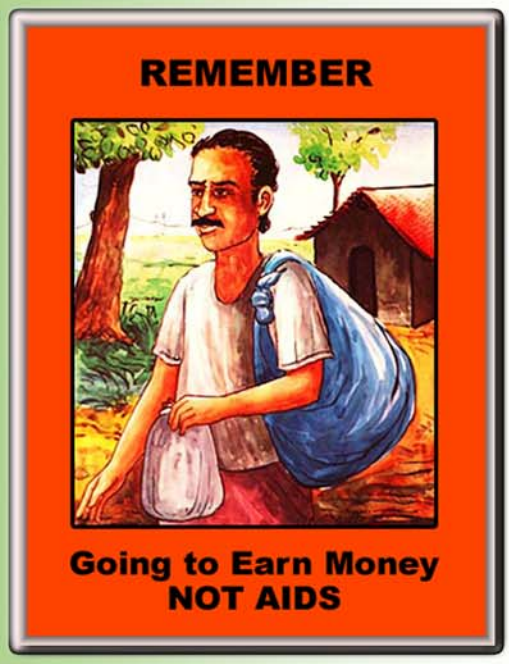
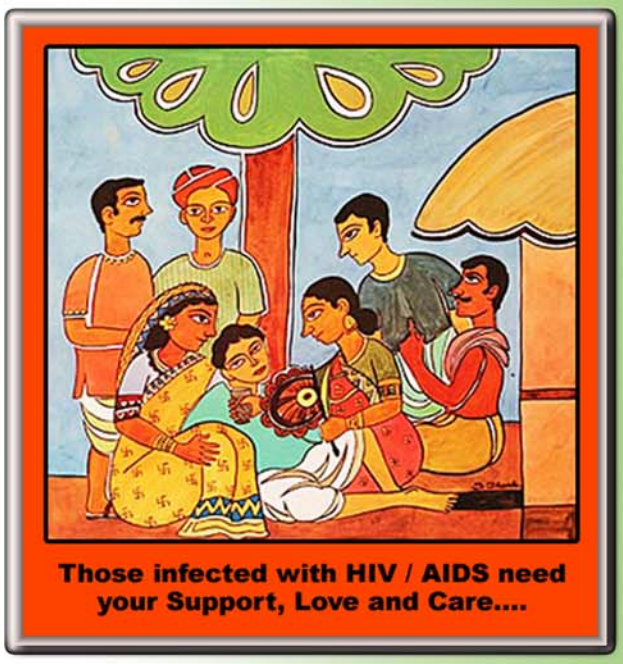
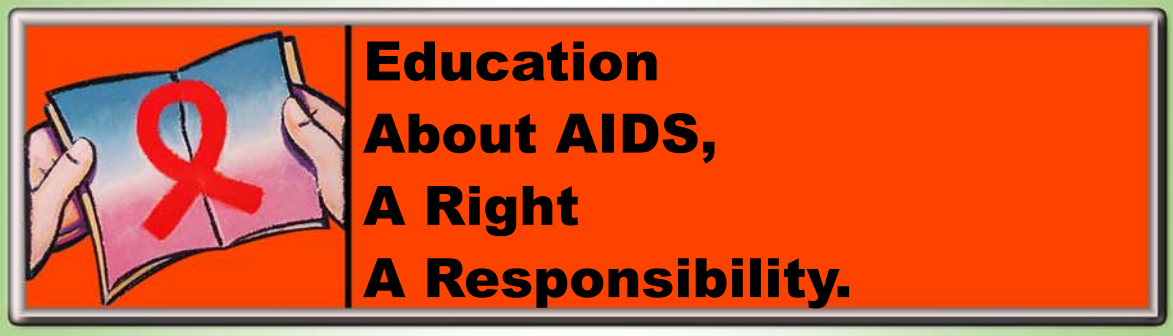
GOVERNMENT OF ORISSA
WORKS DEPARTMENT

ORISSA STATE ROAD PROJECT

FEASIBILITY STUDY AND DETAILED PROJECT PREPARATION FOR PHASE-I ROADS







STRATEGY AND ACTION PLAN FOR PREVENTION AND CONTROL OF HIV / AIDS TRANSMISSION

July - 2007

CONSULTING
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1 Introduction

Works Department Government of Orissa has planned to improve its core network of about 906 km of state highways under Orissa State Road Project(OSRP) with the loan assistance from World Bank in phase-I. OSRP Phase-I has three major component namely Road Improvement Component including resettlement and rehabilitation, Institutional Development & Policy Component and Community Development Initiative component

It is well established that because of improvements of road, mobility of CSW[1]s and truckers also increases and hence chances of transmission of HIV/AIDS. Until the present Road Project (OSRP), Other State road projects[2] were not equipped with special targeted intervention strategy for skirmishing HIV/AIDS transmission. It was integrated with resettlement and rehabilitation in other state road projects. As a result HIV/AIDS issues were remained neglected or weakly emphasized during project implementation. In other words HIV/AIDS prevention programme have not given due attention towards fulfilling social responsibility of the project.

2 Project Locations for Targeted Intervention

Prevention and control of HIV/AIDS transmission is one of the important social responsibility World Bank has recognized in recent past. Hence prevention and control of transmission of HIV/AIDS have become important component of social safeguard instruments prepared during project preparation of present road improvement. For this purpose a settlement level analysis was undertaken to understand socio-economic characteristics of community. From the empirical studies it is established that knowledge level about prevalence rate, epidemiological behavior of HIV is low in the State. Thus there is need to generate awareness about HIV/AIDS epidemiology to general population and at Targeted Locations.(Table 0.1)

Table 1: Project Location for Targeted Intervention

Construction Package*	Road Section	Chainage	No. of Communities	No. of Brothel	Construction camp	Truck Parks
1	Chandbali – Bhadrak (SH-09)	00-45	28	1	1	1
	Bhadrak – Anandpur (SH-53)	00-51	28	4	1	1
2	Berhampur – Taptapani (SH-17)	00-41	19	5	1	1
3	Khariar - Bhawanipatna (SH-16)	02-70	27	1	1	1
4	Taptapani - Raipanka (SH-17)	41-109	14	1	1	1
5	Raipanka – Bangi Jn (SH-17)	109-151	11	-	-	1
	Bangi Jn – JK Pur (SH-04)	161-119	10	-	1	-
6	Jagatpur-Kendrapara-Chandbali (SH-9A)	00-99	55	3	1	2
	Chandbali-Bhadrak (SH-09)	45-53	04	3	-	-
7	Bhadrak – Anandpur (SH-53)	51-57	03	1	-	-
	Anandpur – Karanjia (SH-53)	00-65	22	-	1	1
	Karanjia – Jashipur (SH-49)	45-60	06	-	-	-

[1] Commercial Sex Workers

[2] OSRP is the first state road project which included prevention of HIV/AIDS transmission as integral part of SSIs and also part of concept document(PID) as a part of project planning.

8	JK Pur – Rayagada (SH-04)	119-109	-	1	-	-
	Rayagada – Kereda (MDR-48B)	00-24	07	-	-	-
	JK Pur – Muniguda (SH-05)	00-50	20	2	1	1
9	Muniguda – Bhawanipatna(SH-06)	00-68	32	1	1	1
10	Aska – Bhanjanagar (SH-07)	46-86	26	1	1	-
11	Banarpal – Daspalla (MDR-18&19, SH-65)	00-89	17	1	1	1
			329	**25**	**12**	**12**

Management of risk of HIV/AIDS emerging out from road improvement is important components of present project concept document (PID[3]). Spatial proliferation of HIV/AIDS is the most dreaded and hidden **bye-product** of road improvement. This bye-product's externalities are generally experienced after few years of construction of roads in operation phase. In the context of HIV; Planners perceive the aftermath of road improvement much earlier in project preparation phase itself and develop **strategies** to combat the negative impact.

3 Strategy for Prevention of HIV/AIDS

Realizing the impact of increasing mobility of high risk behavior during construction and operation phase, epidemiological behavior of HIV/AIDS in the context of traditional culture of Orissa State; intervention strategies have been formulated to minimize the risk of road users, construction workers and road side communities.

People of Orissa possess a very rich, traditional culture and their norms; value system is rooted in past history. Generally; innovation strategies and new approach towards change in social behavior and cultural ethos is resisted by the society Therefore intervention strategy requires pointed approach to address HIV/AIDS issues.

There are a number of issues that emerge out in the context of road improvements and the transmission of HIV / AIDS. These issues requires following prevention strategy.

Table 2: Prevention Strategy for HIV/AIDS

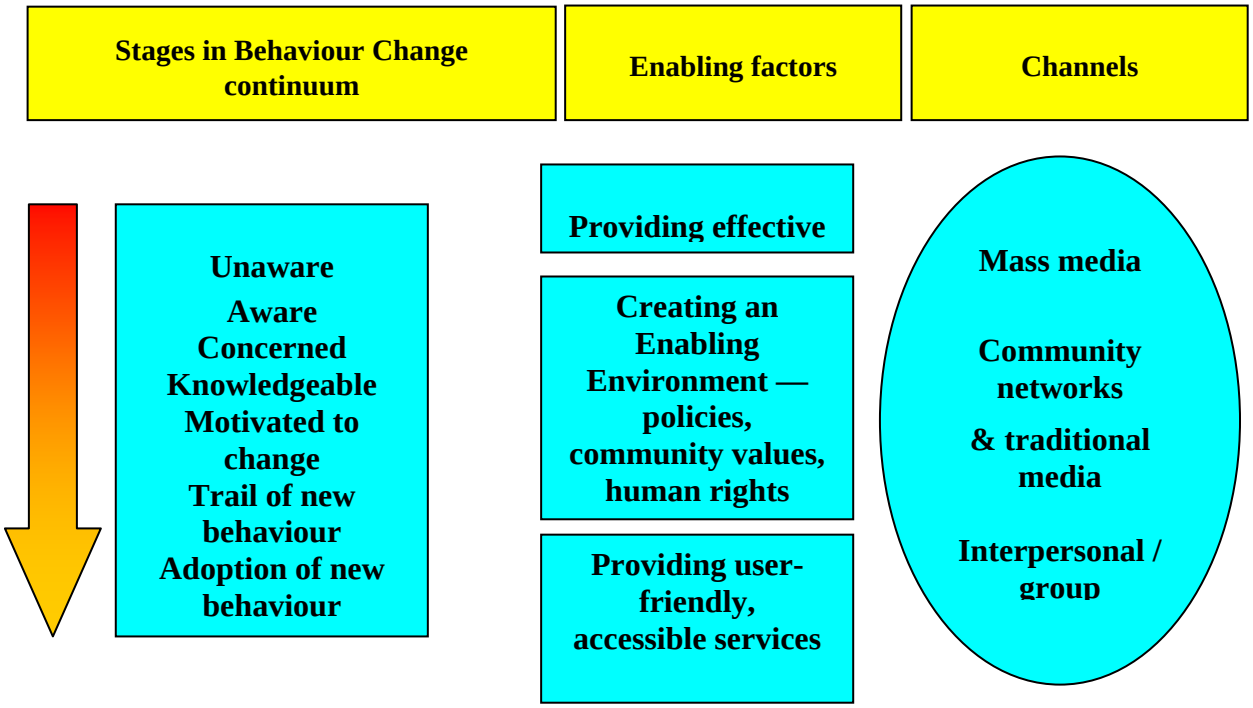
HIV/AIDS Issues	**Prevention Strategy/ Care and Support to HIV infected People**
Target Group Mobility, Migration and High-Risk (Sexual) Behavior Truckers as Frequent Road Users Sex Workers close to the Project Corridor	To increase the level of awareness about prevention and control of HIV/AIDS among the different communities' particularly tribal communities in scheduled areas abutting project road.
Induced HIV AIDS issue Displacement due to Projects – Resettlement Issues and High-Risk Behavior	To promote safe sex behavior through promotion of condom use
	Developing referral awareness for medical care and treatment.
Loss of Livelihood or business leading to loss of income and ultimately forced into flesh trade.	Availability of ART and other facilities to patient
	Social and Psychological support to AIDS infected

HIV prevention aim to change individual behavior, but community interventions often need to be developed to change norms and behaviors at the group level. While HIV risk may grow

[3] Project Information Document August,2005, WB/OSRP/org

quickly in a community, attitudes are a major barrier to popularizing safer behaviors. BCC even bring changes in laggard of the society, a wide array of communication approaches ranging from mass media (radio, television, and newspapers) to person-to-person counseling and conversation used to promote healthy behaviors. Following table discusses BCC strategy in the project corridor.

Fig 1: Framework for BCC



4 Action Plan

Based on strategy as discussed above an action plan is prepared for the prevention and control of HIV/AIDS transmission. The Action Plan identifies important role of institutional stakeholders. They will be stimulating stakeholders in the formulation of prevention strategy and grounding action plan. Consultation with stakeholders such as OSACS[4] and other Targeted Intervention (TI) partners reveals an inbuilt mechanism for the implementation of action plan.

The plan envisages following important component.

- Partnership Development and Capacity Building
- NGO Partnership Development
- Partnering Other Institutions
- HIV / AIDS Capacity Building Training
- Display and Distribution of I-E-C Materials
- Action Plan for Care and Support

5 Implementation Arrangement

Organization for planning and implementation of Action Plan for prevention of HIV/AIDS transmission is utmost important because Works Department is mainly an engineering organization. Timely establishment and involvement of appropriate institutions would

[4] Orissa State AIDS Control Society

significantly facilitate achievement of objectives of the HIV action plan. Present plan has envisaged an in-built institutional framework for the implementation of HIV action Plan. The main institutions which are likely to wok would include:

- Works Department at different level;
- Social Impact Management and Safeguard Unit(SIMSU)
- NGO (Non Governmental Organization);
- OSACS and other Partnering Institution
- Local CBOs and Panchayati Raj Institutions

6 Budget

A consolidated overview of the budget is provided and the cost estimates given below shall be viewed accordingly. The cost estimates for training and capacity building has been provided by OSACS.

The budget is indicative of outlays for the different expenditure categories and is calculated at the 2005-2006 price indexes. The plan outlays for three years is given. Budget for year 2 and Year 3 would have additional provision of inflation. This budget would be entirely financed from the community development initiative component.

7 Summary of the Cost

The cost of HIV action plan is divided in capacity Building and Training, Development and Distribution of I-E-C/BCC materials and partnership development with NGOs. Details of breakup given in below.

Table 3: Summary of the Cost

Sl. No.	Item	Cost(in million Rs)
1	Development of Training Materials	1.82
2	Capacity Building and Training	23.67
3	Development of BCC material	**12.91**
4	Skill building and Exposure	2.32
5	Availability of BCC materials and I-E-C	15.40
Total		**56.12**

Chapter – 1

INTRODUCTION

CHAPTER 1
INTRODUCTION

1.1 General

Works Department Government of Orissa has planned to improve its core network of about 906 km of state highways under Orissa State Road Project (OSRP) with the loan assistance from World Bank in phase-I. This has been learnt that road improvement with enhance mobility increase transmission of HIV/AIDS. Prevention and control of HIV/AIDS transmission is one of the important social responsibilities World Bank has recognized in recent past. Hence prevention and control of transmission of HIV/AIDS have become important component of social management plans prepared during project preparation of present road improvement.

