19.497 | 60.43 | 49.93 |
| Velkuru | 8.450 | 9.000 | 2666 | 42.086 | 55.1 | 38.45 |
| Gangadharanellor | 9.600 | 10.600 | 3505 | 50.87 | 58.74 | 52.52 |
| Nallepallimitta | 17.650 | 17.800 | 406 | 0.00 | 57.64 | 29.56 |
| Kondapalli | 19.500 | 19.800 | 1138 | 34.886 | 41.04 | 39.54 |
| Kottapalligutta | 21.400 | 21.900 | 1976 | 42.763 | 68.22 | 54.91 |
| S.R.Puram | 32.750 | 33.000 | 32921 | 37.611 | 56.99 | 35.73 |
| Annur | 43.000 | 44.500 | 2565 | 81.52 | 52.9 | 38.09 |
| Karvetnagar | 52.400 | 53.100 | 10813 | 30.13 | 63.3 | 48.61 |

| Name of the Village | Chainage | | Total Population | % of SC+ST | % Of Non-Workers | Literacy Rate |
|---|---|---|---|---|---|---|
| | From | To | | | | |
| **Mydukutu-Jammalmadugu Road** | | | | | | |
| Chapadu | 160/600 | 162/370 | 2228 | 23.115 | 43.94 | 35.95 |
| Pallavolu | 162/250 | 162/900 | 4225 | 19.314 | 40.17 | 35.81 |
| Kottapalli | 170/190 | 171/545 | 8384 | 9.697 | 48.06 | 37.57 |
| Rameswaram | 178/000 | 179/000 | 8284 | 7.1222 | 57.53 | 31 |
| Chowduru | 182/130 | 182/720 | 2554 | 10.572 | 54.35 | 28.19 |
| Devagudi | 185/500 | 186/000 | 2107 | 24.822 | 50.74 | 35.26 |
| Goriganur | 190/000 | 191/000 | 1912 | 13.546 | 45.29 | 37.97 |
| **Kandi Sadhnagar Road** | | | | | | |
| Sankarpalli | 17/00 | 19/000 | 12110 | 74.88 | 55.92 | 36.02 |
| Chevella | 31/00 | 33/000 | 14815 | 18.64 | 57.6 | 16.81 |
| Dharmasagar | 51/00 | 52/000 | 481 | 26.61 | 52.39 | 21.21 |
| Shadnagar | 67500 | 67/000 | 674 | 21.51 | 43.77 | 17.21 |
| **Kurnool-Devenkonda Road** | | | | | | |
| Kurnool | 0/000 | 4/000 | 62430 | 27.469 | 47.47 | 27.05 |
| Peddapadu | 04/900 | 07/900 | 4436 | 33.318 | 51.1 | 12.08 |
| Salkapuram | 12/195 | 12/650 | 1552 | 5.9923 | 51.61 | 28.41 |
| Penchikalapadu | 18/370 | 18/995 | 1909 | 10.372 | 44.42 | 24.46 |
| Kodumuru | 34/800 | 35/910 | 19157 | 10.367 | 57.91 | 36.43 |
| Eduladevarabanda | 47/985 | 48/995 | 3071 | 7.6848 | 51.09 | 13.35 |
| Kunkanur | 49/765 | 49/800 | 3343 | 20.341 | 48.76 | 12.56 |
| Karivemula | 56/190 | 56/530 | 3741 | 18.765 | 36.51 | 13.58 |
| Devanakonda | 62/280 | 62/560 | 7156 | 21.353 | 57.69 | 28.52 |

From the above mentioned information following points need to be considered while prevention of HIV/Action Plan is prepared:

(a). Literacy level is lower in project affected settlements(Area of influence)

(b). Proportion of Socially disadvantaged group(SC,ST) is high for Sankarapalli and Annur(two villages), thus special emphasis is required for these two villages.

