

National AIDS Control Programme

Phase IV

Strategic Approach for Targeted Intervention among Female Sex Workers



Female Sex Workers (FSW)

Introduction

Average HIV prevalence among FSWs in India is ~5%, which is much higher than in the general population (<0.5%). There is great heterogeneity in this prevalence – FSWs in many cities/districts have HIV prevalence exceeding 20% (Mumbai brothel based SWs, Pune, Yevatmal, Krishna, Guntur, Bagalkot etc). Further, the rate of partner change (250-750 per year) is much more than in the general population. Some part of India has a concentrated epidemic with the vast majority of infections occurring between sex workers and their clients. As the national program is entering the fourth phase of implementation, it would continue to place the highest priority for FSW interventions along with other core target group interventions.

Much progress has been made in NACP-III towards saturating coverage with FSWs, and coverage has increased from 22.32% to 78%. Due to an increased infrastructure of HIV testing and STI services, the services accessed by FSWs has increased significantly, with proportionate increase in condom use. HIV prevalence, both among FSWs and among the general population, has decreased significantly during the last decade e.g. new infections have estimated to have halved during the last decade.

Working with marginalized groups facing severe stigma and violence is challenging. Three fundamental beliefs that are critical to the success of this program: first, NACO believes in a right to health based approach to ensure that FSWs' fundamental right to health services to prevent HIV /ADIS and avail related services are not violated. Second, as this group is marginalized and often hidden, that the community is best positioned to understand and address their issues, and hence the community (of FSWs) should play a central role in the program. Third, that unsafe sex practices are driven to a large extent by structural issues such as violence, stigma and economic vulnerability, it is important to address HIV related issues through NACP. Other issues can be addressed through respective programs of Govt of India by means of networking and building linkages with respective institutions and authorities. Attending to these bordering issues will assist in addressing matters of increase condom use and reduction of STI episodes.

While FSW programs have been successful overall, the key issues that this program faces are:

- TIs have been configured for prevention, provision to access care support and treatment is to be further strengthened for FSW interventions.
- The package for a TI is the same across the country, irrespective of the HIV and STI incidence/prevalence in the local context. Further, within a TI, differing individuals have different risk profiles, and programs should focus on those with highest risk.
- There are a few critical cities and districts, where despite interventions running for over a decade, HIV prevalence remains high. It is not known if HIV prevalence is

high because positive women are on ART, or whether HIV incidence remains high. These TIs need close monitoring.

- Guidelines for positive prevention need to be drawn out.
- TIs are designed for units of 400-1500, and hence not for scale, considering that over one million sex workers have to receive services.
- Quality is variable: long standing programs in South India have reached certain standards of quality (though they continue to face challenges in some areas) whereas the programs in the north have been recently started, and hence require focused support on improving quality
- While the aim was to strengthen and empower the community, CBOs failed to achieve the level envisaged at the beginning of NACP-III

To address these issues, the report attempts to address the following critical issues:

- Approaches for effective linkages of care, support and treatment with the TI by strengthening sensitization, awareness and capacity within TI as well as expanding linkages with existing care, support and treatment infrastructure of NACO.
- To follow a Know Your Epidemic, Know Your Response, by defining different TI models for different settings. TI services to be continued as in NACP III.
- Evaluating long standing programs where HIV prevalence continues to be high, with the aim of recommending tailored solutions to reduce HIV in these critical areas
- Defining guidelines for positive prevention, including differential medical norms for sex workers to initiate ART, so that transmission is reduced effectively.
- Considering various models for scale e.g. use of technology, mobile phones, TV, radio etc to reach large numbers of FSWs effectively. To explore the possible channel to reach these hard to reach population of FSWs.
- Defining and measuring norms for quality assurance
- Reasserting community responsibility by ensuring that grass root level FSWs take active role in implementation, monitoring and governing the program.

Strategic approaches for NACP IV: For prevention, treatment, care and support - FSW

Vision:

Empower Female Sex Worker communities who respond to their needs and challenges through a comprehensive programme which builds community institutions and achieves prevention of STI and HIV leading to an improved sexual health. The guiding principles in the context of TI and Applicability in FSW TI:

The next generation of TIs for FSWs will continue to focus on prevention and will strengthen linkages with care, support and treatment for positive FSWs by strengthening the capacity of TIs. It will be community led and owned, using right to health based approach, emphasizing on accountability and transparency to all, pegged on gender equity, dignity, respect and partnership, while building on current epidemiological evidence. The implementation

strategies will be differential and need based. Following are the key guiding principles described in detail.

Guiding principles

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

Evidence demonstrates efficacy of TI.¹

GP 2: Right to Health Based Approach to be followed implicitly and explicitly

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

GP 3: Go beyond TI with prevention and care focus

Prevention services should have effective linkages with 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
Supported by Central and State Structures – NACO, SACS, NTSU, TSU, DAPCU

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 through linkages

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 FSWs need strategic approach for effective reach
Human resource, training and measurements to reflect it

¹Rajesh Kumar's NAP III MTR study that TIs are the "best buy";

Address issues of Migration among sex workers,
Address issues of Sex-Trafficking through linkages and advocacy

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
Collaboration with other ministries is essential

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

TI has to focus on 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.

Priorities

Fundamental priority for NACP IV will be scale up and ensuring quality of interventions, reaching saturation through community institutions, zero positives are linked to care and

support system, zero negatives will remain zero negatives through STI care and condom educations, reduction in violence,. Priorities will be led by:

- Building on things we are doing well
- Dropping things which are not working
- Addressing new challenges and emerging gaps
- Innovating to do things we are doing better

Priorities are organized into four:

- a) Epidemiologic and geographic
- b) Sub-group priorities
- c) Programme priorities
- d) Research priorities

a) Epidemiologic and Geographic:

Differential Approach based on geographies

- Urban – Metro
 - Urban – other Cities
 - Hilly Region
 - Rural and scattered population
- Based on the geographies and typology.
 - Staffing should be different (ratio of peer and ORW, structure)
 - Linkages – Volunteer
 - Salaries
 - Administration cost (rent, maintenance, etc)
 - Community members (where ever possible) should be on full time.

b) Sub-group priorities:

Focus should be on the most vulnerable and those who have difficulties in access to any support system or services. Some of the sub-categories are mentioned below. This will need to be refined in each town/city through local consultations:

- a) Young, new and hard to reach
- b) High volume
- c) Poor and street living sex workers
- d) Female Sex workers using drugs and alcohol
- e) Positive sex workers
- f) Repeat STIs

c) Programme priorities:

Risk reduction package:

- a) Behaviour change interventions

- b) Condoms and lubes – free and social marketing
- c) STI Treatment – Provision and linkages
- d) Regular partners to be accessed through linkages
- e) Linkages to ICTC, ART, PPTCT
- f) Developing care and support as an integral part of prevention in continuum by building in-house TI capacity and linkages

Structural intervention package

- a) Enabling environment and advocacy
- b) Community institution building

Vulnerability reduction package:

- a) Violence and crisis response
- b) Mental health services covered through linkages
- c) De-addiction services covered through linkages
- d) Mobility and migration
- e) Key entitlements access e.g. voter card, ration card, UID etc. accessed through linkages
- f) Micro finance and livelihood options covered through linkages

Institution building package:

- a) Governance
- b) Leadership
- c) Vision building and organisational development
- d) Capacity building in management (financial, programme, technical)
- e) Conflict resolution
- f) Systems for the above

Location / need based packages

- Cross group assessment (FSW-IDU) and reworking local strategies
- FSWs injecting drugs – Syringe and abscess management

Key linkages with programme, policies, institutions/ Ministries/ departments:

- Linkages to SRH, NRHM
- Linkage to TB
- Linkage to Malaria
- Primary and secondary health care services
- Linkages with Ministries -Home, Law, Women and Child Development, Social Justice, Civil supplies etc..with a view to create an enabling environment

Project management:

- Capacity building
- Monitoring & evaluation
- Quality assurance

d) Research priorities:

- Operations research on use of mobile phones to reach out to hard-to-reach sex workers
- Cost effectiveness and cost benefit analysis of each component of TI and institutions meant for delivering requisite services

Approach to services

1. Outreach

✚ The Effectiveness of the current Outreach model in varied settings

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.

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 1:40 to 60 should be the peer: sex worker ratio.

Outreach activity in NACP III contributed a lot to reach FSWs and needs to be continued with more focus. Outreach planning has to be designed to address different operational strategies of sex work prevailing. The present blanket outreach approach may not bring the desired result. Different typologies of sex workers are there to be reached with services which need differential approaches. Changing trend from brothel to streets, lodges, houses etc to be taken into account while developing outreach plan. Outreach strategies for urban based sex workers and rural based sex workers to be planned accordingly.

Role of Out Reach Worker (ORW) and Peer Educator (PE) to be demarcated clearly to avoid overlapping and duplication of duties and ensure better results from outreach activities.

Dialogue – based communication based on the network model was reported as being extremely effective in building relationships and hence increasing reach which will promote condom use and increase service uptake.

The objective of outreach is to ensure 100% HRGs accessing all services and also to identify HRGs not availing services, so as to engage with them with more frequency and different communication and behaviour change communication methods to elicit response in terms of motivating them to avail the services.

Effective use of communication materials during outreach activities to be strengthened and skills to use same is to be ensured. The intention is to ensure that HRGs are treated if they are having STI and protected from acquiring other infections including HIV. The strong and correct outreach and BCC should succeed in convincing HRGs to avail the service. Regarding the formats it should be suggested what modifications are needed.

✚ Peer education

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.

Since PEs are not full time workers, which needs to be cleared to the project, PE's work hours may be for 3-4 hours per day. ORWs have to take responsibility to ensure the quality of outreach. Targets are to be realistic. The formats are 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.

There is a need to motivate a sex worker to be the Peer Educator for her community to contribute for the well being of the members of her community. It is not a fulltime work. The relationship of the peer educator with the community members is the key for good outreach which is to be resulted in service uptake. So the communication skills of the PE and acceptance by the community are critical for an effective outreach. It will be more effective if the project has peer educators from all types of typologies from the project the target. The time or hours required for the peer work to be decided at project level according to the nature of the hotspot or site where she is working.

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.

PEs need to contact and bring the FSWs, in their assigned area, to services to ensure better health seeking behaviour with the support of ORWs and other project staff. Based on hotspot analysis a target can be fixed to PEs so that it will help them to have a systematic outreach and hotspot plan for effective coverage and follow up. TI should adapt the PE model to suit the local context like geographical dispersion of the FSWs, density and other operational issues. The formats for the peer educators to be simplified and should be minimum to capture the required information. PE needs to give more emphasis on quality interaction with FSWs in her contact.

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. Need to consider to increase the honorarium of the PEs.
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. STI Management / Sexual and reproductive Health

✚ The mode of delivery of STI Services

The discussion spanned the following areas:

Programme Linked Clinics have been effective in NACP III and should be continued. During the working group meeting the concern of low service uptake in project based STI clinics was raised and requested WG to give suggestions.

Gender insensitivity was also a factor.

✚ Difficulties faced in motivating women for regular medical check ups

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. It is needed for TIs to be more effective in motivating HRGs in visiting clinics and getting regular STI check-up. 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. In older TIs the focus needs to be on building linkages with services and focused prevention based on evidence in a cost effective manner.

General health care check up for FSWs and children could be provided through project based clinic where ever it is applicable but the cost of medicines has to be borne by them. TI cannot have a budget for purchase of general medicines. In other set ups where SRH services are linked to PPP or referral, general health care to FSWs could be linked to community friendly service providers. TI has to identify community friendly doctors through FSWs and build the linkages. It is also important to develop client friendly clinics by TIs. If the regular clients (lovers/husbands) prefer to come to project based clinics, consultation fee and cost of medicine has to be borne by the client. But the project has to ensure the counselling to the client

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

❏ Difficulty in recruiting and retaining doctors and counsellors

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 in such settings.

SRH service package and protocol for the same will be developed by NACO in consultation with STI division in NACO and other experts. Protocol will talk about RMC, presumptive treatment, partner treatment, counselling on SRH follow up etc.

All the STI clinics in the project including PPP model will have colour coded medicines and proper records for the same to be kept in the respective level.

IPC at outreach level needs to focus on service uptake not just pushing them for testing and RMC. FSWs should fully understand the need for speculum examination or regular STI check up, ICTC testing etc. syphilis and HIV testing could be done at the same time.