1.2 Prologue

Need for Strategy and HIV/AIDS Action Plan

It is well established that because of improvements of road, mobility of CSWs and truckers also increases and hence chances of transmission of HIV/AIDS. Until the present Road Project (OSRP), Other State road projects[1] were not emphasized with special targeted intervention strategies (as in present case of OSRP) for skirmishing HIV/AIDS transmission. It was integrated with resettlement and rehabilitation in other state road projects. As a result HIV/AIDS issues were remained neglected or weakly emphasized during project implementation. In other words HIV/AIDS prevention program have not given due attention towards fulfilling social responsibility of the road projects.

Orissa is a low prevalence rate state and awareness about AIDS in general population is moderate. Consultations with high-risk group revealed low to very low commitment to prevent the pandemic. Therefore efforts are required to cover general population for mass awareness about HIV/AIDS and based on first hand information, goal oriented specific intervention program needs to be carried out for targeted population (CSWs, Tuckers, IDU etc). Targeted population can be classified into

1. **Core Groups**
    - CSWs
    - IDUs(They are now increasing in Orissa now)
    - MSM
2. **None core Groups** (which regularly interacts with the core groups)
    - Truckers
    - Construction workers (Construction camps)
    - Migrant laborers
    - Handia/local country liquor sellers (more vulnerable in tribal areas)
    - Children and adolescent (high vulnerable group)

[1] OSRP is the first state road project which included prevention of HIV/AIDS transmission as integral part of SMPss and also part of concept document(PID) as a part of project planning.

People at the margin of society are poor people, especially women at high risk because of potentialities of transforming themselves as CSWs and **HIV/AIDS orphan**. Therefore a targeted intervention is required to focus on these target groups for the present preventive program.

Moreover the State is a buffer zone of high prevalence state of West Bengal and Andhra Pradesh. Orissa is well connected with these two high states by means of road transports. Road improvement and mobility of high-risk groups are positively correlated. Therefore there will be increase mobility of high-risk groups in the state in general and along the project roads in particular. Thus, the state is almost at the fringe of potentially high prevalence of the HIV/AIDS epidemics and **there is need to location specific intervention strategies for the prevention of HIV/AIDS transmission**.

HIV/AIDS transmission is generally caused by mobility of the people such as migration (out&in), sexual activeness (specific age group and socio-cultural behavior of the people), poverty, low literacy and lack of knowledge of epidemiological behavior etc. These causative factors are common to all parts of the state. At present the State is in the category of highly vulnerable status (low HIV prevalence). Based on prevalence rate, spatial distribution of high risk groups and hot pots, potentiality of spread of epidemic; it is evident that there is urgent need to initiate a collective effort to combat such a threat to mankind.

Public consultation, FGDs, NGOs partnership development and joining hands with other institution such as SACS, DFID, USAIDS provides clear cut intervention strategies for the prevention of the HIV/AIDS pandemic. This is also important to understand sexual networking in the project areas and nature of infiltrations of CSWs from distant location as most cases of HIV/AIDS are sexually transmitted.

Above mentioned discussions indicate a strong linkages is required among different stakeholders for an effective preventive program. Effectiveness of these programmes require strong linkages with the community and other stakeholders. These linkages can be established with very effective communication strategy like Information, education and communication (I-E-C) and Behavior change communication (BCC). **Thus target oriented and focused campaign delivery method and partnership development with stakeholders are required for effective implementation of the preventive program.**

From the above mentioned internal debate number of issues have emerge out in the context of road improvement and the spread of HIV / AIDS diseases in the state. Based on these emergent issues following objective have been delineated for the present studies.

1.3 Objectives

1. To understand epidemiology of HIV/AIDS in the context of Orissa State Road project (OSRP)
2. To identify role of intervention strategy for the prevention campaign of HIV/AIDS transmission relevant for OSRP
3. To prepare a target specific action plan as applicable to OSRP

1.4 Methodology

Present study has been based on primary information collected during baseline socio-economic and census survey, consultation and secondary database support. During the survey information were collected about HIV/AIDS epidemiology, behavior change communication, level of awareness about AIDS and other highway related diseases. Focused Group Discussion (FGDs) preparation of village diary has substantiated information base about

HIV/AID and causes of its spread. Identification of hot spots and location of Targeted Intervention (TI) has been established based on information from above mentioned sources.

Consultation with community, behavior of community with HIV positive people, consultation with other institutional stakeholders such as SACS, OXFAME, NGOs (working in HIV/AIDS project in close coordination with SACS), have given basis for the management of implementation framework.

1.5 Structure of Report

This report is an attempt to develop strategies, and framework for implementation. Chapter wise content is mentioned below in the table**.**

Chapter Number	Name of Chapter	Description
1	Introduction	Outlines Project background, objective and methodology adopted.
2	Assessment of HIV/AIDS Scenario	This chapter illustrates status of HIV/AIDS, intervention strategies of OSACS and othe TI partners and highlight of NACP III(2007-2011).
3	Project Locations for Targeted Intervention	Describes causes of HIV/AIDS and road improvement and transmission of HIV/AIDS project roads and socio-economic characteristics of the project area.
4	Strategy for Awareness	Discusses Strategy for the preparation of action Plan
5	Action Plan for the Prevention of HIV/AIDS Transmission	Details of action plan such as BCC/I-E-C plan, capacity building. condom distribution and Partnership development.
6	Institutional Arrangement	This chapter describes role and responsibilities of stakeholders in implementation of HIV/AIDS action plan
7	Implementation Schedule	This chapter outlines implementation schedule and as per construction schedule.
8	Budget	Details out activity wise cost provision of each activities.

1.6 Acknowledgement

The consultant is very much thankful to support and assistance provided by OWD local officials during fieldwork and PIU(World Bank) officials for the assistance provided in developing framework of the report. The consultant takes this opportunity to thank Chief Engineer, PIU (World Bank) for his contribution towards arranging information from SACS.

Finally special thanks is accorded to **M. Hasan** for his valuable suggestion and consistent guidelines for the preparation of the Report during Mission Visit (Jan 2006, March 2006, June 2006, July 2006, and November 2006) , in the World Bank office 24th Jan2006 and 25th August 2006) and constantly providing necessary guidelines through **e-mail**.

Chapter – 2

ASSESSMENT OF HIV/AIDS SCENARIO IN THE STATE

CHAPTER 2

ASSESSMENT OF HIV/AIDS SCENARIO IN THE STATE

2.1 Project Background

The Orissa Works Department (OWD) of the Government of Orissa (GoO) has planned to improve the core network of roads in the state with funding from the World Bank. Based on the road network analysis and feasibility studies, the project proposes to widen and strengthen of about 906 km of the core network, mainly State Highways.(Table 2.1).

Table 2.1: List of the project Road

Sl. No.	Name of Road	SH/MDR	Length (km)	Project Districts
1	**Jagatpur - Kendrapada - Chandbali Bhadrak**			
	a) Jagatpur - Kendrapada - Chadbali	SH-9A	99	Cuttack, Kendrapara
	b) Chandbali - Bhadrak	SH-9	53	Bhadrak
2	**Bhadrak - Anandapur - Karanjia - Jashipur**			
	a) Bhadrak - Anandapur	SH-53	46	Bhadrak, Keonjhar
	b) Anandapur - Karanjia	SH-53	79	Keonjhar, Mayurbhanja
	c) Karanjia - Jashipur	SH-49	17	Mayurbhanja
3	**Berhampur - Raygada**			
	a) Berhampur - Bangi Jn.	SH-17	150	Ganjam, Gajapati, Rayagada
	b) Bangi Jn. - JK Pur	SH4	51	Rayagada
4	**Khariar - Bhawanipatna - Muniguda - Kerada**			
	a) Khariar - Bhawanipatna	SH-16	70	Nuapada, Bolangir, Kalahandi
	b) Bhawanipatna - Muniguda	SH-6	68	Kalahandi, Rayagada
	c) Muniguda - J.K.Pur	SH-5	50	Rayagada
	d) J.K. Pur-Raygada	SH-4	10	Rayagada
	e) Raygada - Kerada	MDR-48B	25	Rayagada
5	**Banarpal - Daspalla - Bhanjanagar - Aska - Digapahandi**			
	a) Banarpal - Daspalla	MDR-18,19	89	Angul, Dhenkanal, Nayagarh
	B) Daspalla-Bhanjanagar	SH-37	61	Nayagarh, Ganjam
	b) Bhanjanagar - Aska	SH-7	38	Ganjam
TOTAL			**906**	

Source: Orissa State Road Project, Works department

Previous chapter has indicated that HIV/AIDS is generally caused by mobility and migration of HRG. Proposed road improvement wll enhance mobility of these HRG. The corridors (mentioned in table 2.1) connect important state highways of the State (SH-9,SH-49,SH17,SH-64 and SH-16) with important high density National highways(NH) of the country(NH-5,NH-201,NH 224,NH-6). Amongst the above mentioned road corridors (as mentioned in table 2.1) few of roads pass through virgin ethnic group in Schedule areas and road improvement need careful analysis and risk support system to protect these scheduled areas so far HIV/AIDS infection are concerned. Following sections deal about HIV/AIDS status, intervention strategies and need for convergence with OSACS in planning and implementation of action plan.

2.2 HIV AIDS Status in the State

In Orissa**,** numbers of reported cases are low in comparison to other state of the country. Reported low prevalence rate is because of traditional culture of the state, lower surveillance data, lack of knowledge about HIV/AIDS in tribal and rural areas especially in primitive ethnic groups. Traditional culture of Orissa and swathe social structure has hidden actual prevalence of HIV/AIDS scenario in the state. The HIV/AIDS, looks like an iceberg(only $1/10^{th}$ part is visible) in the state, thus it is very difficult to establish identification of hot spots, nature, extent & mode of transmission of HIV/AIDS among general population, concentration of commercial sex workers (CSWs), location of road intersection(point) as a diffusion point of HIV/AIDS in the State. However HIV prevalence status may indicate nature and cause of pandemic in the State.

2.2.1 HIV/AIDS Scenario

As per Sentinel Surveillance data 2005, the HIV prevalence rate in Orissa is 0.6%. Since this is less than 1% of prevalence rate, the status of Orissa on HIV/AIDS is considered **LOW**. Because of border to the high prevalence adjoining states(AP and West Bengal) and due to large scale of out-migration to other state (Gujarat, Maharastra, Andhra Pradesh, Tamil Nadu, West Bengal) the HIV prevalence seems to be increasing in Orissa.

Table 2.2: Status of HIV +Ve / AIDS Cases (as on August 31, 2006)

Sl. No.	District	HIV +ve	%age	AIDS cases	%age	Death due to AIDS	%age
1	Angul	95	2.3	26	3.5	22	3.9
2	Balasore	140	3.3	19	2.6	19	3.4
3	Bolangir	37	0.9	5	0.7	5	0.9
4	Baragarh	12	0.3	0	0.0	0	0.0
5	Bhadrak	79	1.9	21	2.8	20	3.6
6	Boudh	0	0.0	0	0.0	0	0.0
7	Cuttack	872	20.8	106	14.3	32	5.7
8	Dhenkanal	8	0.2	1	0.1	1	0.2
9	Deogarh	0	0.0	0	0.0	0	0.0
10	Gajapati	31	0.7	0	0.0	0	0.0
11	Ganjam	1618	38.6	243	32.9	182	32.7
12	Jharsuguda	20	0.5	1	0.1	1	0.2
13	Jagatsingpur	6	0.1	0	0.0	0	0.0
14	Jajpur	65	1.6	24	3.2	24	4.3
15	Kalahandi	22	0.5	0	0.0	0	0.0
16	Kandhamal	5	0.1	3	0.4	2	0.4
17	Kendrapara	49	1.2	69	9.3	68	12.2
18	Keonjhar	12	0.3	0	0.0	0	0.0
19	Khurda	230	5.5	45	6.1	37	6.6
20	Koraput	260	6.2	30	4.1	30	5.4
21	Malkangiri	8	0.2	7	0.9	1	0.2
22	Mayurbhanj	14	0.3	2	0.3	2	0.4
23	Nawarangpur	27	0.6	0	0.0	0	0.0
24	Nayagarh	22	0.5	2	0.3	2	0.4
25	Nuapada	36	0.9	11	1.5	11	2.0
26	Puri	119	2.8	50	6.8	43	7.7

27	Rayagada	134	3.2	39	5.3	25	4.5
28	Sambalpur	212	5.1	20	2.7	20	3.6
29	Sonepur	2	0.0	0	0.0	0	0.0
30	Sundergarh	58	1.4	15	2.0	10	1.8
	TOTAL	4193	100.0	739	100.0	557	100.0

Souce : OSACS 2007

2.2.2 Districts vulnerable to HIV/AIDS:

As per ***ORG MARG*** Situation Mapping report 2005,

- HIGHLY VULNERABLE DISTRICTS = Khurda, Puri, **Keonjhar**, Nawarangpur, **Ganjam**, **Bolangir, Bhadrak, Kalahandi, Nuapada**, Deogarh (10 districts).
- MEDIUM VULNERABLE DISTRICTS = Koraput, **Rayagada**, Nayagarh, Balasore, **Mayurbhanj**, Sonepur, **Cuttack,** Sundergarh, Malkangiri, Jagatsingpur, Sambalpur (11 districts).
- LOW VULNERABLE DISTRICTS = **Angul,** Bargarh, Boudh, **Dhenkanal, Gajapati,** Jajpur, Jharsuguda, Kandhamal, **Kendrapara** (9 districts).

2.2.3 Ongoing Programmes on HIV/AIDS in Orissa

OSACS (Ministry of Health and Family Welfare, GoO) has been the nodal agency for the prevention and control program of HIV/AIDS transmission for different partners such as NACO, DFID, Oxfame, UNAIDS, HLFPPT etc. in Orissa. Ongoing program by OSACS is mentioned in Table 2.3.

Table 2.3: Ongoing HIV/AIDS Programme in Orissa

Sl.No.	Item	Year 2005-2006	Year 2006-2007	Purpose
1	TI Projects	3	33	TI to FSWs,MSM,Migrant labourers,IDU
2	VCCTC	20	35	General population and HRG for counseling
3	Integrated Counseling Centre	-	26	
4	STD Clinics	34	34	Medical check –up and free medicines to all
5	PPTCT	30	32	Prevent parent to child transmission
6	Condom Vending Mechines	3	3	HRG for control of HIV/AIDS
7	Community Care Centre	4	4	PLWHA
8	Drop in Centres	1	1	PLWHA
9	ART Centres	1	1	

From the information mentioned in the above table it is inferred that I-E-C and BCC is weekly emphasized by OSACS, therefore OSRP should emphasize more on I-E-C and BCC.

Condom Vending machines should also be provided, as number of machines is very less. These are NGOs working as TI partners with OSACS. List of NGOs working is appended.