(c). Percentage of non-worker is more than 50% in many villages, it means more I-E-C and BCC requires to change their attitude toward safe sex behaiviour

**Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter**

| Sl. No. | Name of Road AP SRP-Pahse-I | SH/ MDR | Length (km) | Name of Villages/ Towns & Popln. | Vulnerability Factors | Identified Hot Spots | Truck Parking bays | Other HIV Prevention Interventions | CHC/ PHC/ VCTC Services | STI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.** | **Kandi-Shadnagar, Mabubnagar** | MDR | 65.60 | Kandi | CSW, IDU, Truck Parking | ✓ | ✓ | 55%-60% | VCTC<br>1.Shadnagar<br>2.Maboobnagar<br>3.Jedcherla<br>4.Kotakota | |
| | | | | Dharmasagar | Truck Parking, CSW | ✓ | ✓ | 50%-55% | VCTC<br>1.Shadnagar<br>2.Maboobnagar<br>3.Jedcherla<br>4.Kotakota | 1.Mabubnagar HQ hospital |
| | | | | Chevella | Truck Parking, IDU, CSW | ✓ | ✓ | 50%-60% | PHC<br>1.Mabubnagar<br>2.Balanagar<br>3.Jedcherla<br>4.Shadnagar<br>5.Addakula<br>6.Kothakota | |

**Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter**

| Sl. No. | Name of Road AP SRP-Pahse-I | SH/ MDR | Length (km) | Name of Villages/ Towns & Popln. | Vulnerability Factors | Identified Hot Spots | Truck Parking bays | Other HIV Prevention Interventions | CHC/ PHC/ VCTC Services | STI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Sankarpalli | IDU, CSW, Truck Parking | ✓ | ✓ | 55%-60% | VCTC<br>1. Mahboobnagar<br>2. Addakula<br>3. Kothakota | |
| | | | | Shadnagar | IDU, Truck Parking | ✓ | ✓ | 50%-55% | PHC<br>1.Mabubnagar<br>2.Balanagar<br>3.Shadnagar<br>4.Addakula | |
| | | | | | | | | | | |
| 2. | **Kurnool-Devanakonda,** | SH-50 | 60.60 | Salkapuram | Rural area | X | X | - | VCTC<br>Yemmiganur and Karnool.<br>Gadivemula | Kurnool Medical college |
| | | | | Kadumuru | IDU, CSW | ✓ | ✓ | 50%-55% | PHC<br>Gadivemala, Kodumuu, Halkapuram | |
| | | | | Karivemula | Rural area | X | X | - | | |

**Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter**

| Sl. No. | Name of Road AP SRP-Pahse-I | SH/ MDR | Length (km) | Name of Villages/ Towns & Popln. | Vulnerability Factors | Identified Hot Spots | Truck Parking bays | Other HIV Prevention Interventions | CHC/ PHC/ VCTC Services | STI Services |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Kurnool | IDU | ✓ | ✓ | 50%-55% | PHC Gadivemala, Kurnool, Halkapuram | |
| | | | | Pulakurthi | Rural | X | X | - | | |
| | | | | Manchapuram | | X | X | - | | |
| | | | | Kapatralla | Rural | X | X | - | | |
| | | | | Kunkanur | | X | X | - | | |
| | | | | Devanakonda | - | X | X | - | | |
| | | | | Peddapadu | IDU, CSW | ✓ | X | 55%-60% | PHC Gadivemala, Kurnool, Halkapuram | |
| | | | | Kodumur | IDU, CSW | ✓ | ✓ | 50%-55% | VCTC Yemmiganur and Karnool. Gadivemula | |
| | | | | Penchikalapadu | Rural | X | X | - | | |
| | | | | Kuruvanagapuram | | | | | | |

| Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Sl. No.** | **Name of Road AP SRP-Pahse-I** | **SH/ MDR** | **Length (km)** | **Name of Villages/ Towns & Popln.** | **Vulnerability Factors** | **Identified Hot Spots** | **Truck Parking bays** | **Other HIV Prevention Interventions** | **CHC/ PHC/ VCTC Services** | **STI Services** |
| | | | | | | | | | | |
| 3. | **Chittoor-Putttur** | MDR | 60.60 | Karvetnagar | HBSW, Truck Parking | ✓ | ✓ | 55%-60% | VCTC Karvetnagar, S.R.Puam, Lothapalligutta | |
| | | | | Annur | | | | | | |
| | | | | Kollagunta | | | | | | |
| | | | | S.R.Puram | HBSW, CSW | ✓ | ✓ | 50%-55% | PHC Karvetnagar, Kondapalli, Velkuru | |
| | | | | Marripalli | | | | | | |
| | | | | Oddupalli | | | | | | |
| | | | | Kottapalligutta | CSW, IDU, HBSW | ✓ | ✓ | 50%-55% | VCTC Karvetnagar, S.R.Puam, Lothapalligutta Velkuru | |
| | | | | Kotarlapalli | | | | | | |
| | | | | Kondapalli | | | | | | |

| Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Sl. No.** | **Name of Road AP SRP-Pahse-I** | **SH/ MDR** | **Length (km)** | **Name of Villages/ Towns & Popln.** | **Vulnerability Factors** | **Identified Hot Spots** | **Truck Parking bays** | **Other HIV Prevention Interventions** | **CHC/ PHC/ VCTC Services** | **STI Services** |
| | | | | Nallepallimitta | | | | | | |
| | | | | Gangadharanellor | CSW, HBSW, Truck Parking | ✓ | ✓ | 55%-60% | VCTC Karvetnagar, S.R.Puam, Lothapalligutta | |
| | | | | Velkuru | | | | | | |
| | | | | Batrikandriga | | | | | | |
| | | | | Peddakalwa | | | | | | |
| | | | | Venkatapuram | | | | | | |
| | | | | Puttur | HBSW, CSW | ✓ | ✓ | 50%-55% | VCTC Karvetnagar, S.R.Puam, GD Nellore | |
| | | | | | | | | | | |
| 4. | **Mydukuru-Jammalamadugu** | SH-57 | 41.00 | Chapadu | | | | | | |
| | | | | Pallavolu | | | | | | |
| | | | | Kottapalli | | | | | | |
| | | | | Rameswaram | | | | | | |

| Table 5:Vulnerability of Settlements Towards HIV/AIDS Transmission based on Selected Parameter | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Sl. No.** | **Name of Road AP SRP-Pahse-I** | **SH/ MDR** | **Length (km)** | **Name of Villages/ Towns & Popln.** | **Vulnerability Factors** | **Identified Hot Spots** | **Truck Parking bays** | **Other HIV Prevention Interventions** | **CHC/ PHC/ VCTC Services** | **STI Services** |
| | | | | Chowduru | CSW, IDU, Truck Parking | ✓ | ✓ | 50%-55% | VCTC Mydukuru, Devagudi, Jammalamadugu | |
| | | | | Devagudi | | | | | | |
| | | | | Goriganur | | | | | | |
| | | | 228. 00 | | | | | | | |

## 1.7 STRATEGIES FOR HIV/AIDS PREVENTION

In terms of HIV/AIDS prevalence each of the districts are presented with specific factors that increases their vulnerability to HIV for eg. Chittoor has a presence of strong sexual works and Tirupati town in the district has an IDU population. Cudappah shows a presence of home based sex workers and in-migrants due to the quarries. Mahboobnagar district has the characteristics which could fuel an epidemic such as: low literacy rates, limited employment opportunities leading to high levels of poverty, migration and others. Rangareddy and Medak are districts closer to Hyderabad which supports out-migration to Hyderabad.

Given the above situation the APRSP phase-I intends to address HIV/AIDS Prevention and Control program with following strategies:

**Strategies for the Prevention Interventions to the Target community**

**Greater involvement of construction companies, contractors and work force for establishing intervention program**

Consultative meeting will be held to enlist encourage active participation of the critical stakeholders. The focus would be on developing a greater understanding on the impact of HIV/AIDS on the sector and the need to actively engage for halting the spread of epidemic in the workforce. Strong advocacy will be carried out to ascertain commitment and role in prevention of HIV/AIDS.

**Peer education**

Through the selection of peer educators from the community and subsequent peer education service delivery through them, the project will focus on bringing about behaviour change through information sharing, condom promotion and service linkage development. The focus would be moving from enhancing knowledge to bringing about behaviour change.

**Branded Information Centre**

Based on the experiences of setting up Information Centres under the brand Mast as part of Workplace interventions at trucking points at Singereni Colleries and ITC Paper Mills, Khammam, branded Information Centres will be established as a single window approach for services. These centres will provide information, recreation and services at one point. This centre will not only stock HIV related information materials but

also provide STI services and other health services. A condom vending machine will be placed in the centre. Other utility services like phone booth, water, newspaper and play materials like caroms, game boards etc will be made available at the centre.

