1. COVER PAGE

Project title:	**CHARCA - Co-ordinated HIV/AIDS/STD Response through Capacity-building and Awareness**
Project Number:	
UNFIP / UNF Project code:	
Programme Framework topic:	Women & population – more specifically 'Educate and empower young women'
Project Purpose:	To reduce vulnerabilities and increase capacities of young women to protect themselves against STIs and HIV infection.
Duration:	Three years
Expected start date:	1st January, 2002
Docket Number:	
Location:	6 Districts[1] in India where young women have been identified to heightened vulnerabilities to HIV/AIDS - Jaipur (Rajasthan[2]), Guntur (Andhra Pradesh), Kishanganj (Bihar), Bellary (Karnataka), Aizwal (Mizoram), and Kanpur (Uttar Pradesh). Data on the Districts in Annex I.
Name(s) of the UN organisations responsible for management and identification of the lead agency	UN Theme Group on HIV/AIDS (UNDP, UNFPA, UNICEF, UNIFEM, ILO, WHO, UNDCP, UNESCO, World Bank and UNAIDS). The Theme Group includes bi-lateral donors and the National AIDS Control Organisation (NACO), Government of India. **National Level Co-ordinator**: Office of the UN Resident Coordinator **State Level UN Lead agency**: Will differ in each state. Discussions currently on to finalise.
Non-UN executing partners	NACO, SACS, District administrations, Panchayats, NGO's and CBO's.
Statement of approved UNF funding and total overall budget	To be added
Summary of the project	CHARCA aims to reduce vulnerability of young women by providing information, improving their skills and access to quality services. It also aims to build leadership, support networks and the necessary enabling environment. Through this process, it seeks to empower women to protect themselves against HIV/STIs and realise their rights.

[1] India is divided into states, which are sub-divided into (administrative) Districts

[2] District name is followed by the state name in parenthesis

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I. BACKGROUND & ANALYSIS

1. PROBLEM STATEMENT / CHALLENGE / CONTEXT:

a) NEED FOR THE PROJECT:

THE EPIDEMIC:
India has an estimated 3.86 million people in the country infected with HIV[3], an overall HIV adult prevalence rate of 0.8%. Ten percent of the world's population of people with HIV is Indian. The overwhelming majority of these (89%) are in the age group of 15-44 years. In 2000 HIV prevalence was over 1% among antenatal attendees in seven states. Mizoram, one of the states where the project intends to work has over 5% HIV prevalence in high-risk populations. Women constitute 21.4% of known AIDS cases in the country.

India's epidemic is marked by heterogeneity – not a single epidemic but made up of a number of distinct epidemics, often co-existing in the same state. Driven primarily by heterosexual transmission, HIV infection is moving steadily beyond its initial focus among commercial sex workers and their clients, STD patients and Injecting Drug Users (IDUs), into the wider population. There is a noted shift towards women and young people with an accompanying increase in vertical transmission and pediatric HIV.

There is now evidence to show that the HIV epidemic is fast spreading to the general population. ANC rates in seven states have shown an increasing trend. Efforts of the National and State Governments have concentrated on working with priority, 'high risk' groups. Governments are now addressing the epidemic among the general population but given the size and diversity of India, it is an extremely challenging task.

SERVICES:
Government provides 70 % of India's health services. While the Government has an extensive health network, services provided through this (as well as private) means, have yet to reach all the populations in need. In most places infrastructure exists, but no services; where services are available they are of poor quality or not gender sensitive.

Recent findings from population-based studies suggest that rates of RTIs/STDs among women are as high as 20-30% in some parts of the country. Only a fraction of these women actually access quality health services - reasons being economic condition, priority of health of women in the family, movement restrictions, etc. Those who do access services encounter poor quality, sometimes pushing them towards the un-organised health sector.

AWARENESS:
Women have scanty understanding of their reproductive system and have low access to information and medical care. Cultural beliefs, practices and values control women's access to knowledge about their own bodies, particularly matters of sexual health.

[3] NACO, 2001

Female literacy rate is 54 %, close to 189 **million** women still lack the basic capability to read and write[4] Gross enrollment rate in school is 65% for boys and 49% for girls, ages 11-14, with dropout rates of 60% for girls, 54% for boys (middle school); seven states/UTs in India have less than 50% female literacy rates.

To date, the HIV/AIDS epidemic has revealed a male - female ratio of 3:1. **Studies show that 90% of women with HIV have only ever had ONE sexual partner.** Sixty percent of women in India have never heard of AIDS of which 70% live in rural areas.[5] Among women who have heard about AIDS, 33% do not know how to avoid infection and only 19.7% know that using condoms prevents AIDS. This percentage decreases sharply with increasing levels of education and household standard of living. The Government's Family Health Awareness Campaign (FHAC), which covered 14 % of the population in 2000, identified and treated about 27 million cases of RTI/STI.

IMPACT OF HIV ON WOMEN:
Community-based studies reveal that positive and affected women end up fending for the family, repaying debts and supporting hospital costs of their spouse. Single-partner positive women usually are unsupported. A recent study in Karnataka (another CHARCA state) shows 72 % of women PLWAs in care & support homes were housewives - most are abandoned or isolated by their families.

Women suffer drug and alcohol induced violence from spouses and partners, social ostracization, and shame. Some women drug abusers (or wives of IDUs) are forced into selling sex to feed their own habit. Sexual partners of IDUs are likewise infected very quickly as such epidemics tend to reach 60-70% infection levels in the injecting community in a short span of time.

Overall, vulnerabilities linked to the issues above, and to the low age of marriage, limited control over fertility, economic dependence, illiteracy, lack of knowledge about HIV/STD and low overall use of STD treatment services, are contextual for the majority of women, not only the marginalised populations traditionally addressed by targeted interventions against HIV/AIDS. They mean that women have highly increased vulnerabilities to HIV/AIDS and reduced capacities to protect themselves from infection. (For more details please see Annex II)

CHARCA aims to prioritise and modify these vulnerabilities, in collaboration with the district communities involved, to ensure sustainable liberation from those factors that maintain the dangers of potential exposure to HIV.

b) GENDER ANALYSIS:
Gender disparity in India is a charged issue, creating a context of disadvantage that results in women having heightened vulnerability to HIV/AIDS (see Annex II). The sex ratio in 2001 is 933 females to 1,000 males[6]. This is attributed to the neglect of the girl child resulting in higher mortality rates, sex selective female abortions, female infanticide, etc. The sex ratio in the age group 0-6 years has decreased at a much faster pace than the overall sex ratio of the country since 1981.[7]

[4] Provisional population totals: Census of India 2001
[5] NFHS 1999-2000
[6] In Kanpur, where the project is proposing to work, it is as low as 869.

These fundamental threats to women's lives, health and well-being are critical human rights issues. While HIV/AIDS is seen as a multi-sectoral issue, there are contentious issues with respect to law, matrimonial relations, issues of female sexuality, which are based on power structures and certain cultural sanctions for women in society. Cross cutting issues of class and caste, gender, sexuality and poverty contribute to the deprivation of Human Rights of women.

Women living with HIV/AIDS also face special sexual and reproductive health risks and they do not always have access to care for STDs, cervical cancer and unwanted pregnancies. Female-headed households are increasingly facing severe hardships – as health care expenses increase and livelihoods are depleted. HIV/AIDS has also thrown up areas of conflict of rights such as informed consent, confidentiality and partner notification, which work differently for men and women. The gender dimensions in these areas need further investigation.

