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# Report of the Sub Group on TI among Female Sex Workers

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Working Group Consultation 1st Meeting
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**Executive Summary**

NACP IV is being planned. Working groups have been constituted and one of them is the FSW Sub Group which met in Delhi for a three day period to deliberate based on a TOR developed by NACO. The process included looking at what worked and what did not as well as why. The following report captures it and recommendations are made for the purpose of NACP IV.

A summary of what has worked; gaps and key recommendations (in summary) are listed below.

**What has worked well**

1. Robust design to ensure focus on saturating coverage of FSW in TI as the mainstay apart from other core group intervention of NACP III
2. National denominator established through robust validated size estimation process provided essential target setting for coverage and scaling up
3. Massive scale up in coverage of TIs from XXX FSW TIs in NACP II to over YY FSW TIs today, with coverage increasing from XX% to YY% (see presentation by Dr. Dhingra)
4. Strong focus on quality assurance resulting in large improvements in quality and intensity of programme
5. Robust MIS system established for tracking processes, as well as outputs (e.g., number of condoms per HRG per month).
6. Recognition of the rights based approach in the design of the programme:
    a. Importance of community mobilization as a key strategy to establish ownership by HRGs of the programme
    b. Strong emphasis on peer outreach and recognition of structural interventions as critical components of the model of intervention

**Gaps in implementation and design**

1. Rights based approach for community strengthening needs to be reflected in implementation of guidelines
    a. Enabling environment not addressed adequately in budget and activities of TIs - e.g., crisis response, access to entitlements
    b. Community strengthening de-prioritized in implementation of NACP III – e.g., NGO-CBO transition model discontinued
    c. Targets for testing do not take into account the rights of HRGs – this needs to be revised
    d. Trafficking and self-regulatory boards are missing from current TI activities
2. Service delivery gaps
    a. Programme linked clinics better serve HRGs than referral clinics
    b. Outreach requires more flexible allowances for peer educators in different contexts

c. M&E formats are too extensive and can be simplified.
d. Hard to reach/new sex workers require specific focus, and changing sex work environments require some flexibility to address
e. Linkages of HRGs to ART are weak due to lack of focus on ensuring ART access within TIs. TIs should be designed on the principle of continuum of prevention to care/treatment in NACP IV with appropriate human resources, structures, systems and processes in place

3. Flexibility in implementation is lacking
    a. Detailed operational guidelines for different aspects of TIs led to large improvements in scale and quality. However, the diversity and heterogeneity of environments and HIV requires that we go beyond "one template for TI" without compromising the budget integrity.

**Recommendations**

**Community led processes**

Community representation in all policy making bodies in NACO, SACS and DAPCUs should be institutionalized, community groups and organizations should be actively engaged in redesigning the TI processes and provision should be made for building capacities of the state and national organizations to include community groups for policy making.

**Outreach**

- Continue the peer education model which has worked
- Address operational issues related to peer outreach (e.g., adjusting ratios of peers depending on geographic/timing context, honorariums to be adjusted to match other frontline functionaries in health, optimize role of peers in data collection)

**Clinics and STI management**

- Community preferred programme linked STI clinics should continue and be scaled up
- Adjust operational model for STIs and clinics
    - Providing treatment of basic health services and general medicines in order to build an ongoing relationship with the service providers and for better utilization of services
    - When the supply chain for drugs is interrupted, TIs should purchase these drugs locally and get reimbursed by SACS subsequently
    - Targets for syphilis and HIV testing should be reduced and this should be done concurrently
- Adjust staffing model for TI:
    - Revisit doctors remuneration to enable better services
    - ANMs trained on syndromic case management should provide STI services in places where there is non-availability of qualified medical professionals
    - Number of Counsellors to be reviewed and proportionately increased in different geographical settings and Community Counsellors should be considered as a standard approach across all TIs

- Periodic epidemiological studies should be implemented at selected sites in each state to inform strategies

**Condoms**

- Free condom supply to the programme should continue and the female condom should also be made available widely
- Social marketing should not be promoted through TIs (but through SMOs). CBOS should be given the choice to take up or otherwise. However, Overall supply chain management of condoms should be improved to ensure no stockouts.

**Enabling environment**

- Enabling environment to be further strengthened in NACP IV at the National, State, District and the TI level with roles and responsibilities clearly defined for NACO, SACS, DAPCUs and the TIs
    - Linkages to be developed with all partners and networks involved in the rights of FSWs including ICPS, anti-trafficking systems and groups
    - Support national and state level networks of sex workers to take up community led advocacy by providing adequate resources
    - Legal service provision at TI level should be strengthened with increased budget
    - Anti-trafficking activities should be included in the purview of the TIs and self-regulatory boards should be an integral part of FSW TI and it should coordinate with all the committees existing at the district level for the protection of rights trafficking victims
    - Health insurance for community members should be explored and strategies to be developed for social and economic security of HIV positive FSWs

**Monitoring and evaluation**

- Simplify M&E for TIs and Introduce qualitative indicators
- Introduce client satisfaction surveys for all services accessed by the community members under NACP IV and publish report cards for the services availed.