Recommendations

1. Community preferred programme linked STI clinics at the TIs should continue. To ensure optimum utilization of project based clinics by FSWs
2. When TIs get matured, concentrated efforts to be there on prevention than generalized intervention.
3. 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. Medicines for general health care to be mobilized through Govt. Health care outlets.
4. Gender sensitisation and capacity building for the medical professionals in private and government settings driven by the Community members is recommended.
5. A post training service quality review to be done by involving the community.
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. ANMs trained on syndromic case management, should provide STI services in places where there is non-availability of qualified medical professionals.

8. One counsellor in rural and dispersed population is not enough. Number of counsellors to be reviewed in different settings.
9. Community counsellors should be considered as a standard approach across all TIs.
10. Target for syphilis and HIV testing should be reduced and they should be done at the same time

3. Condoms Programme

✚ Supply of Male Condoms, Female Condoms, Lubricants

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

✚ Condom programme strategy

Free condom provision for the programme should continue. More focus required to generate demand for condoms. TI level efforts to be taken to open more outlets in all hotspots and feasible locations with SMOs. Work with SMOs for more visibility of condoms. There will not be any sale target for social marketing of condoms at TI level, but the demand for flavoured and 'high quality' condoms to be met through social marketing approach.

Female condom programme at TI level needs to be strengthened. Demand generation with young and home based sex workers, sex workers who have regular clients and lovers to be focused.

More realistic calculation condom requirement to be at TI to ensure adequate stock. At least three months stock should be with all TIs and shortage to be informed condom TSG and SACS focal persons well in advance.

Project to take an effort to estimate the condoms brining by clients. Wastage and misconceptions on condoms to be tracked through proper condom education.

TSG for condom will work closely with TI for developing effective outlets, more visibility and demand generation techniques. CBOs to be encouraged to focus on condom social marketing as it will be a source of income for them.

✚ Free Supply vs. Social Marketing of Condoms

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.

- Female Condoms to be provided free?
- Change the colour of the condoms
- Pack of two for condoms.
- Condom outlets near liquor shops

- Lubricants to be provided along with Condoms. Some of it is due to the increase in heterosexual anal sex. Lubes also for vaginal sex.

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 to avoid stock out of condoms
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. Some operation research and documentation of practices in the area of condom use should be taken up.

4. Enabling environment

The lack of institutional mechanisms to plan for advocacy with policy makers in addition to police, district administration was seen to be a big gap. Sensitization of the police and other officials was intermittent and currently not adequate

Under NACP III efforts are being taken to strengthen the component ‘enabling environment’. It needs further strengthening at national, state, and district and TI level. Systematic plan is to be developed for advocacy with policy makers in addition to police, district administration etc. Sensitization of the police and other officials was intermittent and currently not adequate. Inter Ministerial and inter departmental advocacy is the need of the hour.

Mechanism for creating enabling environment for community members should be planned and strategized at NACO, SACS, district and TI level with specific role and responsibilities at each level. Efficient efforts to be taken to reduce violence against sex workers. SACS level efforts could be taken to include HIV / AIDS related topics in state level police trainings and ensure the participation of trained community members in the trainings as resource persons. Linkages to be developed with all potential service providers, departments, and partners etc to ensure the rights of FSWs to get health care services and other social protection.

Legal protection and crisis management is another area which needs adequate attention. TI level plan has to be developed for crisis prevention. Site wise and hotspot wise systems to be in place to prevent crisis. SACS can facilitate with TIs for establishing linkages with legal support systems in the state and districts like NALSA at national level. Development partners like UNDP can contribute to this.

Community networks can take active role in advocacy and linkages with Ministries/departments/agencies etc. If TI wants to work on “Anti-trafficking activities through self-regulatory mechanism” it is suggested to link with the concerned Ministry/department dealing the same.

Linkages to be developed with respective departments and Ministries to avail various schemes for Social Protection sex workers and their children, including Health insurance, support for education, self employment schemes etc.

5. Community Mobilization

Community mobilization includes building community-led service delivery and building community based organizations (CBO). Creating community norms is important to sustain behaviour change among individuals in any community. Community mobilization in an HIV/AIDS programme context mainly aims for collective actions and also to influence norms within the community for safe behaviour and to address other structural barriers. The community mobilization process should provide opportunity to each and every community member in the project area to participate in collective decision-making on various issues that affect the community, by establishing successful democratic processes. It also should provide an opportunity to everyone to become the selected or elected leader or representative in various organizational / social forums.

Community mobilization approach for HIV prevention entails upholding of the rights and dignity of people who are at most risk and those who are infected and affected by the epidemic. It ensures active participation by the community and provides for partnership and mutual respect between the community and external facilitators. Building capacity of the community to ensure sustainability and building on the realities of living with HIV and AIDS while maintaining hope based on community collective action are essential components of a successful community mobilization approach.

The effectiveness and efficiency of targeted intervention among core population essentially needs to focus on the barriers that hinder active participation of the community members in all possible tiers through creation of spaces where the community members can play their role effectively. One of the major barrier as identified is the lack of “social space” and an adverse milieu where the preventive or promotive services to contain HIV transmission are delivered through TIs. NACP-III hence identified the importance of “creating enabling environment” as an essential component of TIs by promoting CBO formations. Strengthening of the same needs to be undertaken in NACP IV. The implementation of this vision faced certain problems during NACP III. These need to be rectified and community building, demand creation for seeking health services, community ownership need to be focussed on in a grater manner.

NACO has supported states to assess the community ownership in the programme through various tools including separate evaluation tools. Evaluation assessed the TI implementation and CBO governance and administrative system. During the evaluation an important observation made was the lack of role clarity/role conception among CBO members, management with regards to the eleven additional positions, namely, 3 Shadow leaders, 5 Community mobilizers, 1 Community Coordinator and 2 Community Advocates and poor governance system. Efforts need to be made to work on these lacunas and building the community ownership in the programme. Moving into NACP IV needs for us for community to start taking ownership and responsibility for the success of their programmes. Community is to now come forward as active leaders in the programme building on individual strengths, identifying second leadership which would help to make the HIV programme more efficient.

The National Program stresses the importance of community organizing processes, including its incorporation into the TI program. In response to that, in certain geographies, the process of formation of 'communities of sex workers' has taken place. However, many of these have been ineffective. This is because sex workers have been brought together, without organically driven processes. Lack of community capacity and systematic approaches that are internally driven to reduce the imposed vulnerabilities on sex workers have made them unequal partners. Since community systems are weak, the majority of FSWs and their dependents are unable to access social and political entitlements for e.g. ration card, civil right to vote etc. Forming the CBO driven by organic processes gives members the strength to negotiate for their own rights thereby also contributing by a domino effect to better health seeking behaviour in the community.