Current national efforts to address the gender dimensions have shown that promoting awareness through a sustained community based campaign (FHAC campaign) on women's health and sexual health needs is very useful. CHARCA can give a sustained and focused dimension to the FHAC by building on the information such activities provide, and linking vulnerable women more directly to empowering information and services.

Strategies that focus on men and boys as a part of this effort are critically important. Promotion of discussion between men and women on sex within relationships, discussion of mens' sexualities and beliefs, and on condom use will be a critical aspect of CHARCA so the capacities for female empowerment through information and behavioural negotiation can be collaborative, while male behaviour and attitudes are constructively transformed.

c) POPULATION GROUPS ADVERSELY AFFECTED:

Women in the age group of 13-25, more importantly, those who have no or less access to health services or have very little access to information on reproductive health and options available. There are sub-populations within this group – please see Annex III

The project does not seek to focus on groups addressed through NACP II Targeted Interventions (TI). It tries to address the broader context – the more difficult – general population, rather than sub-populations.

The project will seek to strengthen existing TIs implemented by SACS, NGOs working in reproductive and sexual health and state government departments for them to provide gender sensitive services.

d) ENVIRONMENTAL ASPECTS OF THE PROBLEM

There is increasing evidence that gender inequality is fueling the HIV/AIDS epidemic. Social norms and cultural values set within patriarchal systems heighten women's vulnerabilities as they encourage silence around issues of sex and sexuality that deprives women of the ability to say no to risky practices, keeps women uninformed about prevention, puts them last on the line for care and life-saving treatment and imposes an overwhelming burden for the care of the sick and dying.

While HIV/AIDS is seen as a multi-sectoral issue, there are issues with respect to law, matrimonial relations, issues of female sexuality, which are based on power structures and

certain cultural sanctions for women in society. Cross cutting issues of class, gender, sexuality and poverty contribute to the deprivation of the rights of women.

Restrictive atmospheres for young women translate into little or no interaction or support beyond family. There is a need to build fora for interaction among women. These fora not only can educate and improve awareness but take on contentious issues which no single women can take up.

Social mobilisations for sensitising men (and women) to women's needs are important. Existing social protection for women is fast disappearing are turning into restrictive mechanisms. In general, there is a need for broader debate and social action for realising women's rights. Some of these at micro level could be an atmosphere of openness and at macro level - policies / legislative framework.

Given the vulnerability of young women on the one hand and the difficulty of 'mass reach' on the other, there is a urgent need to build models of interventions, which address women's empowerment, their rights and their vulnerability. There is a need to educate young women on their reproductive health and increase their access to health. It is also important to improve the quality of service delivered and create space for discussions and joint action for women at various levels. Necessary enabling environments to carry out these changes, while sensitising men to young women needs, are a priority.

2. RELATIONSHIP TO UNF / UNFIP PROGRAMME FRAMEWORK & PROJECT CRITERIA

Of the UNF priority areas, this proposal primarily addresses 'Women and Population' and more directly - 'Educate and empower women'. In the Indian context, this probably is one among the first efforts to work on empowerment at District level, especially for the UN organisations. It also complements the existing National Programme of the Government, by taking up a challenging area such as empowerment.

3. NATIONAL / GOVERNMENT COMMITMENT:

The Phase II of the national AIDS control program aims to contain the spread of HIV in states with generalized epidemic to less than 3% and less than 1% among women in states with low prevalence. To achieve this, the program focuses on the following strategies:

1. Interventions targeting populations at high risk
2. Interventions for the general population
3. Low cost community based care
4. Institutional and capacity building
5. Inter-sectoral linkages

Given the diversity of the epidemic and keeping effectiveness in mind, NACO has identified the need for decentralization to the district level and building sustainable capacities[8]. CHARCA focuses on supporting the national program in developing district specific, multi-sectoral approaches that address the vulnerability of young women and develops models that the national program can then scale up. The focus will be on empowering the young women addressing them within the context of their families, partners, immediate community

[8] See 'Second national strategic planning workshop, Bangalore, August 2000', report

and society and strengthening the management and service delivery capacities of the government systems in the district.

Phase II of the National Program is a collaborative project with funding from the World Bank, DFID and USAID with technical support from UNAIDS. The National AIDS Control Policy emphasizes the role of UN organisations.

NACO and SACS have been involved in the identification of the project districts and also the institutional arrangements for CHARCA and have been supportive of the project. NACO is part of building of this proposal and this is further supported by State AIDS Control Societies, who feel the need for such a project to function at district level.

No policy changes/other steps are required for effective implementation of CHARCA. A letter of support to CHARCA from the Government of India is attached as Annex V.

For issues regarding sustainability, please see para 7e.

There are several Government programmes which address parts of what CHARCA intends to do – the FHAC campaign looking at reproductive health of women, Education Department at literacy rates and drop out level of girls, women and child programme, youth programmes, etc. During the district planning exercise, mechanisms will be worked out on how they will work closely together[9]

Recommendations from a national consultation organised by UNAIDS, NHRC and NACO in November 2000 emphasised the need to address the mainstream and not just the marginal populations. CHARCA is seen by the National Government an opportunity to address young women's needs, learn from the experience and feed into the larger national programme.

4. PROCESS FOLLOWED IN PROJECT IDENTIFICATION / FORMULATION:

During the Strategic planning retreat of UNAIDS (Bangalore, August 2000), the need for strengthening the FHAC (National Governments' programme on identifying and treating STI) including developing strategies for empowering women was addressed. The retreat identified the need for developing sustainable models for addressing young women on sexual health issues. This was followed up by discussions of the Virtual team[10] on possible approaches and a concept note on a Coordinated district level response building on the comparative strengths of the UN system was developed within the UNDAF framework of gender and decentralisation. The process drew lessons from current experiences of other projects (e.g. district level RCH project of UNFPA, adolescent life skills project of UNICEF etc.) and in consultation with NACO identified 6 states where these approaches could be piloted.

This was followed by visits of virtual team members to the identified states and districts were identified with the SACS and other key state level stakeholders. Districts were chosen according to HIV/STI prevalence rates, vulnerabilities linked to gender-based developmental indices, and existing or potential UN infrastructural capacities.

[9] It would be premature to commit on the strategy of co-operation as more consultations are required with district stake-holders. This only provides a frame work for further decisions, by stake holders themselves.

[10] See note on Virtual team on HIV/AIDS

The state and district level stakeholders including government, NGO, PLWA representatives, donors, UN organisations and NACO met in Mumbai[11] to identify key program priorities, strategies for program development and processes for district level planning of CHARCA. The group laid down the guiding principles for CHARCA and identified key indicators for the success of CHARCA, including a log frame – Annex VI. (An analysis of problem and possible strategy matrix developed at Mumbai workshop in Annex VII). The final proposal has been put together by the Virtual team working in close coordination with NACO and with the state representatives.

More consultations with districts will follow. The project document will be prepared in the districts, with the local stakeholders continuing to shape the project. Before planning the project document, a needs assessment will be completed at local level, within the framework proposed here.

