Capacity Building Activities for the Link Workers Scheme and Targeted Intervention (TI) Project functionaries through "Kshamta Kendra" in the state of Rajasthan

PRACTICUM REPORT

Johns Hopkins Bloomberg School of Public Health & IIHMR University

By

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MPH Cohort – 09

2021-2023

Under Guidance of

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CERTIFICATE BY THE ADVISOR

IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Khushboo Joshi**, a student of the Master of Public Health Program offered by IIHMR University, Jaipur in cooperation with Johns Hopkins Bloomberg School of Public Health, Baltimore USA has undergone Practicum Training at IIHMR University from 21st March to 25th April 2023.

The Candidate has successfully carried out the study designated to her during practicum training and her approach to the study has been sincere, scientific, and analytical.

The Practicum Training is a fulfillment of the course requirements.

I wish her success in all her future endeavours.

Dr. Anoop Khanna

Professor

IIHMR University, Jaipur.

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CERTIFICATE BY SCHOLAR

This is to certify that the Practicum Project titled submitted by me, Khushboo Joshi with Enrollment No. 0051 under the supervision of Dr. Anoop Khanna (Practicum advisor) and Dr. Ratna Verma (Preceptor) for the award of Master of Public Health carried out during the period 21st March to 25th April 2023 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Dr. Khushboo Joshi

MPH Cohort 9

2021-2023

CERTIFICATE FROM THE ORGANIZATION

IIHMR UNIVERSITY

Date: April 25, 2023

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Dr. Khushboo Joshi**, IIHMR-U/07/2021-23/0051, a student of the Master of Public Health Program offered by IIHMR University, Jaipur in cooperation with the Johns Hopkins Bloomberg School of Public Health, USA, has undergone practicum training as a "Training Officer" under the project "Capacity Building Activities for the Link Workers Scheme and Targeted Intervention (TI) Project functionaries through 'Kshamta Kendra' in the state of Rajasthan" by "Solidarity and Action Against HIV Infection in India (SAATHII)" in collaboration with "National AIDS Control Organization (NACO)" at IIHMR, Jaipur, from 21/03/2023 to 25/04/2023.

The project was focused on conducting capacity-building activities for HIV/AIDS prevention under Kshamta Kendra for TI and LWS staff. During the practicum, she was exposed to Database Management using MIS, Monitoring and Evaluation, Documentation and Reporting, Communication and follow-up with trainees, NGOs/CBOs, and SACS/TSU for organizing training.

We found her extremely inquisitive, hardworking, and willing to put her best effort into the depth of the subject and understand it better. Lastly, she has proven herself as a valuable researcher and public health leader through her integrity and resilience during the project. A person like Dr. Khushboo Joshi would be a great asset to any institution she will join in the future.

I wish her a prosperous academic and professional journey.

Dr. Ratna Verma

Assistant Professor, School of Developmental Studies

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ABBREVIATIONS

"AIDS – Acquired Immune Deficiency Syndrome"

"ARD – AIDS-related Deaths"

"CBO – Community-based Organization"

"DACS – District AIDS Control Society"

"EMTCT – Elimination of Mother-to-child Transmission"

"GFATM – Global Fund to Fight Aids Tuberculosis and Malaria"

"HIV – Human Immunodeficiency Virus"

"HRG – High-Risk group"

"LWS – Link Workers Scheme"

"NACO – National AIDS Control Organization"

"NGO – Non-governmental Organization"

"NACP – National AIDS Control Programme"

"PLHIV – People Living With HIV"

"SACS – State AIDS Prevention and Control Societies"

"SOCH – Strengthening Overall Care for HIV Beneficiaries"

"MTCT – Mother-To-Child Transmission"

"PMTCT – Prevention of Mother-To-Child Transmission"

"UNAIDS – Joint United Nations Programme on HIV/AIDS"

PRACTICUM GOAL AND LEARNING OBJECTIVES

Goal

To acquire analytical and assessment skills, program planning and communication skills, Collaborating/organizational skills, and Community dimension skills by achieving the objectives listed below.

Competency-based Learning Objectives

- Defining a public health issue, gathering, and analyzing data to determine community threats, and recognizing the significance of data in influencing public health concerns.
- Gathering and preparing information to support project planning, formulating policy recommendations, making connections, working together with key stakeholders to promote successful intervention, and recognizing the government's role in health promotion.
- Developing communication plans with stakeholder input, utilizing learned skills to communicate efficiently with several stakeholders, and then implementing effective communication strategies with the partner organization by utilizing interpersonal abilities through a diversity of media for clarifying information and incorporating advocacy skill.

ABOUT THE PRACTICUM ORGANIZATION

A leading university in India**, IIHMR University Jaipur**, was founded in 1984 and has made groundbreaking contributions to research, teaching, and training in the fields of health management and public health. Over the last thirty-five years, the IIHMR has made a position for itself among management institutions in India and worldwide. “IIHMR University has a distinct organizational culture that upholds essential values and ethos such as autonomy, accountability, openness, and transparency”. “Faculty from public health, management, economics, statistics, demography, and social and behavioral sciences work together to create an atmosphere conducive to learning, professional growth, and development”. The government of India designated the institution as an 'Institute of Excellence' for its considerable contribution to training and capacity building.[1]

In its long history, the university has collaborated with the Johns Hopkins Bloomberg School of Public Health in the United States, as well as international organizations such as the World Health Organization (WHO) and the United Nations (UN) in a variety of research, training, and education activities.[1]

ABOUT PROJECT ORGANIZATIONS

NACO –

"The National AIDS Control Organisation is a branch of the Ministry of Health and Family Welfare that leads India's HIV/AIDS prevention and control initiative through 35 HIV/AIDS Prevention and Control Societies. Following the discovery of the country's first AIDS case in 1986, the Ministry of Health and Family Welfare established the National AIDS Committee".[2]

As the epidemic expanded, there was a need for a nationwide program and an organization to direct it. The first National AIDS Control Programme in India (1992-1999) was launched in 1992, and the National AIDS Control Organisation (NACO) was set up to implement it out.[2]

RSACS –

In 1992, the State Government established the state AIDS cell in the Medical Health Directorate to provide a more comprehensive and effective response and to support the smooth implementation of HIV and AIDS prevention programmes. In December 1998, the society was formed under the chairmanship of the Secretary of Health to expedite the implementation of the National AIDS Control Programme.

