National Targeted Intervention Operational Guidelines

Female Sex Workers

VOLUME 3

NATIONAL CENTRE FOR AIDS AND STI CONTROL
MINISTRY OF HEALTH AND POPULATION
NEPAL
NATIONAL TARGETTED INTERVENTION
OPERATIONAL GUIDELINES

VOLUME 3

FEMALE SEX WORKERS
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<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APO</td>
<td>Assistant Programme Officer</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
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<tr>
<td>CB</td>
<td>Capacity Building</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<tr>
<td>CM</td>
<td>Community Mobilizer</td>
</tr>
<tr>
<td>CMIS</td>
<td>Computerized Management Information System</td>
</tr>
<tr>
<td>CPRS</td>
<td>Crisis Prevention &amp; Response Services</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organizations</td>
</tr>
<tr>
<td>CSS</td>
<td>Community Systems Strengthening</td>
</tr>
<tr>
<td>CUN</td>
<td>Condom Use Negotiations</td>
</tr>
<tr>
<td>DIC</td>
<td>Drop in Centre</td>
</tr>
<tr>
<td>DPHO</td>
<td>District Public Health Office</td>
</tr>
<tr>
<td>EDP</td>
<td>External Development Partner</td>
</tr>
<tr>
<td>En</td>
<td>Number of Sexual Encounter</td>
</tr>
<tr>
<td>FGD</td>
<td>Focused Group Discussions</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FIDU</td>
<td>Female Injecting Drug Users</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Workers</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
</tr>
<tr>
<td>HDR</td>
<td>Human Development Report</td>
</tr>
<tr>
<td>Hep B</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resource</td>
</tr>
<tr>
<td>HRB</td>
<td>High Risk Behaviour</td>
</tr>
<tr>
<td>HSCB</td>
<td>HIV AIDS and STI Control Board</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
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</tr>
<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioural Survey</td>
</tr>
<tr>
<td>ICRW</td>
<td>International Centre for Research on Women</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
</tr>
<tr>
<td>NGO Partner</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>NGO PartnerP</td>
<td>Information Procurement Plan</td>
</tr>
<tr>
<td>KASP</td>
<td>Knowledge Attitude Skill and Practice</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
</tr>
<tr>
<td>MARP</td>
<td>Most at Risk Population</td>
</tr>
<tr>
<td>MPR</td>
<td>Monthly Progress Report</td>
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<tr>
<td>MSM</td>
<td>Men having Sex with Men</td>
</tr>
<tr>
<td>MSW</td>
<td>Male Sex Workers</td>
</tr>
<tr>
<td>N&amp;S</td>
<td>Needle and Syringe</td>
</tr>
<tr>
<td>NA</td>
<td>National Authority</td>
</tr>
<tr>
<td>NACP</td>
<td>National Aids Control Programme</td>
</tr>
<tr>
<td>NCASC</td>
<td>National Centre for AIDS and STD Control</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organisation</td>
</tr>
<tr>
<td>NSEP</td>
<td>Needle and Syringe Exchange Program</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>ORW</td>
<td>Outreach worker</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PAL</td>
<td>Performance, Accountability and Learning</td>
</tr>
<tr>
<td>PE</td>
<td>Peer Educator</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
</tr>
<tr>
<td>PHDP</td>
<td>Positive Health, Dignity &amp; Prevention</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV &amp; AIDS</td>
</tr>
<tr>
<td>PM</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>PO</td>
<td>Programme Officer</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission of HIV and AIDS</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>QAS</td>
<td>Quality Assurance System</td>
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<tr>
<td>QPR</td>
<td>Quarterly Progress Report</td>
</tr>
<tr>
<td>RO</td>
<td>Regional Office</td>
</tr>
<tr>
<td>RSM</td>
<td>Review and Sharing Meeting</td>
</tr>
<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Cooperation</td>
</tr>
<tr>
<td>SCM</td>
<td>Syndromic Case Management</td>
</tr>
<tr>
<td>SE</td>
<td>Social Entitlement</td>
</tr>
<tr>
<td>SI-TWG</td>
<td>Strategic Information Technical Working Group</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SS</td>
<td>Social Security</td>
</tr>
<tr>
<td>SSH</td>
<td>Secondary Stakeholder</td>
</tr>
<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender</td>
</tr>
<tr>
<td>TI</td>
<td>Targeted Intervention</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td>ToT</td>
<td>Training of Trainers</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children`s Fund</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCTC</td>
<td>Volunteering Counselling &amp; Testing Centre</td>
</tr>
<tr>
<td>VDC</td>
<td>Village Development Committee</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</table>
3. STRUCTURE OF TI OPERATIONAL GUIDELINE