5. RELATED PAST AND CURRENT ACTIVITIES:

Under NACP II the focus till now has been on developing and implementing Targeted Interventions addressing highly vulnerable populations (e.g. Sex workers etc.). The need for addressing the general population particularly women, with effective strategies has been identified[12]. In this effort, the Family Health Awareness Campaign (FHAC) was launched by NACO addressing men and women in the reproductive age group across the country on STIs/RTIs and condoms using interpersonal communication and services for screening and treatment. Over 300 Million people were reached and treating over 27 million people with STIs. CHARCA builds on a sustainable model for the FHAC through building long term capacities within the district to address issues of sexual health within the existing structures and building collaborative and reinforcing networks of different UN constituencies including women's groups (Mahila sangams), micro finance and self help groups (DWACRA, JRY), RCH projects at district level, youth groups (e.g. NSS, NYK etc.).

Recommendations from a national consultation organised by UNAIDS, NHRC and NACO in November 2000 emphasised the need to address the mainstream and not just the marginal populations, in order to avoid contributing to womens' subordination and vulnerabilities to HIV/AIDS. Recommendations included a. Right to information and communication, b. Right to association, c. Gender equality; need to work with men, d. Legal rights of women and e Right to sex education (life skills). CHARCA seeks to address the realization of these rights by women.

The UN system also has a number of initiatives in the states where the projects are to be implemented and will build on the technical and managerial capacities of the UN system and its partners. The project itself will use the principles[13] of

- Self and community identified needs of young women in reducing vulnerability
- Complement the existing programs of the Government
- Working within the UNDAF framework, building on the existing capacities of the UN system at the district level. This framework has identified in tandem with the Government of India's development priorities two overarching priority themes – promoting gender equality and strengthening decentralisation.

[11] See 'CHARCA planning meeting, Mumbai July 2001' report

[12] NHRC/NACO/UNAIDS national consultation in November 2000 emphasised the need to address the mainstream and not just the marginal populations to avoid additions to 'women's subordination and vulnerabilities to HIV'

[13] Principles evolved at the CHARCA planning meeting, Mumbai, July 2001

Concept of CHARCA has found wide support. The UN Theme Group meeting held on 22nd August 2001 reiterated its support to the project. There was general consensus regarding the draft concept note and the approach to UNF for funding. Meanwhile the UN Resident Coordinator System, on behalf on the UN Country Team in India has pledged $20, 000 accessed from the SIDA/ DGO fund for UNDAF initiatives.

II. OBJECTIVES & STRATEGY

6. PROGRAMME / PROJECT OBJECTIVIES, ACTIVITES & ANTICIPATED RESULTS

Based on lessons from the implementation of Phase I of the National AIDS Control Program and experiences within the country of other UN projects, CHARCA aims to develop a coordinated district level response to HIV. Phase I was characterized by the AIDS response being restricted to predominantly a health response with the Health departments being responsible for the implementation at the state and local levels. While the program has addressed the immediate priorities of addressing the vulnerable populations, efforts to address the young people particularly women within a larger development and empowerment framework has been limited. Also Phase I was centrally planned and managed with limited community/stakeholder participation and ownership. In light of the new National AIDS Policy and also the principles of NACP Phase II, CHARCA aims to initiate two key processes.

- **Coordinated action**: The project will facilitate the response at the district level for coordination between the different stakeholders – UN entities, government departments/agencies, NGOs, women's groups and other service providers – for a comprehensive and cost effective response. This will be initiated with each UN Organisation advocating for participation and facilitating collaboration/partnership of its line Ministry and partners in the state. The UN Virtual team on HIV/AIDS will facilitate this process at the national and state level.

- **Decentralized planning and implementation**: Given the diversity of the epidemic and the socio-economic and cultural diversity, the need for local, community developed and owned strategies are key for a sustainable response. CHARCA aims to develop sustainable capacities at the district level to develop, manage and maintain interventions at individual, family, community and district level in reducing vulnerability of young women to HIV.

a) PROJECT GOALS OBJECTIVES:

GOAL: ***Reduce vulnerability of women, particularly young women (13-25), to HIV infection in six select districts in India***

PURPOSE: To reduce vulnerabilities and increase capacities of young women to protect themselves against STIs and HIV infection.

b) MAJOR ACTIVITIES:

(See annex VIII for a timeline)

CHARCA will embody a phased approach at District level. There will be a preparatory, pilot and substantive phases:

1) **Preparatory:** Needs Assessment, District level baseline study (gender issues, beneficiary identification, vulnerability factors, violence, services availability and quality, information requirements, existing support groups & infrastructure), District level plan – bringing stakeholders together and Setting up the monitoring and 'Telling the story' system.

2) **Awareness building and Social Mobilisation:** (for young women & men) through: School AIDS education, Peer education (young women and men), Out of school outreach, General Outreach, Mass campaigns, Q&A session, Group discussions, Reaching women's groups, apex bodies where they exist, to increase awareness through them and building women's leadership;

3) **Building skills:** School based training, group discussions, training workshops, demonstration, leadership skills, and role plays which help young women build their skills of negotiation, building and organizing community groups, women's groups and support mechanisms to achieve their rights, within their context.

4) **Improving services:** User surveys on quality of services, Presentation of user surveys to service providers, Workshops on quality of service improvement (users & providers), Awareness workshops for women on what they are entitled to, Advocacy workshops to highlight quality of services and women's perception, Setting up feedback mechanisms which respond to young women's needs; improved sexual health services including STD services for men

5) **Building support structures:** Identifying existing women's groups and apex bodies, Promoting and setting up new groups (where they do not exist), Capacity building exercises – training, exposure visits for women, Setting up interaction fora and strengthening them, Promoting youth leaders and an agenda for them

6) **Creating enabling environment:** Workshops, meetings and regular interaction with Police, Legal system representatives, Media and religious leaders, Case studies of young women who have solved their issues through the support networks, Media articles that create awareness, Bringing together institutions for benefit of young women, Fostering 'mini-movements' that support realization of rights of young women, Fora for discussion for men, especially adolescent.

7) **Project Management:** Setting up of co-ordination mechanisms and working arrangements at district level, Selection and contracting of partners (NGOs and Government institutions), Building and fine tuning monitoring systems, Review and interaction for project management – district, state & national, Systems for technical support

c) INDICATORS TO MEASURE PROGRESS:

CHARCA will be a success if in the districts chosen, at least 90 % of young women have appropriate information, skills to protect themselves from STI/HIV. They have access to quality services and are able to discuss their problems in facilitative fora and access help. Young men, leaders, opinion makers, police, legal and administrative systems are sensitized and an enabling environment is created which protects and help realise the rights of young women.