On December 19, 1998, the Rajasthan State AIDS Control Society was established under the Rajasthan Society Act of 1958. The National AIDS Control Programme is being executed by an AIDS cell constituted within the Directorate of Medical and Health Services, Government of Rajasthan, Jaipur.

The AIDS cell receives all AIDS money as grant aid from the "National AIDS Control Organization (NACO), Ministry of Health and Family Welfare, Government of India".[3]

SAATHII –

"Solidarity and Action Against HIV Infection in India (SAATHII)", founded in 2002, is a national non-profit organization in India that works to provide socioeconomically marginalized women and children, communities affected by the HIV/AIDS and tuberculosis epidemics, and groups marginalized because of their sexuality and/or gender identity with universal access to healthcare, justice, and social protection. SAATHII's programs are carried out across 36 Indian states and union territories in collaboration with national and state government agencies and health facilities, 26,796 private health institutions, and 200+ civil society organizations.[4]

ROLES AND RESPONSIBILITIES

Role Title

Training Officer

Responsibilities

- Organizing training programs-fixing dates, venues, and RPs in consultation with SACS/TSU.
- Communication/liaison with SACS/TSU for organizing training.
- Communication with master trainers.
- Communication and follow-up with NGOs/CBOs.
- Communication and follow-up with trainees.
- Documentation and reporting.
- Other programs management.
- All arrangements and others.

PROJECT TITLE

Capacity Building Activities for the Link Workers Scheme and Targeted Intervention (TI) Project functionaries through "Kshamta Kendra" in the state of Rajasthan

OBJECTIVES

1. Creating awareness about the importance of using condoms, services available for STIs, and the importance of regular screening by making available learning opportunities to the TI staff of NGOs/CBOs working at the grassroots level, through various training methods.
2. Increasing knowledge and encouraging skills like analytical thinking and problem-solving among TI and LWS staff to help them overcome their barriers to HIV/STI risk reduction.

METHODOLOGY

Pre and Post-test knowledge of all the participants from different districts of NGOs/CBOs was taken on paper before and after 5 days of training sessions held at Kshamta Kendra (IIHMR University) through a questionnaire (developed by SAATHII). A post-training feedback form was also given to the participants after their training. A total of three batches (involving 94 participants) were trained from 20th February to 3rd March 2023.

The training was given in the regional language Hindi to help the participants understand better. After the training session, data from hard copies were transferred to Excel sheets and MIS for record and analysis.

The following data were entered into the MIS on a timely basis:

HR details of the LWS and TI project staff and implementing NGOS and CBOs partners. Training details such as the TI typology, TI cadres, number of trainees, dates, and locations. Pre and post-test scores and training evaluation data. And training reports.

Through a Computerized Management Information System (CMIS), regular analysis and review of data captured were carried out which helped in the improvement of the quality of data, minimization of reporting errors, improving the timeliness of reporting, and enabling understanding of trends and programmatic thrust areas for "outreach/peer unit-wise to strengthen actions right at the base unit level".

INTRODUCTION

The "human immunodeficiency virus (HIV) is a virus that causes significant cell damage and, as a result, reduces the body's ability to fight infections and diseases". It can be transferred by a person's bodily fluids who already has HIV. It spreads most commonly during unprotected intercourse or through the sharing of injectable drug equipment. If HIV is not treated, it can typically develop into "acquired immunodeficiency syndrome (AIDS)", which is the final stage of HIV infection that happens when the body's cells are damaged beyond repair.[5]

According to the recently released India HIV Estimation 2019 report, "the estimated adult (15-49 years) HIV prevalence trend in India has been falling since the epidemic's peak in 2000 and has been stabilizing in recent years".[6] These decreases show general progress in the fight against HIV, but they may disguise continued or "increased spread among populations most at risk, such as sex workers, men who have sex with men (MSM), and drug users".[7] In most of the world, HIV/AIDS epidemics are concentrated in the most vulnerable populations, and where HIV epidemics occur in general populations, primarily in Sub-Saharan Africa, these populations may

nevertheless have very high disease burdens in comparison to others.[8], [9], [10], [11] Unfortunately, our awareness of the burden of HIV in the most vulnerable populations is limited, owing to the fact that these populations are underrepresented in national HIV surveillance systems and are concealed and stigmatized in many settings.

Although HIV infections are decreasing in India, there are still an estimated 24.01 lakh individuals, including 51,000 children. The number of People Living with HIV (PLHIV) in India is 24.01 lakh, according to the government's HIV Estimation 2021 report, as announced by the Minister of State for Health and Family Welfare. Around 45 percent (10.83 lakh) of the total estimated PLHIV are women, with children under the age of 12 accounting for the remaining 2 percent (51,000). “Maharashtra has the most estimated PLHIV (3.94 lakh), followed by Andhra Pradesh (3.21 lakh), Karnataka (2.76 lakh), Uttar Pradesh (1.78 lakh), Tamil Nadu (1.63 lakh), Telangana (1.56 lakh), Bihar (1.43 lakh), and Gujarat (1.14 lakh)”.[12] Together, these eight states account for 72 percent of the total estimated PLHIV in India.

According to UNAIDS, around 37.7 million individuals worldwide were infected with HIV as of 2020. In India, the figure was around 2.3 million infections. While India's prevalence rate in 2016 was 0.30%, ranking 80th in the globe, as of 2018, this rate has substantially decreased in contrast to other countries.[5] The main causes of the country's high number of HIV infections are ascribed to low literacy rates[13], especially in rural areas, as well as widespread labour mobility. Female sex workers, males who have sex with men, transgender groups, and injectable drug users are among the high-risk HIV populations in INDIA. Currently, India spends roughly 5% of its health budget on HIV/AIDS prevention and treatment.

HIV ESTIMATES IN INDIA

"NACO and the Indian Council of Medical Research-National Institute of Medical Statistics (ICMR-NIMS) (New Delhi)" collaborated on the following estimates, which were guided by NACO's National Working Group (HIV Estimations 2021).