**Others**

- Community to community capacity building should be adopted as a preferred pedagogy and learning materials and methods need to be developed based on how sex workers learn (adult learning techniques)
- An in-depth analysis and review of the existing budget for TIs should be done in consultation with the community representatives and also review the need for two different budgets, one for NGO and other for CBO
- Pprivacy and confidentiality should be protected and a redressal mechanism to deal with of confidentiality breach should be inbuilt into the programme A code of conduct to ensure the above should be developed by NACO in consultation with the community members and adhered to by programme functionaries at all levels.

Section A

1. Background and Introduction[1]
   1.1. NACP III and FSW TI

Given that more than 75% of the HIV transmission globally occurs through sexual route, sexual networks and sexual behaviour of a population plays the most critical role in transmission and, therefore, prevention of HIV.

HIV epidemics in different populations in the world can be broadly classified into two types-
**a) concentrated epidemic** if transmission primarily occurs in the "core" or "high risk" or "most at risk" groups of female sex workers, men who have sex with men, and injecting drug users, and their sexual partners; and protecting them from HIV infection would prevent the HIV transmission in general population because of low prevalence of concurrent multiple partnerships in the general population and
**b) generalized epidemic**, if the transmission is sustained by sexual behavior of multiple concurrent partnership in the general population irrespective of the "core" groups mentioned above[2].

India's HIV epidemic is a concentrated one, because the concurrent partnership in the general population is low and most women in general population have only one sexual partner, therefore effective prevention of HIV in these high risk groups is considered adequate for the effective control of the HIV epidemic in the whole population in India[3].

In fact, targeted interventions aiming at empowering these high risk groups with knowledge, skills, services, commodities and protecting their fundamental human rights have resulted in declining of prevalence in these groups and the whole population, especially in the high prevalence states[2].

A study commissioned as a part of the mid- term review of the National AIDS Control Programme Phase III concluded that HIV epidemic has been controlled in India and the prevalence is declining primarily as a result of great increase in condom use in commercial sex and preventive strategies should be continue for these groups to sustain the results achieved[4]. Another study documented that the FSW TIs in India reduces HIV prevalence by 47% (from 1995-2015) and are very cost effective strategy ($ 104 per HIV case averted)[5].

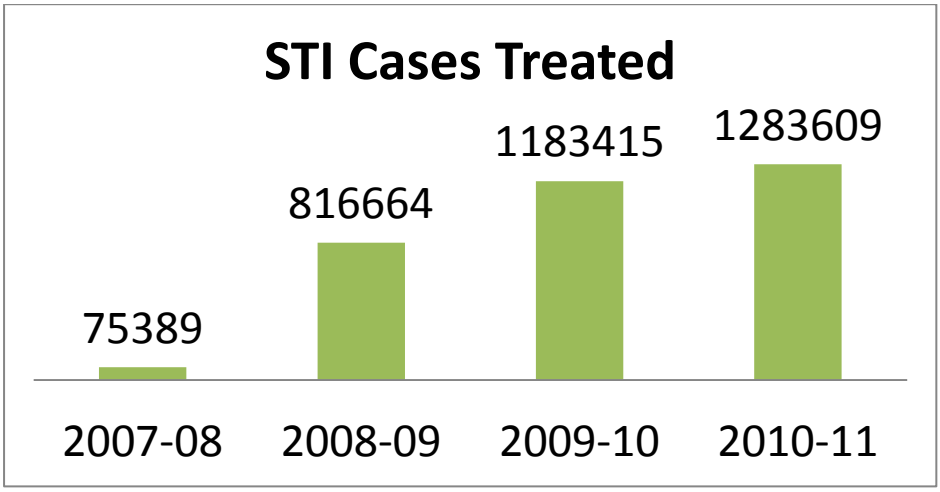
Targeted interventions in India were started in early nineties in Kolkata (Sonagachi Project, supported by NORAD and WHO) and Mumbai (interventions in red light areas of

[1] This section was not discussed in the group but written up in the interest of introducing the report
[2] David Wilson, Daniel T Halperin, "Know your epidemic, know your response": a useful approach, if we get it right, LANCET, Vol 372 August 9, 2008
[3] REDEFINING AIDS IN ASIA, Crafting an Effective Response, Report of the Commission on AIDS in Asia, Page 3 Oxford Press, 2008.
[4] Impact Assessment of Targeted Interventions on HIV in India, Interim Report, Kumar R, Mehendale S, Panda S, and India TI Study Group, 2009
[5] Prinja S, Bahuguna P, Rudra S, et al. Cost effectiveness of targeted HIV prevention interventions for female sex workers in India, Sex Transm Infect (2011). (Downloaded from sti.bmj.com on April 14, 2011) doi:10.1136/sti.2010.047829