Detailed indicators have been developed. Please see Annex VI – log frame.

d) INNOVATION:

- ✓ Taking *'country owned and country grown'* approach, to *'community owned and grown'*.
- ✓ Viewing the project through the lens of women's empowerment and social justice and not as medical or health issue.
- ✓ CHARCA does not seek to create structures – instead works in improving, networking and bringing together agencies to address young women's issues
- ✓ Working through collectives/facilitating the formation of collectives where none exist. Building capacity of single issue focused collectives to address social and gender justice issues
- ✓ Involving men as equal partners, from the beginning.
- ✓ Working to build capacities among formal fora meant to address issues of violence and discrimination against women and girls: counseling centers, police stations, schools, health centers,
- ✓ Best available training resources at national level for capacity building channeled centrally
- ✓ Project design flexible and responsive to implementation issues. An evolutionary planning mechanism – where CHARCA and central level provides broad framework and as the implementation starts, stakeholders influence the design of the project to their needs. A phased approach within each District is proposed.

e) SUSTAINABILITY:

CHARCA aims to develop a better coordinated functioning of existing services and systems rather than setting up new structures. The project will build on the NACO/SACS and other governmental and non-governmental initiatives and enable increased effectiveness and collaboration. CHARCA aims for **technical sustainability** through: increased local ownership, participation and skill building **managerial sustainability** by: enhancing management capacity at NACO/SACS and district level structures including Panchayats and *mahila mandals* (womens groups) **financial sustainability** of the project would be enhanced through: efforts to mobilize long-term local political support (e.g. Panchayats using their own budgets for interventions); state support to district level initiatives (as part of national policy on decentralization)

CHARCA will build capacities of community to take up work – rather than implementing on their behalf. Also the capacities to demand services built, along with networks and fora. Networking with existing NACP II ensures that service quality improvements are sustained.

Lessons learnt from capacity building exercises for service providers, will be fed into existing programmes of the Government. Mechanisms to interact (fora) will provide platforms for continuing discussions.

f) GENDER & ENVIRONMENTAL CONSIDERATIONS:

Vulnerability[14] of young women takes different forms depending on their status, environment that they live in, marital status, etc. The needs/ rights of each group could also be different. Please see Para 2.b for gender analysis and 2.d for environmental considerations.

[14] Also see para 2.b on Gender analysis.

7. BENEFICIARIES:

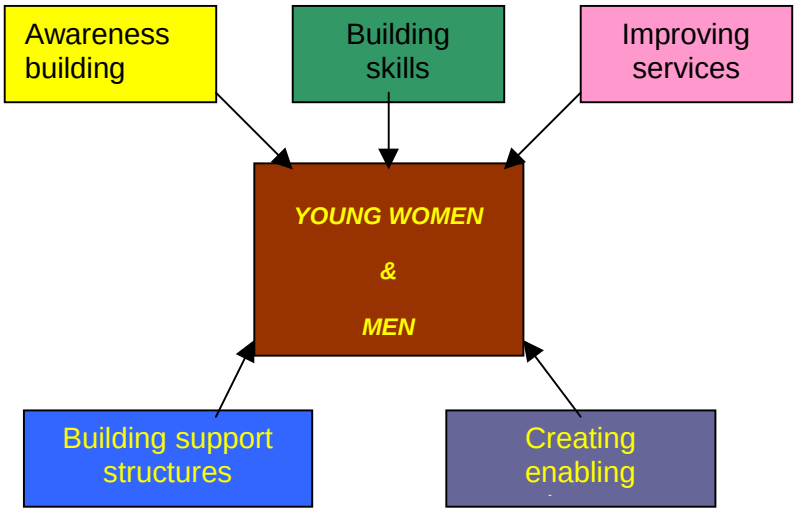
Women of all ages, particularly in the age group of 13-25. There are about 5.7 million women[15] in six districts. Project seeks to reach at least 90 % of this population, who live in both rural and urban settings.

Please see Para 1.c for more details

8. PROGRAMME STRATEGY AND RISK:

CHARCA concept and programme will evolve around the priority needs. Hence it is visualised that there will be a broad project document at national level (for which this is the beginning) and a detailed planning exercise at district level, which includes a needs assessment. This concept note provides a broad framework, with adequate scope for innovation and adaptation at district level.

Overview of CHARCA strategy



Awareness:
Provide context sensitive information to women on reproductive health and rights, which will increase their awareness and lead to behaviour change. It will also help women understand their situation better, their options and action leading to protection.

Building skills:
Building skills of women to negotiate and to have more control over their reproductive health and their rights in general within their existing community and domestic frameworks.

Building up of local leadership and support networks to take up issues of young women, where it does not exist. They will be the key stakeholders who will run this programme – the UN Organisations and the Government will support.

[15] Aged 7 and above. For more details see Annex I

Improving services:
CHARCA will work on the demand and supply side. On the demand side improving capacities of women to demand quality services and on supply side, working with service providers (Government and others) to provide gender sensitive and user friendly services. It will also examine current 'blocks' to accessing health services and work with the women in overcoming them.

CHARCA will strengthen existing infrastructure of Government, UN Organisations and NGOs. It will not create new ones. Close overlap with Government at District Level through sharing of management arrangements (where RCH committees exist, CHARCA will try to work through them). CHARCA will work in strengthening Government's implementation, especially those initiatives aimed at women (with special emphasis on agencies dealing with crime against women)

Building support structures:
Where no CBOs or support groups for women exist, CHARCA will facilitate formation of such groups. Where civil society institutions exist, CHARCA will work to build their capacities in being active support structures for young women. CHARCA will build and nurture fora for larger discussions and action.

Will aim for a broader redressal of young women's issues – as empowerment and social justice – rather than narrow medical or social issues.

Creating enabling environment:
CHARCA will work with the Police, Legal system, Media and religious leaders in creating an environment, which fosters equality and ensures justice. It will also sensitise and improve Police and Legal services for women, especially those who are vulnerable.

Risks:
A challenging project carries several risks. Key among them are
a) CHARCA is able address barriers for skills getting translated into action
b) Existing inadequacies in health infrastructure affecting improved health services delivery (especially where macro policy issues are concerned)
c) Sensitive socio-cultural issues may require more time than three years

For more on risks, see Annex VI – Log Frame

9. VALUE ADDED OF JOINT UN INTERVENTION:

CHARCA provides an opportunity to build on the work of individual agencies and to tap their competencies and synergies – from National to district level. 18 UN Organisations are signatories to the Government of India's UNDAF which gives priority to the themes of promoting gender equality and strengthening decentralisation. This joint commitment will feed into the CHARCA initiative, which can gain from this synergy and convergent approach. At the National level, the UN organisations involved can provide policy and direction to the project, through a national level steering mechanism. At the district level the UN organisations have infrastructure, contacts, existing programmes, NGO partners, goodwill and experience. These strengths vary in different districts. CHARCA will identify and bring together the UN organisations at district level in supporting the programme. A competency matrix and mechanisms for co-ordination at district level at annex VII.

In each state, based on core competency and presence, a state level UN Lead Agency has been identified. The other UN organisations who can contribute will bring in their experience and support directly to the project, co-ordinated by the Lead Agency. Agencies like UNIFEM will have an important role to play in CHARCA but do not have a state presence (infrastructure). However their role will be cross cutting in all the six districts.

While the lead agencies take up leadership roles in respective states, other agencies bring in their experience and expertise through meetings of the Steering Committees and specific theme inputs. Bilateral who are working in some of the states have a role to play. Their contribution to CHARCA will also be ensured through local mechanisms.

UNAIDS will play the role of a facilitator, coordinator and information channel for the different agencies. Individual district planning exercises will further define needs, agency strengths and partner roles.

10.VALUE ADDED FROM NGO & CIVIL SOCIETY PARTNERSHIPS:

Young women's issues can be best taken up and addressed by civil societies. The needs are varied and response has to be to the situation. Hence the project will actively involve CBOs, local leadership (especially youth), NGOs and Media. Where civil society institutions are lacking (like women's network), CHARCA will seek to create them through existing Government or other programmes.