Since the epidemic's peak in 2000, the estimated adult HIV prevalence (15-49 years) has declined nationally. Prevalence reduced from 0.55% in 2000 to 0.32% in 2010 and 0.21% in 2021. The northeastern states with the greatest prevalence of adult HIV are Mizoram (2.70%), Nagaland (1.36%), and Manipur (1.05%), followed by the southern states (0.67% in Andhra Pradesh, 0.47% in Telangana, and 0.46% in Karnataka).[14] "The number of People Living with HIV (PLHIV) are estimated at around 24 lakhs." The majority of PLHIV are found in southern states, including Maharashtra, Andhra Pradesh, and Karnataka ranking as the top three. In India, 62.97 thousand Annual New Infections (ANI) are anticipated in 2021. Nationally, ANI is predicted to decrease by 46.3% between 2010 and 2021.[15]

"A declining trend is noted in most States. Top 3 States with most rapid decline is Himachal Pradesh (with around 73% decline from 2010-2021), Tamil Nadu (around 72% decline), Telangana (nearly 71% decline)". It is projected that there will be an increase in the northeastern states of Tripura, Meghalaya, Arunachal Pradesh, Assam, Sikkim, and Mizoram as well as the Union Territories of Dadra and Nagar Haveli and Daman and Diu. In India, there will likely be 41.97 thousand AIDS-related deaths (ARD) in 2021.[15] Between 2010 and 21 ARD is anticipated to decrease nationally by 76.5%. "Except for Puducherry, Arunachal Pradesh, Meghalaya, and Tripura, all states/UTs show a downward trend. The greatest ARD reduction is expected in Chandigarh, Telangana, and West Bengal". [14]

The most recent HIV projections for 2021 offer vital information that will aid in further "geographic and population prioritization of HIV prevention, testing, treatment efforts [ART & PMTCT] under the NACP, as national efforts are in the 'last mile' towards the AIDS 'End-Game'."[15] Because HIV estimates suggest that the disease is unevenly distributed throughout states and territories, more precise population and location planning and programming is required for guiding efforts.

Table 1. Summary of the HIV/AIDS Epidemic in India, 2021[15]

Indicators	Disaggregation	Value
Adult (15-49 years) Prevalence	Total	0.21
	Male	0.22
	Female	0.19
No. of PLHIV (In Lakh)	Total	24.01
	Adult (15+ years)	23.31
	Women (15+ years)	10.50
	Children (<15 years)	0.70
	Young people (15-24)	1.70
HIV incidence per 1000 uninfected population	Total	0.05
	Male	0.05
	Female	0.04
New HIV Infections (In Thousand)	Total	62.97
	Adults (15+ years)	57.97
	Women (15+ years)	24.55
	Young people (15-24)	15.08
AIDS-related deaths (In Thousand)	Total	41.97
	Adult (15+ years)	39.46
	Women (15+ years)	11.26
	Children (<15 years)	2.51

	Young people (15-24)	1.12
Decline in new HIV infections since 2010 (%)	Total Adult (15+ years) Women (15+ years) Children (<15 years)	46.25 44.48 43.75 60.82
Decline in AIDS related deaths since 2010 (%)	Total Adult (15+ years) Women (15+ years) Children (<15 years)	76.54 76.44 82.74 77.92
PMTCT need	Total	20.61
Final MTCT Rate of HIV (%)	Total	24.25

Figure 1. State/UT-wise Adult HIV Prevalence (%) 2021[15]

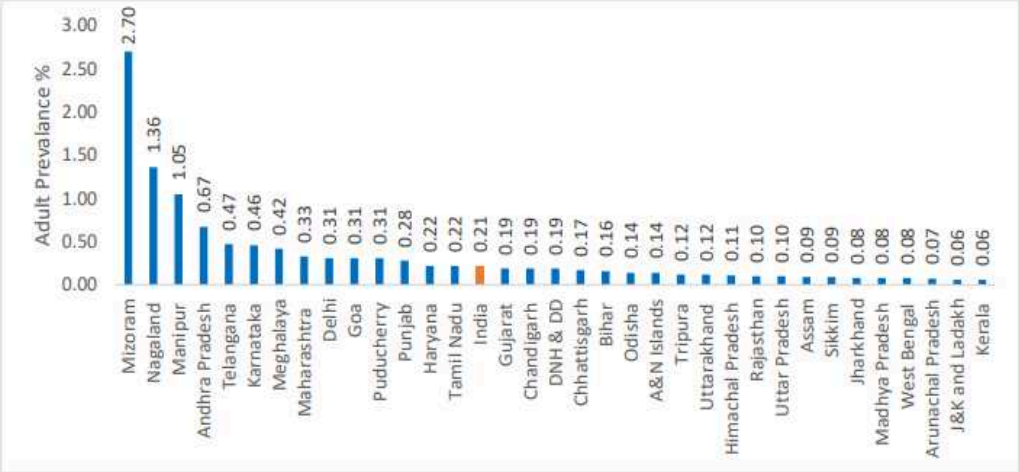
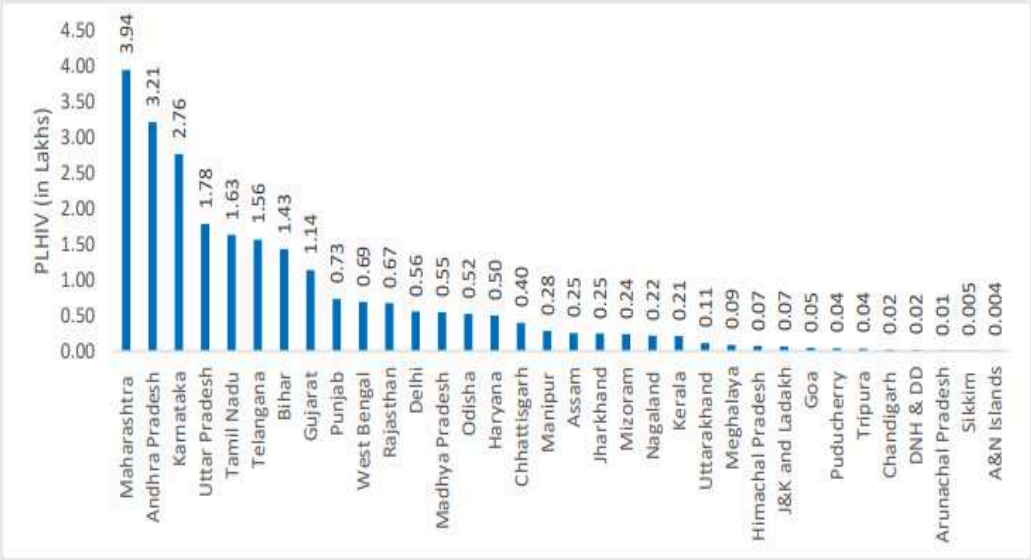