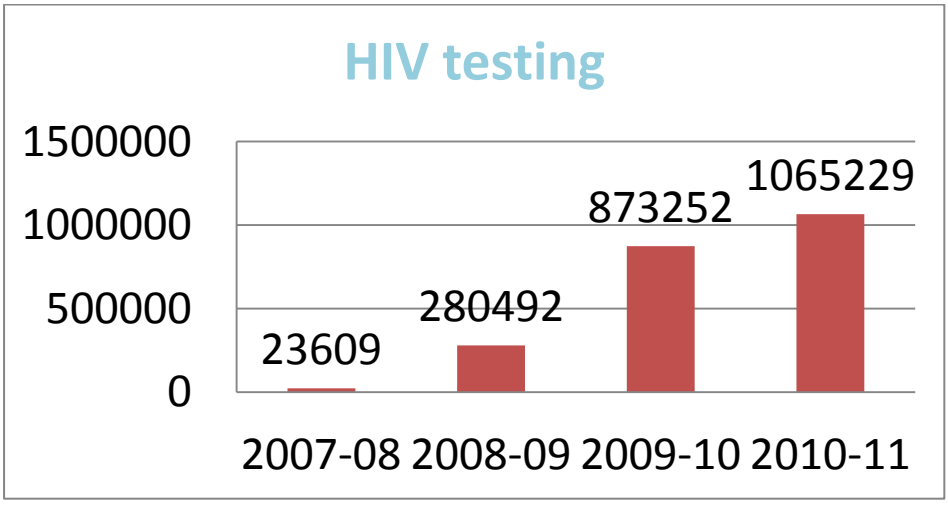
Kamathipura, Grant Road, Mumbai). These interventions were massively scaled up from mid-nineties. For example, FSW TIs increased from 5 in 1995 to 454 in 2011 with concomitant increase in coverage from few thousands in 1995 to 709,000 in 2011. Much of the scaling up happened during NACP III. For instance, the total number of FSWs covered increased from 2.82 lakhs in 2007-2008 to 7.09 lakhs during 2010-2011 which includes both NACO and AVAHAN (other donor) supported interventions in six high prevalence states.

An expert group, constituted for size estimation for NACP III estimated that there are 12.63 million FSWs in India. Following a national mapping study of FSWs in 2008, the size estimated was 8.68 lakhs, therefore, currently about 81% of the FSWs are covered by TI. ([6]). Consistent condom use among FSWs and clients increased from 50% to 73% between 2001 and 2006 nationally. HIV prevalence declined steadily among the general population in India during this period.

It is also important to note that there has been great improvement in service provision for the FSWs. The total number of STI cases treated is shown in the figure below:

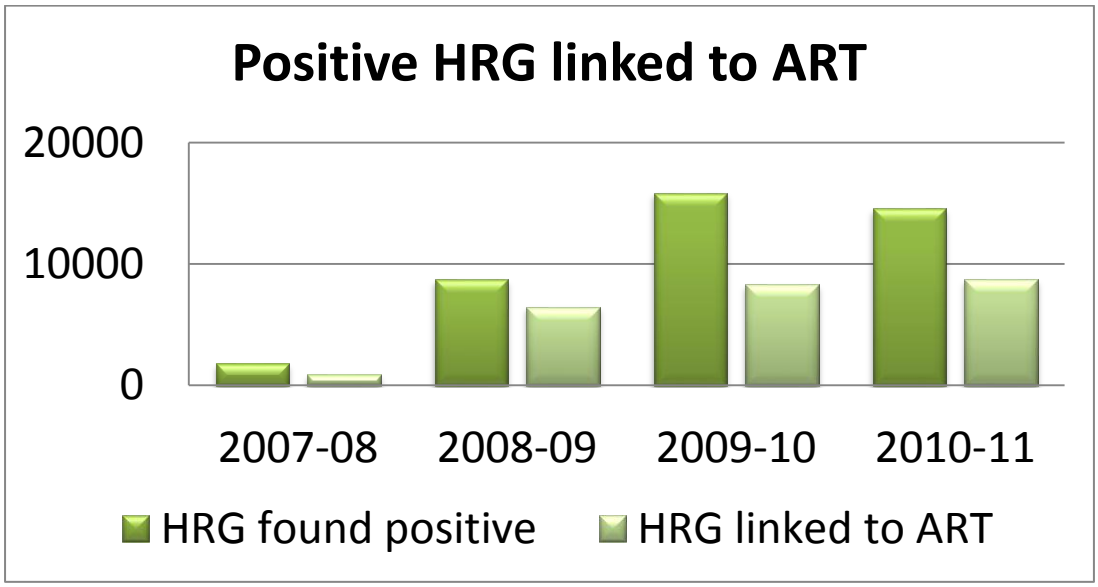



More detailed analysis of the STI case management is needed. ICTC coverage also increased and total number Tests on FSW forr HIV is shown below:




[6] Presented by Dr. N. Dhingra, DDG, NACO, on TI for NACP IV TI WORKING GROUPS, 2 May 2011

However there is a huge gap in linking the HIV positive FSWs to the ART centers as shown in the figure below:




Key lessons learnt from the interventions during NACP I to III shows that:

a. TIs are highly effective and cost effective strategy for HIV prevention in India. TIs for FSWs in India reduced HIV prevalence by 47% from 1995 to 2015. TIs are very cost effective strategy with the cost of only US $ 104 per HIV case averted.
b. Structural interventions which addresses the issue of HIV/AIDS prevention from a much broader perspectives of fundamental human rights and socio-economic empowerment of FSWs, is one the successful models for HIV/AIDS prevention among FSWs
c. Networking and collectivization of FSWs is one of the strategies for their empowerment.
d. Advocacy, networking and collectivization of the FSWs are a continuous process. TI among FSWs has resulted in decline of harassment in general, but still much needs to be done.
e. Sex work scenario is ever changing and posed challenge in NACP III. The FSW TIs should continue to focus on the most disadvantaged and highly vulnerable FSW.