VOLUME 1

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VOLUMES 2

Implementation and Scale up

VOLUME 6

Project Management System

PROJECT SET UP
PACKAGES OF SERVICES – FSW
STAFF STRUCTURE
BUDGET

RATIONALE
PRINCIPLES
NATIONAL MANAGEMENT STRUCTURE
NGO SELECTION GUIDELINE

PLANNING
STRATEGIC INFORMATION
HR AND CAPACITY BUILDING
FINANCE AND PROCUREMENT

ANNEXURE: TOOLS AND CHECKLIST
4. GLOSSARY OF TERMS AND DEFINITIONS

4.1 GLOSSARY OF TERMS

1. Most at Risk Population:

Persons, who are at the risk of contracting HIV, due to risk behaviours (unprotected non-regular-partner sex, sharing injecting equipment) that these groups are exposed to or engage in. For the purpose of HIV focused prevention programming in Nepal, four MARPs have been prioritized. These are Female Sex Workers (FSW) and their Clients, Male having Sex with Male (MSM), Injecting Drug Users (IDUs) and Migrants.

2. Targeted Interventions:

Targeted Intervention is a cost effective HIV prevention model for reaching people who are most at risk of HIV infection\(^1\). The program provide prevention services that include information focusing on behavior change (through educative sessions, peer education, counseling etc), treatment services for STIs, Condom services or Needles and Syringe program for IDUs and facilitation of enabling environment. Beyond these traditional components, most of the Targeted Interventions world over are now focusing also on community system strengthening, care and support services through linkages and focus on vulnerability reduction through addressing other needs of MARPs that are indirectly linked to the risk of HIV infection.

3. Harm Reduction:

The emergence of the concept of ‘harm reduction’ in HIV/AIDS prevention programmes began with the promotion of condoms among the sex workers. Since involvement in sex work had inherent risk to HIV, it was important to promote the idea of ‘safe sex’ by ensuring use of condom during every penetrative sexual encounter. Studies have proven the efficacy of condoms as an effective tool to control sexually transmitted infections and HIV. The idea is that even if one cannot provide the perfect solution, at least the damage can be controlled and/or reduced.

The same principle of damage control is applied to the practice of injecting drug use and the risk of HIV. Since drug users often shared needles and syringes whilst injecting, increasing their risk to HIV, giving them clean needles and syringes in exchange for the used ones or putting them on Opioid substitution treatment helps in

\(^1\) [http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf](http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf) (Last accessed on 16 June 2010)
reducing the harm linked to risk of HIV infection due to sharing of needles, untreated abscesses, Hepatitis B and C etc.

Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than primarily on the prevention of drug use itself, and the focus on people who continue to use drugs\(^2\):

4. **Outreach:**

Outreach is one of the key delivery mechanisms within targeted intervention, focused on providing information and services (including BCC) at the convenience of the MARPs – that is reaching out to location where MARPs can be reached and in the timings best suitable for them. Outreach is a process and not a one-time activity. Outreach consists of the following sub-activities - registration, repeat contact, risk assessment and risk reduction inputs through one to one and one to group BCC sessions, Referral for VCT, health care (STI) and to the drop in centre, distribution of condoms and sterile injecting equipments etc.

5. **Risk Assessment:**

Risk assessment is a process of identifying behaviors of MARPs, which are currently risky, or has had a history of such behaviors/habits that contributes towards a risk of acquiring STIs/HIV or transmitting such an infection. This is done with the objective of helping MARPs increase his/her perception of risk and making appropriate behavioural choices.