Figure 2. State/UT wise PLHIV (In Lakh) 2021[15]



HIV ESTIMATES RAJASTHAN STATE

Table 2. Epidemic Estimates 2020[14]

	Indicator	Male	Female	Total
1.	Adult (15-49) HIV Prevalence (%)	0.13	0.08	0.11
2.	Estimated PLHIV	38,613	23,482	62,095
3.	Estimated Children Living with HIV	1,513	1,326	2,839
4.	Annual New HIV Infections	1,062	682	1,744

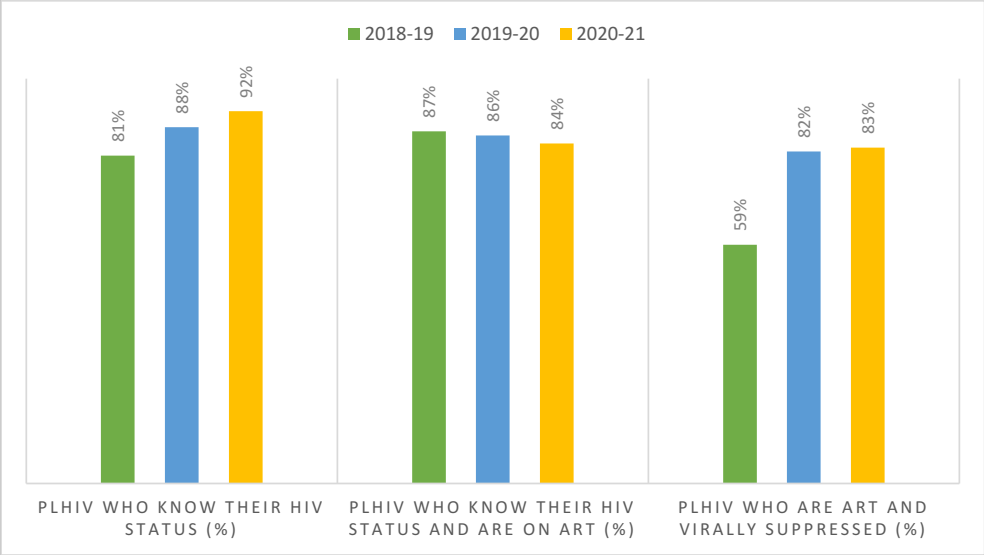
5.	Annual AIDS related deaths (ARD)	210	74	284
6.	Change in annual new HIV infections since 2010 (%)	-64	-60	-62
7.	Change in annual ARD since 2010 (%)	-65	-72	-67
8.	EMTCT need	-	842	842

Table 3. HIV/AIDS related knowledge stigma and high-risk behaviour in general population (2015-2016)[14]

Indicator	Male	Female
Adults (15-49 yrs) with comprehensive knowledge about HIV/AIDS (%)	37.4	39.1
Youth (15-24 yrs) with comprehensive knowledge about HIV/AIDS (%)	36.2	20.9
Adults willing to care for a relative with HIV/AIDS in own home (%)	88.1	80
Adults willing to buy fresh vegetables from a shopkeeper or vendor who has HIV/AIDS (%)	79.9	76.3
Sexually active adults (15-49 yrs) having high-risk sexual behaviour (%)	6	0.3

Condom use during last higher-risk intercourse (%)	34.8	
Sexually active youth (15-24 yrs) having higher-risk sexual behaviour (%)	28	0.8
Condom use during last higher-risk intercourse (%)	38.2	

Figure 3. Progress on 90-90-90 (2020-21)[14]



PROJECT BACKGROUND

Genesis

Sero-surveillance was started as part of India's response to the HIV/AIDS epidemic in 1985. The National AIDS and STD Control Programme (NACP) was established in 1992, institutionalising the start of a comprehensive response to the HIV/AIDS epidemic in India. Earlier responses

(1985–1991) concentrated on searching for HIV in various population groups and locations, screening blood before transfusion, and targeted awareness generation.

SAATHI, a Principal recipient (PR) of the Global Fund Grant, implementing phase- III of the GFATM program that includes components of capacity building for HIV prevention, testing treatment, and care service providers, HIV interventions among incarcerated populations, and the Elimination of Mother-to-child transmission. This program was implemented in April 2021 and will be completed by March 2024.

SAATHI, as part of its support to NACO through phase – III of the GFATM program, aiming to establish institutional mechanisms for the training of TI (Target Intervention) service providers based on the previous experiences of NACO through establishing 19 Kshamta kendra Targeted intervention training center across the states of India. While adapting to the ongoing needs of targeted intervention, Kshamta Kendra aims to train the TI staff of the NGOs and CBOs who work among core groups such as FSW, MSM, Hijra/Transgender, People Who Inject Drugs (PWID), and the staff of the Link Workers Scheme (LWS). The locations of these 19 Kshamta Kendras were decided based on the number of TI projects and geographic spread. Amongst which Rajasthan was chosen as one of the TI training centers. In Rajasthan, Kshamta Kendra was established in IIHMR University, Jaipur who is providing training to the outreach workers and Peer educators of the different districts of state.

Purpose and Objectives of Kshamta Kendra

The purpose of Kshamta Kendra is to provide adequate and appropriate capacity building support to Targeted Intervention projects in their respective states/region.

Its objectives are to improve the knowledge and skills of TI service providers in an innovative and sustainable manner across the country over 2021-24. Training of TI and LWS staff of the

NGOs and CBOs are trained based on various training modules developed by NACO and the Blended Training (BT) program. The Kshamta Kendra across the states is envisioned as a collaborative effort of NACO, SACS, SAATHII – PR, SR/SUs and training centers where every individual partner has specific roles to accomplish.