Key Program Targets to be achieved at the end of NACP IV

- Saturation of coverage against the national estimation
- All sex workers should receive non stigmatized, quality services for Prevention, Care, Support and Treatment that are acceptable to them (100% coverage with the above stated parameters)
- Reduction of violence in sex work setting by 80% from NACP III baseline.
- Community mobilization leading to development of sex worker collectives by end of NACP IV.
- Increase of condom usage to with regular clients to 80% from the base line for NACP III.
- Reduction of HIV prevalence from present 5% to 1% by end of NACP IV.
- 70% of sex workers will be undergoing regular medical check up
- Reaching out of 70% of hard to reach sex workers
- 60% exclusive FSW TIs will be led by community,

Specific Intervention Priorities

1. Increased coverage in the north
2. Improving quality of intervention across all TI
3. Active participation and sharing of responsibility by community in all levels of decision making in TI including governance and representation
4. Building ownership, leadership and accountability of SACS in program development and implementation based on the State's perspectives and needs
5. Strategy to reach out hard to reach, young and trafficked women
6. Addressing trafficking and violence through self-regulatory board with necessary advocacy with WCD and other Govt of India Departments
7. Convergence of prevention, care, support and treatment with linkages and capacity development of TI
8. Development of state and district level community resources for the capacity building of TI staff.

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. Institution mechanisms for community participation in police training and sensitisation to be put in place
4. Linkage to be developed with all partners and networks involved in the rights of FSWs including ICPS and other groups.
5. Community led advocacy work to be supported.
6. Legal service provision at TI level should be strengthened
7. Health insurance for community members should be explored and strategies to be developed for linking social and economic security of HIV positive FSWs.

Other Issues

1. Changes suggested for institutional structures

It was commented that existing structure for monitoring and capacity building is not cost effective neither looking into the community's perspective nor efficacy. So it is suggested that the existing TSUs, SRTCs be re-structured and making it smaller units with the role to coordinate capacity building using a State resource pool of community and non-community technical resources. State and district level resource pool to be developed and attached to STRCs.

2. Best practices on outreach to be compiled and shared to better leverage learnings.
3. Training and attitude of doctors need to be revisited and we should look at how to improve it. Efforts to be taken to develop HRG friendly clinics in govt. Health care.
4. Education should not be criteria for peer selection. Literacy as per census definition could be used. It is important for TIs to be careful in selecting PEs.

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

Sex workers should represent and participate in all stages of decision making and take responsibility also in line with the guiding principle on ownership. This representation was seen as requirement for the improvement of quality of Targeted Interventions. This very process of participation, representation and sharing responsibility can make a strong NACP IV planning and implementation. 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 with responsibility

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.

Key Challenges

■ Client approach

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 regular clients together with the sex workers. In brothel settings, customers care centres had been tried out successfully by DMSC and could be replicated. Efforts need to be taken to identify regular clients and to build linkages for service access. TI capacity needs to be strengthened to reach out regular clients through effective outreach and linking to required services.

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.

■ Coverage

The changing face of the epidemic, ground realities and the gaps in implementation have thrown up many challenges to the HIV response. These lie largely in the areas of Coverage, Service Access, Strategies, Programme structure and Community Mobilization. Expansion of TIs in the Northern states has been a challenge, as the current model requires an NGO or CBO to be available in the district who is interested in and capable of taking on the TI. Where this has not been possible, saturation could not be achieved.

In the Southern states, although there has been good coverage of 70 – 80%, there are gaps due to the nature of sex work that is home-based and anonymous.

In non brothel settings, new sex workers have been difficult to reach, and even more difficult to retain contact, being at the peak of their career and unwilling to work for the honorarium currently offered. Sex workers from this group are extremely busy and also unwilling to take on a peer educator role as it requires many hours of their time filling formats and fulfilling programme responsibilities.

The dispersion/ mobility of sex workers in some locations and the high peer ratio in the current model has made good coverage difficult.

Coverage has also being severely compromised by certain practices that drive sex workers underground rather than bringing them into the fold of services. The drive to increase service access has been translated into practice by fixing targets for testing

Another major challenge has been lack of mechanisms to include the local knowledge DAPCUs and SACS or the ground level expertise of Civil Society and communities. All these have been viewed as implementing bodies or beneficiaries without drawing upon their

practical knowledge and wisdom. This has led to technically sound ideas which either cannot be universally applied or which have other implications.

■ Young and Hard to Reach sex workers.

There was indepth 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. TIs should focus more in new and young FSW to bring them to TI services.

It was also suggested that yearly analysis of the social networks of sex workers will help to identify newer networks as well as the nodes or nodal points of the network. Role of Mobile phones. This will be of special relevance to new/hard to reach sex workers and for follow up. This will allow for segmentation of HRGs to better reach them
Pilot program to test and validate technology and its role.

■ 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. Experience of DMSC was shared 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*. It is to be initiated through advocacy with respective Ministries and departments who is responsible for anti trafficking activities.

■ Care and Support (C&S)

It was recommended that systematic approach for C&S for FSWs should be ensured in TI. Standalone TI that expects same or similar approach in care and support does not work for this population.

While Targeted Intervention was conceived primarily for prevention the discourse of care and support accentuates prevention has been in global discourse for over a decade. The advent of ART led interventions to target the population of sex workers to access counselling and testing and with targets set for the same in the last two years had made thousands of members of the community to be tested in an unprecedented manner. Now it is clear that significant numbers of people with HIV infection among sex workers are accessing testing and therefore referral to ART.

Currently the thinking has changed from Treatment as prevention to Treatment is prevention which leaves community members not have primary access to care (social, psychological and community care) and support through community coming together. This needs to be

addressed in NACP IV and thereby demonstrating that prevention, care continuum will have a high impact on the HIV transmission as well as quality of life of HIV positive sex workers. The Care Support continuum should be adequately addressed with required resources

In the context of identifying good numbers sex workers with HIV, a focused attempt is required at project level to bring them to required services. TI needs to provide psycho-social support to infected FSWs and empower them to ensure better positive living. TI can conduct small gathering of the positive sex workers once in a month, facilitate the interaction with other positive HRGs and health care providers, giving 'higher level' of counseling etc. TI has to take lead to develop linkages with positive networks in the area, ICTCs, ART units, TB clinics, CCC etc for required services.