2.2.4 National and International Support for the prevention and Control of HIV/AIDS in Orissa

Under MAINSTREAMING on HIV/AIDS, Orissa State AIDS Control Society(OSACS) has collaborated with the following organizations

- UNDP for establishing ICT kiosks in Ganjam, Nayagarh and Kendrapara districts (Orissa) and Surat, Alang (Gujarat) for promoting Safe Migration.
- Catholic Relief Services (CRS) and Lepra India for providing Care & Support programmes for 86 HIV +ve persons in Ganjam district.
- Hindustan Latex Family Planning Promotion Trust (HLFPPT), Population Services International (PSI) and Parivar Seva Sanstha (PSS) for promoting social marketing of condoms in the State.
- Hindustan Latex Limited (HLL) for installing Condom Vending Machine (CVM) in Orissa.
- OXFAM for providing drugs for opportunistic infections; training of Private and Government Medical Practitioners; training of State level trainers on Counselling; Media advocacy and PRI sensitization.
- Indian Oil Corporation Limited (IOCL) for information and services dissemination among the truckers through their retail outlets.
- Hotel & Restaurant Association of Orissa (HRAO) for information and services dissemination through their district level associations.
- Department of School & Mass Education for imparting School Adolescence Education Programme in the Government Secondary schools and +2 Colleges of the State. This will be a continuing activity every year. The curriculum on HIV/AIDS have been decided to be finalised for Class – IX to Class – XII for incorporation in the syllabus during this academic year for which action has already been initiated by Orissa Secondary Board of Education and +2 Council.
- UNICEF for providing training for PPTCT programme in the State and technical support to the School Adolescence Education Programme.

2.3 NACO Initiatives in NACP III

NACP Phase-III will start from April 2007 to March 2011with following objectives

- Prevention of new infections in high-risk groups and vulnerable populations.
- Increasing the proportion of persons living with HIV/AIDS receiving care and treatment.
- Strengthening the infrastructure, systems and human resources in prevention and treatment programs at the district, state and national levels.
- Establishing nation wide strategic planning, programme management, monitoring and evaluation system.

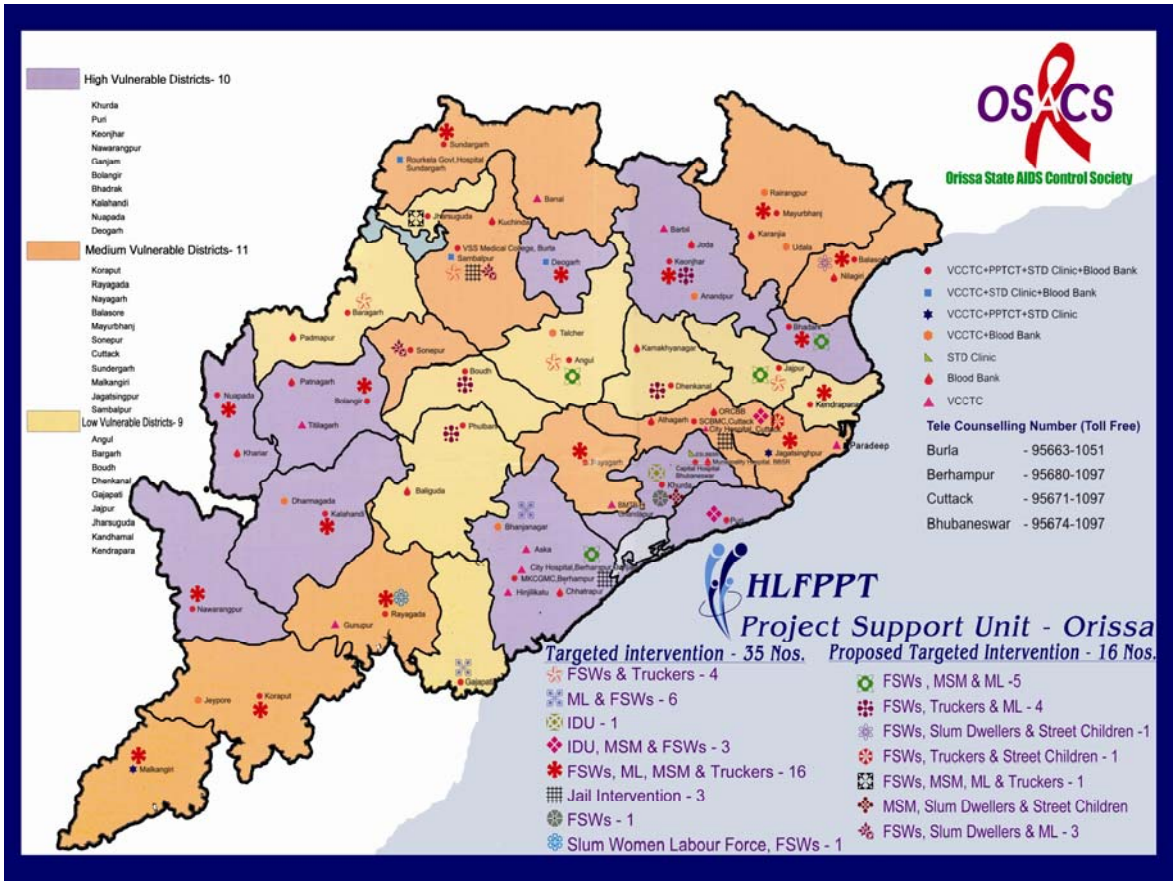
Major Activities of NACP-III in Orissa

- 150 new TIs will be taken up in order to saturate the core and bridge groups.

- 408 STD clinics will be opened in Medical institutions of Orissa.
- 65 licensed Blood Banks will receive support from OSACS
- 15 Blood Component Separation Units will be set up in the State.
- 408 VCCTCs up to the PHC level will be set up.
- 408 PPTCTs up to the PHC level will be set up.
- 29 Community Care Centres up to the district level will be set up in the State.
- 6 ART centres will be set up in the State.
- 29 drop in centres will be set up to the District level in the State.
- ART treatment will be provided to the PLWHAs in the State.

2.4 Need of Convergence with SACS Programme

Orissa State Road projects(OSRP) is mainly a road improvement and maintenance of road project has considered HIV/AIDS is modern threat especially after improvements of the proposed roads. These proposed corridors are covered under ongoing HIV/AIDS prevention programme of OSACS. To avoid overlapping herein convergence of HIV/AIDS prevention and control program is sought. Fig. 2.2 provides ongoing TI programs in Orissa.



Field investigation revealed that the proposed corridor under road improvement does not have enough evidence of detailed I-E-C and BCC intervention measures of OSACS.

Reconnaissance survey and first hand information collected along the roads suggest that there is a need to emphasize I-E-C and BCC along the project road. Jagatpur-Bhadrak-Chandbali-Anandpur-Karanjia section has not evidenced I-E-C campaign materials. However

Berhampur-,Raygada Section has evidence of I-E-C materials. To avoid repetition of TI intervention program, convergence with OSACS (along with its TI partners mainly NGOs) will provide detailed intervention strategies to cover these areas. OSRP TI(implementing NGO) partner will be joining hands to OSACS TI partners in the proposed project Districts and ongoing program.

Chapter – 3
PROJECT LOCATION FOR TARGETED INTERVENTION

CHAPTER 3

PROJECT LOCATION FOR TARGETED INTERVENTION

3.1 Background

From the cross-cultural examples and statistical evidences; it is believed with significant level of confidence that most cases of HIV are transmitted through unprotected sex and important vectors are truckers, CSWs and construction workers (HRG[1]). Brothel, Dhabas, major crossings are centres of the transmission (Hot Spots[2]). The interaction of truckers and CSWs mobility (high risk groups) are reinforced because of improvement of road transport. The epidemic also follows **laws of diffusion** and **distance decay principles**. It means diffusion will be faster near high prevalence region and it will decrease from the high prevalence region to low prevalence region. Region and State of low prevalence rate[3] (high vulnerable status) like Orissa is more susceptible to the impact of road improvement and mobility of these high risk groups. Thus to understand issues associated with road improvements and epidemiology of HIV/AIDS an extensive fieldwork, consultation , FGDs at the local level, community level, at major brothel and Dhabas is done. These exercises have not only helped to understand cause, nature and extent (epidemiology) of HIV/AIDS in the State and along the project road but also assisted in the formulation of Strategy and Action Plan for the Prevention of HIV/AIDS. Following section outlines epidemiology, important potential hot spots of road improvement.

3.2 Epidemiology of HIV/AIDS

Human Immunodeficiency Virus (HIV) is virulent to immune system of body. People infected with the virus may not have symptoms in early stages of infection. AIDS (Acquired Immunodeficiency Syndrome) is later stage of HIV virulent infection. A person with HIV infection has AIDS when S/he has immune system count below a standard level (200 CD4 count). A person of any age sex, race etc can get HIV, which is evident from epidemiological study and research that HIV is generally caused by unprotected sex using unsafe needles, blood transfusion (Table 3.1). This is also evidenced from epidemiological study that HIV can only be transmitted if infected blood, semen, vaginal fluids or breast milk gets into the body. Having understood the causative factors, following sections examines location of Targeted Intervention (TI) along the project route.

Table 3.1: Epidemiology of HIV/AIDS

Sl.No.	Causes of HIV	Vectors
1	**Unprotected sex with a person having HIV**	***CSWs, People of high sexual activeness, Truckers, laborers in construction camp, migrants,MSM***
2	Sharing of Needles, Syringes to inject drugs	Intervenes drug users(IDUs)
3	Babies can be infected from mother during pregnancy, breast feeding	Infected mother(AIDS Orphan)
4	Health care and maintenance worker may exposed to blood	Heath officer

[1] High Risk Group
[2] Also known as Targeted location for Intervention
[3] State with low prevalence rate is more prone to virulent infection because epidemiological behavior of disease is not understood appropriately by the society hence prevalence rate is also underestimated. Thus there is need to generate awareness about the pandemic in the State.

3.3 Communities along the Project Corridor

A settlement level analysis was undertaken to understand socio-economic characteristics of community. From the empirical studies it is established that knowledge level about prevalence rate, epidemiological behavior of HIV is low in the State. Thus there is need to generate awareness about HIV/AIDS epidemiology. Communities along the project corridor are divided in two parts. Communities living in non-scheduled areas are practicing agricultural in rural areas and business and other activities in urban areas. They are more exposed to HIV infection at present. Communities living in scheduled areas are still not much aware about the disease but due to road improvement they would be interacted more frequently to the people of complex societies and exposure to HIV will be high. Therefore intervention approach should emphasize strategies to control HIV/AIDS in non-schedule areas and prevention strategies in scheduled areas.

Table: 3.2: Communities along the road (Targeted Location)

SH-09(Bhadrak-Chandbali) (00-45 Km)

Communities	Chainage	Communities	Chainage	Communities	Chainage
Bhadrak	00-01	Tihidi PurunaHat	16-17	Santarapur	28-29
Sarkar Nagar	01-02	Tihidi	17-18	Gaddi	30-31
Mirzapur	02-03	Mangarajpur	18-19	Kheranga	33-34
Haladidihi	03-04-05	Golapokhari	19-20	Nalagunda	36-37
Barik Chhak	05-06	Kolha	20-21	Digachhia	37-38
Ichhapur	06-07	Kamaria Bazar	21-22	Motto	39-40-41
Dolosahi	09-10, 11-12	Aruha	22-23	Naugorada	41-42
Alinagar	12-13	Santhapur	23-24-25	Ugratara	42-43
Ranipur	13-14	Pirahat	25-26		
Nandapur	14-15	Harsinghpur	27-28		

SH-53 (Bhadrak-Anandpur) (00-51Km)

Communities	Chainage	Communities	Chainage	Communities	Chainage
Bonth Chhak	00-01	Tillo Badasahi	17-18	Chorgadia	33-34
Bhadrak	01-02	Tillo	18-19	Bancho	34-35
Bagurai	02-03	Bonth	19-20	Dadhibanpur	35-36-37
Randia	03-04	Chainpur	22-23	Fakirpur	40-41-42
Mundimara	06-07	Orali Chhak	24-25	Anandpur	42-43-44-45-46
Barapada	07-08-09	Basantia	25-26-27	Padmapur	47-48
Ganijanga	11-12	Biranchipur	27-28	Sarangi	48-49-50
Hasinpur	12-13	Jalakalanga	29-30	Bankhidi	50-51
Palasa	13-14	Hatadihi	30-31		
Ambagadia	15-16	Chhenapadi	31-32		

SH-17(Berhampur-Taptapani) (00-41Km)

Communities	Chainage	Communities	Chainage	Communities	Chainage
First Gate	00-01	Dengapadar	11-12	Nua Maulabhanja	28-29
Dakhinnpur	03-04	Narayanpur	13-14	Puruna Maulabhanja	29-30
Lanjia	04-05	Gania Nala	15-16	Dengausta	32-34
Balkrishnapur	05-06	Pitamabarpur	17-18	Kansamari	34-35
Padarbali	07-08	Gokarnpur	18-20	Pudamari	36-38

Patitapabanpur	08-09	Anangapur	20-21		
Balipada	09-11	Digapahandi	22-25		

SH-16(Bhawanipatna-Khariar) (02-70 Km)

Communities	Chainage	Communities	Chainage	Communities	Chainage
Udit Narayan Pur	05-06-07	Turkel	27-28	Gandharla	49-50-51
Kamthana	07-08-09	Seinpur	30-31	Turekela	52-53-54
Sana Khairamala	09-10	Belapada	33-34	Jamakhunta	54-55
Karla guda	12-13	Salepada	36-37	Dohelpada	56-57
Pastipada	14-15-16	Borda	39-40	Sriram	57-58
Manik Padar	18-19	Kurusud	43-44	Tukula	60-61-62
Karlapada	20-21	Turkbhata	45-46	Risigaon	62-63
Demuani	22-23	Kotamara	46-47	Lachhipur	64-65,66-67
Ghughurpala	24-25	Chandtara	47-48	Khariar	69-70-00

SH-17(Taptapani-Raipanka) (41-109 Km)

Communities	*Chainage*	*Communities*	*Chainage*	*Communities*	*Chainage*
T. Gobindapur	*45-46*	*Mohona*	*67-69*	*Odapanka*	*84-85*
Belaguda	*50-51*	*Chapetapanka*	*71-72*	*Birikot*	*89-91*
Kamalapur	*53-54*	*Bramunidei*	*73-74*	*Mundimeara*	*101-102*
Luhagudi	*54-55*	*Adava*	*80-81*	*Raipanka*	*108-109*
Liliguda	*63-64*	*Podagaon*	*81-83*		

SH-17(Raipanka-Bangi Jn) (109-151Km)

Village	*Chainage*	*Village*	*Chainage*	*Village*	*Chainage*
Nuagada	*113-115*	*Khamariguda*	*126-127*	*Muchikipadar*	*137-138*
Goibandha	*117-118*	*Mardiguda*	*128-129*	*Antorjholi*	*140-141*
Hatapada	*123-125*	*Akhusinghi*	*131-132*	*Gumuda*	*141-143*
Kenduguda	*125-126*	*Khilamunda*	*132-134*		

SH-04(Bangi Jn-JK Pur) (161-119 Km)

Communities	*Chainage*	*Communities*	*Chainage*	*Communities*	*Chainage*
Ramanaguda	*155-158*	*Rabadi*	*145-146*	*Kolanara*	*122-123*
Karniguda	*154-155*	*Hati Khamba*	*138-139*	*Amblaghata*	*119-120*
Palupai	*150-151*	*Mukundapur*	*137-138*		
Tandikana	*148-149*	*Kailashpur*	*136-137*		

Jagatpur - Chandbali (SH-9A) (00-99 Km)