Risk assessment also includes how consistently a condom is used, alcohol use while at work, involvement in group sex, extent of violence experienced, sharing of needles for injecting drugs and identifying STI symptoms.

6. **Risk Reduction:**

It is a process of decreasing a MARPs risk behaviors from a previous stage of higher/more risks to a stage of lower/reduced risk of contracting HIV infection. It is done using counseling/interpersonal communication/behavior change communication. The intervention is person-centered. Risk reduction can also be accomplished by resetting social or community norms (e.g. “normalizing” condom use, or regular usage of health services). The process of resetting social and/or community norms can occur incidentally, but can also be done through specific outreach and communication strategies.

\(^2\) [http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf](http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf) (last accessed on 8th June 2010)
7. Site and Hot Spots

A site is referred to as an “intervention site” which is a contiguous geographical area demarcated by a definite boundary such as a locality. Each site will be in itself independent geography for planning intervention – particularly for outreach planning. Within a district there could be more than one intervention site depending on number of towns or cities that needs to be covered for reaching out to the MARPs.

Areas within a site where there is significant concentration of HRGs are referred to as “hotspots”. Within hotspots, HRGs may solicit, cruise, and interact with other HRG members or have sex or share injecting equipments and drugs. Therefore there could be many hotspots within a site.

8. Formative Research

When a new intervention is designed, it is important to understand the needs of the community vis-à-vis the intervention objectives. Formative research is carried out before a program is designed or implemented with a focus on understanding the needs of population to be covered through the intervention. Formative research has three stages of action: 1. Mapping location (focusing on identifying risk sites and spots and providing an estimation of MARPs), 2. Situational Assessment (Detailed assessment within the identified risk site on actual intervention needs of the target community) 3. Baseline Study (provides information on status of biological and behavior indicators at the start of the project which will be compared after a period of intervention to assess whether any progress has been achieved through the services provided.)

9. Primary and Secondary Stakeholders

Primary Stakeholder – The Most at Risk Populations (MARPs) – FSW, MSM, IDUs and Migrants.

Secondary Stakeholders – Who are engaged with the project indirectly and have influence (positive or negative) on the project deliverables - but are not beneficiaries of the project (Police, Health Care Providers, Local Leaders etc)

4.2 KEY OPERATIONAL DEFINITIONS IN FSW INTERVENTIONS

This section discusses definitions and typologies of sex work which is central for evolving differential strategies based on their profile, needs and risks.

For the purpose of targeting and filtering a female sex worker is defined “as a woman who engages in consensual sex in return for money or payment in kind”.

Based on the above definition – FSW who will be reached through the targeted intervention will include:
• A girl or a woman who is engaging in a consensual\(^3\) sex. Sexual act include -
  peno-vaginal, anal or oral sex
• Involving transaction of commercial value, either money or anything in kind

It is important to differentiate the following behaviour since the risk of HIV infection is
much lower when compared to the above characteristics:

• Women who indulge in pre or extra marital sex
• Women who once indulged in sex in return for money or kind but currently do
  not practice sex work.

**Client of FSW:** A client is defined as a male who has bought sex from FSW for which
he has paid in money or in kind.

The below section discusses the various type of sex work transaction that occurs in the
context of Nepal. These typologies are **defined based on the place of solicitation of
clients alone and not the place of sexual encounter**. The key typologies that exist
among FSW are as follows:

**Street Based Sex Workers** are those who solicit on streets or in public places such as
bus stops, market junctions, cinema halls, Highways, transport area, parks, places of
worship or any such place of public utility. Street based sex work may entertain the
client in a lodge, brothel, client room or any other place including public places
mentioned above.

**Home Based Sex Workers** are those who operate from their place of residence. Usually
the clients come on their own or through networks of pimps and other fellow sex workers. The emerging practices of solicitation of clients are through mobile phone.