### 1.2. NACP IV preparation and Working Groups

NACO, working towards the development of NACPIV considered a similar approach followed in the preparation of NACP III to convene working groups in several thematic areas. One such area is the TI working group under which several sub groups have been created. The Sub group on TI for FSW was constituted by NACO which includes representatives from NACO, NTSU, TSU, Development Partners, Civil Society Partners, Community based organization representatives (FSW), sex worker leaders and other experts. The working group is expected to deliberate over 3 days at the beginning and come up with a report that will be widely circulated and thereafter deliberate again a couple of times before coming up

with recommendations for NACP IV. However, there is no articulated National and TI strategy yet and this needs to be considered if there has to be a coherent National Response to HIV in India.

2. The Process followed for the discussion and the draft first report

2.1. The Core Group Consultation

Significantly large number of people drawn from diverse environments that include personnel from NACO TI division, NTSU, TSUs of the State, Development partners, Civil Society Organizations, Community based organizations of FSW, MSM, Transgender, IDUs and field practitioners as well as experts have been drawn in to form the Core Group to set the agenda for the discussion as well as substantive aspects of what should be manifesting as TI in NACP IV.

The Core group met over one day and deliberated to define the Guiding principles as well as a matrix for analysis of "what worked, what did not work and why" and distil lessons for application in NACP IV. This formed the basis of discussion in the Sub groups identified by NACO.

2.2. The Sub Group Process

The sub group assigned the task of discussing and coming up with recommendations for NACP IV TI among Female Sex Workers at the outset identified that there is low representation in the group by the community members and therefore placed a request for additional members of the sex workers community to be brought it. NACO, NTSU and TSU personnel conferred with the group and expanded participation by bringing in 5 additional participants from sex worker groups.

The Sub group chair was designated to be Dr. Jana and within the group specific individuals doubled up as translators. There was simultaneous translation in Bengali, Kannada and Hindi. This made the discussion participatory but consumed double the time and therefore the group overall felt that the time available for discussion was less.

The overall discussion initially considered the guiding principles and its applicability but went ahead to discuss the program components and analyse what went right and how as well as what went wrong and why. This helped in the distilling of recommendations in general. There was overall consensus and in areas where there was a difference of opinion the sex workers were asked for their final opinion and the recommendations were made on that basis.

It was recognized that there is significant State and Regional Variations and therefore this group was not fully representative of the diversity. Therefore it was ratified at the outset that the discussion should be carried out in respective states or in region among

sex worker community groups and organizations so that NACP IV will be stronger than NACP III.

Much of the discussion is captured in the forthcoming chapters and recommendations are crystallised.

2.3. The draft report

The first draft report is "work in progress". It is a culmination of the discussion and the notes taken, presented to the entire working group and thereafter, based on some of the additional recommendations given by the Core Group the revisions were done. A final presentation on 5th May in the presence of DG NACO and AS NACO. This report has tried its best to capture what was discussed and therefore the recommendations. The process has just begun and it should not be seen as cast in stone. At the end of three weeks and after several open consultation, in the next meeting of the sub group the recommendations will be further refined.

Section B

1. The guiding principles in the context of TI and Applicability in FSW TI

GP 1: TI should continue to be the mainstay of HIV prevention in NACP IV

Evidence demonstrates efficacy of TI.[7]

GP 2: Rights Based Approach to be followed implicitly and explicitly

Respect and Dignity to the community
Code of Conduct
Consent and Confidentiality
Testing follow the norms of Voluntary Testing

GP 3: Go beyond TI with prevention focus

Prevention, Care, Treatment and Support need to be TI mandate
Nomenclature as Targeted Intervention for prevention, care, treatment and support
Modify the model to incorporate this vision for TI

GP 4: Community Led

Vision of NACP III retained and reiterated and ensured that it is resonant in all aspects of the TI program
Address Structural Barriers
Assist Enabling Environment through laws, legislation, policy, norms, practices and culture
Address violence of any sort including police violence

[7] Rajesh Kumar's MTR study showing that TIs are the "best buy"; Data from Avahan showing declines in HIV prevalence among SWs

Supported by Central and State Structures – NACO, SACS, NTSU, TSU

GP 5: Occupational Health Intervention Model

Protection from harm
Working with sex work system
Support from co-workers
Address issues at workplace such as brothel, lodges etc

GP: 6 Community to Community learning for Capacity Building as principal method

Acknowledge the inherent capacity of sex worker community
Bring in adult learning methods that incorporates the way sex workers learn
Adopt best practices from projects that are leading in a particular approach

GP: 7 Design and Strategy should be based on epidemiological principles

Young, New and Hard to reach
Human resource, training and measurements to reflect it
Address issues of Migration, Sex-Trafficking

GP: 8 Not Just Disease Prevention Approach

Encompass public health and social development approach since HIV in marginalized population goes beyond the public health approaches alone
NACO to collaborate with other ministries to make this happen

GP: 9 Flexibility in service delivery

Cater to differentials and variants
Nature of sex work, Nature of sites
Say no to “one template TI”

GP 10 Sensitive Program Management

Supportive Supervision than just monitoring
Stand by the side of implementer and assist to achieve than give feedback on what is happening
Institutional structures are placed to assist the achievement of goals
Guided by the guiding principle herein articulated

GP 11 Demand creation

Demand driven than supply driven

GP 12 Different and Special Strategies across set of States

Epidemiology
Stage of program
State Capacity
Local Context

Variable region (e.g. North East India)

GP 13 Gender Responsive

RCH Approach

GP 14 Partnership driven

Move from contractor/ contracted relationship to partnership with increased accountability on both sides.