Communities	Chainage	Communities	Chainage	Communities	Chainage
Jagatpur	01-00	Gopapur	30-29	Haladidiha	55-54
Jagatpur	02-01	Katarpada	31-30	Jajhanga	56-55
Khaira	03-02	Sukarpada	32-31	Tarando	57-56
Pira Bazar	04-03	Ranipada	34-33	Trilochanpur	58-57
Pira Bazar	05-04	Banamalipur	35-34	Barua	59-58
Padmapur	06-05	Katikata	36-35	Patharkani	62-61
Padmapur	07-06	Kusunpur	37-36	Gangapada	63-62
Padmapur	08-07	Sapanpur	18-17	Gogua	65-64
Mohajanpur	09-08	Machhuati	19-18	Badamulabasanta	66-65
Paga Chhaka	10-09	Katakia	38-37	Pahala	67-66
Bahugrama	11-10	Chandol	39-38	Kasananta	73-72

Nondolgara	14-13	Chandol	40-39	Kasananta	74-73
Nondolgara	15-14	Anuapada	42-41	Gopalpur	75-74
Naliamohan	16-15	Khamol	43-42	Bilikana	76-75
Sishua	17-16	Chandibazar	44-43	Bharatpur	77-76
Salepur	21-20	Balia	45-44	Singiri	78-77
Kulia	22-21	Jantilo	46-45	Singiri	79-78
Kulia	23-22	Balabhadrapur	46-47	Malapatana	80-79
Kulia	24-23	Duria	49-48	Gopinathpur	82-81
Patapur	25-24	Duria	50-49	Gopinathpur	83-82
Bahabalapur	26-25	Tinimuhani	51-50	Aul	86-85
Nischintakoili	27-26	Gulnager	52-51	Kalapahada	87-86
Nischintakoili	28-27	Gulnager	53-52		
Nischintakoili	29-28	Garapur	54-53		
SH-09(Bhadrak-Chandbali) (45-53 Km)					
Communities	**Chainage**	**Communities**	**Chainage**	**Communities**	**Chainage**
Kakharudihi	45-46	Panchapada	47-48-49		
Kuanrasara	46-47	Chandbali	49-50, 51-52		
SH-53 (Bhadrak-Anandpur) (51-57 Km)					
Communities	**Chainage**	***Communities***	***Chainage***	***Communities***	***Chainage***
Guirabani	52-53	*Kodapada*	*54-55*	*Bhogapur*	*56-57*
SH-53 (Anandpur-Karanjia) (51-57 Km)					
Village	**Chainage**	***Village***	***Chainage***	***Communities***	***Chainage***
Godabhanga	63-62	*Jualikata*	*35-34*	*Badadisil*	*11-10*
Satkosia	57-56-55	*Chainbainsi*	*32-31-30*	*Kadadiha*	*08-07*
Gulgulia	53-52	*Khajuripada*	*28-27*	*Kuduma*	*04-03*
Mahuldiaha	50-49	*Kendujiani*	*25-24-23*	*Rasamatala*	*03-02*
Jamunalia	47-46	*Ashanbani*	*22-21*	*Karadia*	*02-01*
Taramara	44-43	*Kendumundi*	*18-17-16*	*Karanjia*	*01-00*
Khuntapasi	40-39	*Patabila*	*15-14*		
Thakuramunda	38-37-36	*Kalakata*	*13-12*		
SH-49 (Karanjia-Jashipur) (45-60 Km)					
Communities	**Chainage**	***Communities***	***Chainage***	***Villag* Communities *e***	***Chainage***
Karanjia	60-59	*Kurulia*	*56-55*	*Tato*	*53-51*
Sarubali	59-58	*Kanakada*	*55-54*	*Gidhibash Chhak*	*50-49*
MDR-48B (Rayagada-Kereda) (00-24 Km)					
Communities	**Chainage**	**Communities**	**Chainage**	**Communities**	**Chainage**
Pitamahal	03-05	Jamadevi Pentha	15-16	Kereda	24-25
Jamidipeta	09-10	Kunchika Valsa	18-19		
Gudam	14-15	Seskhal	19-20		
SH-05 (JK Pur - Muniguda) (00-50 Km)					
Communities	***Chainage***	***Communities***	***Chainage***	***Communities***	**Chainage**
Penta	*01-02*	*Kenedie Chhak*	*19-20*	*Fatamunda*	41-42
Jangulibadi	*02-03*	*Gundaguda*	*23-24*	*Gailakana*	42-43
Kamuguda	*06-07*	*Chatikana*	*29-30*	*Hatamuniguda*	44-45
Thirubali	*09-11*	*Gatiguda*	*31-32*	*Brujipada*	45-46

Khedapada	*12-13*	*Dangerbank Chhak*	*33-34*	*Bada Dandara*	46-47
Dumuniguda	*13-14*	*Bisham Cuttack*	*34-38*	*Hatamuniguda*	47-48
Bhatapur	*16-17*	*Chanchardaguda*	*38-39*		
SH-06 (Muniguda-Bhawanipatna) (00-68 Km)					
Communities	***Chainage***	***Communities***	***Chainage***	***Communities***	**Chainage**
Muniguda	*65-66*	*Indirapada*	*43-44*	*Deypur*	11-12
Jumunaguda	*64-65*	*Ambadola*	*41-43*	*Gopinathpur*	09-10
Brusikhamar	*61-62*	*Pokharibandha*	*36-37*	*Basumatipur*	08-09
Patraguda	*59-60*	*Sikarpur*	*28-30*	*Dangergoda*	07-08
Hata Dahikhola	*56-57*	*Sikarpur*	*28-29*	*Bijepur*	06-07
Ghodaguda	*54-55*	*Kauguda*	*25-26*	*Ichhapur*	05-06
Dahikhola	*53-54*	*Kiding*	*25-26*	*Jagannathpur*	03-04
Bandhuguda	*52-53*	*Banjori*	*23-24*	*Medinpur*	02-03
Badamanjirkupa	*49-50*	*Kucheijore*	*21-22*	*Sitabadipada*	01-02
Ranipada	*46-47*	*Santapur*	*18-19*	*Bhawanipatna*	00-01
Jhagodinala	*45-46*	*Chichaig*	*17-18*		
SH-07 (Aska-Bhanjanagar)					
Communities	**Chainage**	**Communities**	**Chainage**	**Communities**	**Chainage**
Aska	46-47-48	Khandarabali	60-62	Binchana	73-74
Aska	48-49	Nimina	62-63	Gobara	74-76
Taluk Chhak	49-50	Kendupadar	63-64	Sadangipalli	76-77
K. Nuagaon	50-51	Munigadi	64-65	Kanteipalli	79-80
Debabhumi	51-52	Singipur	65-66	Saluapalli	80-82
Jhagadei	52-53	Indupur	66-67	Kaindi	82-83
Gunthapada	54-56	Gangpur	68-69	Jilundi	83-85
Sumantapalli	56-57	Pailipada	70-71	Agajhola	85-86
Balisara	57-60	Khetribarapur	71-72		
MDR-18&19, SH-65 (Daspalla-Banaral)					
Communities	**Chainage**	**Communities**	**Chainage**	**Communities**	**Chainage**
Daspalla	00-01	Patanda	01-02	Madhykhanda	07-08
Gania	00-01	Punachandrapur	02-03	Gholahandi	11-12
Kainsiri	00-01	Chitipada	03-04	Adakata	14-15
Narasinghpur	00-01	Janisahi	03-04	Karadapada	19-20
Sidhamula	00-01	Kishoraprasad	03-04	Gopalapur	20-21
Jogi Bandha	01-02	Erapada	04-05		

*Villages of scheduled areas are mentioned in Italics

Source: Consultant study

3.4 Way Side Amenities (Bus Bay and Truck Parks)

It is expected that traffic would increase after development of proposed transport corridors. Consequently, There will be change in economy, transport, tourism, land use along the corridor, which in turn, will bring change in occupational pattern. There will be more dhabas, truck parks, rest areas along the project road. These facilities would be attracted by small business house such as dhabas, motor mechanic shops and other related economic activities. These places would also attract CSWs, MSM (hot spots), truckers and other road users. Thus these places would be targeted locations for prevention of HIV/AIDS program. (TI locations).

Table: 3.3 Way Side Amenities along the project road in the Proposed Corridor

Location	State Highways		Name of Communities	Remarks
	From	To		
SH-9	1/500	1/600	Bhadrak	Finalized
SH-53	4/700	4/800	Karanta	Finalized
SH-17	42/400	42/500	Khemandikholo	Finalized
SH-16	21/900	22/224	Belapada	Finalized
SH-9A	88/900	89/000	*Kalpohada*	*Not finalized*
SH-49	11/00	12/200	*Jassipur More Randia*	*Not finalized*
SH-64	13/00	13/100	*Tulmull*	*Not finalized*
SH-5	43/00	43/100	*Gawlakana*	*Not finalized*
SH-6	12/300	12/400	*Deypur*	*Not finalized*
SH-4	38/00	38/100	*Hatikhamba*	*Not finalized*

*Location (in italics) of truck parks would be finalized after approval of alignments by OWD.
Source : consultant Study

3.5 Brothel and Other Hotspots

As mentioned earlier, illegal sexual activities are like an iceberg in Orissa. There are not many recognized brothels (Female Sex Workers for fixed location). But informal flesh trades do exist along the project stretch especially near junction of National Highways (NH) and truck parks. Few tribal have been located doing such illegal activities along the road during night along the National Highways of high traffic density. It is expected that after improvement of proposed corridors under OSRP there may be migration of these HRG from the NH to OSRP roads. These locations will be hot spots for targeted intervention. Information about brothels and other hot spots is presented in Table 3.4.

Table: 3.4 Brothel and Other Hot Spots along the Project Corridor (Within 1 km Radius)

Project Corridor	Location	Chainage	Major hot spots
Jagatpur-Chandbali-Bhadrak(SH-9)	Jagatpur	00-02	Dhabas, Truck camps(Informal0
	Kendrapara (Lalbagh Brothel),Tinimohani Chak(Informal),	51-50	Truck Camps, Brothel
	Ashuresar Village		Brothel(informal)
	Moahu(1km of Aul)	86-85	Brothel(informal)
	Chandbali Bus stand	49-52	Migratory CSWs
	Tihadi	17-18	Brothel(Informal)
Bhadrak-Anandpur-Jasipur(SH-53&SH-49)	Bonthchak(Towards old Bus Stand, Bhadrak)	00-01	Brothel(Informal)
	Randia(Near Facor)	03-04	Brothel(Informal)
	Senapadi Chhak(Truck Halt)	31-32	Brothel(Informal)
	Anandpur	42-45	Brothel(Informal)
Berhampur-Jkpur(SH-17&SH-4)	Berhampur Bus stand, Berhampur 1st Gate	00-01	Migratory CSWs and informal hidden CSWs
	Digapahandi	22-25	Migratory CSWs and informal hidden CSWs
	Mohna	67-69	CSWs(Informal)
	J.K.Pur	119-120	CSWs(Informal)

Kareda-Raygada Bhawanipatna-Khariar(SH-5,SH-6.SH-16)	Raygada		CSWs(Informal)
	Bishamkatak	34-38	CSWs(Informal)
	Muniguda	65-66	CSWs(Informal)
	Bhawanipatna	00-01	CSWs(Informal)
	Khariar	69-70-00	Brothel**(Cultural roots)**
Aska-Bhanjnagar-Daspalla-Bonharpal (SH-7,SH-37,SH-64)	Aska	46-49	CSWs(Informal)
	Bonharpal	0/00	CSWs(Informal)

Source: Consultant study

Conclusion

Orissa is a culturally rich State. It is difficult to identify exact number and location of brothel and other hot spots. However with the improvement of road and increased mobility of high-risk groups; intervention strategies require specific targeted module such as I-E-C and BCC. These strategies will be grounded by suitable implementation and management framework.

Chapter – 4

STRATEGY FOR THE PREVENTION OF HIV/AIDS TRANSMISSION

CHAPTER 4

STRATEGY FOR THE PREVENTION OF HIV/AIDS TRANSMISSION

4.1 Introduction

Management of risk of HIV/AIDS emerging out from road improvement is important components of present project concept document (PID). Spatial proliferation of HIV/AIDS is the most dreaded and hidden **bye-product** of road improvement. This bye-product's externalities are generally experienced after few years of construction of roads in operation phase. In the context of HIV Planners perceive the aftermath of road improvement much earlier in project preparation phase itself and develop strategies to combat the negative impact.

4.2 Prologue

Realizing the impact of increasing mobility of HRG during construction and operation phase, epidemiological behavior of HIV/AIDS in the context of traditional culture of Orissa State and location of important hot spots; intervention strategies have been formulated to minimize the risk of road users, construction workers and road side communities.

People of Orissa possess a very rich, traditional culture and their norms; value system is rooted in past history. Generally, innovation/strategies and new approach towards change in social behavior is resisted by the society Therefore intervention strategy requires pointed approach to address HIV/AIDS issues.

From the consultation, group discussion and other empirical studies, key technical elements for HIV are grouped into three main categories: **prevention** of HIV/AIDS for those at risk for HIV, **Control** of transmission in potentially affected areas by targeted intervention & **care and support** for those infected or affected by HIV/AIDS within a defined corridor which influences road side business and econometrics. The intervention measure also outlined sustainability of strategies adopted.

4.3 Prevention Strategy

There are a number of issues that emerge out in the context of road improvements and the transmission of HIV / AIDS. These issues require following prevention strategy

Table 4.1 Prevention Strategies for HIV/AIDS Prevention

HIV/AIDS Issues	Prevention Strategy/ Care and Support to HIV infected People
Target Group Mobility, Migration and High-Risk (Sexual) Behavior Truckers as Frequent Road Users Sex Workers close to the Project Corridor	To increase the level of awareness about prevention and control of HIV/AIDS among the different communities' particularly tribal communities in scheduled areas abutting project road.
Induced HIV AIDS issue Displacement due to Projects – Resettlement Issues and High-Risk Behavior	To promote safe sex behavior through promotion of condom use
	Developing referral awareness for medical care and treatment.
Loss of Livelihood or business leading to	Availability of ART and other facilities to patient

HIV/AIDS Issues	Prevention Strategy/ Care and Support to HIV infected People
loss of income and ultimately forced into flesh trade.	Social and Psychological support to AIDS infected

4.3.1 Approaches for the Prevention of HIV/AIDS Transmission

From the above-mentioned paragraphs I-E-C is one of the most important prevention strategy This will emphasize all targeted location and potential road users. Prevention strategy for HIV/AIDS in the present context will based on nature of road users, HRG and distribution of HRG along the project road. Ubiquitous presence of HRG will warrant for more intensive preventive strategies. table 4.2 illustrates IEC campaign strategies.