**STI and general health clinics**

The experience of setting up STI clinics in the State for community populations has shown excellent results in ensuring access to services. The concept will be expanded to reach the migrant, displaced population and the truckers.

**Life and social skills training for displaced and community youth**

The FHI experience in reducing risks in vulnerable youth through life skills training will be brought into the program. In addition, a component of social sills will also be incorporated.

**Structural interventions for building enabling environment**

Advocacy will be carried out to iimproved working practices and conditions where movement of families will be encouraged. Security and recreational facilities for workers/ drivers will be increased. Improved working schedules, development of crèches and teaching of children to facilitate women to work and children to be taken care will be undertaken.

The program components will include behaviour change communication (BCC); counselling services; condom promotion; and increasing access to quality STI services; voluntary counselling and testing services; and care, support and treatment services.

The overall program will be managed, provided with regular technical assistance, monitored and capacitated by a team of professionals under the Nodal Level NGO and the community level interventions will be carried out by a network of package level NGO's

Agency and the community level interventions will be carried out by a network of NGO's

**Table 6: HIV/AIDS Action Plan**

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| **I** | Evolve workable guidelines from | **Finalize the Intervention Approaches** | The Nodal NGO team will interact with the SACS and NGO's and review the operational guidelines for developed for different audiences and | Nodal NGO,SMU,APS |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | experiences for adoption in new interventions within each target group | | finalise the intervention approaches for the different project components | ACS |
| | | **Communication Guidelines** | The Communication Officer will work develop/adapt the key messages that needs to be provided in the communities and monitor the communication interventions so as to reach the audience with appropriate messages and reduce audience fatigue. Building a brand for the project where uniform messages are provided and a logo displayed across the packages which the community could easily identify with. This could be also mounted on the Be-Bold or Asha campaign adapted in the State. | Nodal as well as package NGO, |
| | | **Develop Systems both for the Nodal NGO and the Package Level NGO** | Uniform systems for program management, program implementation, capacity building, monitoring, and reporting to be developed by the nodal NGO and shared with the APRDC and with the package level NGO's for them to follow. | SMU,PMU |
| **II** | Achieve comprehensive and effective coverage of audiences with messages and services. | **Desk review at Nodal NGO Level** | There are different mapping, BSS and other population specific studies conducted in the state of Andhra Pradesh. The team in the Nodal NGO will conduct desk review on data available from the specific project areas and attempt to derive some level of baseline data against which the project achievements could be measured | Nodal NGO, SMU, package NGO |
| | | **Interaction with APSACS and other agencies working in the Project area** | As part of the program planning process the Nodal NGO team will regularly interact with the APSACS and other donors in the supporting NGO's and the field level NGO's already working on different issues in the project areas to understand the situation and assess the gaps in the programs that needs to be addressed. | Nodal NGO |
| **III** | **Capacity** | **Clarity on roles** | The standard clause in the health and safety section of the World Bank | Package |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | **enhancement of service providers (Contractors and Package NGO) to deliver services as per accepted minimum standards within one year of commencement of the intervention** | | contract envisages that the contractors will be responsible to their workforce (engaged both directly and indirectly) and implement programs in-house to educate them on HIV and increase their access to prevention services.<br>The Nodal NGO and package NGO's will work with the staff of the contractors to sensitize and orient them on the issues related to HIV/AIDS. Thereby getting a buy-in from the contractors and mobilizing them to initiate in-house workplace intervention programs. Where their staff would be trained as Peer Educators and they will regularly conduct prevention education sessions in-house.<br><br>**Implementing NGO's (Package Level)**<br>The package level NGO's who are contracted by the project will be working among different audiences in the communities. The NGO staff would also be available to the contractor's worksites to provide training and setting up the workplace intervention program. | Manager, package NGO,contractor |
| | | **Build technical capacity of the project teams** | Capacity building is seen as a priority area. The Nodal NGO will be responsible to build overall capacity of the NGO's. This would be done by organizing workshops where the Resource Persons could be from the Nodal NGO itself or other Resource Persons who were identified in coordination with APSACS and other agencies working on HIV/AIDS could be brought in to conduct specific sessions. | Nodal NGO, Package NGO,contractors |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | During the fourth month of the project- after submission of Action Plan by NGO's, a three day technical capacity building workshop will be organized. The project teams from the different NGO's will participate in the training. The wide range of topics related to HIV/AIDS prevention and care and support will be covered. As the training needs assessment will be conducted before the training the topics will be based on the needs expressed by the staff.<br><br>Project personnel will be given one-day trainings every quarter (based on the training needs assessment) to carry out project activities effectively. The Project Coordinators / and Training Officers will conduct most of these internally. | |
| **IV** | **To implement behavior change intervention among the different audiences** | **Provision of Behavior Change Communication to the mobile labor population and the population living along the corridors** | BCC interactions will be initiated from the start of the project. The Outreach workers, during these inter-personal interactions will focus on STIs/HIV/AIDS issues, *Care and Support to PLHA issues*, clear doubts or myths and misconceptions, make referrals to the referral centers, and distribute free condoms. These shall be procured from the Andhra Pradesh AIDS Control Society (APSACS). For effective behavior and attitude change repeated and reinforced messages would be provided to the target audience.<br>Each Outreach worker would conduct approximately four one-to-one interactions in one day and one 1 to group interaction each day. | Package NGOs, APSACS, District Health Department |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | **Peer Educators**<br>To broad base the projects' outreach and develop ownership of programs the project will identify and train peer educators. Peer educators will be gelled into the project activities for effectiveness, acceptability, ownership, and sustainability. The peers will be provided with incentives to keep them motivated.