## 2. The main topics of discussion and the Recommendations

The following section captures the essential discussion that took place and the recommendations made for NACP IV.

### 2.1. Representation and Participation in Decision Making

Sex workers should represent and participate in all stages of decision making in line with the guiding principle on ownership. This representation was seen as requirement in all aspects of HIV program and not just restricted to Targeted Interventions. This very process of participation and representation can make a strong NACP IV planning and implementation, it was said. The role of community members in the program was stated to be unclear. They cannot be passive recipients of services. It was felt that NACP IV should articulate their role with clarity. Structures that are currently present at National, State, District and TI level should have community representatives in the Governing Board, Executive Committee etc. The Working Group members pointed out that Participation and Representation are different and that the space for each has to be clearly carved out.

#### Consultation

While appreciating the fact that a few community members could join the working group discussions, the members said that there had to be a wider nationwide consultation and inputs from various settings and regions had to be brought in. This is because of the socio cultural variations across the country and sex work is integral in that socio cultural milieu.

The Indian Network of Sex Workers, a National Collective offered to hold this consultation with support from SACS. This should take into consideration all registered CBOs as well as representation of FSWs from sites where there are no CBO. This will help in feeding into the working group process effectively and will make sure TI will take into consideration the variability in the country.

As per the Guiding Principle on Community Led Processes, the members stressed that communities had to be actively engaged from the conceptualisation through the design, implementation, documentation, monitoring and evaluation of the programme. This calls not only for creation of a mandate but should be built into the National Review Mechanisms to assess if this is actually taking place.

This active engagement by a wide group of community members at the policy level needed capacity building of state and national level organisations and update on a regular basis. The members felt that NACO should set aside resources for these processes on an ongoing basis.

**Recommendations:**

1. **Community representation in all policy making bodies in NACO, SACS and DAPCUs should be institutionalised.**

2. **All processes including monitoring and evaluation, advocacy and capacity building should be re-designed through active engagement and ownership of community groups and organisations**

3. **NACO should make provision to build capacity of state and national level organizations so that community groups can effectively participate and contribute in national programmes, with special reference to policy making arenas. This needs to be clearly articulated in the Capacity Building strategy for FSW.**

2.2. Outreach

**Issue 1: The Effectiveness of the current Outreach model in varied settings**

**Discussion** The existing outreach model was examined from the point of view of peer education, structure of human resources, methods of communication and effectiveness in reaching different hard to reach populations,

There was consensus that on the whole, the peer education model works, but that it may need to be adapted to diverse contexts and settings. There was extensive discussion on the structure of human resources.

Geographical dispersion ( issue of distance needed to be travelled by a peer educator everyday) and geographical concentration ( number of women per site) and such operational issues may require a differential human resource strategy option, the members felt. E.g. the 1:60 peer: sex worker ratio.

Two examples of the peer+ volunteer combination and the social network model, which increased effectiveness. The members noted that since different structures may be required in different contexts and scenarios, flexibility had to be built in, to reorganise human resource combinations at the frontline, even within the given the resource envelope

Dialogue – based communication based on the network model was reported as being extremely effective in building relationships and hence increasing reach and was recommended by some community members. This is going to promote condom use and increase service uptake.

**Issue 2 : Peer education in NACP IV**

**Discussion:** The group discussed in depth what motivated a sex worker to contribute to the well being of the members of her community by becoming a peer. They also emphasised that the relationships between the peer educator and the community members was the key to good outreach and communication that yielded results.

High and unrealistic, externally set targets for clinic visits, testing etc were seen to detract from the relationship building processes. The formats were also found to be cumbersome, time consuming and taking away the time the peer could be motivating community members on health seeking.

In most settings, most peer educators needed to work full time to cover targets and the honorarium was not commensurate with the time they put in. With the raise in the honorarium of other frontline workers, there was the need to put these frontline functionaries at par.

Incentives were discussed, but members felt that performance linked incentives based may lead to coercive practices and superficial interventions . So caution needed to be exercised in introducing this.

**Recommendations**

1. **Peer educator model works and TI should adapt the PE model to suit the local context like geographical dispersion of the FSWs, density and other operational issues.**
2. **Honorarium of the PEs should increased and brought at par with Anganwadi workers and other frontline functionaries.**
3. **Peer outreach programme should be designed in such a way that they get maximum time for quality interaction with the community members. Dialogue based communication should be promoted.**

2.3. STI Management

**Issue 1: The mode of delivery of STI Services**

**Discussion:** The discussion spanned the following areas:

Programme Linked Clinics have been effective in NACP III and should be continued. Private clinics were expensive and not accessible to all while service utilisation at the government hospital was poor because of the negative attitude of the service providers in most places. Gender insensitivity was also a factor.

Community preferred providers was the key to this problem and if this was adhered to, even private clinics worked in some places.