Table 4.2: IEC Campaign Strategies

Sl. No.	Targeted Location	I-E-C Strategy	Institutional Actors
1	Road side Communities	Display and Distribution of I-E-C materials,Mahila sammelan,Panchayat sammelan,Street Theatre,Film show,Best Vilage award, Gadhua tuth(Bathing Ghat discourse) of female, Sobha Yatra,wall writing,	Implementing NGOs,SMU(OWD)
2	Haat (weekly Market) & Goru hat	Street theatre, songs, Display and distribution of I-E-C materials ,Wall writing, Communicating I-E-C with animal benchmark in animal market	Implementing NGOs
3	Truck Parks	I-E-C materials, film screening, Peer group education	Implementing NGOs,SMU(OWD), peer educator
4	Construction camps	I-E-C materials, film screening, Peer group education	Implementing NGOs,SMU(OWD)
5	Brothel	Display and Distribution of I-E-C materials, CSWs sammelan,Best pimps, Street Theatre, Film show,.	Implementing NGOs,SMU(OWD)
6	Other hotspots	Display and Distribution of I-E-C materials	Implementing NGOs,SMU(OWD)
7	Leaders aam Sabha	Display and Distribution of I-E-C materials, wall writing	Implementing NGOs,SMU(OWD)
8	Exihibition	Display and Distribution of I-E-C materials,	Implementing NGOs,SMU(OWD)
9	Schools and Other Institution	Peer Group education,Teahers sammelan, Quiz contest among students,school theatre.	Implementing NGOs,SMU(OWD)

4.3.2 Activities Related to I-E-C

Road Yatra by SMU and local Engineer

A Road procession of OWD officers, implementing NGOs and officers from District administration will be flag off the HIV/AIDS campaign from important locations. These locations will be important communities as motioned in chapter 3.

Pradarshini(Exhibition)

There are numerous weekly haat along the project areas. There will be mass contact program at these places to attract the attention of common people through exhibition. People will be encouraged to participate in mass contact program.

Path Prant Yatra (Natak or street theatre)

A skit will be prepared with references to the local area, culture, art, architecture and important current happening to ensure the maximum attention of the target audience. The skit will be in the local dialect to make it easily communicable. This play will be first and foremost entertaining and there will be no direct reference to the HIV/ AIDS. It will, in a very subtle and humorous manner, highlighting the problems and know-how of the HIV/ AIDS.

Lok Sangeet (Local Songs)

The songs will be prepared highlighting the different aspects of HIV/ AIDS in the folk tradition of the project area.

Mahila Sabha

It has been observed that if change has to be brought in; then women folk, both of younger and older generation will have a very important role to play. With the help of women panchyat member, a meeting of women will be called where the problem related to the HIV/AIDS can be discussed. A small film or a skit can be performed to in these meeting to make the gathering more lively and interactive. ***"Pokhari Sammelan"*** of women in Orissa can be important location for this purpose.

Sobha Yatra

A procession of important people of the area will be taken out emphasizing the theme of HIV/ AIDS. This procession will have people performing different kind of activities like magician, folk singers of that area etc.

Kishor Sena

It is believed that children are a great opinion maker in their home and locality. To ensure the participation of the students first a team will visit school. After performing a skit highlighting the danger of HIV/ AIDS and interactive session with them a poster/quiz competition will be organized in the school. The first three posters from every school will be part of a mobile exhibition, which will be exhibited at several places. At every place people will be encouraged to pick three best posters. And after taking into account the people's opinion three best posters will be identified and awarded. A procession of the children will be organized in the award winning villages first followed by in other villages.

Gram Panchyat Sammelan

In every panchyat, a meting will be called of all the members and there cooperation will be solicited to make this program successful and its importance in their areas. Separately another meeting of women panchyat member will be called to impressed upon them that how important there role in turning this program in to a success story and how important it is for the wellbeing of the society. 15^{th} working day(Grievance day) is the date of meeting of gram panchayat in Orissa and will be suitably tied –up with this meeting.

Meeting of Teachers

To ensure that the educational institutions should help this campaign a meeting of the teachers will be called at block level. This meeting will ensure their participation in the

campaign. It is very important because these teachers can help not only ensuring the participation of the students but also in creating a positive feeling towards this campaign among masses.

The Best Village

The village showing the biggest change in the HIV/ AIDS awareness scenario during the campaign will be given a prize at the District level.

Film Screening

Films made by agencies such as NACO, UNAIDS, DFID on HIV/ AIDS can be screened at public places. It will help to create a favorable climate for preventing HIV/ AIDS.

Wall Writing

Wall painting will be done in every villages abutting project road to disseminate information. To ensure longer durability painting quality will be maintained.

Haat

Weekly market is the characteristics of present project stretch especially in scheduled areas. Goruhaat is also a common to all areas. Any information if communicated through these places will be propagated in hinterland quickly.

Sadharan Sabha

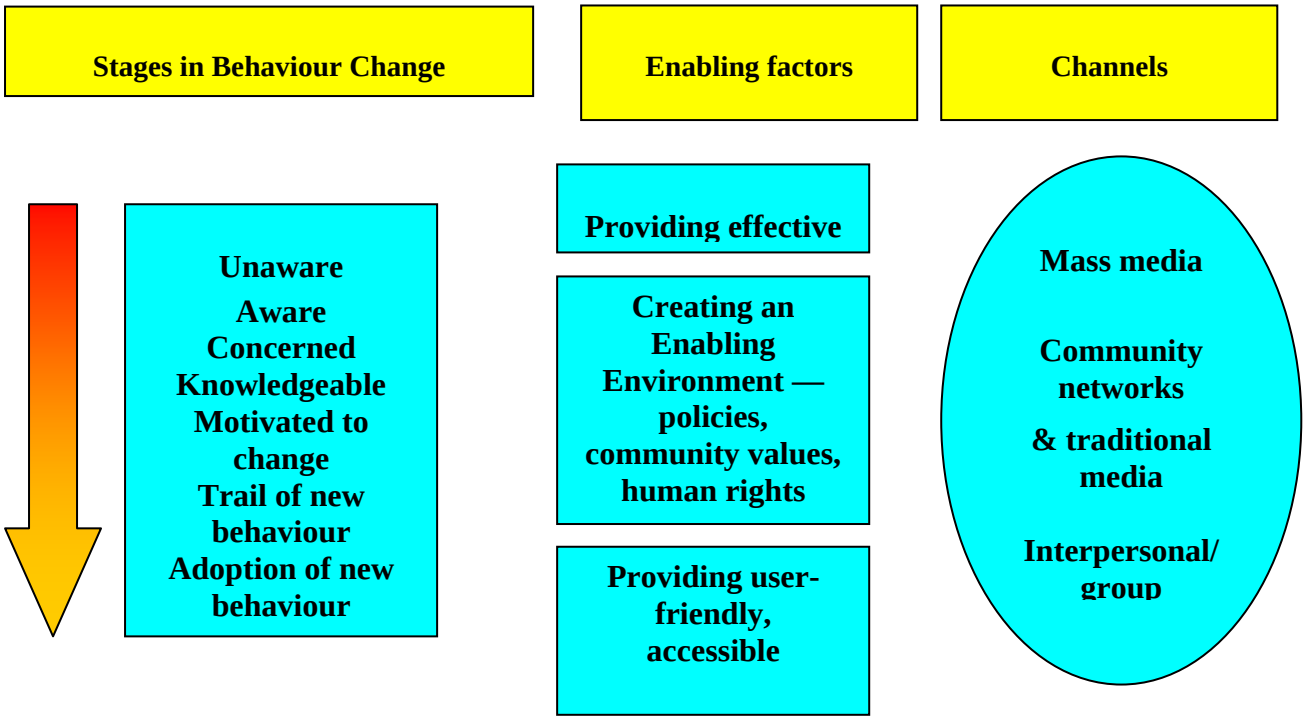
Orissa is known for local level participation in State affairs and vis-vis. Sadharan sabha(other than electoral sabha) of important leaders of the State in the project District. This could be a better location for songs, natak and distribution of I-E-C related to HIV/AIDS.

Other Important I-E-C could be mass media campaign, bimonthly Handout, Leaflet distribution along the project corridor.

4.3.3 Behavior Change Communication (BCC)

Prevention programs of HIV also aim to change individual behavior. Community interventions are often required to develop change norms and behaviors at the group level. While HIV risk may grow quickly in a community, attitudes are a major barrier to popularizing safer behaviors. BCC even bring changes in laggard of the society, a wide array of communication approaches ranging from mass media (radio, television, and newspapers) to person-to-person counseling and conversation used to promote healthy behaviors. Following table discusses BCC strategy in the project corridor.

Fig 4.1 Framework for BCC design



Behaviour Change Communication goals:

- Increase perception of risk or change attitudes toward use of condoms.
- Increase demand for services.
- Create demand for information on HIV and AIDS.
- Create demand for appropriate STI services.
- Interest policymakers in investing in youth-friendly VCT services.
  Promote acceptance among communities of youth sexuality and the value of reproductive health services for youth.
- Increased safer sexual practices (more frequent condom use, fewer partners).
- Increased incidence of healthcare-seeking behavior for STIs, TB and VCT (for example, calls or visits to facilities).
- Increased use of universal precautions to improve blood safety.
- Increased blood donations (where appropriate).
- Improved compliance with drug treatment regimens.
- Adherence by medical practitioners to treatment guidelines.
- Increased use of new or disinfected syringes and needles by IDUs.
- Decline in stigma associated with HIV/AIDS.
- Reduced incidence of discriminatory activity directed at PLHA and other identified high- risk groups.
- Improved attitudes and behavior among healthcare, social service and other service delivery workers who interact with PLHA, SWs, IDUs and other marginalized groups.
- Increased involvement of opinion leaders and policymakers, private sector managers and community members.

Table 4.3: Issues and Strategy of BCC

Sl.No.	Key Issues	BCC Strategy
1	Community dialogue	Will stimulate community discussion on factors that contribute to HIV/AIDS, such as risk behaviors and the environment that creates them and demand for information and for prevention (and care and support services, wherever applicable)
2	Provision of information and education	Will provide individuals with basic facts in language and visual/media formats that are simple and easy to understand and motivate positive behavior change
3	Promotion of services and products	Will communicate promotional information on HIV/AIDS programs and services which could include treatment, Drugs, institutional support groups including PLWHA (People Living With HIV/AIDS) networks and social and economic support, wherever applicable
4	Promotion of services and products	Will communicate promotional information on HIV/AIDS programs and services
5	Stigma	Will convey the issue of stigma to attempt to influence the social response in all communications as it relates to prevention. Stigma often presumes a negative behavior on the part of those individuals stigmatizing others, and manifests itself in a range of ways, from ignoring the needs of a person or group to psychologically or physically harming the stigmatized. BCC programs that address stigma can benefit from motivated persons or groups, such as PLWHAs, CSWs and MSM, who can work effectively for change as policy advocates and serve as caregivers and peer educators.

4.4 Strategy to control HIV/AIDS Transmission

4.4.1 Condom Promotion strategy

Condom promotion encompasses a set of interventions to promote the adoption of policies and strategies aiming at increasing the acceptability, availability and use of condoms.Condom Promotion is basically done by targeting the user group.

Condom promotion is a key HIV/AIDS strategy because:

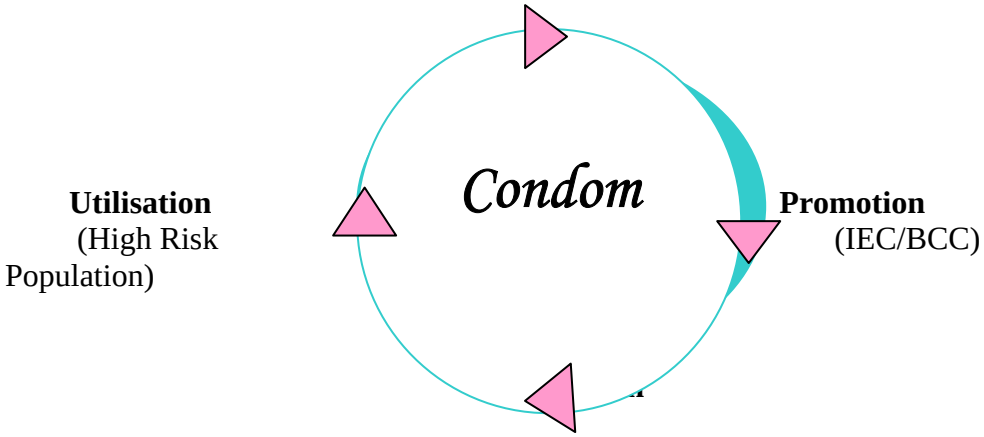
- The consistent and correct use of condoms significantly reduces the risk of HIV and other STIs;
- Condoms offer simultaneous protection against unwanted pregnancy and the possible transmission of STIs/HIV.

4.4.2 Orissa State RoadProject Needs

- Sensitize people for using condoms as the best preventive step against HIV and STD.
- Convince the clients and the commercial sex workers, about the importance of use of condoms as a means for preventing the HIV transmission.
- Make available low cost and good quality condoms to the people all over the country easily at the time and place when they need it.

To inculcate better understanding, overall strategy is presented through the following vicious cycle:

Figure 4.2 Condom Distributions& Procurement



(Emphasis on Effective Channel)

4.4.3 Objective of Condom Promotion

The objective of the condom promotion is to ensure easy access to good quality, affordable and acceptable condoms to promote the safe sex encounters. Condom promotion will be strengthened by :

(i)Condoms are available and affordable to high-risk, including rural population.

- Train NGO personnel in interpersonal communication and distribution skills, product knowledge, and HIV/AIDS knowledge.
- Establish condom distribution network to cover high-risk areas and rural areas in all 14 districts of OSRP coverage.
- Develop partnership with non-partner NGOs to expand condom social marketing base in rural areas.

(ii) Sustainable system for supply of condoms functioning.

- Establish and maintain cost-effective social marketing operations, including premises, staff, systems for procurement, sales and distribution, promotion, finance and administration.
- Engage commercial condom marketers, social marketing organisations and NGOs in discussions to coordinate condom promotion and distribution.

(iii) Condom acceptability increased.

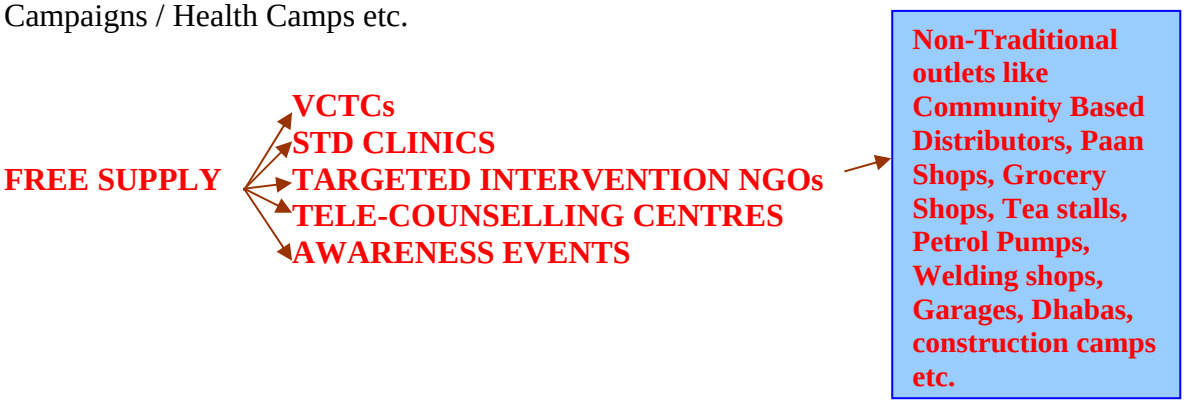
- Identify the key determinants of condom use and acceptability among target population through research.
- Develop key BCC messages based on the identified key determinants.
- Develop and implement a mix of communication activities to promote the key messages. Monitor the impact of communication activities and fine-tune accordingly.