**Lodge Based Sex Workers** are those who operate from the lodge. Here too clients come on their own or through networks of pimps and other fellow sex workers. The lodge manager or any other designated person usually controls the transactions and takes a part of the money for allowing sex workers to use the

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\(^3\) FSW do experience coercion or forced sex. In case where a women is forced into prostitution / sex trade against the will to be considered as victim and needs to be offered appropriate services including sexual and reproductive services.
Entertainment Facilities Based Sex Workers can be further categories as follows:

- **Bar and Restaurant Based sex workers** are those who operate in bars and restaurant. Normally they work as waitress and maintain lively conversation or keep company with the client for the duration of their stay. The client or the female sex worker negotiates and decides on place of encounter which is normally outside the premises.

- **Bhati Based Sex Workers** are those who operate from makeshift tent/sheds erected often on the road side. Normally there would be more than one sex worker operating in such facility. Usually the clients come on their own or through networks of pimps and other fellow sex workers. Clients can buy local liquor from the facility and foods items served are brought from other restaurant. Usually a screen or some other material is used to separate the sitting area from the place of encounter. The Bhati can be owned by a male who takes his share of money. There are also instances where Bhati is owned by a female sex worker who operates the business and offers herself for sex work.

- **Dhaba Based Sex Workers** are those who are based at road side eatery place often used for resting by long distance travelers such as truck drivers. These are normally situated on the side of highway or major transportation hub / bay. The sex workers do not go out to solicit for clients. Usually the clients come on their own or through networks of pimps or through word of mouth.

There are no major instances of brothel based sex work in Nepal.
Female Sex Workers and HIV vulnerability

As per the IBBS findings, the HIV prevalence among FSW was 2.3% in the Terai Highway District. In another study in 2008, HIV prevalence among FSW in Kathmandu was 2.2% and 3% in Pokhara.

As quoted in UNGASS 2010 report, the overall HIV prevalence among FSW between time periods is as follows:

<table>
<thead>
<tr>
<th>MARP</th>
<th>Location</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSW</td>
<td>Kathmandu</td>
<td>2.0</td>
<td>1.4</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pokhara</td>
<td>2.0</td>
<td>2.0</td>
<td>3.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22 Terai Districts</td>
<td>2.0</td>
<td>1.5</td>
<td>2.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

The prevalence levels among FSW are lower compared to IDUs and MSM/MSW. Still there is a need to achieve better coverage and scale among FSW to ensure, the prevalence level, which has shown an increasing trend between 2006 and 2008, needs to be checked. The challenge remains in reaching out to all FSW population in the country. As per the UNGASS Country Report 2010, the coverage is at 41% in 2008, just a marginal increase from 39% in 2006. HIV testing among FSW is quite low but better when compared to other MARPs. In 2008 only 32% and 31% FSW got themselves tested for HIV in Kathmandu and Pokhara region respectively. 61% FSW got to know their HIV status in 22 Terai Highway Districts. According to IBBS 2008, the prevalence among truckers was 1%. This has programme implications as truckers are commonly seen as clients of FSW. Though there is no data to analyse trend, this is a very mobile group, and needs to be addressed to contain the epidemic.

There is an opportunity to contain HIV epidemic among FSW since the prevalence levels are still low. However there are challenges in terms of ‘reaching out to FSW and providing basic prevention services’. It is important to attain a ‘saturated coverage (regular contact & STI care) of FSW to at least 80% in order to contain the epidemic.

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6. SETTING UP A TARGETED INTERVENTION

This section details out key steps to be followed in setting up Targeted Intervention for Female Sex Workers (FSW). The section is more relevant to NGOs/CBOs who are starting a new targeted intervention, while it will still be useful for the existing TIs to use this as guide during preparation of Project Annual Plan (PAP).

This diagram summarizes the key steps and process involved in setting-up TIs. It is to be kept in mind that, though these are independent steps, they can run parallel. (While formative research is initiated, infrastructure and some of the systems could be brought into operation.)

Following paragraphs describe briefly the key project set up steps leading to effective project operations.