**Issue 2: Difficulties faced in motivating women for regular medical check ups**

**Discussion:** In certain areas members, home based sex workers were reluctant to come frequently for RMCs, go in for speculum examination and presumptive treatment, especially when they were asymptomatic.

Some of these difficulties could be attributed to target driven approaches which prevented building health seeking as a right to be claimed. Targets for both syphilis and HIV testing were high, and the community members had to seek these tests repeatedly. Where the community was given the space to decide on clinic visits, and fully understand the need for speculum examination or regular STI check up, the experience had been positive.

The counsellors were also unable to provide enough time on these issues as the format filling took most their time

Since the provision of general medicines and basic health services at the programme linked clinics had been withdrawn, the interaction with the clinics had been reduced. Earlier, community members would come in or bring their children for basic services like cold, fever, diarrhoea. This built a relationship with the clinic team and led to better health seeking for STIs too.

Withdrawal of partner treatment had left women open to repeat infections

Even as the next generation TIs are put into place, we do not have adequate data on the pattern of STI infections, geographical variations, antibiotic resistance etc on which to plan appropriate STI treatment

The interrupted supply chain led to interruptions in both treatment and health seeking behaviour

**Issue 3 : Difficulty in recruiting and retaining doctors and counsellors**

**Discussion:** In many settings especially urban ones, it was increasingly difficult to recruit and retain the doctors at the current remuneration. This low remuneration led to low priority given to these clinics by the doctors who were irregular or absent causing difficulties to the women and the programme. In some settings, there were no MBBS doctors available.

In TIs with geographically dispersed populations, a single counsellor cannot cover all the clinics regularly. Professionally qualified counsellors are difficult to recruit and retain in the rural settings. Experiences were shared regarding the effectiveness of community members trained as counsellors or health advisors in such settings.

**Recommendations**

1. **Community preferred programme linked STI clinics at the TIs should continue.**
2. **Clinical services for STIs should go back to providing treatment of basic health services and general medicines in order to build an ongoing relationship with the service providers and better utilization of the services.**
3. **Gender sensitisation and capacity building for the medical professionals in private and government settings driven by the Community members is recommended.**
4. **A post training service quality review to be done by the community.**
5. **Clients especially partners of the sex workers should be provided full treatment, simultaneously as part of the " Sex workers and their clients approach"**
6. **Periodic epidemiological studies should be implemented to generate evidence on STI pattern, geographical variation, antibiotic resistance patterns, changing STI profile and STI strategies for the FSWs and clients should be designed based on the evidence generated.**
7. **Remuneration for doctors attending clinics should be increased.**
8. **The ANM position at the STI clinic has been removed in the revised TI model, but should be put back. ANMs trained on syndromic case management, should provide STI services in places where there is non-availability of qualified medical professionals.**
9. **One counsellor in rural and dispersed population is not enough. Number of counsellors to be reviewed in different settings.**
10. **Community counsellors should be considered as a standard approach across all TIs.**
11. **When supply chain for drugs is interrupted, TIs should purchase these drugs locally and should be reimbursed.**
12. **Target for syphilis and HIV testing should be reduced and they should be done at the same time**

2.4. Condoms

**Issue 1: Supply of Male Condoms, Female Condoms, Lubricants**

**Discussion:** The supply chain issues were barriers to proper condom use. Shortages in male condoms in many states were reported. The poor maintenance of condom vending machines was also brought up as a factor in poor access. Female Condoms are available as part of the programme only in some states. With greater demand for anal sex, the need for lubricants in FSW TIS were highlighted

**Issue 2: Need for a condom strategy**

**Discussion:** The discussion touched upon the need to have a more comprehensive condom strategy. A better strategy for clients was required. Ashodaya"s study of the level of closeness in the relationship in the sex worker –client/partner vs the likelihood of condom use indicated a differential strategy for different sexual partners. Client PEs, Customer care centre or clients were also discussed .

The evaluation of condom use should also consider this . It should also look at how the condoms brought in by clients are accounted for in assessing demand vs supply.

The link between empowerment and condom use is not adequately understood and the condom strategy is isolated.

**Issue 3: Free Supply vs. Social Marketing of Condoms**

**Discussion:** There was consensus that free condom supply should continue. While social marketing by CBO's could be an option, it should not be mandatory nor linked to peer performance.

**Recommendations**

1. **Free condom Supply to the programme should continue and the female condom should also be made available widely**
2. **Social marketing should not be under pressure nor tied to honorarium. There should be a choice for CBOS whether they want to take up social marketing or not**
3. **Supply chain should be improved**
4. **Condom evaluation methodology should review how to build in data of client supplied condom counts**
5. **Variable strategies for different type of clients should be developed. For brothel settings, customer care centre, working through lovers and positively inclined clients**
6. **TI should look at sex workers and clients as one unit.**
7. **Some operation research and documentation of practices in the area of condom use should be taken up.**

2.5. Enabling Environment

**Issue 1: The Component of Enabling environment, weak in NACPIII**

**Discussion:** The lack of institutional mechanisms to plan institutional mechanism and plan for advocacy with Police, district administration was seen to be a big gap. Sensitization of the police and other officials was intermittent and currently not adequate

With 367 anti-human trafficking cells and training of ICPS being rolled out, the opportunity for Sex worker CBOs to be part of it needed to be planned .