Core Functions of KK

Identification of master trainers and creating and maintaining resource pool at state.

Plan, organize and conduct training programs using prescribed modules and various methods for the TI staff in the state.

Build capacities of TI project functionaries to ensure qualitative improvement in their functioning to achieve the objective of prevention of new HIV infections among core groups and the target groups that LWS caters to.

Collect data on the qualities of the training on a continuous basis, analyze and improve the effectiveness of the training.

Ensure field visits, learn the impact of the training on TI and LWS staff through observing their quality of work, document the best practices or proven practices in targeted interventions from the state and collect the training as well needs of the TI and LWS staff.

Liaison with various stakeholders such as NACO, SACS, DAPCU, TI NGO and CBOs, SAATHII, and sub recipients/subunits to SAATHII-PR, master trainers and development agencies in their respective states/region.

Targeted Intervention

As a strategy for HIV prevention, Targeted intervention is an effective means to contain HIV/AIDS prevalence in Rajasthan state. 47 TIs are currently working with core groups, among which 2 TIs are working with MSM & 6 with IDUs, 19 with FSW population and 11 are core composite interventions. In a similar manner, 3 TIs and 6 TIs respectively work with truckers and the migratory community. Hence, the Rajasthan State AIDS Control Society employs a total of 47 TIs as part of the Target Intervention.

The following components, which make up a targeted intervention's main actions, are emphasized and focused on:

- Gathering Information
- The NGO will provide access to STI services either directly or through a partnership with a public or private facility
- Behavior changes communication
- Utilization of condoms and access Monitoring
- Building ownership, and
- An enabling environment

Various lists of TI, Link workers (LWS), Transite Intervention & Opiod Substitution therapy (OST) Centers are allotted for NGOs in all the districts of Rajasthan for this intervention.

Table 4. TI/LWS/TRANSITE INTERVENTION & OST CENTERS

S.N	DISTRICTS	NAME OF NGOs	EXCLUSIVE/ COMPOSITE UNIT
Targeted Intervention			
1.	Ajmer	Rajasthan Mahima Kalyan Mandal	Exclusive
2.	Ajmer	Society For Community Organization and People's Education (SCOPE)	Bridge Composite
3.	Ajmer	Vani Sanstha	Exclusive
4.	Ajmer	Jeevan Prakash For People Living with Positive Sansthan	Core Composite
5.	Alwar	Saksham Mahila Samiti	Core Composite
6.	Alwar	Shanti Yuva Mandal	Exclusive
7.	Banswara	Shree Mateshwari Vikas Seva Samiti	Core Composite
8.	Banswara	Marudhara Seva Sansthan	Exclusive
9.	Barmer	M.R. Morarka – GDC Rural Research Foundation	Exclusive
10.	Barmer	Bikaner Network For Peoples Living With HIV Sansthan	Core Composite
11.	Bharatpur	Amar Jyoti Sansthan	Core Composite
12.	Bhilwara	Indian Public Educational Society	Core Composite
13.	Bhilwara	Gramin Uthan Manav Sansthan	Bridge Composite
14.	Bundi	Rashtriya Manav Vikas Samiti	Core Composite
15.	Chittorgarh	Arpan Seva Sansthan	Core Composite
16.	Chittorgarh	Gramin Mahila Vikas Sansthan	Exclusive

17.	Churu	Society For Community Organisation & People's Education (SCOPE)	Core Composite
18.	Dungarpur	Jeevan Asharam Sanstha	Core Composite
19.	Ganganagar	Maharishi Dayanand Vikas Samiti	Core Composite
20.	Hanumangarh	Maharishi Dayanand Vikas Samiti	Core Composite
21.	Jaipur	Saksham Mahila Samiti	Core Composite
22.	Jaipur	(SCOP) Society for Conscious over All Progress	Exclusive
23.	Jaipur	Vatsalya	Exclusive
24.	Jaipur	Saksham Nayi Zindgi Samiti	Exclusive
25.	Jaisalmer	MRMorarka GDC Rural Research Foundation	Core Composite
26.	Jalore	Adarsh Saraswati Mahila Shiksha Evam Gramin Vikas Samiti	Exclusive
27.	Jhalawar	Shikshit Rojgar Kendra Prabandhak Samiti (SRKPS)	Exclusive
28.	Jhunjhunu	ACIL Navasarjan Rural Development Foundation	Core Composite
29.	Jodhpur	Gram Vikas Seva Sansthan	Core Composite
30.	Karauli	Saksham Mahila Samiti	Exclusive
31.	Kota	Rajasthan Nat Samaj Sudhar Samiti	Core Composite
32.	Kota	Shikshit Rojgar Kendra Prabandhak Samiti	Exclusive
33.	Kota	Society for conscious over all progress	Exclusive
34.	Nagaur	Gram Vikas Seva Sansthan	Exclusive

35.	Pali	Rajasthan Mahila Kalyan Mandal	Core Composite
36.	Rajsamand	Indian Institute of Human Help	Exclusive
37.	Sawai Madhopur	Saksham Nayi Zindgi Samiti	Core Composite
38.	Sikar	Gramin Vikas Evam Paryavaran Sansthan	Core Composite
39.	Sirohi	Training Awareness Behaviour Change About Health And Rehabilitation Society (TAABAR Society)	Exclusive
40.	Tonk	Rashtriya manav Vikas Samiti (RMVS)	Core Composite
41.	Udaipur	Meera Sansthan	Core Composite
42.	Udaipur	Manav Sewa Santhan	Exclusive
Link Worker Scheme			
1.	Bhilwara	Matrix Society For Social Services	
Transite Intervention			
1.	Ajmer	Rajasthan Mahila Kalyan Mandal	
2.	Jaipur	TAABAR Society	
3.	Udaipur	Manav Sewa Santhan	
OST Centers			
1.	Ajmer	OST Center, J.L.N. Medical College	
2.	Ganganagar	OST Center, Govt. Hospital	
3.	Kota	OST Center, M.B.S. Hospital	

Figure 4. Components of Targeted Intervention

OUTREACH WORKERS AND PEER EDUCATORS' INDUCTION TRAINING

The IIHMR University – Rajasthan Kshamta Kendra (KK) has completed the training of 51 number of Outreach Workers from 26 different Targeted Intervention Organizations. The participants were trained in 3 batches, where the batch size was 51 so 2 breakaway groups were formed for better understanding of the participants.