■ Women in sex work who are IDUs and using alcohol

Special attention needs to be paid to Female Sex Workers who are also persons who inject drugs. This calls for the following.

- Needle Syringe exchange
- Abscess prevention & management
- To create platforms for interactions and coordination between IDU TI and FSW TIs or any other TIs.
- Capacities building of peers and other on IDU and FSW intervention
- Condoms and Needles should be available across TIs

Risk assessment has shown that over 50 percent of women sex workers abusing alcohol show suicidal behavior. Therefore linkages to be established to service providers to address mental health issues and detoxification of sex workers.

Repeat STIs another area to be addressed with effective strategies in NACP IV. Focus needs to be given to FSWs reporting repeatedly with STIs.

Stigma and Discrimination related issues also to be addressed.

✚ Non-availability of NGOs/CBOs

In some area even after JAT and TAC it is still hard to find a NGO/CBO. It can be recommended that the best performing TIs in the state to function in different districts and areas where the JAT and TAC was unable to locate performing TIs.

Operational Issues

1. In NACP II the SACS model was mooted to promote decentralized and independent organization for effective delivery of prevention, care and treatment services. Constituted as a society that has the autonomy and authority to design and implement interventions as part of its mandate, it was envisioned as part of a State Response.

However, over the period most of the SACS has become a sub office of NACO and their authority and responsibility limited thereby limiting their response to address the epidemic in a coherent manner. There is a significant variation regarding the stage of the epidemic,

coverage of sex workers population, technical capacity, and cultural diversity including the sex trade structure and operation SACS in NACP IV need to take more active lead and responsibility in the HIV intervention

State level intervention is to be inline with National programme and this is to be ensured and supported through strengthening and capacity of SACS

2. Service access

Service access has been hampered by several factors. The standardized approach and guidelines that NACP III has for all the states and districts Irrespective of HIV burden impedes effective program implementation. To develop the ownership towards the program, the state should have the flexibility and freedom to decide an effective model at the state level.

Lack of flexibility in implementation guidelines have been a great barrier. These detailed operational guidelines for different aspects of TIs have not been able to adequately address the diversity and heterogeneity of environments, and changing sex trade scenarios. There is a need to develop typology based strategies in NACP IV

Although the peer educator is the mainstay of the targeted intervention programme , the programme has not been able to fully harness her key strengths. The peer educator model is based on the understanding that the relationships between the peer educator and the community members is the key to good outreach and service access. There is a need to strengthen the capacity of the PEs The documentation formats are , time consuming and taking away the time the peer could be motivating community members on health seeking.

The service utilisation at the government hospital has been poor because of the negative attitude of the service providers in most places. Other logistical issues like distance to service area, timings etc have also affected the access. Gender insensitivity has also been a factor.

Motivating women for regular medical check ups has been a challenge. In certain areas members, home based sex workers have been reluctant to come frequently for RMCs, go in for speculum examination and presumptive treatment, especially when they were asymptomatic.

Even as the next generation TIs are put into place, lack of adequate data on the pattern of STI infections, geographical variations, antibiotic resistance etc on which to plan appropriate STI treatment hampers planning and strategising.

The interrupted supply chain has been a serious challenge leading to interruptions in both treatment and health seeking behaviour

In TIs with geographically dispersed populations, a single counsellor could not cover all the clinics regularly. Professionally qualified counsellors have been difficult to recruit and retain in the rural settings. Low service uptake at project based STI clinics is a concern in the view of cost effectiveness. Projects need to ensure the optimum utilization of services in the TIs for the benefit of the community.

A lack of a comprehensive condom strategy has been a challenge. The link between empowerment and condom use has not been not adequately understood and incorporated into planning. Therefore, the condom strategy is isolated. It does not go beyond supply and even demand creation to look at causes.

Restricting prevention to addressing just risk and not vulnerability has posed the challenge of sustainability of change. The lack of social security and social protection mechanisms continue the vulnerabilities that lead to risk. The lack of institutional mechanisms for advocacy with Police and district administration has been a big gap. Sensitization of the police and other officials has been intermittent and currently not adequate. DAPCUs and SACS have expressed a sense of disempowerment and lack of autonomy in being able to devise effective ground level strategies and the programme is very centralised.

Moreover, many sex workers have also felt that under NACP III, TIs for female sex workers focused their service delivery on sex workers at an individual level, ignoring their broader relationships with their families and communities. This seriously undermined the efficiency of the interventions. These welfare related services are to be addressed with advocacy and linkages with respective ministries and departments.

3. NGO led TI to CBO led TI - Transition process

NGO to CBO transition as well as guidelines for CBO run TI have not received adequate attention. While the aspiration to do this transition is clear and mandated as well as output indicators of 50% CBO run TI have been articulated, it has not happened. Transition preparation (while TI is still with the NGO), assistance in transitioning process to be more systematic. Milestones to be place to assess the progress of transition process. It should be a total transition as there should not be any remote control by NGOs after the taking over the project from NGO, CBOs to be supported by SACS, technical support unit and identified community resource persons based on the need.

4. Programme Design

a) Monitoring and Evaluation

There is no internal monitoring mechanisms and analyssi of data in most of the TIs. Focusing mostly on quantitative data excluding qualitative data has led to an incomplete picture on the performance of TIs.

Evaluation processes, lack of sensitivity of evaluators, lack of qualitative assessments and exclusion of community perspectives have led to many achievements and gains of the TIs being missed. There is a need for capacity building of TI staff to use the monitoring formats appropriately. Tools like line listing are to be used upholding sensitivity to needs or community, gender and confidentiality with regards to identification

b) Capacity Building

One of the key challenges in transitioning projects from NGOs to CBOs as envisioned in NACP III has been the inadequacy of the capacity building plan to meet this objective. The

approach to HIV prevention has been just in relation to the project level capacity which when working with marginalised communities has been inadequate.

For example, despite evidence indicating the continued impact of economic vulnerabilities of marginalised populations across regions forcing them to adopt risky and unsafe health practices, social entitlements and livelihood support strategies have not been integrated into the programme strategy. TI can take the facilitating role to link with social protection schemes.

The relevance of the content, the effectiveness of the methodology used and the capacity and perspective of current trainers in STRCs have sometimes impeded the capacity building processes. The exclusion of knowledge assets in the community has been a serious limitation. The continued and iterative development of their technical capacities in programme management to make their participation substantive, meaningful, and effective has been patchy.