Inter-ministerial dialogue between department of health and home at Govt. of India to be pursued on trafficking issues and with WCD and the Law ministry on ITPA

Dissemination of the Supreme court judgement, that women in sex work has right to life and various govt. schemes needed to be provided to them.

No resources set aside in NACP III so far for building collective voice on advocacy issues. Networking and solidarity building is currently outside the TI

There was extensive discussion on the economic security of positive sex workers and the need for evolving strategies to address this. The importance of Social Security and Social Protection in this context were discussed. Experiences shared by some of the community members illustrated the social protection and negotiating power that these yielded for safe sex negotiation. Co-operative, microcredit, bank , running enterprises to generate additional resources for economic security were some of the examples cited. Other suggestions included cash deposits and health insurance.

**Recommendations**

1. **Enabling environment to be further strengthened in NACP IV at the National, State, District and the TI NGO level.**
2. **Starting from NACO to SACSs, DAPCUs NGOs; the role and responsibility and mechanism for creating enabling environment for community members should be planned and strategized.**
3. **Strategies to reduce violence against sex workers and to change / amend existing legislation should be put in place : example detailed plans on empowerment of sex workers**
4. **Institution mechanisms for community driven police training and sensitisation to be put in place**
5. **Linkage to be developed with all partners and networks involved in the rights of FSWs including ICPS and other groups.**
6. **Community led advocacy work to be supported . NACO should support national and state level networks of sex workers, setting aside adequate resources.**
7. **Legal service provision at TI level should be strengthened with increased budget.**
8. **Anti-trafficking activities through self-regulatory mechanism should be an integral part of FSW TI and it should coordinate with all the committees existing at the district level for the protection of rights of the victims of trafficking. Health insurance for community members should be explored and strategies to be developed for social and economic security of HIV positive FSWs.**

2.6. Monitoring and Evaluation

**Issue : The current approach of Monitoring and Evaluation**

**Discussion:** There was consensus that the Monitoring and Evaluation system needs a larger focus on quality in NACPIV

The discussion hinged around the current structure of the monitoring and evaluation system that made information flow one way and was not brought back to the implementers to assess the effectiveness of the programme. The emphasis on numbers and targets to the exclusion of qualitative data was raised, especially in the indicators measuring effectiveness.

There was widespread dissatisfaction with the excessive number of monitoring indicators and the overloaded formats which the members felt were time-consuming to fill and took away time from the programme. The community members felt that that their involvement was critical in re-designing the monitoring indicators.

There was extensive discussion on how the current monitoring system was hindering the utilization of services. The points brought by the members included intrusion into the lives of women in sex work and invasion of their privacy, breach of confidentiality and insensitivity regarding precarious social situations in which their marginalised status kept them. The issue of line listing was debated by the members as community members felt that the system undermine communities fear and apprehension regarding breach of privacy and confidentiality as a result of which many are avoiding service outlets and not inclined to disclose their sex-worker identity. This will be discussed further in wider community consultation.

The need for participatory evaluation was emphasised and the inclusion of community members in the review/ evaluation teams stressed.

The current induction programmes for building sensitivity of the various programme functionaries was seen to be inadequate A code of conduct for for all NACO, SACS, TSU, NGO, DAPCU and visiting consultants working in TIs ( in the area of data collection, in field visits and in individual interviews or group sessions) was seen to be a critical need.

**Recommendations**

1. **The approach of M & E should focus on effectiveness of the programme**
2. **The indicators should be fewer , sensitive and simple to measure; the process of monitoring should not take precious time away from program implementation**
3. **Qualitative indicators should be introduced in programme monitoring**
4. **Formats need to be simplified and should be relevant**
5. **Privacy and confidentiality of the sex workers should be protected and redressal mechanism for the breach of confidentiality should be in built into the programme**

6. **Maximum care should be taken to protect their rights, while improving the coverage of services**
7. **A community led committee to develop guidelines for the researchers keeping in mind the marginalised and stigmatised social positions of the sex workers.**
8. **A code of conduct of all staff should be developed by NACO with the community members and adhered to by programme functionaries at all levels.**
9. **Client satisfaction survey introduced for all services under NACP IV accessed by the community members. Assessment of performance of counsellors and POs also to include the feedback of the community.**
10. **Regular MIS feedback to the implementing agency will inform the program.**
11. **Report cards for the services in six high prevalence states**

2.7. Capacity Building

**Issue: Current capacity building design not adequate.**

**Discussion:** It was widely felt that the methodology and content of the current capacity building design needs to be revisited. A social development approach to HIV prevention was needed to build the capacity of community members at individual, community and society levels not just in relation to the project.

It was felt that there is enough evidence of the role of community ownership in ensuring quality and coverage. So, community capacity building as a continuous process was needed.

The importance of Social Security and Social Protection discussed earlier being critical ( see enabling environment), it was felt that capacity building support in building some of these social security mechanisms should be part of TIs, Given the marginalised status of positive sex workers not just in the larger community but even within the community of sex work itself, helping the community to develop economic and social security measures was critical.

The community members strongly felt that the capacity building component needs to be driven by their felt needs . The group members expressed that the trainings needed to go beyond classroom teaching and be relevant. The need for decentralisation of PE training was instance, was strongly felt.