<br><br>The Peers will be drawn by mobilising the youth in the communities and workforce and by working closely with the Self help groups. These Peers would serve as the change agents and would be a long-term investment of the project into the communities.<br><br>**Mass media**<br>Mass media with local folklore like Hari Katha will be utilized. Puppet, video shows and street plays will be effectively used for larger coverage. Each project will organize one large community level event a month. Each of the NGO projects will take steps to develop its own street playgroups-engaging their Peer Educators, based on experiences drawn from other HIV/AIDS prevention projects. Other local NGOs folk media will also be effectively used wherever possible.<br><br>**Life skills training to the youth**<br>The changing scenario with the development of new roads will place | |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | greater challenges on the youth which can increase risks and vulnerability. The Life and social skills module will be fine-tuned for the project linked youth which will be carried out on a weekly basis thus preparing them for taking responsibility and face challenges through greater preparedness and skills.<br>**Generating an enabling environment**<br>Contractual nature of the work, alcoholism, low wages, absence of health service linkage and migrant nature of work, violence etc. increases the risk to HIV. Advocacy initiatives will be carried out with the traffic police, the transport department, the dhabawallas and hoteliers, trucker's associations, construction contractors and companies, district administration including the Panchayat Raj, Public Works Department, Oil companies, Travel and tourism department, the Legislative Forum etc for mechanisms that will reduce risks and vulnerabilities including increasing access to prevention services.<br>**Creation of appropriate mechanisms and capacities to implement and monitor the interventions**<br>Instituting monitoring at the beginning of a program's life will ensure that the goals and objectives defined during program design are clear, measurable, and relevant, and that the actual program is the same as the one that was planned. Individual behaviour tracking and a user friendly computerised MIS for tracking of STIs among PSH including behaviour | |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | change towards adoption of safe sex practices will be introduced to track behaviour change.<br><br>Projects will be reviewed after one and half year to measure the progress of effectiveness to review the existing strategy and to strengthen the project in achieving the goal. Specific studies with the objective to find out the Training Impacts, Communication review, Impacts made by the projects, issues related typical sexual behaviours practices. In order to promote experience sharing between program stake holders to improve programme implementation it is proposed to established learning systems a part of NACP-III through best practice documentation and cross project exposure visits.<br><br>**Workshops and training of NGO's/ CBOs**<br>To increase coverage of communities on the whole road stretch effectively, the project will seek out to NGO's/ CBO's who are working in the project areas on different social issues and orient them on the issues related to HIV so as to integrate HIV prevention as part of their ongoing activities in the communities.<br>• Public meetings; Group discussions, meeting with the different audiences.<br>• Posters, larger bill boards, banners and mobile hoardings;<br>• Leaflets of other objects with HIV/AIDS safety messages | |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | embedded; street plays, magic shows, puppet show, short films, Nukrad Natak, Road site retro boards.<br>• Travelling loudspeaker vans; | |
| | | **Provision of condoms at the work locations and to the other population (free distribution and social marketing)** | During one-on-one interactions and group meetings, the Health Educators and Peer Educators will educate people on the correct use of condoms and discuss with them issues pertaining to their use (such as the negotiation of condom use between sexual partners). Additionally, condom outlets (vending machines) will be established in strategic places preferably within the construction camp located within the project areas covering both the work site and the residential colonies.<br>In addition to dispensing condoms, these outlets will provide information (pictorial and textual) on correct condom usage and its role in preventing the transmission of HIV and other STIs. Health Educators will obtain condoms at no cost free distribution from the AP State AIDS Control Society and will be responsible for replenishing condom stocks and maintaining the outlets.<br>If there is a request for additional condoms, apart from the free distribution mechanism, the Project Coordinator will contact social marketing organizations (e.g. Population Services International and Hindustan Latex Limited) to make branded condoms accessible to the target audience. | |
| | | **Provision of Counseling Services** | Health Educators and Peer Educators on the project identified with basic skills/interests in Counseling will be further referred to participate in Counseling workshops being organized by different agencies working on | |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | HIV and AIDS in AP such as APSACS, FHI and others. Once these people have the necessary skills they will be given the responsibility to counsel clients who require/seek counseling in the project areas. | |
| | | **Provision of STI services through referral** | The project will increase the access of the audiences to STI services by strengthening referral linkages between contractors health clinics and public and private health care providers. The syndromic case management chart developed by NACO will be provided to health care providers as a guide. The Outreach workers will follow-up on a regular basis with the referral centers on the number of people referred and who have accessed STI care from these referral centers. | |
| | | **Increase access to HIV testing for the population to assess their HIV status through referral linkages to government accredited testing facilities** | If clients express a desire during a counselling session or BCC event to undergo an HIV test, she/he will be referred to a networked VCT facility for the HIV test. After the individual concerned undergoes the pre-test and post-test counseling at the VCT, she/he will be encouraged to visit the project counselling center for follow-up counselling. A system for following up on project referrals to VCT centers will be instituted after having met with the counsellor at the VCT. | |
| | | **Create an environment of reduced stigma and discrimination** | The project would take conscious efforts to work on the issue of reducing stigma and discrimination. This would be done by discussing the challenges faced by individuals and families affected by HIV and the supportive role of the community. In addition, PLHA network members will be engaged to conduct positive speaking sessions in the communities where they would be sharing their testimonies which would have an effect of increasing acceptance of PLHIV in the communities and also would | |