The role of NGO and civil society is critical – they shall be carrying forward CHARCA from the outset. UN organisations, in partnership with the Government will only be facilitating the process. NGOs that have pledged interest and have been actively involved at this stage have included Rotary International, Family Planning Association of India, INP+ (Indian Network of Positive People), Population Council, Mahila Samakhya, Adithi and the Chief Minister's Employment Programme.

11.CHARITABLE PURPOSE JUSTIFICATION FOR UNF:

This project can be deemed an exclusively charitable project, as it addresses vulnerability of women, works towards empowerment, eliminating prejudice and stigma while defending the rights of women.

III. PROGRAMME MANAGEMENT & IMPLEMENTATION

12.MANAGEMENT & ADMINISTRATION:

As the project takes a multi-agency approach, a clear definition of roles is essential. The table below sets out planned implementation arrangements:

LEVEL	EXECUTION	SUPERVISION	FUNDS FLOW
National:			
Primary[16]:	-	CHARCA National Steering Committee Chaired by the UN Resident Coordinator	*Resident Coordinator System / Individual UN Agencies*
Secondary:	-	*UN Theme Group*	
Support:	-	*UNAIDS*	
State:			
Primary:	-	CHARCA State Steering Committee	*Lead UN Agency / SACS*
Secondary:	-	*SACS Governing Council*	
Support:	-	*Lead UN Agency*	
District:			
Primary:	*Local NGO, located within key services, e.g., VCT*	CHARCA District Steering Committee	*NGO*
Secondary:	*Lead UN agency*	*AIDS Committee*	*Lead UN Agency /AIDS Committee*
Support:	*Nodal Officer for HIV/AIDS, SACS, Health functionaries at District Level*	Advisory Board of Primary Stakeholders, *External Resources*	

For an analysis of core competencies and proposed inputs from different agencies, see Annex VII.

The entities in italics (green) are existing bodies / stakeholders. The new decision making bodies proposed are few, and will be drawn from existing entities. For example, The CHARCA District Steering Committee may be a core team drawn from the AIDS Committee or from other functional committees operating at district level (this varies from district to district). The CHARCA Committee at all levels will include all the important stakeholders. Every effort will be made to use existing committees and strengthen them through inputs and additional representative members.

[16] Responsibility

A separate Advisory Group of women (beneficiaries), which will guide these committees, is also being considered. These arrangements, along with sharper definition of roles will be finalised after full discussions with all stakeholders.

The project will receive overall guidance on execution through the CHARCA National Steering Committee of which the UN Resident Coordinator will be the Chair. Secondary responsibility lies with State level UN lead agencies. This would be different in different districts (for more details see para 10). After approval of the project before implementation commences a memorandum of understanding will be signed by the executing and implementing partners, defining the roles and responsibilities of each in respect to implementation, monitoring and reporting.

It is envisaged that all UN organisations could either have their funds received through the Resident Coordinator System in-country or, where this is not possible, they would receive their proportion of funds directly from UNF, and spend the funding and report on its disbursement through the agencies' normal mechanisms through a coordinated report. Monitoring of spending and reporting[17] of this in India would be documented and fed back through a coordinated report by the UN Resident Coordinator and the Theme Group Chair with support from the UNAIDS Secretariat.

Administrative cost charges will be 5% of the total budget, per agreements with UNF.

13.INPUTS:

The inputs to the project include:
Infrastructure – Provided by SACS - at district level provided by the relevant service bases, e.g., VCT centers.
Programme funds (including UN Organisation & NGO costs) – For funding from UNF
Other funds: DFID, USAID, CIDA, SIDA, Population Council and other foundations being approached for matching funds/Co financing of project and have shown a keen interest to be associated with the project. Some of the bilaterals have agreements with Government of India for support in the states eg. 4 of the 6 CHARCA states have bilateral presence- in Rajasthan and Karnataka (CIDA); in Andhra Pradesh (DFID); in Mizoram (AUSAID). AUSAID has firmly committed AUD 100,000 for the project. The Population Council will offer technical assistance and is in the process of determining what financial contribution it can make. Rotary International has indicated its commitment to the project, particularly in district level mapping. Co financing of US$20,000 is already available from SIDA/DGO through the UN Resident Coordinator system. We are confident that other such commitments will be made in the coming months.

14.REPORTING:

Each agency receiving funds directly from UNF will spend and report on its disbursement through the agency's normal mechanisms. Monitoring of spending and technical reporting in India would then be fed back through a coordinated report by the Resident Coordinator and Theme Group Chair based on submissions of individual agencies with support from the UNAIDS Secretariat. Inputs for the reporting process will be provided by the State level UN agencies and their NGOs.

[17] Reporting will be done by each agency receiving funds directly from UNF/UNFIP

Other than formal reporting, regular reviews are proposed: The CHARCA District Steering Committee meeting every month, State Committee meeting bi-monthly and the National Committee meeting every quarter. The State and National Committee Meeting locations will be the district / states on rotation basis, and will be as frequent as required during the first year. (More on this see para 16)

15.MONITORING & EVALUATION:

Monitoring of CHARCA project will be at different levels - Covering activities, outputs, outcomes, processes, impact: at the community, district, state and national levels.

A primary objective of monitoring is learning. As several aspects of the project are qualitative, a well-defined monitoring system is essential. Also monitoring systems will feed into decision making processes, especially shaping strategies.

Key phases (and milestones) of the project are:

- Planning phase – where baseline study is complete, needs clarified, infrastructure mapped. This is followed by consultations and a detailed district plan, involving all stakeholders.
- Piloting – Implementation will be taken up in 2 administrative blocks in rural areas and one part of the urban area. Setting up of systems and institutional mechanisms will also form part of this phase.
- Substantive phase – Learning from the pilot, the project will be implemented across the district. More partners will be enrolled, and the project's reach extended.

On completion of each phase, there will be a detailed review involving all stakeholders. The agenda for these reviews will be set by the monitoring system and the pre-defined indicators. Some indicators, which the project will be using to monitor, are given in the log frame (see Annex VI). These will be refined during preparation of the project document (and after consultations with all stakeholders).

Tools that will be used in monitoring will include regular collection of field data, comparing them with baseline, small learning loops[18], studies and reviews, which includes case studies (Telling the story). The case studies will provide important contributions to understanding and sharing of the project's qualitative progress.

Primary responsibility for monitoring will lie with the State level UN lead agencies. The NGOs and external resources will provide inputs.

There will be two evaluations of the project – one mid-term (just after the pilot phase) and another end-term. Evaluation will be participatory and involve primary stakeholders as far as is practical. This, along with the achievement (or progress towards achievement) of pre-agreed indicators will be used for the evaluations. External resources will be used as found necessary.

The evolution of the monitoring system is important. Most 'consultant driven' systems have remained on paper. CHARCA will experiment with community lead systems, which include 'word pictures', descriptive indices, voice recordings and pictures as much as possible. This will keep the system nearer and understandable to all primary stakeholders. All written

[18] Challenges in the project will be taken up one at a time, experiments on approaches and feedback to all stake holders on experience

material will be in local language (or bilingual). The system itself will be evolved from expectations of the stakeholders.