STRCs and TSUs –Community members raised their concern about the changing role of TSU which has became more of a monitoring unit rather than providing technical support to programs.In states where there are both STRC and TSU are in operation there is need to develop clarity in role, responsibility and division of work of both these structure and also to look it from the point of cost-effectiveness. As maintaining of

institutional structures require substantive amount of money. A section of community members finds no importance of having both the structures in place. They suggest either to rename TSU as monitoring unit or to merge it with SACS. Community members also felt the necessity to build the capacity of STRC first so that they can play their role effectively as capacity building unit. Members also suggested the role of STRC would be to co-ordinate capacity building program through mobilizing human resources which includes community members with adequate skill and capacity rather than delivering capacity building of their own. This required further discussion during consultations.

Community to Community Learning was discussed at length and it was felt that experience and expertise sharing from Community members of one CBO to another Community faculty for capacity building of community members had worked in many places.

A partnership of Community Faculty or any training institute like STRCs at all levels: in the assessment of training needs, designing and conducting the training was suggested. A community Resource pool concept was also discussed.

**Recommendations**

**1 Community to community capacity building should be adopted pedagogy**

**2 CB should be initiated at multiple levels**

**3 Materials and methods need to be how community of sex workers learn**

2.8. Budget

**Issue 1: Current TI costing and the budget lines**

**Discussion:** There was a discussion about the varying budget of TIs for NGOs and CBOS, and there was a strong view that it should not be different.

The current CBO/ NGO budgets have many areas that need a change (staff structure, shadow leadership, community development). More in depth analysis is needed with implementers from the CBOS.

***Budget for CBO formation and development is currently not available.*** Considering all TIs are to be managed by CBOs by the end of NACP IV, the budget for CBO formation, leadership building needs to be considered. This would be part of the community building process supplementing the TI and should be kept outside the TI. Community representatives need to be part of the budget review

**Recommendations**

1. **An in-depth analysis and review of the Budget of TIs in consultation with the community representatives i**
2. **Review of the need for two different budgets , one for NGO and other for CBO**

3. INCLUSIVE TI

3.1. Client

The Working group discussed the TI model in the context of the changing environment. There was an agreement that there should be an increased focus on clients together with the sex workers. It was proposed that TI for FSWs should be called as TI for FSWs and clients, treating FSW and clients as one unit. The members concluded that the scope should cover clients, regular partners, lovers, babus etc. Some of the activities proposed were regular partners' and lovers' capacity building, involvement as peer educators for the male clients. In brothel settings, customers care centres had been tried out successfully by DMSC and could be replicated.

As there were several individual experiences at TIs of reaching out to clients and regular partners in different contexts, it was concluded that these experiences and good practices should be documented and disseminated. ***Operations research in this could also guide the strategy for the client and regular partners' involvement in the FSW TIs.***

3.2. Young and Hard to Reach sex workers.

There was some discussion on young and hard to reach sex workers and some experiences from different areas were shared, but it was decided to take the discussion into the sex worker consultations for in-depth analysis. However, it was clear that strategies are required to reach the most difficult to reach since they get infected with HIV by far quicker.

3.3. Trafficking and Self Regulatory Board

The issue of underage sex workers was discussed at length, and the group including all the community members had a consensus that they should discourage this and help with rehabilitation support for the minors. Experiences were shared from different parts of India about Self Regulatory Boards. Decision was made that building ***capacity of sex work organisations to handle anti trafficking program should be made and recommendation was made to establish self-regulatory board to combat trafficking as an activity of TI***.

3.4. Care and Support (C&S)

***It was discussed and decided that C&S for FSWs should be an integral part of TI. Stand alone TI that expects same or similar approach in care and support does not work for this population.***

4. Areas that needs more intense deliberation and recommendations
    - Young, New and Hard to reach sex workers
    - Decriminalization of sex work
    - Occupational health paradigm
    - Line listing as in current form
    - Role of TSU and STRC
    - Care and support for FSW as part of TI
    - Community led capacity building
    - Strategy to include regular partners and clients

5. The Current Consultation and its limitations

    5.1. Representativeness

    NACO has tried it best to make the TI discussion rich by making community participation integral to the working group process. However, in a country where diversity is both the asset and the challenge, it is important to recognize that the group was not representative enough. Therefore steps need to be taken so that groups of communities of sex workers participate in the process and come up with recommendations that are critical to those environments.

    5.2. Availability of documents

    While there have been several studies, evaluation and reviews conducted on TI in the past (during NACP III), the group was not provided any information. It was given to understand that the working group may come up with fixed solutions if were given any such inputs and therefore not be creative. However, the practitioners from the ground were able to share anecdotes and others were able to recall analysis which assisted the process of discussing and coming up with meaningful recommendations.

    5.3. Absence of Strategy

    It has to be recorded that NACO did not share any TI strategy with the working groups and therefore there was no FSW strategy shared either. In the void of National Strategy, nested TI strategy or even a FSW strategy, it was difficult for the sub group in coming up with recommendations that could have by far taken into consideration the issues of law and sex work, social protection of sex workers etc.

6. Next Steps
    - Wider Consultation which includes state/regional consultation of community representatives
    - Development of a comprehensive FSW TI Strategy through articulating Vision and Goal of TI in NACP 4