| Sl. No. | Objective | Strategies | Action | Responsibility |
|---|---|---|---|---|
| | | | serve as an effective prevention strategy. | |
| | | **Referral for Care, Support and Treatment Services for people living with HIV and AIDS (PLHIV)** | Linkages will be established with agencies providing home/ community based care and the positive network groups to provide support to people living with HIV/AIDS (PLHIV) and their families within the project setting. The Health Educators and Peers will provide the necessary information to PLHA about these centers and make referrals for such services. | |

## 1.8 IMPLEMENTATION MECHANISM AND INSTITUTIONAL ARRANGEMENT

Detail institutional arrangement for the implementation of HIV/AIDS action plan is already mentioned in Social Management Plan(RAP),but there are some other institutional stakeholders who will be involved in HIV/AIDS planning and implementation and their active role is envisaged. Among important stakeholders, APSACS will be involved as nodal partner to assist APRDC in planning, implementation, monitoring entire HIV/AIDS prevention program for APRSP. Following sections highlight institutional stakeholders and their responsibilities in managing HIV/AIDS action plan.

As learnt from the HIV/AIDS prevention strategies adopted by the important stakeholders including some of donor agencies that target group(audiences),intervention mechanism target area, and other strategies for prevention and control of HIV/AIDS transmission is unique but diverse. Proposed project under APRSP has specified its target population, intervention area and intervention strategies limited to road users,road side communities within the periphery of one kilometer either side. After careful examination of strategies and action for the prevention of HIV/AID following stakeholders are identified to play important role in implementation of the project.