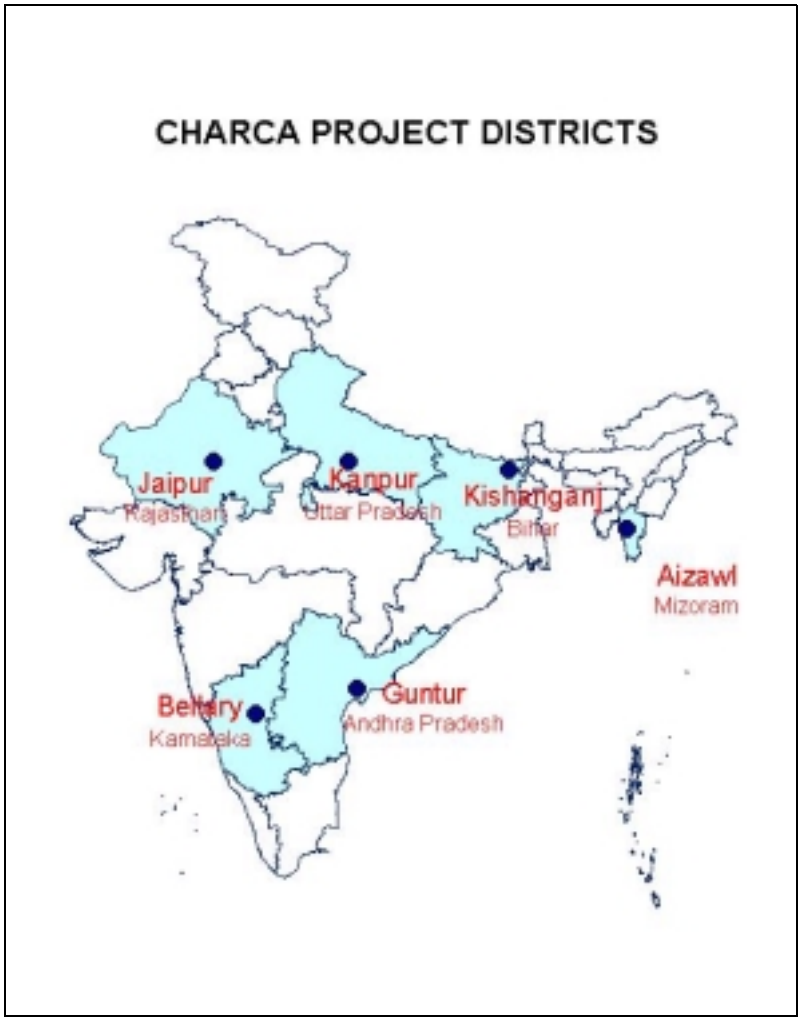
The National Government is building a monitoring system for its SACS. CHARCA will absorb the positive aspects of the system and with a view to promoting as much integration is possible.

Review meetings at district, state and national level are critical to monitoring. These meetings will review key indicators and steer the project towards the goals. Key input into this process will be the formal monitoring system and the informal one (comprised of primarily stakeholder views – as transmitted through advisory committees).

A separate budget has been provided for monitoring and evaluation.

Annex I – Key Statistics– CHARCA Districts

District	State	Female population (7+)			Female Literacy (Total)
		Rural	Urban	Total	
Guntur	**Andhra Pradesh**	**1,217,674**	**503,941**	**1,721,615**	**35.85**
Kishanganj	**Bihar**	**334859**	**36,688**	**371,547**	**10.38**
Bellary	**Karnataka**	**519,692**	**228,611**	**748,303**	**31.97**
Aizwal	**Mizoram**	**83,113**	**103,724**	**186,837**	**85.51**
Jaipur	**Rajasthan**	**1,056,256**	**712,983**	**1,769,239**	**28.69**
Kanpur Nagar	**Uttar Pradesh**	**137,468**	**777,430**	**914,898**	**58.82**
	Total:	**3,349,062**	**2,363,377**	**5,712,439**	



Annex II - Vulnerability context of young women in India to acquiring STI/HIV

1. Close to 60% of women in rural India get married before the age of 18. The average age of marriage in India is 19.7 and 60% of married women become mothers well before they are 19 years[19]. There are an estimated 540 maternal deaths per 100,000 live births, varying from 619 deaths in rural areas to 267 deaths in urban areas.[20] Women suffer high levels of malnutrition, stress and anemia - more than 50% of all married women in India are anemic[21]. Mortality rates among adolescent mothers is 3-4 times higher than in older women.
2. Women have very limited control over fertility, reproduction and contraception. Sterilisation accounts for more than 75% of total contraception and female sterilisation accounts for more than 95% of all sterilisations. Abortion is a contraceptive method for many women - about 70,000 women die from **unsafe abortions** each year.
3. The percentage of the poor in the total population stands at 26% in 1999-2000[22]. Most women workers are not officially recognised as workers and data indicates that **2%** of women workers are in the formal sector. A study of women workers found that 85% of women earn only 50% of the official poverty line income and have no access to social security[23]. Other critical factors that add to existing vulnerabilities include migration - due to displacement, ecological destruction and lack of sustainable livelihood options. Trends indicate that large numbers of women and young girls are trafficked into prostitution each year.
4. Though access to literacy is increasing the female literacy rate is 54.16%; close to 189 **million** women still lack the basic capability to read and write[24].Gross enrollment rate in school is 65% for boys and 49% for girls, ages 11-14, with drop-out rates of 60% for girls, 54% for boys (middle school); Seven states/UTs in India have less than 50% female literacy rates - Arunachal Pradesh, Dadra and Nagar Haveli, Uttar Pradesh, Jammu and Kashmir, Jharkhand, Rajasthan and Bihar (the latter two being identified CHARCA project states).

[19] Kalyani Menon Sen and AK Shiva Kumar: Women in India how Free, How equal, 2000 commissioned by the Office of the UN Resident Coordinator in India

[20] NFHS 2 indicates that estimated 540 deaths per 100,000 live births for the two year period preceding the survey

[21] KMS and AK Shiva Kumar: Women India, 2001 OUNRC India

[22] Planning Commission document, 2000

[23] Kalyani Menon Sen and AK Shiva Kumar: Women in India Office of the UNRC in India, 2001

[24] Provisional population totals: Census of India 2001

5. 1980-1990 witnessed an increase of 74% in crimes against women with rape, molestation and torture by husbands and in-laws showing the highest rate of growth. Children account for 30% of total rape victims. There is a prevalent myth that sexual intercourse with a virgin will rid oneself of STD infection – this helps account for the high number of girl children and adolescents who are victims of rape.
6. As with HIV, women acquire STDs at an earlier age than men. Gonorrhea and syphilis are asymptomatic in 50-80% of women and often go untreated. Recent findings from population-based studies suggest that rates of RTIs/STDs among women are as high as 20-30% in some parts of the country. Women have scanty understanding of their reproductive system and have low access to information and medical care. Cultural beliefs, practices and values control women's access to knowledge about their own bodies, particularly in matters of sexual health and in expressing their sexuality, which are constrained by dictates of the concept of a "good" woman who is expected to be ignorant about sex and passive in sexual interactions.