4.4.4 The Free Condom Strategy:

The Govt Health Deptt and all the local Health Service Centres provide the Free Condom to the Community.

These Condoms are specific brand (NIRODH) and free of cost and easily available to the user on requisition.

Some of the NGOs and CBOs provide the Free Brand (Nirodh) during Awareness Camps / Campaigns / Health Camps etc.



As per NACO guidelines, the condoms are to be made freely available to the Core Group like Female Sex Workers (FSW), Injecting Drug Users (IDU) and Men having Sex with Men (MSM).

4.5 Linking Prevention and Control of HIV/AIDS Program with Other Social Management Activities

As part of resettlement strategy; places of high traffic density, location of ensured community participation and administrative support will be selected for development of truck parks as a resettlement site for relocation of project displaced business communities. The site will be equipped with all kind of facilities like motor mechanic shops, chemist shop, general store condom vending machines etc.. The site will act as centre of information dissemination. I-E-C and BCC strategy. Every HIV/AIDS campaign will take-off from this centre. The site will also be centre of awareness of the project by package level NGOs. There will be a HIV/AIDS kiosk for information regarding HIV/AIDS, ensured periodic availability of doctor and medicine

4.6 Care and Support Strategy

When a person gets exposed to HIV, society does not accept the infected persons in normal circumstances. AIDS orphan[1] are the most sufferer. People who are infected with HIV require social and psychological support from the society and from their family members. The date on which this HIV/AIDS awareness campaign will start and the date it will finish it is expected that all HIV infected[2] people will get treatment and ignorance and negligence will no more be as stringent as at it is now. Therefore the strategy will aim at to achieve care and support services to cent-percent HIV infected people and especially to AIDS orphan

Making ART drugs available to all infected people is itself a challenge. It requires a well planned realistic strategy that will effectively implement and sustain programs to access to ART all those who are eligible involving several partners like SACS, DFID,

[1] In Kendarpara parents infected with HIV/AIDS died recently and their 3 years child also HIV infected is denounced by their near relative is now under care and support of local NGO. In Berhampur, an AIDS infected mother allowed to admit her child only after intervention of NGO working for HIV/AIDS in the city.

2 WHO 3m of 5m HIV/AIDS treatment and ART to all by 2010.

UNAIDS.OSACS will provide ART to implementing NGOs. There is need to develop community[3] care home for AIDS orphan.

- Secure commitment from SACS for ensuring availability of ART
- Strengthen and internalize implementing NGOs capacity for partnership development.
- Ensure uninterrupted supply of ART through internal financing
- Ensure treatment adherence through partnership development including (PLWHA) for de-stigmatizing people.
- Care and support to AIDS orphan
- Adequate financial support

4.7 Strategy for Sustainability of Program

Implementation framework of OSRP phase-I envisages a time bound road improvement program in which prevention of HIV/AIDS transmission is a social responsibility of the project. After the completion of construction activities HIV/AIDS program should continue as it was during construction period.

Activities for proposed program to continue in future:

- Secure commitment from SACS for ensuring sustainability of program.
- Strengthen, internalize and train out reach worker (ORWs/other resident workers) (para medical officer) as peer educators to continue the program.
- Toll plaza should be given responsibility of partnership development with ORWs (paramedical officers, Out reach worker) and road safety awareness raisers.
- Road safety awareness raisers and paramedical officers should have close coordination and linkages.
- Emergency van of highways should also be act as information centre and equipped with semi-medical facilities and act as kiosks
- Kiosks and some support should be given to paramedical officers, outreach workers(ORWs) within the communities
- Socially active people (representatives/PRI) of society, Nehru Yuva Kendra, Bajrang Dal and other volunteer organization etc should be given education, training, and incentives for sustainability of programs time to time to time to time. This budget should be indicated in toll collection and road safety management.
- OSRP Phase II & III should link road safety and prevention of HIV/AIDS program together to have target specific social goals of the project.
- Recommendation of M&E consultant[4] should be grounded at the earliest.
- Linking the program with **mission shakti** to get government patronage
- Linking program with Families and child welfare Department
- Identification of Village people who can be directly interact with package manager in operation stage and can act as peer educator in operation stage.

[3] Community care home will be part of IPDP, for that detail discussion with OSACS, community and local institutional partners is in progress

[4] One of the objective of M&E consultant is to suggest corrective measures of ongoing HIV/AIDS programme and ways and means of sustainable management of the prevention and control of HIV/AIDS programme.

Chapter – 5

ACTION PLAN FOR THE PREVENTION OF HIV/AIDS

CHAPTER 5

ACTION PLAN FOR THE PREVENTION OF HIV/AIDS

5.1 Introduction

Based on strategy discussed in previous chapter an Action Plan is formulated in the following section. The Action Plan discusses framework of partnership development, training to awareness raisers, distribution of I-E-C materials and approaches towards BCC. Partnership development and capacity building exercise will be done at Headquarter (PIU) level and awareness campaign at package level.

5.2 Partnership Developments and Capacity Building

One of the basic requirements of this plan to be successful is to assess capacity of the Works Department, and enhance institutional capacity by strengthening it through skilled manpower, resources such as, fund flow, I-E-C materials, training and networking. Partnership development could be the most important tool to strengthen OWD implementation capability. In this regard following activities is required.

5.3 NGO Partnership Development

Project Coordinating Unit PCU, (OWD) being an engineers institution, lacks enough manpower, skilled persons/resource persons for effective communication and implementation of HIV Action Plan. This HIV Action Plan implementation is time bound and goal oriented activities. Therefore, NGOs partnership development is required for the prevention and control of HIV/AIDS transmission. Since other social management and safeguard instruments are also being prepared and will be implemented simultaneously NGOs partnership will be collective to enable OWD implement critical activities , buffer activities of parallel SSIs such as information dissemination, awareness etc to ensure community participation. This will reduce cost on the implementation. However, having understood quantum of the work involved and length and breadth of coverage of the project, two tier implementation strategies is formulated. NGOs services will be hired at State level and at package level. State level NGOs (nodal) will be providing consulting services to PIU at headquarter level. Prime task of the nodal NGO will be institutional strengthening, training to awareness risers and coordination with SACS, DFID, UNAIDS etc. Package level NGOs will be hired for each package to ground Action Plan in realities. Roles and responsibilities of NGOs have been outlined in annexure.

5.4 Partnering with Other Institutions

Prevention and control of HIV/AIDS transmission has become one of the most important agenda of Government through NACO, SACS. This is also prime concern of several international agencies such as WHO, UNAIDS, DFID etc. Few international funding agencies, NGO etc have also realized threats associated with the AIDS pandemic. These agencies easily come forward to join hands with local partners to combat the threat to the society. In this regard OWD has been in constant touch with SACS and seek help in implementation arrangement. ***Interdepartmental Memorandum of Understanding (MoU) will be signed in this regard.*** Social Development Advisor along with nodal NGO will work for partnership development with these multilateral organizations. This organization will assist Social Management Unit (SMU), PCU in formulating Campaign Delivery Method, Campaign Implementation plan, Training to awareness raiser, availability of I-E-C materials and transformation brought in epidemiology, symptoms and treatment methodology etc.

5.5 HIV / AIDS Capacity Building Training

Capacity Building in the context of HIV/AIDS prevention in road improvement comprises following set of activities.

To have an active cadre of health educators consisting of motivated volunteers from the trucking community, migrant laborers and Sex workers or the persons linked to the occupation of target populations. They will effectively reach these target populations with correct and complete information and provide counseling on HIV/AIDS and other sexual and reproductive health issues to ensure responsible sexual behavior. They may be peer educators also. Following objective is assigned for capacity building.

Peer educators: School Teachers, PHC nurses, Truckers, Pimps, CSW, Dhaba Workers(Truckers favorite boys, Old Dhaba Owners).

Key Capacity Building: Technical Capacity Building, Counseling and Communication Technique, Way of teaching about correct use of condoms etc

Providers: SACS, DFID,UNAIDS SIMSU(PCU, Works Department),Local Social Organization

Activities planned for capacity building and providing enabling environment are as follow. Various modules of training for capacity building of the institutional actors at various levels have been proposed. Trainings will be imparted by SACS

Table 5.1: Capacity Building and Enabling Environment

Sl.No.	Capacity Building	Enabling Environment(Advocacy)
1	Needs Assessment workshop	Advocacy workshop with the Police
2	Proposal writing workshop	Advocacy workshop with the Media
3	Induction Training for project staff nos	Advocacy with the Civil Societies & Opinion Leaders
4	Induction Training for Peer Educators	Advocacy with Religious leaders / Groups
5	Training on Syndromic Mgmt. To TI doctors + Nurses	Advocacy with Hoteliers / Dhaba Owners
6	Refresher training for Project Staff	Advocacy with Labour contractors at construction camps
7	Refresher training for ORWs	Advocacy with Beauty / Massage parlours
8	Refresher training for Peer Educators	Advocacy with PLWHA networks
9		Advocacy with district administration
10		Advocacy with Works Department officials
11		Advocacy with Supervision Consultant
12		Advocacy with Deptt. of Health & FW
13		Advocacy with Petrol Pump owners associations
14		Advocacy with the PRI members
15		Advocacy with Tourism & Transport Deptt.

5.6 Quantity of I-E-C Materials for Display and Distribution

Awareness creation by distributing I-E-C materials will be adopted for Targeted Intervention (TI) locations. These locations are communities along the road,hospitals schools along the project areas. major junctions, truck parks, toll plaza, construction workers camps etc. The content could be massage about prevention strategy, threat of HIV/AIDS, correct use of condoms. Targeted Intervention[1] (TI) location will be road side communities, truck parks, brothel, and construction camps. Specific intervention plan will target Truck Park, construction camps and brothel along the project corridor. Following tables outline number of TI location along the project corridor.

Table 5.2: Number of TI Location

Construction Package*	Road Section	Chainage	No. of Communities	No. of Brothel	Construction camp	Truck Parks
1	Chandbali – Bhadrak (SH-09)	00-45	28	1	1	1
	Bhadrak – Anandpur (SH-53)	00-51	28	4	1	1
2	Berhampur – Taptapani (SH-17)	00-41	19	5	1	1
3	Khariar - Bhawanipatna (SH-16)	02-70	27	1	1	1
4	Taptapani - Raipanka (SH-17)	41-109	14	1	1	1
5	Raipanka – Bangi Jn (SH-17)	109-151	11	-	-	1
	Bangi Jn – JK Pur (SH-04)	161-119	10	-	1	-
6	Jagatpur-Kendrapara-Chandbali (SH-9A)	00-99	55	3	1	2
	Chandbali-Bhadrak (SH-09)	45-53	04	3	-	-
7	Bhadrak – Anandpur (SH-53)	51-57	03	1	-	-
	Anandpur – Karanjia (SH-53)	00-65	22	-	1	1
	Karanjia – Jashipur (SH-49)	45-60	06	-	-	-
8	JK Pur – Rayagada (SH-04)	119-109	-	1	-	-
	Rayagada – Kereda (MDR-48B)	00-24	07	-	-	-
	JK Pur – Muniguda (SH-05)	00-50	20	2	1	1
9	Muniguda – Bhawanipatna (SH-06)	00-68	32	1	1	1
10	Aska – Bhanjanagar (SH-07)	46-86	26	1	1	-
11	Banarpal – Daspalla (MDR-18&19, SH-65)	00-89	17	1	1	1
	Total		**329**	**25**	**12**	**12**

* Construction package 1to 5 is in year one road

Above mentioned locations will be TI locations for I-E-C, BCC and condom promotion. Following activities will be done at the above-mentioned location.

[1] Details have been mentioned in chapter 3.

Table 5.3: Implementation Target			
Sl. No.	**ACTION PLAN FOR TARGETED INTERVENTION**	***Location Implementation Target***	**Quantity**
1.	TI Locations (Truck Halt) consulted[2]	12x36	432
2.	Number of TI Locations (Construction Camp) consulted	12x36	432
3.	Number of TI Locations (Roadside Communities) consulted	329x 36	11844
4.	Number of TI Locations (Brothel) consulted	25x72	1800
5.	Number of Medical Services available along corridor covered under referral	To be established	
6.	Number of Awareness Camps conducted	(329+12+12+25)x36	13608
7.	Number of Group Meeting held	(329+12+12+25)x36	13608
8.	Number of BCC workshop / meetings conducted	(329+12+12+25)x6	2268
9.	Number of Trainings conducted for OWD Staff	6	6
10.	Number of Trainings conducted for NGO Staff	12	12
11.	Number of Trainings conducted for Outreach Workers/ Peer Educators	12	12
12.	Number of Trainings conducted for Private Medical Service Providers	12	12
13.	Number of OWDstaff trained	13	13
14.	Number of NGO staff trained	33	33
15.	Number of I-E-C brochures/Balloning / pamphlets distributed	(329+12+12+25)x36x3	40824
16.	Number of I-E-C posters distributed	(329+12+12+25)x36x3	40824
17.	Number of RI brochures / pamphlets distributed	(329+12+12+25)x36x3	40824
18.	Number of RI posters displayed	(329+12+12+25)x36x3	40824
19.	Number of condoms distributed free	(329+12+12+25)x36x30	408240
20.	Number of condoms distributed through social marketing	(329+12+12+25)x36x15	204120
21.	Number of I-E-Ci conducted(Path prant yatra, exihibition, haat ,film	(329+12+12+25)x3	1134
22.	Number of CSWs interacted with	25x20x36	18000
23.	Number of construction labourers interacted with	12x120x36=100%	51840
24.	Number of sex customers at brothels interacted with	25x36x10	9000
25.	Number of pimps / intermediaries at brothels interacted with	25x36x2	1800

[2] As mentioned in chapter 3 there are 329 communities,12 truck parks,12 construction camps and 25 identified formal as well as informal brothel.These are TI locations.

Framework of HIV/Action Plan Implementation (A Methodology for Campaign Delivery)

The Methodologies of Action plan is shown in Table 5.4. The table addresses task wise and sub task wise activities to be performed and the beneficiaries of the project. This is prepared as per the requirement of ToR and addresses all aspects. Detailed activity has been given in annexure 5.1.