- Andhra Pradesh State AIDS Control Society
- Social management Unit(APRDC)
- Nodal NGO
- Package Manager
- Package NGOs
- Contractors
- District Health Department

### a) Andhra Pradesh State Aids Control Society (Apsacs)

APSACS is the nodal agency in the State to plan and implement initiatives for the prevention and control of HIV/AIDS prevention in the State. APSACS is assisted by its program manager(project support unit).NACP III envisages independent strategies for different target groups. After having examined APSACS present engagement with NACP III and other program, APSACS will be involved to provided guidance to APRDC, capacity building and strategies intervention program. Actual implementation will be done by APRDC. Following are specific role of APSACS in the present program:

- Develop strategies and plan for synchronizing ongoing current prevention program with prevention program under APRSP
- Initiate capacity building and training to institutional stakeholders of APRSP
- Provide BCC materials to NGOs working under APRSP

- To evaluate/monitor prevention program and suggest corrective measures to improve efficiency of the program

**b) District health Department**

District health department will be nodal department at the District level to ground the HIV/AIDS action plan. Their role will be

- Guide facilitating NGOs at package level in providing training and capacity building
- Provide I-E-C and BCC materials to facilitating NGO(package)
- Assist in organize District level mass education program like health mela,DWACRA gatherings,SHG mela
- Assist package manager in advocacy campaign
- Periodic monitoring HIV/AIDS prevention program carried out by facilitating NGOs

**c) Social Management Unit (SMU)**

- Detail role and responsibilities of Social management Unit is already discussed in Resettlement Action Plan. The SMU will be working in close coordination with nodal NGO, package NGOs and APSACS. The SMU will be working as bridge between APRDC and other stakeholders including contractors.

**d) Nodal NGO**

Operational procedure of implementation of Social Management Plan including HIV/Action Plan envisages services of one Nodal NGO (at the project level) to function as the technical support unit similar to mechanism of implementation of program in APSACS. Though detailed roles and responsibilities is mentioned in terms of Reference(ToR) as annexure specific roles and responsibilities of nodal NGO pertaining to HIV/Action Plan implementation include the following.

- Coordinate with package NGOs for implementation of the Plan,
- Training to outreach workers of package level NGOs,
- Develop strategies for information dissemination,
- Develop project related BCC materials useful for HIV/AIDS prevention
- Training and capacity building of contractors staffs,
- Develop strategies for advocacy with different department using recent approach of APSACS,
- Assist SMU in providing logistics for training and capacity building session imparted by APSACS for SMU(APRDC), officers of package unit of APSHP offices, contractor staffs

**e) Package Manager**

The Package Manager, with close involvement of Department of Health(CMO office) of the District, will finalise plan of action for the prevention of and Control of HIV Action Plan. Specific responsibilities of the Package Manager include the following:

- Finalize plan of action for HIV/AIDS prevention for package NGO
- Provide adequate budget for each activities on time
- Ensure budget availability for I-E-C and BCC materials
- Participate in District level meetings of Health Department
- Appraise SMU(APRDC) innovative intervention strategies required
- Formulate corrective measure for intervention

### f) Package level NGO

In order to facilitate implementation of SMP, one NGO at the Package level will be engaged which will also work as link (and liaise) between the project and local communities and other stakeholders. The specific roles and responsibilities of the Package NGO in the implementation of Package level SMP including HIV/AIDS Action Plan are as follows:

(i) Work closely with the local communities particularly the project affected people, vulnerable groups, road users and have regular interactions with the local communities and develop good working relationship.

(ii) Coordinate with different District level agencies and other development organizations for the successful implementation of SMP.

(iii) Put into practice the implementation strategies developed by Nodal NGO. This essentially requires close collaboration and working with APSHP, District Administration (particularly Revenue, Health), offices of the line Departments and other relevant agencies and ensures successful SMP implementation.

(iv) Liaise with the District Administration and other development agencies to dovetail their development programs for the socio-economic improvement of affected communities and vulnerable groups.

(v) Develop innovative mechanism/methodologies to ensure active involvement of various project stakeholders in the implementation of SMPs.