5. Community mobilisation

Community Mobilisation which is an important component of Targetted Interventions has lost its original meaning. The major challenge has been the reduction of this component to increasing traffic to TI services. It has lost the original meaning of collectivisation to reverse the process of their social exclusion and marginalisation. Collectivisation as a process that increases self confidence and self worth which in turn creates a motivation for self care has been lost in the current race to mobilise towards an action (like clinic attendance or testing) which is externally driven. This cannot have a long term impact on health seeking behaviour or HIV transmission.

The idea of being mobilised within a framework of health and rights, to develop a sense of ownership over the programmes that are meant for them, and to expand and sustain the changes beyond NACP IV has been lost.

6. Positive Care

With availability of testing and of ARTs, many positive sex workers are coming forward to receive services, but issues of stigma and discrimination in the health services, the community and sometimes even within their own and the within the non-sex work positive community prevent easy access.

Informed consent, confidentiality and breach of privacy by service providers at TIs and other service points of NACP such as ICTC or ART centres they are referred to, has been widely experienced.

The decline of care in the latter part of NACP III and the focus on just provision of ARTs has affected sex workers deeply. In such a marginalised population, care needs assume a great significance. The lifestyle of women in sex work, which includes a high use of tobacco and alcohol, poor diet and often poor living and working conditions, makes the positive among them far more prone to opportunistic infections than other positive women. Lack of family carers is often another issue. Care and support and convalescent care when recovering from

sever opportunistic infections are critical needs. Support for care of their children when they are ill is another critical are that is missing.

7. Line listing or contact register

Some Regional community consultation report, civil society report articulates that line listing should not be continued or to be modified. However, during TWG deliberations, there was a divided opinion. During 2nd TWG meeting, community members held a separate discussion. While many were of the opinion that it should not continue, but many others feel it should be there but with a difference. The suggestion was that it should have only name/ID number, no other personal information and will be used by the PE for her to monitor who among her contacts have gotten services, condoms etc helping in monitoring of the programme. This will not be shared with anybody outside the programme. What was very evident from the discussion was their spirit of accountability to their community as well as their moral responsibility to protect the identity of the sex workers. Hot spot wise data of HRGs is essential in the programme point of to ensure TI services are reaching to all FSWs operating in assigned area. This would help TI project team to have tracking of services and mobility of FSWs. There will not be any question of breaching the privacy as required capacity building will be done at each level.

Monitoring and Evaluation of FSW TI

Keeping at par with the guiding principles of FSW TI in NACP IV, it is suggested that any strategy or activity which is likely to increase the social exclusion of sex workers and/or deny them their rights should not be included under NACP IV. While the NACO aims scale up services to saturate coverage of sex workers at a policy level, such practices at the ground level downsizes the programme. Strategies need to be defined in a way that they achieve the program goal thus making the program more effective. Therefore conferring rights to socially marginalised and epidemiologically vulnerable key populations that ensures availability, accessibility and effective utilisation of all relevant HIV prevention, treatment, care, and support services can have an epidemic impact. In this context M&E assumes special attention. Following are some of the issues that were discussed during the various consultations undertaken by CSO and Multi-stakeholders meeting:

- Community involvement and participation at all stages of M&E is critical and voiced by all. This will ensure maintaining the quality of the program as well as develop ownership of the program. This involves from format designing (simple and to take into consideration the literacy level of the community) to identifying the indicators, deciding the targets, analyzing the data and assisting them to use it for their progress. Therefore, sex workers are not only information provider but true owners of the data.
- Build linkages and visibility in DAPCU. A district level monitoring committee can be formed with the representation of FSWs and quarterly / half yearly review could be conducted on the performance of the TIs that district. This will ensure community representation at decision making bodies. However, there were discussions that this group does not need to be limited to only district representatives but can have sex workers from other districts.
- Formats need to be simplified and community friendly.

- Identify minimum essential indicators which are acceptable to the community and also cater to the needs to program.
- M&E should focus on assessing quality regularly and not only quantity.
- Guidelines to be developed to ensure confidentiality at all levels. 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. Maximum care should be taken to protect their rights, while improving the coverage of services.
- A code of conduct 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.
- Characteristics of the monitoring indicators:
 - Fewer, sensitive and simple to measure
 - Measuring of indicators should not take away a lot of time from implementation
 - Qualitative indicators should be introduced for program monitoring just like there are for CBOs.
- Regular feedback to the implementing agency should be recorded and follow up action to be ensured. Analysis to be undertaken actively at TI level, PM to ensure it.

Indicators for programme assessment

Sr. No.	Area	Indicator	Suggested Target	Frequency of Reporting	Number (For one year period)
1	Physical / Venue-based Outreach	Estimated No. of FSW			
		Denominator	One time	One time	1000
		No. of FSW ever contacted (at least once)		Annual	
		% Regular Contacts (defined as once in every 15 days and received at least 2 essential services in a year)	80%		800
2	STI/Clinical	% who come to TI STI clinic once	100%	Annual	1000
		% who come to STI Clinic Quarterly	35%	Quarterly	350
		% Treated with presumptive treatment for STIs	40%	Annual	400
		% who are screened for Syphilis	100%	Annual	1000
		If TI-run clinic present: % of those who reported unprotected anal , oral and vaginal sex and who consented for internal examination	100%	month	

3	Condom	% of monthly risky sexual acts covered by free peer-delivered condom/lube distribution and through depots	100% of estimated demand as per condom/lube gap analysis		
		% reporting condom use in the last time they had vaginal or anal or oral sex with male partner			
		Consistency of condom use in the past three months	100%	(can be measured in baseline and endline surveys)	
4	Linkages	HIV testing: % tested at ICTC	100%	6 months	1000
		No of registered FSW referred to HIV Testing & Counselling and who know their results		Monthly	
		Total number of persons who are diagnosed HIV-positive (as reported back to TIs)		Quarterly	
		No. of HIV-positive persons referred to and registered at ART centres	100% (of all HIV-positive persons)	Monthly	
		Number and percentage of eligible persons who are on ART	(100% of eligible persons should be on ART)	Quarterly	
		% of persons on ART who receive adherence support	100%	Monthly	
		% of HIV-positive persons referred to DOTS	100% (of all HIV-positive persons)	Monthly	
		% of HIV-positive persons with TB who received treatment for TB and HIV	100%	Quarterly	
5	Enabling Environment	All hot-spots have at least one local community group (formerly 'self-help group') to deal with crisis situations (such as police harassment or violence).			
		Proportion of reported incidents of rights violations or violence addressed within 24 hours	(at least 30-40% of incidents being responded to within 24 hours)	Monthly	