Table 5.4: Campaign Delivery Method

Tasks	Description of action	Frequency of action	Time Frame
Task 1Iniating Implementation of HIV/AIDS Plan	Team Mobilization and Start-up Meeting	One time at Project Starting	
	Literature Review	As part of Project	
	Reconnaissance Survey	A part of Project	
	Primary Survey to Determine Baseline Status	A part of Project	
	Discussions and Consultations with all the Stakeholders	All along project period of 36 months	
	Preparation of Methodologies for Campaign Implementation	Only One time	
Task 2: Deliver Training to Awareness Raisers	Conduct Training of Awareness Raisers	Once in every year	
	Number of Trainees/ Persons to be Trained (Each training is of one day programme and will be organised for about 40 - 50 persons)	Twice in a month by resource person	
	Modes of Training and Training of Awareness Raisers		
Task 3: Deliver HIV/ AIDS Awareness Campaign	Conducting HIV/ Awareness Campaign	-	
	Capacity Building for project staffs and Clients (approximately 20 persons for single time)	Once in every year	
	Posters (A-4, A-3, A-0 size)	Twice in a month	
	Brochures (Small and handy leaflets)	Twice in a month	
	Banners (Cloth and Glow Material)	Twice in a month	
	Hoardings (Normal size hoardings)	Once in a month	
	Wall Paintings (various sizes)	Twice in a month	
	Radio Programme	6 Times in a week	
	Cable TV Broadcasting	6 Times in a week	
	Video Programme	Twice in a week	
	Loud Speaker Mode of Relay	Twice in a week	

Tasks	Description of action	Frequency of action	Time Frame
	[3]Fairs and Festivals Quiz competitions and awards etc	Thrice in a month Thrice in a month	
	e) Gatherings in markets/ *haat/ bazaars* (approximately 100 persons benefited at a time)	Twice in a week	
	f) Street Plays/ Nukrad Natak/ Puppet Show (approximately 100 persons benefited at a time)	50 in first year 100 in second year 150 in third year	
	g) Women Gathering (approximately 100 persons benefited at a time)	150 in first year 150 in second year 200 in third year	
	h) Condom Promotion Strategy i) Condom distribution (1500 condoms per month and assuming 50 beneficiaries at a time)	Once in a week	
	j) Medical Care and Behavioural change (Assuming 100 beneficiaries at a time)	Once in a week	
	Quality Control Measures to for Campaign Delivery	-	
	Establishment of Testing Centers for Identification of HIV/ AIDS (Assuming 50 beneficiaries at a time)	Thrice in a month	
	Stakeholder's meeting / Focused Group Discussion (FGD)	Regular	
Task 4: Monitoring, Evaluation and Coordination	Creating Monitoring and Evaluation System for the Project	A part of project implementation	
	Impact Evaluation and Suggestions	A part of project implementation	
	Strategy for a Sustainable System	A part of project implementation	

The above mentioned activities are indicative in nature. Detailed campaign implementation will be finalized when the partnering NGO operationallize this plan. Fig below provides a flow chart showing steps to be followed during implementation.

[3] Note: Approximately 100 persons assumed to be benefited at a single time.

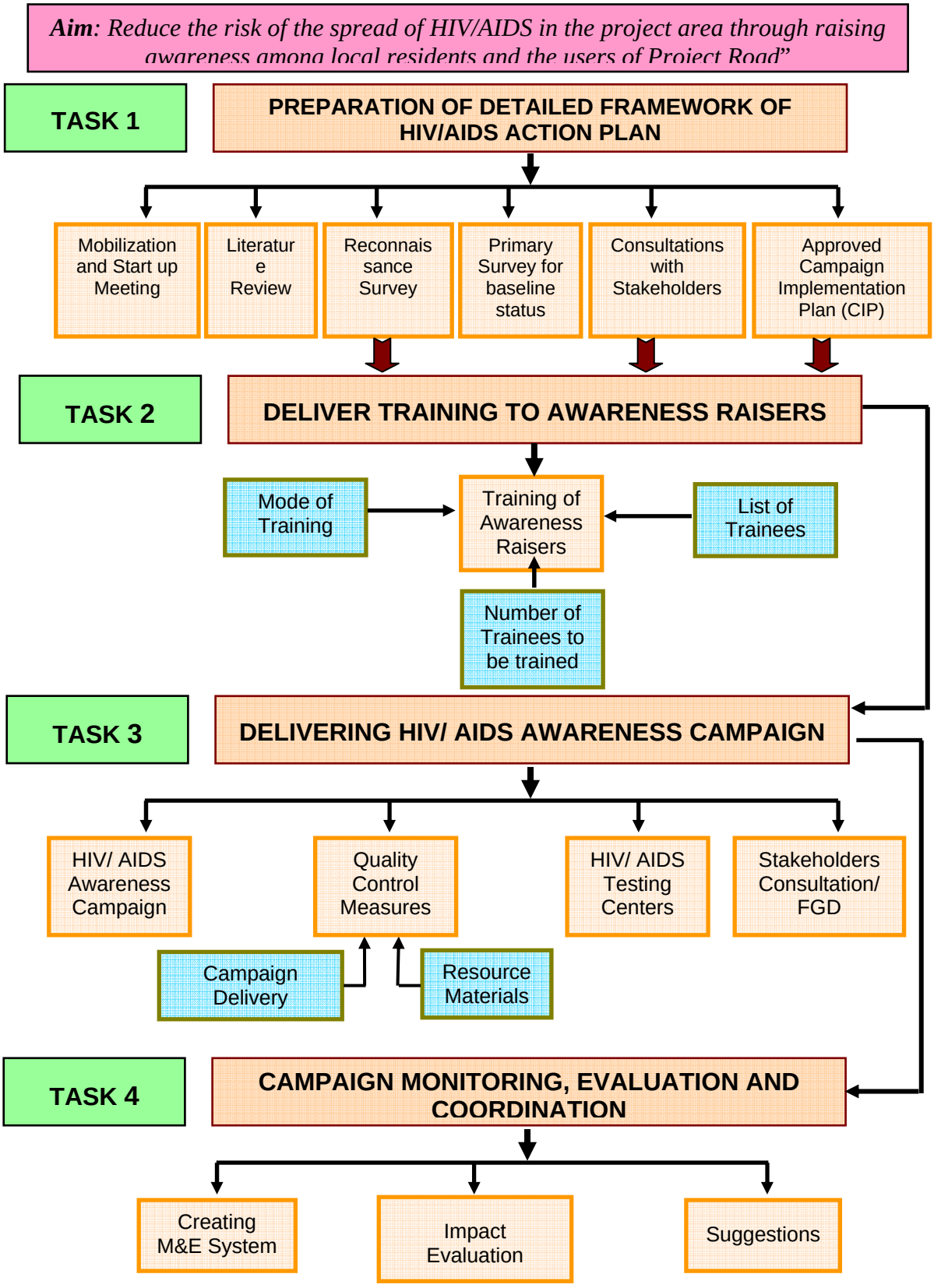


Figure 5.1: Concept and Tasks for Preparation of Awareness Campaign

5.7 Action Plan for Care and Support

This initiative will ensure access to ART for all people who are at risk of exclusion due to social and economic barrier. Following action will be initiated by package level NGOs

- Identify people who are infected with HIV/AIDS within a Corridor of 1 km along the project route
- Identify AIDS orphan along the project route
- To find out status of HIV infection
- Ensure Availability of ART.
- Coordinate with OSACS for further medical facilities in the vicinity of the area
- Ensure AIDS orphan has received social care and psychological support

Based on stages of HIV/AIDS infection suggested treatment could be as follow.

- Highly Active Anti Retroviral Treatment[4] (HART)
- Preventive treatment to avoid opportunistic infection
- Treatment for HIV related illness
- Healthy living practices.

However in present project, care and prevention strategy depends on initiatives of OSACS and other institutional partners. These institutional partners make HAART and other drugs available directly to HIV/AIDS patients. The care and support strategy also include construction of community care centers. These centers will be finalized in consultation with OSACS. For this purpose partnership with OSACS, Department of Family and Health, and Chief Minister Office could be initiated by PIU.

5.8 Fund Availability and Location of Community Care Home

This has been learnt during consultation that OSRP is a dream project for Orissa. During the consultation with OSACS it is inferred that assistance from Chief Minister Fund could be possible for community care home. OSACS could also contribute in this planning. OWD with the help of partnering NGO will take up initiative for construction of community care home at least one and OSACS will be partnering in management of community care home. Berhampur will be the location for the community care home. (Requirement and management of care home is appended). Detail activities will be finalized after formal agreement between OSACS and OSRP.

[4] HAART is combination NRTI, NNRTI, protease inhibitors, entry inhibitors of dugs and suitability depends nature of infection vis-vis combination of drugs.

Chapter – 6

INSTITUTIONAL ARRANGEMENT

CHAPTER 6

INSTITUTIONAL ARRANGEMENT

6.1 Institutional Framework

Organization for planning and implementation of Action Plan for prevention of HIV/AIDS transmission is utmost important because Works Department is mainly an enginnering organization and lack expertise in social issues especially HIV/AIDS. Timely establishment and involvement of appropriate institutions will significantly facilitate achievement of objectives of the HIV action plan. Present document in hand has envisaged an in-built institutional framework for the implementation of HIV action Plan. The main institutions, which are likely to wok, will include:

- Works Department at different level;
- Social Management Unit (SMU)
- NGO (Non Governmental Organization);
- OSACS and other partnering Institution
- Local CBOs and Panchayati Raj Institutions;
- District Administration and other partnering institutions.

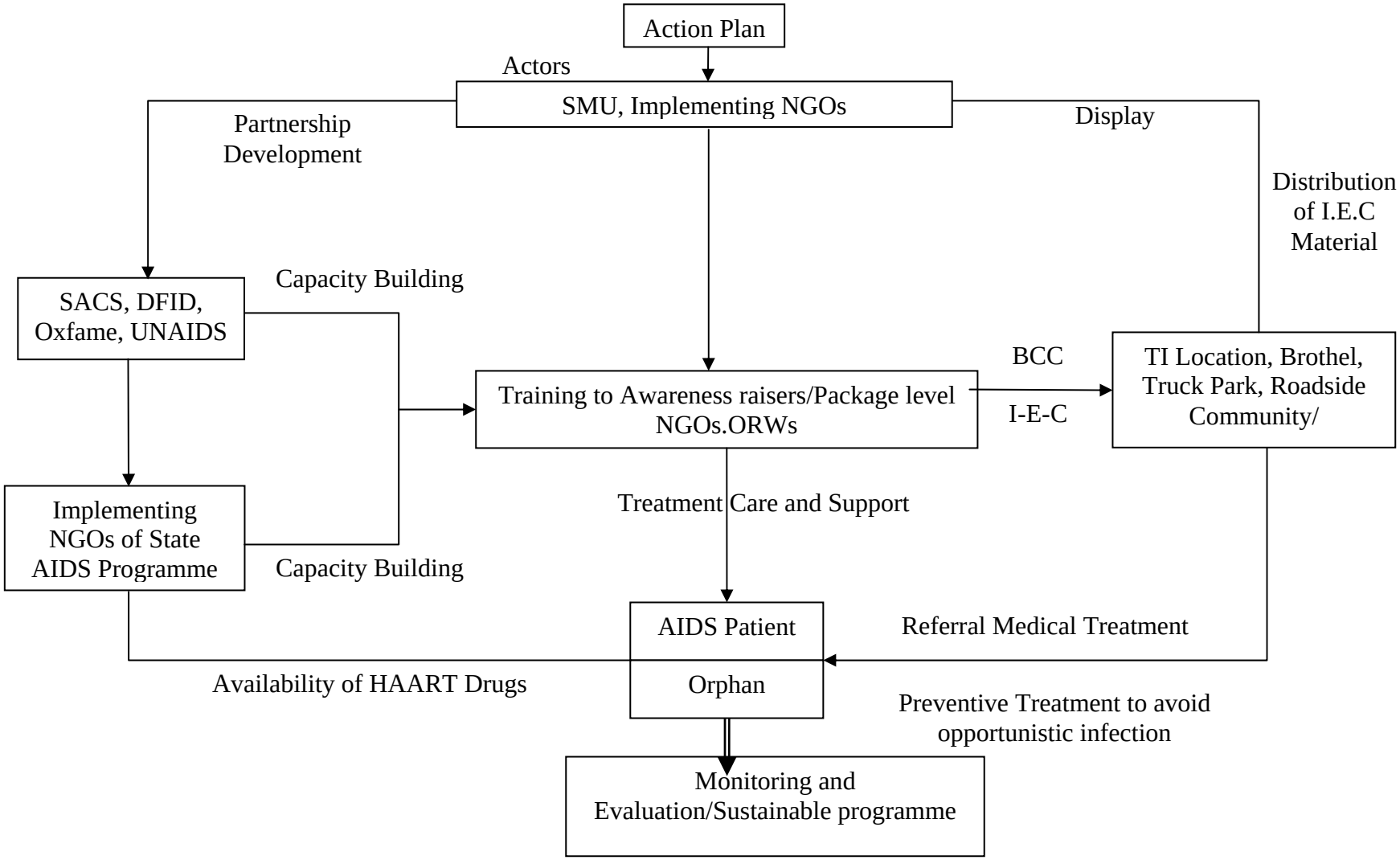
Detailed implementation framework has already been mentioned in Resettlement Action Plan. Following section identifies role of partnering institutions in implementation.

6.2 Partnering Institutions

OSACS with its Project Support Unit (PSU) would be the Nodal agency for monitoring and providing technical assistance. OSACS would identify and liaison with other important institutional stakeholders to participate in the OSRP implementation plan. For this purpose, Works Department and OSACS would be working closely. Social Management Specialist (SMU) would be the coordinating officer and would lisaon with OSACS. Responsibilities of OSACS and other partnering institutions will be :

- Framework for advocacy and training module
- Need Assessment Workshop
- Assist in preparation and development of I-E-C
- Training to Stakeholders.
- Documentation of and Development of BCC strategy and Capacity building Research
- Production of Annual Report
- Strengthening of NGO partnership forum
- Ensure sustainability of program by linking OSRP HIV/AIDS program with ongoing OSACS program. (Fig6.1).

Fig 6.1 Institutional Arrangement



Chapter – 7

IMPLEMENTATION SCHEDULE

CHAPTER 7

IMPLEMENTATION SCHEDULE

7.1 Implementation Schedule

The implementation framework envisages two tier implementation arrangements. Implementation of HIV action plan emphasizes training and capacity building as important component, which will be done mostly at Headquarter level. Advocacy and enabling environment is another important component and will be done at District Headquarter level. However implementation of awareness campaign would be done in TI locations along the project road. For this purpose partnering NGOs has to play important role. Details implementation schedule is mentioned Fig 7.1.