RECOMMENDATIONS FROM A NATIONAL CONSULTATION ORGANISED BY UNAIDS, NHRC AND NACO IN NOVEMBER 2000

a. Right to information and communication: Accurate messages on HIV/STD transmission to different categories of women must be provided. Information should not be moralistic and must address both preventive and curative aspects. Information about the costs of treatment, drugs and counseling should also be made available. Information about treatment of STDs is essential. Differential packages for differential populations should be considered.
b. Right to association; right to form groups and work for collective interests of the group.
c. Gender equality; need to work with men in addressing society to remove silence around sexuality and to challenge culture of shame and blame linked to issues of women's right to bodily integrity.
d. Legal rights of women: legal changes for empowering women for equality such as property, marital rape, domestic violence and the need to advocate for the Domestic Violence Bill and Marital Rape Bill.
e. Right to sex education (life skills): to empower girls and women and reduce myths of male and female sexuality, using alternate media for communication and reach out to as many groups as possible.

ANNEX III – Sub-populations who are particularly vulnerable

a. Single women (divorced, abandoned, widowed),
b. Physically & mentally challenged women, especially without family support
c. Women from troubled families,
d. Belonging to migrant families
e. Displaced
f. Poor families
g. Culturally & socially oppressed or subjudicated (like devadasis)
h. Places with recurrent droughts
i. Women displaced from traditional modes of trade
j. Women in highly protected (joint) families
k. Women, whose husbands travel substantially, for work
l. Women in sex trade
m. Women from alcoholic families
n. Women living in the streets
o. HIV Positive women
p. Young adolescent women, with limited mobility
q. College students
r. Migrant workers
s. Women survivors of sexual abuse and rape
t. Trafficked women and girls
u. Men in similar circumstances who are unaware of the threats they pose to their partners

Annex IV - Letter of support to CHARCA from the Government of India

NACO

NAVREET SINGH KANG
Director (Finance)

स्वास्थ्य एवं परिवार कल्याण मंत्रालय
राष्ट्रीय एड्स नियंत्रण संगठन

GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NATIONAL AIDS CONTROL ORGANISATION

D.O. No. M-18011/3/2001-NACO
Dated the 24th August, 2001

Dear Dr. Miller,

This is with reference to the discussions regarding the CHARCA proposal during the UN Theme Group meeting of 22nd August.

We are in agreement with the conceptual framework of the project and would support its implementation in the selected States. However, the following suggestions may be incorporated into the proposal:

1. The composition of the State Steering Committee may be specified to designate the Health Secretary of the concerned State as its head; and a representative from the State AIDS Control Society should also be included in this Committee.
2. Likewise, every District Steering Committee should be headed by the concerned District Magistrate and also include an officer of the States AIDS Control Society, besides other related departments.
3. The selection of executing NGOs should be done by the State/District Steering Committee.
4. It is understood that the exact funds flow mechanism has not yet been finalized. If however it is proposed to fund NGOs directly through the concerned UN lead agency, it then needs to be ensured that funds are released to implementing NGOs only on basis of the recommendation of the State/District Steering Committee. Also, the exact break-up of the budget would depend upon the mechanism that is adopted.

It is felt that the above issues should not stand in the way of submitting the proposal for consideration, but would need to be resolved before the project gets underway.

This issues with the approval of Special Secretary and Project Director (NACO).

With regards,

Yours sincerely,

(N.S. Kang)
Director (Finance)

Dr. David Miller,
CPA, UNAIDS,
55, Lodhi Estate,
New Delhi.

नवीं मंजिल, चन्द्रलोक बिल्डिंग, 36 जनपथ, नई दिल्ली-110001
9th Floor, Chandralok Building, 36 Janpath, New Delhi-110001
E-mail : nskang@vsnl.net Tel. : (91) (11) 3731780, Fax : (91) (11) 373 1748

Annex VI: Logical frame work

Narrative summary	*OVIs*	*RISKS & ASSUMPTIONS*
SUPER GOAL: To reduce the rate of HIV infection and to strengthen India's capacity to respond to HIV / AIDS[25]	Same as in NACP II	Same as in NACP II
GOAL: Reduce vulnerability of young women (13-25) to HIV infection in six select districts in India	• X[26] women report that they had a say in choice of contraception (2) ➢ STD treated among women shows an increasing trend (by X %) - (2) ➢ At least X number of crimes against women (domestic and otherwise) taken up by networks and support groups for resolution (3) ➢ Awareness `of women of their rights and support available in case of violence increased from X to Y (2) ➢ X number of Networks and support groups exhibit capacity to address young women's vulnerability, especially beyond the project period (2) • Some examples of cultural and social changes reflect societies concern for young women's vulnerability • At least X 'movements' to protect women gain momentum and have in them seeds of the project's vision (2) • X Instances of stigmatisation and discrimination taken up by groups for resolution (2) • X existing Government programmes adopt key strategies of the project, within their framework (2) ➢ X % of women report (anecdotal) on how information & skill building provided was useful for their protection (2) ➢ X % of men report higher sensitivity to women's needs and acceptance of role of support systems (2)	Larger district administration issues affect improvement of services Sensitive socio-cultural issues, may require more time than three years Frequent changes in district / state administration and its impact Severe drought and natural calamities, which increase vulnerability or encourage migration

Means of Verification (MOV):
1 – Document; 2 – Survey / study; 3 – Internal monitoring systems of the project

[25] Goals of National AIDS Control Programme (NACP) II, Government of India
[26] X/Y/Z – figures will be decided after a wider stakeholder consultations, during the district planning exercises

Narrative summary	*OVIs*	*RISKS & ASSUMPTIONS*
PURPOSE: Capacities of young women increased to access information and services, to protect themselves against STIs and HIV infection	➢ X number of service providers take up at least three key improvements in providing gender sensitive and contextual services (3) ➢ X number of women served through support groups, networks and CBOs (3) ➢ Number of persons accessing health services increased by X % (2, 3) ➢ X % of women report ability to negotiate and assert their rights, with regard to their health (2) • Political establishment subscribes and includes messages of women's capacities as a part of their campaigns (2,3) • Use of Condom increases from X to Y (2) • X % of women know where user friendly health services are available (2) • X % of women say they are able to negotiate sexual relations (2) • Young women take up roles in creating and running support networks (2) • Instances where women re-energise existing cultural / familial support systems	Project is able address barriers for skills getting translated into action Larger /other district administration issues affect improvement of services Political establishment is sympathetic to women's issues and does not take contra stand

Means of Verification (MOV): 1 – Document; 2 – Survey / study; 3 – Internal monitoring systems of the project