During the training the participants were trained according to the module introduced by SAATHII by the different qualified trainers distributed in 5 days and 20 chapters.

All the participants were asked about their expectations from the training program on the first day of Orientation followed by the satisfaction of their expectations at the last day of training.

Also, a pre-test was conducted for all the participants to assess their knowledge and required information followed by the Post Test at the end of training to assess the outcome of training sessions. During the training, training feedback from all participants was taken to ensure the quality of training. Each day the training session started with a recap of the previous day and the queries and doubts of participants were cleared. Also, various activities were conducted in between the sessions to make learning and teaching interesting. Group Work, Group Discussion, Role Plays and Audio Video Tools were also used to train the participants.

A special session on Virtual Outreach/ Net-reach was also conducted to train participants for the coverage of hidden and hard to reach population using the latest online technologies and available social sites and apps. For the clear and better understanding on the various tools and formats such as hands on exercise on SOCH, use of field reality and data for effective planning and implementation, condom stocking and reporting, and outreach daily diary.

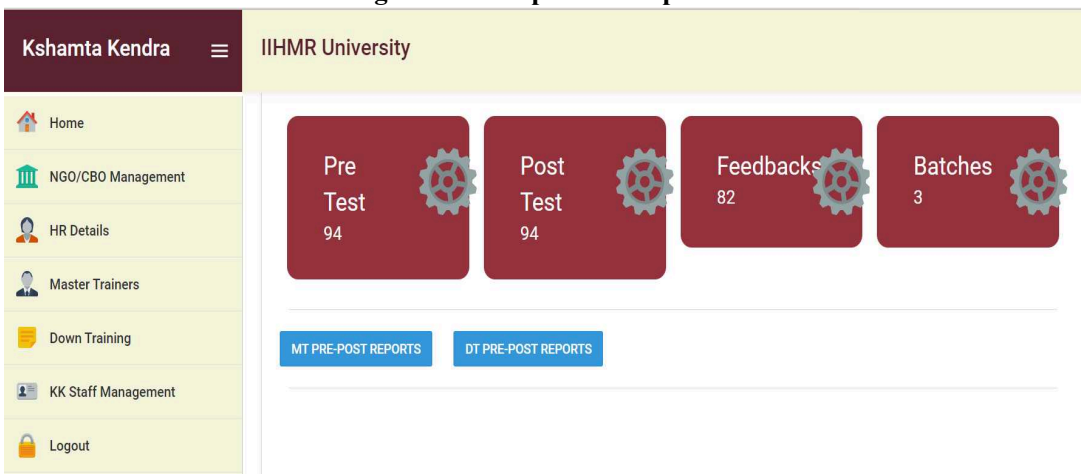
Figure 5. Batch 1 ORW (FSW)

Figure 6. Introductory Session

Figure 7. Training Session

Figure 8. Group Activities

Figure 9. Example of MIS portal



An example of Pre and Post-Test Questionnaire for knowledge check before and after training sessions:

Questionnaire.pdf

Table 5. Number of Participants according to the Batches

Batch No.	Number of TI Organizations	Number of Participants
Batch I (20/02/23 – 24/02/23)	26	51
Batch II (27/02/23 – 03/03/23)	18	27
Batch III (27/02/23 – 03/03/23)	4	16
Total	48	94

Table 6. List of Topics covered in Training

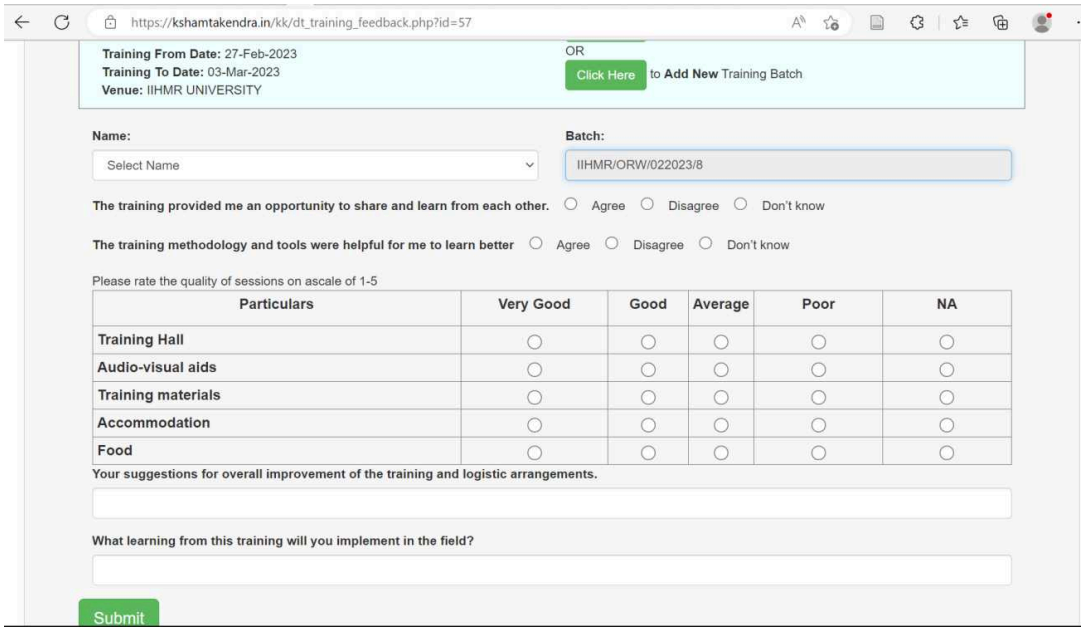
Chapter	Topic
Day 1	
Chapter 1: Introduction to health system, National health policy and National HIV/AIDS strategy	• Introduction to Health System - National Health Policy • National AIDS Control Programme (NACP) • National Strategic Plan (NSP) • Revamped Strategies • Sampoorna Suraksha (SS) strategy
Chapter 2: Introduction to HIV/AIDS	• Modes of transmission • Prevention methods • Common signs and symptoms • Care and treatment • Myths and misconceptions
Chapter 3a: Introduction to TB and STI and RTI	• Modes of transmission • Prevention methods • Common signs and symptoms • Care and treatment • Myths and misconceptions
Chapter 3b: Introduction to Hep B & C	• Modes of transmission • Prevention methods • Common signs and symptoms • Care and treatment • Myths and misconceptions
Chapter 4: Comprehensive EMTCT Cascade ofServices	• Route of HIV Transmission to the baby • Early detection leads to elimination • Care during labour and delivery • Feeding guideline • Infant prophylaxis • HIV Exposed infants (HEI) Testing • Syphilis • EMTCT services in Private Health Sector
Day 2	
Chapter 5: Understanding Core Groups (FSW/ TG/MSM/ PWID)	• Revamped TI strategy • Who are the core groups?