**STEP 1: FORMATIVE RESEARCH:*

Formative research will focus on generating information and data about estimates of FSWs, identify key high sex work sites, needs and aspirations, relevant to the intervention, baseline on level of awareness related to HIV, current skills, practices, barriers for service uptake, field level challenges, etc. Formative research will employ the tools such as, Mapping and Needs Assessment. (Details on the tools and process in Volume 6)

**STEP 2: PLANNING PHASE:**

Based on the evidence generated from the formative research, the NGO partner along with FSWs will prepare the implementation plan. The team will evolve key objectives, strategies, process, outputs and outcomes. The plan so evolved will contain clear design and direction for delivery of services, roles of all project staff and inform key stakeholders about the intent of the project.
During the planning phase, Micro Planning tools will be used for - Outreach plan, plan to engage stakeholders, service delivery plan and risk mitigation strategies. (Details on the tools and process in Volume 6)

**STEP 3: SETTING UP INFRASTRUCTURE FOR MANAGEMENT AND SERVICE DELIVERY:**

This is focused on setting-up and operationalizing key infrastructure such as office space and Drop in Centre (DIC) facility including STI clinic, VCTC, condom depot, etc. This section details out the process to be followed:

**Office Set-up:**
The NGO partner may or may not have an existing administrative office in the locality where intervention is being set up. In case the NGO partner does not have an office it is important to locate the office in the project area. Options can be explored whether to co-locate the office within or in and around DIC for better management and optimizing resources. If NGO partner has an existing office in the project area, then it needs to make necessary modification to accommodate additional staff and other requirement of the project.

**Drop In Centre (DIC) Set-up:**
DIC and other service infrastructure is lifeline of any prevention projects often providing ‘safe place’ for FSWs to seek information, treatment, advice and to advocate for their rights and dignity. Such an infrastructure should cater to the needs of the intended group and be responsive to their changing needs.

One DIC should ideally be set up to cater to a population of 500 to 1250 IDUs. This will also be finalized based on the density and distance. DIC should be accessible to a beneficiary within 20 to 30 minutes by road.

<table>
<thead>
<tr>
<th>Drop In Centre</th>
<th>Urban</th>
<th>Town</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 DIC : &gt;700 FSW</td>
<td>1 DIC : &gt;500 -700 FSW</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Branding:** DIC branding strategy needs to be developed. National TI Division will take the initiative to develop the branding strategy for all DIC across the country which will have a common name and logo. This will facilitate access to any of the DIC across the countries for MARPs who are on the move.

The steps for setting up DICs and other service centers are detailed below.
1. **Understanding the needs of the Project Beneficiaries (FSW):** As part of the Needs Assessment, the project will understand from the FSW their need for a DIC. It will explore as to what they expect out of DIC and which is the preferred location and what key services and facility are required to address their sexual health needs as well as injecting behaviour (for FSW IDUs)

2. **Location of DIC:** The NGO partner along with FSW community members will select a location that is best suited for them. On short-listing, the NGO team will initiate efforts to locate a premise. On locating couple of suitable premises, further short-listing will be done and one final building to house DIC will be selected. In all the processes, the community members will be involved. While finalizing the premises, it is important to discuss details with the landlord on the purpose for which the DIC is being set up. The premises should have at least two rooms and a hall that can accommodate around 15 persons at the same time and also at least two toilet facilities.

3. **Creating safe place around DIC:** On finalization of location of DIC, the NGO partner along with community will make visit to neighborhood and meet key leaders in the vicinity to apprise about project activities. These meetings will aim at providing clear and detailed information about the kind of activities planned at DIC and to allay any fear they might have.

4. **DIC Management Committee (DMC):** DMC will be created with the participation of key secondary stakeholders and community members (Local community leaders, police representatives, local NGOs, Prominent personalities in the locality, Project Manager, DIC staff, FSW representatives etc). This committee will meet to review the services within the DIC and discuss issues related to stigma in the locality and ways to ensure participation of the local community. It is suggested for the DIC to meet at least once a month at the start of the project. Once the project has taken off, frequency could be once in three months.

5. **Configuring services of DIC:** Based on primary data and minimum standards set by EDP/NCASC for DIC services, NGO partner along with community members will develop menu of services that DIC will offer. It will also discuss about how to deliver such services and should there be any user free for the same. A minimum package of services that should be made available for HIV prevention is suggested in the box given.