7.2 Implementation Mechanism

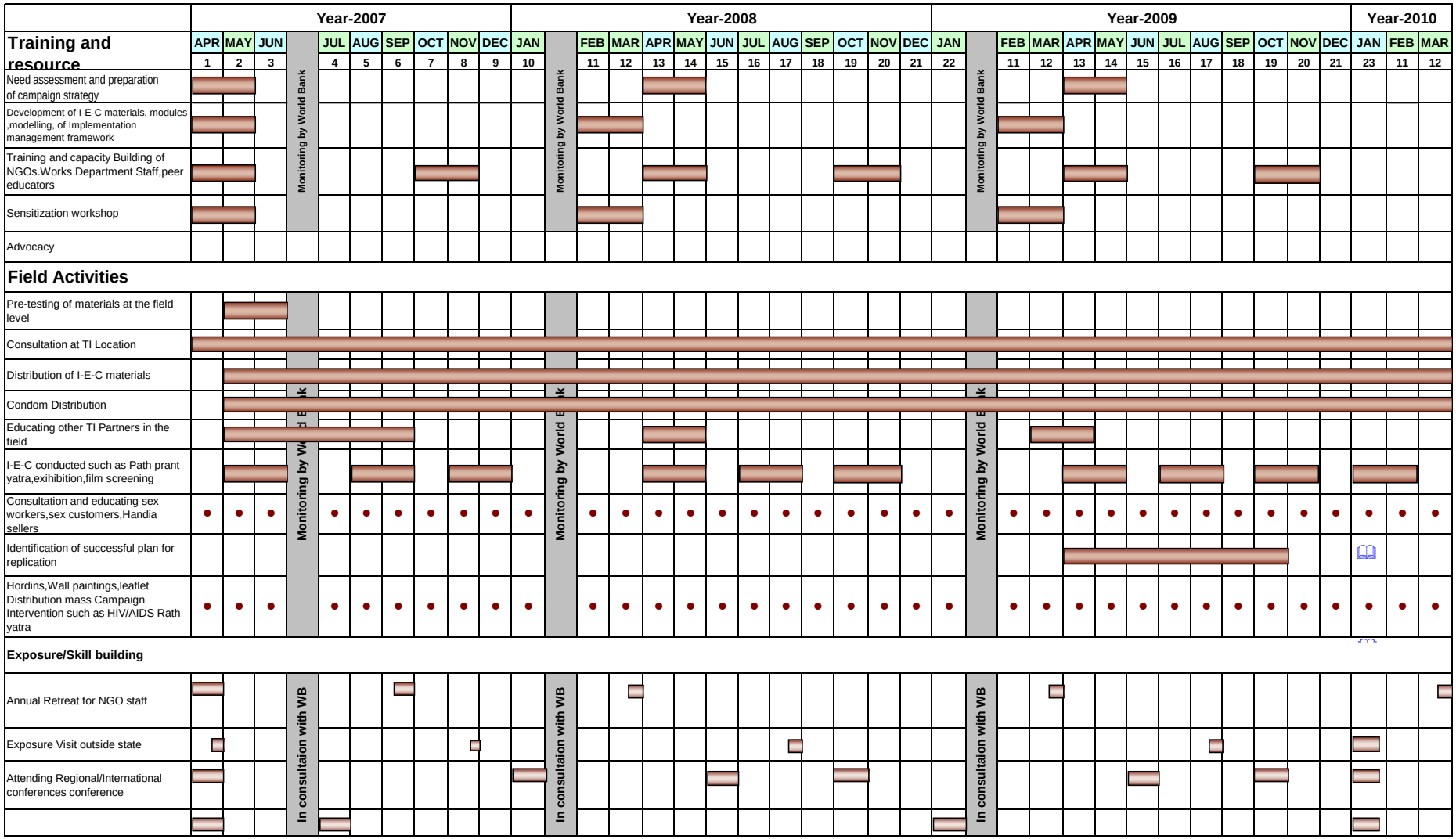
Social Management Unit (SMU), PIU will be responsible for successful and timely completion of each activities as mentioned in fig 7.1.

Completion of many activities such as advocacy with construction workers, supervision consultant or OWD local staffs would depend upon construction schedule. Time frame work of implementation suggests three years period for project implementation in each contract package. The campaign can be extended at least up to the completion of construction works or start of OSRP phase II whichever is earlier to ensure sustainability of awareness program.

7.3 Schedules for Project Implementation

The period for awareness campaign is of 36 months. However, monitoring and evaluation will continue beyond the period of implementation with the help from OSACS.

WORK PLAN TIME SCHEDULE



Chapter – 8

COST AND BUDGET

CHAPTER 8

COST AND BUDGET

8.1 Introduction

A consolidated overview of the budget is provided and the cost estimates given below shall be viewed accordingly. **The cost has been prepared in close coordination with OSACS, Orissa.**

The budget is indicative of outlays for the different expenditure categories and is calculated at the 2005-2006 price indexes. The plan outlays for three years are given. Budget for year 2 and Year 3 would have additional provision of inflation. This budget would be entirely financed from the Road Improvement Component.

8.2 Summary of the Cost

The cost of HIV action plan is divided in capacity Building and Training, Development and Distribution of I-E-C/BCC materials. Implementation of HIV/AIDS action Plan would be in concurrence with other social management plans. Details of breakup are given below.

Table 8.1 Summary of the Cost

Sl. No.	Item	Cost(in million Rs)
1	Development of Training Materials	1.82
2	Capacity Building and Training	23.67
3	Development of BCC material	**12.91**
4	Skill building and Exposure	2.32
5	Availability of BCC materials and I-E-C	15.40
Total		**56.12**

Table 8.2 Budget for Development of Training Materials

Sl. No.	Type of Training material	Content of the material	Type / Design	Rate	Quantity	Amount (Rs.)
1.0	**Development of Modules**					
1.1	Training Material for Project Staff in Oriya	Self learning Capacity building tool for the PM, Counsellor, Accountant	1	70	500	35000
1.2	Training Material for Field staff in Oriya	Self learning Capacity building & practical tool for the PEs	1	70	500	35000
1.3	OSRP newsletter	Field level programme documentation initiative	12	10	900	108000
1.4	Strategy document on BCC	Self learning Intervention tool on BCC related to TIs	1	60	450	27000
1.5	Strategy document on Condom Promotion	Self learning intervention tool on condom promotion related to TIs	1	60	450	27000
1.6	Strategy document on Advocacy & Networking	Self learning intervention tool on Advocacy related to TIs	1	60	450	27000
1.7	Hiring of Consultant for development of materials		1	50000	24	1200000
1.8	NGO Intervention Operational guidelines	Programmatic & Financial guidelines	1	50	100	5000
1.9	MIS partner recording & reporting system		1	30000	12	360000
		Sub - Total				**1824000**

Table 8.3: Year wise Budget for Capacity Building / Training

Type of Training	Nos. of participants	Nos. of days per training	Nos. of Training	YEAR - I		YEAR - II		YEAR - III		TOTAL		Level at which training to be imparted	
CAPACITY BUILDING FOR TI PARTNERS				**Nos**	**Budget**	**Nos**	**Budget**	**Nos**	**Budget**	**Nos**	**Budget**	**State**	**Region**
Needs Assessment workshop[1] (9 TIs)	27	2	3	1	50000	1	50000	1	50000	3	150000	3	
Proposal writing workshop (9 TIs)	27	2	3	1	50000	1	50000	1	50000	3	150000	3	
Induction Training for project staff (4 staff per NGO per 100 kms) - 9 nos.	36	2	3	1	50000	1	50000	1	50000	3	150000	3	
Induction Training for ORWs	72	3	6	2	100000	2	100000	2	100000	6	300000	3	
Induction Training for Peer Educators	72	3	6	2	100000	2	100000	2	100000	6	300000	3	
Training on Syndromic Mgmt. To TI doctors + Nurses	OSACS shall provide training									0	0		
Refresher training for Project Staff (4 staff per NGO per 100 kms) - 9 nos.	36	2	3	1	50000	1	50000	1	50000	3	150000	3	

[1] There will be 9 NGOs in 900 km.

Refresher training for ORWs (9 TI)[2]	72	3	6	2	100000	2	100000	2	100000	6	300000	3	
Refresher training for Peer Educators (9 TI)	72	3	6	2	100000	2	100000	2	100000	6	300000	3	
Sub - Total	**414**	**20**	**36**	**12**	**600000**	**12**	**600000**	**12**	**600000**	**36**	**1800000**	**24**	**0**
CAPACITY BUILDING FOR NON PARTNERS													
Sensitization workshop for non-partners[3]	**120**	**1**	**12**	**4**	**120000**	**4**	**120000**	**4**	**120000**	**12**	**360000**	**6**	**6**
CAPACITY BUILDING OF PLWHA NETWORKS													
Strengthening of PLWHA network	**120**	**1**	**4**	**4**	**120000**	**4**	**120000**	**4**	**120000**	**12**	**360000**	**6**	**6**
ENABLING ENVIRONMENT													
Advocacy workshop with the Police[4]	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41

[2] 8 ORWs would be selected by NGOs for training in 100 km stretch. They would be trained to continue the programme in post implementation period.
[3] Non-partners are other OWD staffs not involved in implementation such as staffs of rural road, NH division. They may get posting in OSRP in later part of implementation.
[4] There are 14 Districts in proposed project road. Advocacy would be done in each Districts Training module for 30 person have been considered as per OSACS training modules norms..

Advocacy workshop with the Media	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with the Civil Societies & Opinion Leaders	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with Auto Rickshaw & Tyre repairing shops	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with Hoteliers / Dhaba Owners	840	1	28	28	840000	28	840000	28	840000	84	2520000	1	41
Advocacy with Trucker Associations[5]	840	1	28	28	840000	28	840000	28	840000	84	2520000	1	41
Advocacy with Labour contractors at construction camps	840	1	28	28	840000	28	840000	28	840000	84	2520000	1	41
Advocacy with Beauty / Massage parlours	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with district administration	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with Works Department officials	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41

[5] Advocacy with directly associated groups such as trucker, Dhaba owners has been intensified.

Advocacy with Supervision Consultant	90	1	3	1	30000	1	30000	1	30000	3	90000	1	41
Advocacy with Petrol Pump owners associations	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Advocacy with the PRI members[6]	658	1	22	22	660000	22	660000	22	660000	66	1980000	1	65
Advocacy with Tourism & Transport Deptt.	420	1	14	14	420000	14	420000	14	420000	42	1260000	1	41
Sub - Total	7048	14	235	233	6990000	233	6990000	233	6990000	699	20970000	14	598
NGO PARTNER FORUM													
Strengthening of NGO Partner Forum[7]	9	1	2	2	60000	2	60000	2	60000	6	180000	6	
TOTAL	**7711**	**37**	**289**	**255**	**7890000**	**255**	**7890000**	**255**	**7890000**	**765**	**23670000**	**56**	**610**

[6] Advocacy with PRI partners are two representatives from each village(329x2).
[7] Strengthening of NGOs forum of OSRP TI partners for sustainability and uniformity of programme implementation.

Table 8.4 Budget for Development of BCC Materials

Sl. No.	Type of IEC / BCC material	Content of the material	Type / Design	Rate	Quantity	YEAR-I	YEAR-II	YEAR-III	TOTAL
1	2	3	4	5	6	7	9	10	11
1	Development of IEC/BCC materials								
1.1	Flip book/Flash Card/Flex for Field staff	Generic	3	100	500 each	150000		150000	300000
		Thematic (FSW/IDU/MSM)	3	100	500 each	150000		150000	300000
1.2	Kit bag for Peer Educators & Field staff	For carrying BCC/IEC materials	1	50	800	40000			40000
1.3	Booklet of FAQ	For PEs & ORWs	1	50	500	25000	25000		50000
1.4	Mobile Exhibition kits @ Rs. 2000/-	For Group sessions	1	2000	500	1000000			1000000
1.5	BCC Strategy & Capacity Building Research for OSRP	State level strategy for Core & non-core groups	1	300000	1	300000			300000
1.6	Webpage maintenance	Periodic updating & maintenance	1	50000	1	50000	50000	50000	150000
1.7	Condom Vending Machines	Multipurpose vending machines	1	16000	100	1600000			1600000
1.8	Documentation of Case Studies/Best practices	Field report of TI partners	4	100	100	40000	40000	40000	120000
1.9	HIV/AIDS Kiosks	For sustainability of the programme		1500	450	675000	675000	675000	2025000
1.10	Production of Annual Report	Programmatic & financial outlay & achievements for one year	1	1000	50	50000	50000	50000	150000

1.11	Cost of design for all BCC & IEC materials	Cost implications for designing through reputed advertising agencies				50000	20000	20000	90000
1.12	Wall painting @ Rs. 8/-	Wall painting along the highways	10 X 10 sq. ft.	8	1000	800000	800000	800000	2400000
1.13	Hoardings @ Rs. 20,000/-	Depicting the HIV/AIDS messages		20000	20	400000	400000	400000	1200000
1.14	Model of Penis @ Rs. 150/-	For demonstration of condom use		150	500	75000			75000
1.15	Leaflets in Oriya @ Rs. 1/-	HIV/AIDS messages	2	1	50000	100000	100000	100000	300000
1.16	Stickers @ Rs. 8/-	Bus / Truck / Taxi	4	8	5000	160000	160000	160000	480000
1.17	Balloons	For enhanced visibility		1000	432	144000	144000	144000	432000
		Sub - Total				5665000	2320000	2595000	10580000
2	Pre-testing of the materials at the field level	Design development & pre-test of the prototype material				25000	25000	129750	179750
3	Hiring of an Consultant for design & development of the above materials			60000	12	720000	720000	720000	2160000
		GRAND TOTAL				6410000	3065000	3444750	12919750

The above-mentioned activities and budget are in concurrence with the overall OSACS activities.

Table 8.5 Cost Calculation of Exposure / Skill building of OSRP / Partner NGO Officials

Sl. No.	Particulars	Nos. of persons	Nos. of days	Nos. of times	Nos. of External Resource person	PSU / OSACS / TI staff		Work shop expenses	External Resource person			TOTAL	YEAR - I	YEAR - II	YEAR - III
						Travel @ Rs. 1000/-	Hotel @ Rs. 1500/-	Fooding & Kits	Travel @ 20000/-	Hotel @ Rs. 2000/-	Fees @ Rs. 5000/-				
1	Annual Retreat for OSRP and NGO staff	40	3	3	2	120000	540000	405000	120000	36000	90000	1311000	437000	437000	437000
2	OSRP / Partner NGO staff Exposure visit to other States	15	5	3		135000	337500	225000				697500	232500	232500	232500
3	OSRP / Partner NGO staff attending the National & Regional Conferences	10	3	3		90000	135000	90000				315000	105000	105000	105000
	TOTAL											2323500	774500	774500	774500

Table 8.6 Budget For Awareness Campaign at TI Locations

Sl. No.	Action Plan for Targeted Intervention	Implementation Target	Cost(Rs)
1.	TI Locations (Truck Halt) consulted	12x36	25920
2.	Number of TI Locations (Construction Camp) consulted	12x36	25920
3.	Number of TI Locations (Roadside Communities) consulted	329x 36	710640
4.	Number of TI Locations (Brothel) consulted	25x72	108000
5.	Number of Medical Services available along corridor covered under referral	To be established	Included
6.	Number of Awareness Camps conducted	(329+12+12+25)x36	Included
7.	Number of Group Meeting held	(329+12+12+25)x36	6804000
8.	Number of BCC workshop / meetings conducted	(329+12+12+25)x6	1134000
9.	Number of Trainings conducted for OWD Staff	6	Included
10.	Number of Trainings conducted for NGO Staff	12	Included
11.	Number of Trainings conducted for Outreach Workers/ Peer Educators	12	Included
12.	Number of Trainings conducted for Private Medical Service Providers	12	Included
13.	Number of OWDstaff trained	13	Included
14.	Number of NGO staff trained	33	Included
15.	Number of I-E-C brochures / pamphlets distributed	(329+12+12+25)x36x3	204120
16.	Number of I-E-C posters distributed	(329+12+12+25)x36x3	204120
17.	Number of RI brochures / pamphlets distributed	(329+12+12+25)x36x3	81648
18.	Number of RI posters displayed	(329+12+12+25)x36x3	81648
19.	Number of condoms distributed free	(329+12+12+25)x36x30	50000
20.	Number of condoms distributed through social marketing	(329+12+12+25)x36x15	Included
21.	Number of I-E-Ci conducted(Path prant yatra, exihibition, haat ,film screening)	(329+12+12+25)x3	2268000
22.	Number of CSWs interacted with	25x20x36	
23.	Number of construction labourers interacted with	12x120x36=100%	3110400
24.	Number of sex customers at brothels interacted with	25x36x10	540000
25.	Number of pimps / intermediaries at brothels interacted with	25x36x2	108000
	Total		**15456416**