	• Risk and vulnerability factors of each subgroup (TG-H/ MSM/ FSW/PWID • Common issues among the groups • Criminalization, stigma, discrimination, and violence • against Core groups
Chapter 6: Understanding Targeted Interventions under NACP	• STI Management • Condom Programme • Commodity Provision • Behavior Change Communication • Harm reduction strategy • Enabling environment • Community Mobilization • Revamped Strategy • Changing Patterns: Geographical, Virtual Network, and High-Risk Practices • Changes in Patterns • Geographical Patterns among MSM/TG/FSWs/PWIDs • Virtual Network Patterns • among MSM/TG/FSWs/PWIDs • - High Risk Practices Patterns among MSM/TG/FSWs/PWIDs • Program implications and strategic recommendations
Chapter 7: Role and responsibility of ORWs	• Introduction to roles and responsibilities of an ORW • Values & attitude • Skills/Characteristics of ORWs • Handholding for PEs
Chapter 8: Interpersonal Communication (IPC) and skill building	• What is IPC? • principal elements of communication • How adults learn • Verbal and non-verbal communication • Active listening • How to ask questions • Building trust and relationship with core groups • Use of Cell phones and visual aids and social media

Chapter 9: Gender, Sex and Sexuality	• SOGIESC – Sexual Orientation Gender Identity and Sex Characteristics • Components of sexuality • Sexual Health and vulnerability to HIV
Chapter 10: Community Based Screening	• Introduction to Community Based Screening • ORWs roles in CBS • Cold chain management • Bio-medical waste - collection and disposal
Day 3	
Chapter 11: Commodity provision	• The basics of commodity • provisions for FSWs/ MSM/ TGs/ PWIDs • Role of commodities in HIV prevention • Barriers to condom/ lubes/N&S/ swab use with clients • Commodity gap analysis • Self-risk perception • The basics of social marketing (SM) of condoms • Demonstration of commodities
Chapter 12: Stakeholder Management and Analysis	• What is a Stakeholder? • Key Stakeholders in HIV Program - Health and non-health stakeholders • Stakeholder management and analysis techniques
Chapter 13: Crisis Intervention	• Details of crisis • Different crisis situations • Crisis management • Documentation of crisis
Chapter 14: The HIV and AIDS (Prevention and Control) Act, 2017	• Introduction to the Act • Notification of the Act • Central government rules • Case discussion
Chapter 15: Outreach Activities	• Importance of Outreach with vulnerable population • Principle of Outreach • Outreach strategies • Implementing Outreach

	• Monitoring of outreach
Day 4	
Chapter 16: Newer Initiatives in HIV prevention	• Community System Strengthening • Concept, Core components • Community Led Monitoring - Community champions, Role, CAB • Understand the difference between PrEP and PEP • PrEP for HIV Prevention • PEP for HIV Invention
Chapter 17: Peer Educator Selection and Training	• What is a peer educator (PE)? • Why peer education? • Role of the PE • PE selection criteria • Process of PE selection/recruitment • Informal approach to selecting potential PEs • Formal selection process • Capacity building plan for PEs • Review and Rotation of PEs • PEs progression pathways
Day 5	
Chapter 18: Referrals and Network	• HIV/STI/TB/HB Testing • Treatment support • Access to EMTCT program • Legal and social support • Network support • Social Protection • Entitlements and schemes
Chapter 19: Record maintenance and reporting and M&E tools practice sessions	• Understanding the formats • Hands-on-exercise with SOCH • Use of field reality and data for effective planning and implementation • Condom stocking and reporting Outreach Daily diary