### Minimum Package of Services in DIC:

1. BCC (access to risk reduction information through one to one, one to group, IEC materials)
2. Risk Reduction Counselling
3. STI Treatment
4. Primary Health Care (Minor illness, minor abscess, wounds etc)
6. Entertainment – TV, board games, literature, movies
7. Referral Services for PLHIV care and support
8. Referral to Rahab/Detox/After Care services
6. **Interior and layout planning:** The community members should be involved in the process of planning the interiors and location of services within the DIC.

7. **Demand Generation:** The project will implement a systematic IEC Campaign technique to launch and popularize the DIC and its services among the FSWs.

8. **Staffing and Office hours:** The timing of the DIC will be decided in consultation with FSW representatives and based on findings from the Needs Assessment study. The proposed staff structure of the DIC is shown in staffing section. This will need to be finalized based on DIC requirements of FSWs in the locality. Based on the minimum package of services suggested above, following is the proposed staff structure. This structure is suggested for DICs with catchment population of 500 and above. For smaller number of population, separate counselor may not be required as the number of FSWs catering to is low. In this context, the DIC coordinator should be trained in counseling and should double up as a part time Counselor. *(On staffing structure please refer to staffing section in this document)*

**STEP 4: PROJECT SYSTEM DEVELOPMENT:**

This step focuses on evolving appropriate systems that will standardize understanding of processes and procedures and ensure quality delivery and management of the interventions. Any prevention project that needs to deliver effective processes and high quality outcomes, needs systems. These systems range from simple stock keeping to systems related to financial management, human resource management, systems for monitoring, evaluations and learning, procurement and supply etc. These systems are vital while implementing a project by an Organization there by reducing the scope for confusion and personal interpretation of procedures and policies.

The systems so evolved needs to be comprehensive, simple, operational and easy to communicate. The organization needs to have written, ratified and widely disseminated systems in the following areas:

- **Office Administration**
- **Procurement & Supply Management**
- **Financial Management**
- **Human Resource Management**
- **Monitoring, Evaluation and Learning Systems.**

- **Office Administration:** The systems will address areas such as asset management, logistic support, office supplies, break-down service, rental and maintenance contract management, etc
- **Procurement and Supply Management:** This system will address the procurement process and procedures, authorization, demand assessment, storing, supply management, stock maintenance, etc
• **Financial Management:** This system will outline accounting systems, authorization, controls, financial delegation, approvals, etc.

• **Human Resource Management:** HR systems will detail out process of hiring, interview procedures, approval, performance management, compensation, contracting, benefits, terms of references, exit, etc.

• **Monitoring, Evaluation & Learning Systems:** This system will detail out the monitoring and evaluation framework, reporting formats, data follow, learning systems mechanisms etc.

The above systems will be discussed in greater detail in the section on Project Management.

**STEP 5: RECRUITMENT AND CAPACITY STRENGTHENING:**

Though recruitment is part of project system (HR system), it is discussed here in greater detail, since recruitment and induction are critical elements as part of the set up of a project.

The success of the project depends on the right kind of people selected for the job and also how quickly these positions are filled. The NGO partner will put in place a system for rapid recruitment of project staff. The following steps will be adopted for quick and effective recruitment.

1. **Finalize project structure** and obtain required approval for all positions from the NCASC TI division.

2. **Form project set-up team** comprising of decision makers of the Organization and other specialists. This team will be charged with the responsibilities of recruitment along with setting up the project.

3. **Preparations of TOR:** Based on the guidelines provided for TORs of staff in this document (Staff TOR in the annexure) TORs are finalized with specific qualification and experience descriptions. Once the TOR is ready, advertisement will be prepared for dissemination with specification on the requirement.

4. **Publicize the vacancies both internally and externally.** Recruitment of internal team members has its advantage since the person is familiar with Organizational processes and procedures. If this is not the case, the NGO partner will look for talent from outside the Organization through advertisements using locally appropriate media options.

5. **Recruitment and Appointment:** CVs will be shortlisted and staff will be recruited through a formal process (according to recruitment policies of the NGO). If any staff recruited is blood relatives of the Board or existing employees, this needs to be specifically communicated to NCASC.