6	Community Mobilization	No. of community groups formed.		Annually	
		No. of FSW reached through community mobilization meetings	20%	Quarterly	200
		No. of meetings/events held for >500 FSW	3	year	500
6	Advocacy	No. of sensitization meetings with police		Quarterly	
		No. of sensitization meetings with govt. healthcare providers		Quarterly	
7	Crisis Intervention	No. of crisis situations dealt with		Monthly	

Keeping at par with the spirit of the community, it is further suggested that the indicators and formats be finalized through a process of community consultation. This document does not capture much about evaluation; however, informal discussions with various experts revealed that a baseline, mid-term and end of project evaluation may a good step forward in addition to the annual sentinel surveillance.

Important Program Targets for FSW Intervention

Ongoing	New/addition/revised	Suggestions
100% registration of KP as against target given to TI		Projects are free to reach out beyond the target given.
100% condom demand to be met through direct outreach	100% of lubes as per requirements to fixed. Polling booth survey once in year	Include clients in the condom usages survey using polling booth method, introduction of Female Condoms and Lubricants in all FSW TIs, Emphasis to encourage condom usages among regular partners/lovers. Realistic calculation for lubes to be done.
100% Clinic access in a quarter	30% of registered KPs is accessing clinic services every month	Alternate visit to govt. facility for RMC, RPR and ICTC visit
100% Syphilis Screening once every six month	100% Syphilis Screening once every six month	More focus on new entrants and STI cases Timely procurement is expected
All detected positive to be linked with		Positive prevention – all positives to be provided condom and STI

ART		services regularly
Increase detection of violence	50% increase in violence detection by the end of 1 st year	
Reduction of Violence at the end	80% reduction of violence by end of 5 th year	

Linkages and convergence

The convergence should be thought on the broader platform which should ensure that HRG gets all possible benefits and entitlements which are awarded by the government. The ministry of women and child development, department of civil supplies, road and transport, education, Health, and other relevant ministries which provides benefits to the HRG should be consulted and approached. All the district (DAPCU if existing) and state authorities (SACS) should be facilitating the convergence from there end.

There are few basic services provided to the HRG in the TI programme there is need for the extending more services to the HRG from the TI programme by fostering string linkages with all other health care facilities. Convergence with general healthcare delivery system will provide HRG with larger basket of services. Some of the areas under where convergence with NRHM and NUHM is highlighted below.

1. Stigma free and client friendly government service delivery facilities:

The TI NGO should enumerate all the health care facilities in their area of intervention. One of the TI functionaries should entrusted to work in close coordination with the staffs of the health care facility for reducing stigma and in making client friendly services. The TI NGO should also ensure the health care providers are sensitized on the HRG related issues so that they are educated on the needs and issues and concern of the of the HRG. In order to get acceptance and larger participation the TI NGO should try to involve in some of the day to day activities of the health care facilities like making proper queue, cleanliness of the premises, distribution of drugs and commodities etc.

2. Provision of Sexual and reproductive health services:

The HRG will continue to receive services for STI/RTI in the same way as they are getting currently in the programme through (static clinic/PPP/government facilities etc) but TI should try to provide at least one Routine Check up visit to the government health facilities in the first year and then increase the frequency of visit to the government health care facilities in subsequent year.

The TI NGO should also look into the other reproductive needs of the HRG like family planning choices, Medical termination of pregnancy (abortion), Pregnancy etc. through the existing health care facilities in the area

NACO and Maternal health division should be coordinate together to provide incentive of Janani Suraksha Yojana (JSY) to the HRG and to the peer educator for referring the HRG for

institutional delivery like ASHA. These initiatives will also help will also help the HRG to avail more services form the government health facilities.

3. TB Services in the TI NGO:

NACO /SACS and Central TB Division (CTD) at the central / State TB division level to coordinate for extending TB services through the TI NGO for HRG. There is high proportion of HIV prevalence in HRG and hence there will be more TB cases among them. The CTD has TI NGO scheme which provides opportunity for the TI NGO to ensure participation in the TB programme. The peer educator can also acts as DOTS providers and gets the incentive of DOTS providers.

The TI NGO should coordinate with the district TB division and engage itself in RNTCP programme and provide screening of TB services to the HRG.

Capacity Building

Multiple levels of capacity building are required for implementing TIs at the state level. This would be in three broad categories:

1. SACS / TSU level

A module on induction training to be developed for SACS/TSU to train, mentor and offer supportive supervision for implementing agencies. Fund managers/monitors and admin staff of SACS will be included in the induction program that will include field exposure visits to sensitise them on field issues and challenges of community interventions.

2. Building capacity among implementing agencies and service/products providers

SRTC, where ever applicable, will be the coordinating body for capacity building of TI staff. NGO/CBO leaders and staff will go through induction training and will receive technical orientation. The training methodology would include visits to learning sites, interaction with the community in the field ,meeting with gate keepers, visits to health care provider settings, condom out lets and interaction with law enforcement personnel. The outreach staff training should be organized in the community setting and can be coordinated by STRC staff. The training will include exercises to bring about attitudinal changes for an effective intervention. Peer educators will be identified and trained by the community experts and staff of the project. Interactive methods will be used to sensitise peer educators on their role as community representatives in the intervention.

Condom demand generation techniques will be trained by TSG condoms and SMO staff in coordination with TI in that area. Community members should be taken as resource persons. The purpose is to sensitise the vendors and include them in our efforts to reach FSWs and their clients and share information on how to stock and sell condoms without stigmatising the consumer.

3. Building capacity among advocacy enabling agencies and individuals

SACS/TSU will play a major role along with the local implementing agency to coordinate and build the capacity of the advocacy agencies (media, law enforcement staff, and legal clinic staff). TSU will initiate the process; continuous sensitisation will be undertaken by the local agency to make it cost effective and efficient capacity building need to co-ordinate training through developing a state level resource pool of community and technical experts as trainers whose working days would be hired. TI can be essentially implemented through NGOs or CBOs. However, if the intervention has yielded good results, and there is tangible evidence of strong community participation, SACS can consider funding CBO and provide technical support to strengthen implementation. The partnership with CBO or NGO is to increase awareness among community to avail services to prevent HIV, encourage participation/ownership process building, enhance local stakeholder coordination, and establish linkages with services for health, social entitlements and advocacy.