Figure 10. An Example of Down training feedback form



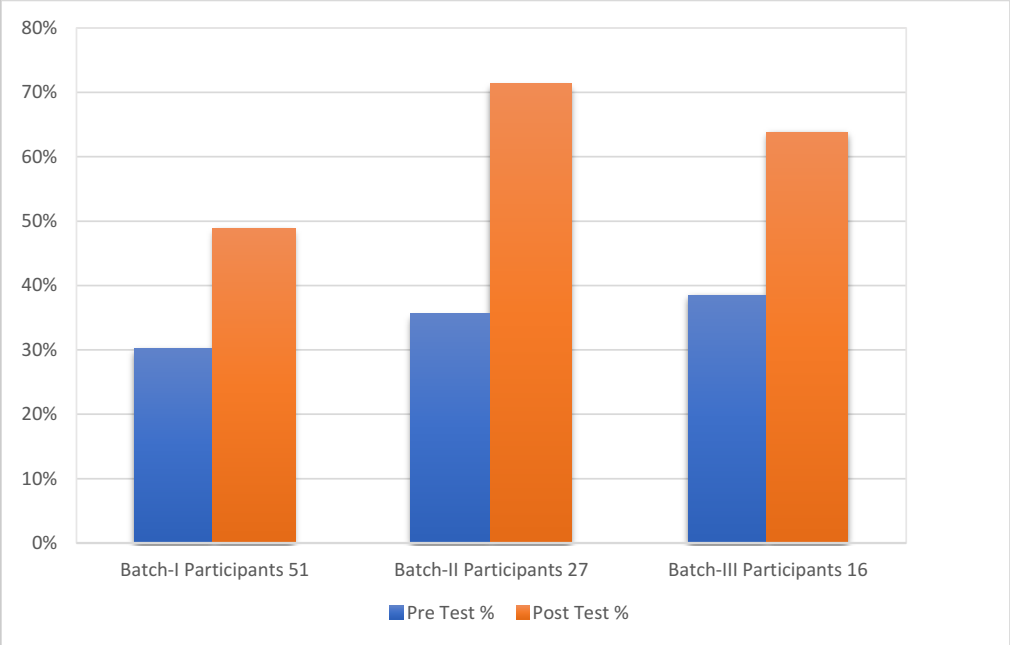
RESULT

Overall increase in knowledge after the training sessions is clearly observed in Post-test among majority of the Batch – 2 participants (by 71.1%) followed by Batch – 3 (63.75 %) and then Batch – 1 (48.65%) as compared to Pre-Test which was very less in Batch – 1 participant (30%) followed by Batch – 2 with 35.5% and Batch – 3 with 38.5% pre-test score.

Table 7. Down Training Records of ORW at IIHMR University (Kshamta Kendra) and Knowledge Increment

Batch	Max Marks	Total Participants	Added Records (Pre/Post)	Avg Pre Score	Avg Post Score	Increment Score	Pre-Percentage	Post Percentage	Increment Percentage
IIHMR/ORW/022023/3 (Rajasthan)	20	51	51/51	6	9.73	3.7	30%	48.6%	18.6%
IIHMR/ORW/022023/7 (Rajasthan)	20	27	27/27	7.07	14.22	7.15	35.3%	71.1%	35.7%
IIHMR/ORW/022023/8 (Rajasthan)	20	16	16/16	7.69	12.75	5.06	38.4%	63.7%	25.3%

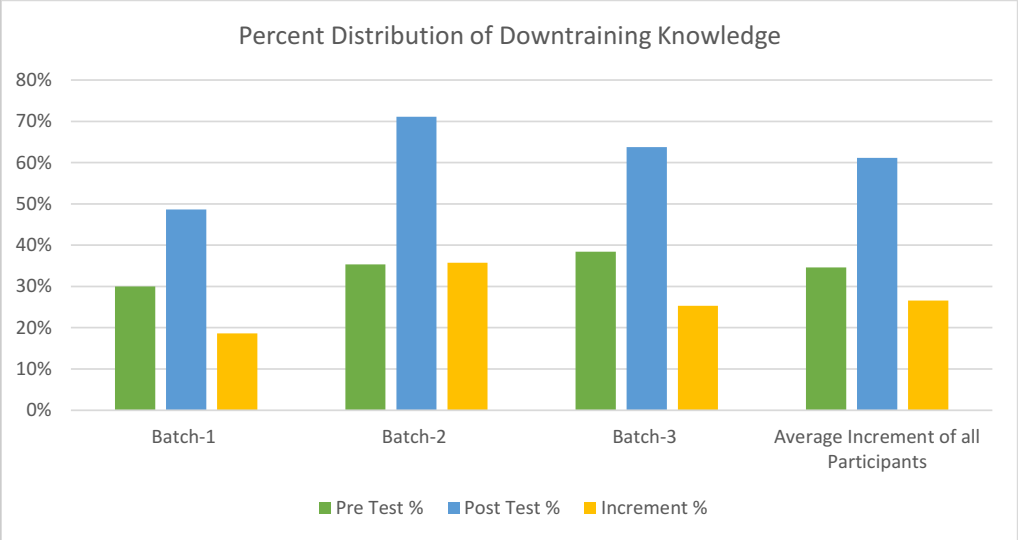
Figure 11. Knowledge Increment Distribution according to Batches



All ORW participants (total – 94) have an average Post-Test percentage of 61.17 with only 26.57% average increment by an average Pre-Test percentage of 35.

As most of the participants were not able to understand the training presentations even if it is translated in Hindi language. The reason might be whether they were less interested, or they found it hard to concentrate and understand the learnings. Therefore, we should include more practical activities along with the lessons.

Figure 12. Average Distribution of Knowledge Increment among all the Participants



As per the results of the Training feedback forms, the majority of the participants were found to be satisfied with the overall training at IIHMR University. All the participants "agreed' that they got an 'opportunity to share and learn' at IIHMR, they found the 'methodology' helpful, and the 'training hall', 'audio- visual aids, 'training materials' were very good.

Majority of the participants found the 'accommodation' at IIHMR to be good, but 'Food' was considered poor for most of them.

Most of the participants gave some suggestions for the training improvement and that they will implement these learning in the field along with a few lists of their learning for implementation in their own fields.

CONCLUSION

The Capacity Building Activities and Training for Link Workers Scheme and Targeted Intervention Project Functionaries held at IIHMR university (Kshamta Kendra) from February 21st to March 3rd, 2023, successfully improved the knowledge and skills of targeted intervention (TI) and LWS staff in an innovative and sustainable manner.

There is a need to improve behavior change communication in those populations of TIs and Link workers who are still struggling from drug addiction and are still drug addicts as those participants were not able to concentrate and understand the trainings which in turn resulted in inadequate knowledge and skills even after 5 days of training and activity exercises on HIV/AIDS prevention strategies.

Overall, IIHMR played a vital role for NACO in strengthening and achieving the goal of halting and reversing the epidemic in India, through its contribution of successfully completing the capacity building training.

PRACTICUM EXPERIENCE

Making the decision to pursue a profession in public health was the best one I've ever made. And selecting IIHMR University, Jaipur as my practicum organization was a tremendous learning experience. It definitely opened my eyes to new opportunities and made me more observant of my surroundings and others. The department provides a comprehensive range of health services and even advocates for the maintenance of a home environment conducive to health promotion. The roles of public health that I have learned include monitoring community health; diagnosing ailments and investigating their treatments; informing, educating, and empowering the

community about their health; mobilizing partnership among the various factions of the community; developing health policies; enforcing health laws and connecting the community to health care; and, most importantly, conducting research and evaluation of the existing health situation. I realized that an evidence-based approach to decision-making is not as simple as it seems, but it must be the best method to have been chosen by the health-care community.

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