6. **Induction:** The newly recruited team will undergo a detailed induction training which will include – Organization background, project design, processes, policies, systems and expected roles. The induction will focus on domain knowledge (HIV, STI, condoms and allied health issues). The induction process will help the newly recruited team to quickly grasp the Organizational goals, project outcomes, their roles, etc thereby enabling them to start their work more confidently.
7. **Handholding and Mentoring:** The newly inducted team over a period of time requires handholding and mentoring on various issues related to field processes, strategies, secondary stakeholder management, etc. The senior team or the project set-up team will have to play a vital and responsive role to allay their difficulties and to install a sense of security and confidence. This will go a long way in contributing to improved performance of the project staff and better project outcomes.

Please refer to Project Management Section – for more details on Capacity Building and Human Resource Management.

**STEP 6: PROJECT LAUNCH:**

This step focuses on introducing project and key activities to primary and secondary stakeholders. During this step the project will concentrate on creating enabling environment by orienting and engaging key primary and secondary stakeholders and at the same time launching the project. Key activities will involve Entry Point Programmes, Advocacy, Linkages and Networking.

This section is more applicable for those NGO partners who are being contracted newly and starting new project. However the existing projects has ample scope to implement these during the beginning of following project year.

The focus of this section is to guide NGOs on how to launch the project involving primary and secondary stakeholders.

1. **Preparing Ground:**
   - Setting context and Planning with primary stake holders. Involve the FSWs in the planning process
   - Orientation and sensitization of secondary stake holders: NGO Partner will identify key stakeholders who have potential to influence the outcomes and who need to be informed about the proposed project.

2. **Launch:**
   - Below are some of the practices that can be adopted based on the local realities:
     - Launch the project around a theme. Some examples of themes are:
       - Stigma Reduction,
       - I am for Change,
       - I know my responsibilities what about you, etc
     - The themes should run for at least a week’s time so that it can reach out to substantial number of FSWs.
3. Prepare for exigencies:

- NGO partner needs to scan the environment to identify possible challenges they could face from primary and secondary stakeholders. On identification of the problems, the partner will have to put in place a mitigation strategy. It is also important to keep the senior management in standby mode to address any such untoward incidents.

- NGO partner will have to take special care of media. It is important to provide information to media when asked for. If not responded, the media may try to get information from other sources which may be wrong and counterproductive to the project. On carrying the wrong report, the project may face more challenges and damages. Hence NGOs needs to be ready with Press Note during any event that gets implemented during the course of project period.

The diagram below summarizes the key steps, key focus and components of programme set-up phase.
**Key Steps**

**Formative Research**
- To understand the situations, risks, vulnerabilities, key players, risks, existing policies, programmes and more importantly the needs and aspirations of MARP.

**Planning**
- To evolve goals, objectives and key outcomes the project aims to achieve by the end of the project.
- To understand the resource requirement including skills and capacities.

**Infrastructure for Management & Service Delivery**
- To set up and operationalize key service infrastructure such as project office, drop-in centers, condom depots, etc.

**Systems**
- To evolve appropriate systems and procedures for standardization and clarity in operations.

**Recruitment & Capacity Strengthening**
- To attract best talents and skills; recruit team members; build/strengthen capacities on core issues, core deliverables including induction.

**Launch**
- To introduce the project appropriately to key stakeholders and to create an environment for its effective operations.

**Key Focus**

**1. Mapping**
- 2. Needs Assessment

**Components**

**1. Micro Planning**
- a) Outreach Plan
- b) Stakeholder Engagement Plan
- c) Service Delivery Plan
- d) Risk Mitigation strategies

**1. Office Set-up**
- 2. Drop-in centres set-up
- 3. Condom Depots

**1. Office Administration**
- 2. Procurement & Supply Management
- 3. Financial Management
- 4. Human Resource Management
- 5. Monitoring, Evaluation & Learning Systems

**1. Capacity building Needs Assessment**

**1. Entry Point Programmes**
- 2. Advocacy
- 3. Linkages & Networking
7. PROGRAM COMPONENTS

This section details out minimum package of services that will be offered by NGO Partners under TI project for FSWs. The minimum package of services is categorized further into Risk Reduction Programmes and Vulnerability Reduction Programmes.