Narrative summary	OVIs (MOV in brackets)	RISKS & ASSUMPTIONS
OUTPUTS:		
1. Gender and context sensitive information made available to young women	➢ Understanding vulnerability – a district specific document (3) ➢ Communication strategy developed, which includes life-skills (1) ➢ Partners in implementation adopt communication strategy and show evidence of its implementation (2) ➢ X communication material developed, implemented using appropriate media (3) ➢ Implementing partners use the material to provide information (3) ➢ Information provided includes options for women (contraception, protection against violence, livelihoods, support networks, dispute resolution)	Resistance from the community and sometimes women themselves to changes Focus on gender sensitivity does not lead to isolation of women
2. Skills of women enhanced to negotiate and have control over their health	• X % of women report (anecdotal) on how improved skills help control over their health (3) • Y % of men report accepting negotiation for the women's point of view (3) • Skill building workshops / training reaches at least X women (2)	Women want to negotiate – breaking existing barriers
3. Support systems that address women's vulnerability (esp. violence & rights issues) built and reinforced	▪ Cadre (X number) of youth leaders and opinion makers built (3) ▪ Y Number of community based networks and support groups built (3) ▪ Z Number of women addressed through these groups (3) ▪ Sensitisation, training of key service providers (like police) on domestic violence, violence against women & rights of women (3) ▪ X number of Fora for discussing and addressing rights issues built (3) ▪ Community reports violence and rights issues discussions lead to positive action in the case of X women (2)	Leadership's & support groups are not coloured by politics and political parties
4. Quality of services for women improved to be gender sensitive and user friendly, through advocacy and networking	➢ X % Women reporting 'better quality', accessible and 'user friendly' services (2) ➢ Y number of services providers (for women), sensitised and trained on women's needs (3) ➢ Field level best practices protocol developed and implemented (1) ➢ At least X key agencies providing services build feedback and corrective mechanisms (2) ➢ Existing Government mechanisms of protection to special category of women strengthened	Larger /other district administration issues affect improvement of services Existence of NGOs / CBOs / individuals, interested in taking forward the project's objectives

Narrative summary	*OVIs (MOV in brackets)*	*RISKS & ASSUMPTIONS*
5. An enabling environment at district and village level of sensitivity to young women's needs built and nurtured	• Important line departments and ministries (X nos.) have demonstrated their intent by adopting parts of project vision, within their work • Police and legal system demonstrate improvement in their services, which are gender contextual • Political establishment and X religious leaders raise issues and backs women's networks in their work • Fora (which includes young women representatives) with credibility and power for discussing and resolving issues with regard to young women's issues - functional at different levels • X instances where support groups were able to successfully intervene and resolve issues of violence, rights, stigma and discrimination against young women	Larger /other district administration issues affecting project Changes required do not entail larger legal or structural changes, which have state wide impact

Means of Verification (MOV):
1 – Document; 2 – Survey / study; 3 – Internal monitoring systems of the project

Annex VII - Input matrix of UN agencies in CHARCA Project

THEMATIC AREAS	UNDP	UNFPA	UNICEF	UNIFEM	ILO	WHO	UNDCP	UNESCO
Care & support						X		
IDU & HIV							X	
Poverty & HIV	X							
Gender equality & women's rights				X				
Reproductive &Child Health		X						
Capacity building	X	X	X	X	X	X	X	X
MTCT			X			X		
Youth, adoloscent health		X	X					X
School based education		X	X					
Out of school / non-formal education			X					X
Marginalised groups	X							
Workplace interventions / Private sector partnerships	X				X			
Legal & ethical issues	X			X	X		X	
Children			X					
Networking / partnerships / Civil Societies / PLWAs	X	X	X	X	X	X	X	X
Stigma / discrimination issues	X			X	X	X		

ANNEX VIII - Implementation plan

	YEAR 1 – JAN 2002 TO DEC 2002				YEAR 1 – JAN 2002 TO DEC 2002				YEAR 1 – JAN 2002 TO DEC 2002			
	Q 1	Q 2	Q 3	Q4	Q5	Q 6	Q7	Q8	Q 9	Q 10	Q11	Q12
1. PREPARATORY:												
1.1. Needs Assessment	X											
1.2. District level baseline study	X											
1.3. District level plan – bringing stakeholders together		X										
1.4. Setting up the monitoring and 'Telling the story' system			X									
2. PILOT PHASE:												
2.1. Awareness building: (for young women & men)			X	X								
2.2. Building skills:			X	X								
2.3. Improving services:			X	X								
2.4. Building support structures:			X	X								
2.5. Creating enabling environment:			X	X								
2.6. Review				X								

	YEAR 1 – JAN 2002 TO DEC 2002				YEAR 1 – JAN 2002 TO DEC 2002				YEAR 1 – JAN 2002 TO DEC 2002			
	Q 1	Q 2	Q 3	Q4	Q5	Q 6	Q7	Q8	Q 9	Q 10	Q11	Q12
3. SUBSTANTIVE PHASE:												
3.1. Awareness building: (for young women & men)					X	X	X	X	X	X	X	
3.2. Building skills:					X	X	X	X	X	X	X	
3.3. Improving services:					X	X	X	X	X	X	X	
3.4. Building support structures:					X	X	X	X	X	X	X	
3.5. Creating enabling environment:					X	X	X	X	X	X	X	
3.6. Review												X
4. PROJECT MANAGEMENT:												
4.1. Setting up of co-ordination mechanisms and working arrangements at district level		X										
4.2. Selection and contracting of partners (NGOs and Government institutions)		X		X								
4.3. Build and fine tune monitoring systems			X		X							
4.4. Review and interaction for project management – district, state & national	X	X	X	X	X	X	X	X	X	X	X	X
4.5. Systems for technical support		X										

Note:
Timeline of major activities given here. Project document will include a Gantt chart with sub-activities and tasks. Some of the above activities will run simultaneously. Each phase is a milestone (except project management), when project will be reviewed.

ANNEX IX - Budget

Given below is a tentative budget, based on the strategy, activities and outputs described earlier.

	Amount (USD)	Totals
PREPARATORY:		
1.1.Needs Assessment	60,000	
1.2.District level baseline study	60,000	
1.3.District level plan – bringing stakeholders together	30,000	150,000
PILOT & SUBSTANTIVE PHASE:		
Awareness, Building skills, Building support structures	1,200,000	
Improving services, Enabling environment:	600,000	
Communication material	800,000	
Telling the story	600,000	
Technical support- UN agencies	480,000	
Monitoring:	400,000	
Sharing of experiences-meetings, workshops:	270,000	4,350,000
PROJECT MANAGEMENT COSTS:		
District Offices		
Personnel-National hired:	720,000	
Office costs:	90,000	
Travel:	120,000	930,000
National office:		
Personnel-National:	120,000	
Travel:	60,000	180,000
TOTAL:		5,610,000
Administration cost (5 %)		280,500
GRAND TOTAL:	**USD**	**5,890,500**

ANNEX X - Letter of Support, AUSAID

AUSTRALIAN HIGH COMMISSION
DEVELOPMENT COOPERATION
SECTION

AusAID
Australian Agency for International Development

29 August 2001

Dr David Miller
Country Programme Adviser
UNAIDS India
New Delhi

Dear David

Thank you for your letter of 24 August 2001 requesting AusAID support for the CHARCA Project to be coordinated by UNAIDS. The project is well outlined and important from the view of reducing vulnerability of young women and empowering them to protect themselves against HIV.

As you may be aware AusAID is working with the National AIDS Control Organisation on a proposed HIV/AIDS Prevention and Care Project for Manipur, Meghalaya, Mizoram and Delhi. In addition, AusAID through the India Australia Community Assistance Scheme is providing assistance to NGOs to work with communities affected by HIV/AIDS.

AusAID is pleased to collaborate with UNAIDS on the CHARCA project and agree in principal to provide financial support up to a maximum of A$ 100,000 under the India Australia Community Assistance Scheme. In view of AusAID's interest in the North Eastern region we would appreciate if the proposed support be utilised for activities in Mizoram.

We look forward to working in partnership with UNAIDS.

Yours sincerely

Kerry Groves
First Secretary
Development Cooperation