SACS could explore the possibility of engaging private providers to offer STD treatment for the community. The doctors to be identified by the community and they can be trained on syndrome management of STD. Reimbursement systems can be worked out for consultation and drugs distribution should established.

DAPCU will ensure linkages are established between the partner implementing agencies and service providers at the district level. In those districts where DAPCUs don't exist TSU POs will take responsibility to facilitate these linkages. However maintaining the linkages will be the role of the implementing NGO/CBO.

4. Community mobilization

A systematic capacity building plan will be developed and implemented to strengthen the quality implementation by CBOs. Capacity building for facilitation of transition of NGO led TI to CBO led TIs will be designed; state and district level resource pool will be developed for the same. Community resource group will be attached to SRTCs as trainers.

Overall Recommendations and Suggestions for NACP IV

Priorities

- Increased coverage in the north, Improving quality of intervention across all TI
- Active participation of community in all levels of decision making in TI including governance and representation with responsibility
- Building ownership, leadership and accountability of SACS in program development and implementation
- Strategy to reach out hard to reach, new, and young sex workers including self-regulatory board
- Convergence of prevention, care, support and treatment through building linkages
- Decentralized capacity building guided by the community and cost effectiveness

- NACO to further strengthen State's leadership, authority and accountability to ensure sustainability of program
- Strengthen community led processes and building of sex workers community both at TI and National level to ensure effectiveness and sustainability of the program
- **Financial implications and sustainability**
 - Cost effectiveness and cost benefit analysis need to be an integral part of NACP IV design
 - Existing high cost elements like multiple structures created at State and National level should be replaced by smaller and effective and community friendly units with minimum high cost benefit ration
- **Linkages**
 - Development of a system at state and district level to ensure proper functioning and effectiveness of linkages with respective stakeholder (NRHM etc)
 - To promote linkage with private sector and to foster a process of partnership building

Summary Recommendations

1. Governance

- Representation
 - National AIDS Control Program has several structures. One of them is the SACS which is the main arm of implementation of the program in the State. The executive body/ governing body of the SACS should include adequate representations of sex worker community members.
 - The other bodies such as DAPCU, NTSU, TSU, STRC have a direct impact on sex workers and therefore it is critical to ensure representation sex worker community members. This would impact the scaling up and improvement of quality of interventions.
- Authority and Accountability
 - In NACP IV, the approach should be to decentralize governance structures which have authority to deliver appropriate services and stand accountable.
- Roles and Responsibility
 - Clarity of roles and responsibility including utility and cost effectiveness of Multiple structures which are in operation at the State Level (SACS, TSU and STRC) should be clarified before institutionalizing in NACP IV.

2. Program Management

- Flexibility in design and management
 - There should be flexibility in program design and management. State should have the onus to develop and advance the TI based on their understanding keeping in view State/Regional variations regarding sex trade structure and functioning and its socio political environment.

- Comprehensiveness
 - The TI in NACP IV to build linkages to include the family and children of FSW in addition to her clients to make it more holistic and with comprehensive service provision.
- Ownership influences quality
 - Community organizing and ownership building initiated in NACP III, should be strengthened further in NACP IV. Capacity development of sex workers should be through community to community transfer of knowledge, skills and capacity.

3. Enabling Environment and Social Exclusion

- Policy to practice
- Programme to build processes so that there is complete replication of policy in practice being sensitive at the same time of the needs, right to health and confidentiality of the community members.
- NACO/ SACS Role
 - The responsibility to create enabling environment should lie with NACO and SACS who need to develop appropriate National and State level strategies in consultation with the sex worker community members in NACP IV. Local level advocacy and linkages to be created by local NGO/CBO. Sex workers networks to contribute in advocacy relate activities.
- Self Regulatory System
 - Self-regulatory board to be part of the TI comprising of community members to help advocate for issues which members need help with like linking and advocating at district level for issues around below 18 yrs of sex workers.

4. Stigma and Discrimination

- At Service Points
 - The community of sex workers suffer from stigma and discrimination in a variety of ways. Critical among them is at the service points. In environments where services are embedded in the TI the service utilizations is significantly high.
- Integrated into Intervention
 - Activities that are able to address stigma and discrimination need to be integral to the intervention and therefore budgeted so that specific contextual stigma reduction activities can be implemented. If due emphasis is not given to this aspect of sex work and sex workers lives, sustainable action by communities will not be possible.

5. Positive Sex Workers

- Prevention, Care, Support and Treatment as part of TI
 - With the increasing number of HIV positive sex workers being identified and are promoted for treatment services, the needs of PLHA sex workers should be addressed. This should be address through building linkages so that it minimises stigma and discrimination. Required capacity building to be done at TI level.
- Critical Key Services
 - To strengthen linkages with ART centres for helping and supporting PLHIV through activities that are budgeted. This could manifest in the form of

community care centres and community drop in centres for positive sex workers. With the emphasis on HIV testing through ICTC referrals, in the last two years, far more sex workers know their HIV status and therefore NACP IV should conceive proper plans to address the specific needs of HIV positive sex workers with linkage initiatives.

Rights Based Approach to Public Health

Rights based approach to any public health system forms the backbone of the programme. It needs to be inculcated in to the programme both at policy making and at implementation level. Globally recognized understanding is that the central problem that is impeding the fight against HIV/AIDS constitutes violation of Human Rights of people through- stigmatization, discrimination and violence. This comes from a common understanding an individual who is living in areas or coming into contact with people and situation that continuously stigmatize, discriminate and threaten them, are less motivated and inclined to seeking testing thereby delaying treatment and hence forth impeding control and prevention of HIV/AIDS control.

NACO inherently upholds in the fight against HIV/AIDS the essential principles of universal access, comprehensiveness and participatory decision making. Thereby ensuring values of universality and equality in access to services. It stands for looking beyond the notion of health as mere search for physical well-being and technical measures focused only on the treatment of individuals. Every individual has the right to access services equally. Fortunately or unfortunately HIV infection is aided by social exclusion whereby marginalised populations are most vulnerable to HIV infection whether through sex or sharing infected syringes. Important to note is people fighting the battle with or of HIV/AIDS are valued citizens, whose life is as important as anyone else's.