(vi) Help in the monitoring and evaluation of SMP at the Package level

(vii) Work in close coordination with Nodal NGOs and APRDC staff in the implementation of SMP

(viii) Attend to any other relevant responsibilities assigned by the Project/Package Manager

**g) Contractor**

The contractors will be working as per contract clause related to HIV/AIDS in general condition of Contract (GCC). But to fulfill corporate social responsibilities, the contractors have following roles.

(a). Extend support to package NGO in educating workers engaged in construction work,

(b). Provision of a doctor for periodic check-up of construction workers

(c). Organize weekly program for I-E-C plan.

**Budget for Managing HIV/Action Plan**

The HIV/AIDS Action Plan has been endorsed by APSACS (Re:No. 4451/R&B/AIDS/2008) with an agreement to integrate HIV/AIDS prevention, care, support and treatment services into the existing services for HIV/AIDS available in the project area. APSACS also agreed to provide technical support and IEC/BCC materials to take up awareness program.

The total budget for implementation of HIV/AIDS Action Plan is estimated Rs 14.96 million. The budget has been worked out in consultation with APSACS and keeping in view the services of nodal NGOs available to the project. Further, all technical support, IEC material and other instruments would be available from APSACS. The multiplication of these materials will be done under the project. The unit rate available from APSACS has been the base of for estimating the budget. The detailed budget for improvement and up gradation component (430 km) is mentioned in table below.

## Table 7 Budget for Implementation of HIV/AIDS Action Plan

| Sl. No. | Type of IEC / BCC material | Content of the material | YEAR-I | YEAR-II | YEAR-III | YEAR-IV | YEAR-V | TOTAL |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 6 | 7 | 8 | 9 | 10 | |
| **1** | **Development of IEC/BCC materials** | | | | | | | |
| 1.1 | Flip book/Flash Card/Flex for Field staff | Generic | | | | | | 500,000 |
| | | Thematic (FSW/IDU/MSM) | | | | | | |
| 1.2 | Kit bag for Peer Educators & Field staff | For carrying BCC/IEC materials | 50,000 | | | 50,000 | | 100,000 |
| 1.4 | Mobile Exhibition kits @ Rs. 2000/- | For Group sessions | 200,000 | 200,000 | 200,000 | 200,000 | 200,000 | 1,000,000 |
| 1.7 | Condom Vending Machines | Multipurpose vending machines | 500,000 | 500,000 | 500,000 | 500,000 | 500,000 | 2,500,000 |
| 1.8 | Documentation of Case Studies/Best practices | Field report of TI partners | | 40,000 | 40,000 | 40,000 | 40,000 | 160,000 |
| 1.9 | HIV/AIDS Kiosks per village | For sustainability of the programme | 500,000 | 500,000 | 500,000 | 500,000 | 500,000 | 2,500,000 |
| 1.10 | Production of Annual Report | Programmatic & financial outlay & achievements for one year | 50,000 | 50,000 | 50,000 | 50,000 | 50,000 | 250,000 |
| 1.12 | Wall painting @ Rs. 8/- | Wall painting along the roads | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 500,000 |
| 1.13 | Hoardings/- | Depicting the HIV/AIDS messages | 40,000 | 40,000 | 40,000 | 40,000 | 40,000 | 200,000 |
| 1.14 | Model of Penis @ Rs. 150/- | For demonstration of condom use | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 500,000 |
| 1.15 | Leaflets in Telugu @ Rs. 1/- | HIV/AIDS messages | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 750,000 |
| 1.16 | Stickers @ Rs. 8/- | Bus / Truck / Taxi | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 750,000 |
| 1.17 | Balloons | For enhanced visibility | 150,000 | 150,000 | 150,000 | 150,000 | 150,000 | 750,000 |
| **2** | **Hiring of an Consultant for design & development of the above materials** | | **500,000** | **250,000** | **250,000** | **250,000** | **250,000** | 1,500,000 |
| **3** | **Training and capacity building** | | **100,000** | **100,000** | **100,000** | **100,000** | **100,000** | 500,000 |
| **4** | **Exposure Visit for project staffs** | | 500,000 | 500,000 | 500,000 | 500,000 | 500,000 | 2,500,000 |
| **Total One crore forty nine Lakhs and sixty thousands only** | | | | | | | | **14960000** |