The risk reduction programme focuses on behaviors and internal factors that influence the capacities and abilities of FSW to protect her from HIV infection. It therefore works towards enhancing knowledge about HIV & other STIs transmission, information about available services, knowledge and skills to use condoms, about positive prevention, care and support services & treatment”.

The vulnerability reduction programme focuses on those factors that are outside the control of FSW. These factors influence the practice of safe sex behavior among FSW. For e.g.: there are situations when a women is fully aware that condoms can protect her from HIV infection but due to high level of violence from client & partners she may fear from using the same thereby contributing to heightened exposure to the infection. The issues of violence, lack of legal support, lack of financial aid, or inaccessible to social entitlement schemes to name few, will make her position weak there by making her more susceptible for exploitation and leave her with no options for negotiation from point of strength.

Thus vulnerability reduction programme focuses on providing services related to protection from violence, providing legal aid to address violation of rights & provide linkages to financial services besides programmes such as anti-trafficking, working with children of female sex workers, etc.

This document also suggests optional package of services that can constitute anything that furthers the positive health and improves quality of lives of FSW. The concerned Projects can use their discretions whether to include it or not. The below chart summarizes the minimum package of services offered to FSWs:

<table>
<thead>
<tr>
<th>Risk Reduction</th>
<th>Delivery Mechanism</th>
<th>Vulnerability Reduction</th>
<th>Delivery Mechanism</th>
<th>Optional Package of Services</th>
<th>Delivery Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. BCC</td>
<td>NGO Partner</td>
<td>a. Crisis Response</td>
<td>NGO Partner</td>
<td>a. Anti Trafficking Programme</td>
<td>NGO Partner with referral</td>
</tr>
<tr>
<td>b. STI Treatment and Care</td>
<td></td>
<td>b. Access to social entitlement programmes</td>
<td></td>
<td>b. Income Generation</td>
<td></td>
</tr>
<tr>
<td>c. Condom Programming</td>
<td></td>
<td>c. Stigma and Discrimination reduction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Positive Prevention Including HIV testing &amp; counselling</td>
<td></td>
<td>d. Alcohol De-addiction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The section below discusses the Risk Reduction and Vulnerability Reduction strategies.

### 7.1 PACKAGES OF SERVICE

#### 7.1.1 BEHAVIOUR CHANGE COMMUNICATION (BCC):

Behaviour Change Communication is central strategy for facilitating behavioural change among specific target group on issues of health, safety, livelihood or education. BCC strategy has assumed critical and central role in addressing the HIV transmission dynamics. Over a decade or so this strategy is further strengthened due to various experiments and researches that have shown positive outcome in fighting against HIV infection.

**Behavior change communication (BCC)** is the strategic use of communication to promote positive health outcomes, based on proven theories and models of behavior change. BCC employs a systematic process beginning with formative research and behavior analysis, followed by communication planning, implementation, and monitoring and evaluation. Audiences should be carefully segmented (Different MARP groups and sub typologies), messages and materials are pre-tested, and both mass media and interpersonal channels are used to achieve defined behavioral objectives.\(^6\)

FSW are at the highest risk of contracting HIV through sexual route than any other route of transmission. In this context the BCC will aim at the following key behaviours and focus on bringing about positive change.

<table>
<thead>
<tr>
<th>Current Practices</th>
<th>Desired Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Sex without a condom</td>
<td>Consistent and Correct use of condoms in every sexual act with appropriate lubes</td>
</tr>
<tr>
<td>Anal Sex without a condoms</td>
<td>Consistent and Correct use of condoms in every sexual act with appropriate lubes</td>
</tr>
<tr>
<td>Unsafe Oral Sex</td>
<td>Use of flavored condoms in the act</td>
</tr>
</tbody>
</table>

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\(^6\) Definition borrowed from Centre for Global Health, Communication & Marketing.
<table>
<thead>
<tr>
<th>Sharing Needles / Reusing</th>
<th>Use fresh and sterile needles in every act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Untreated STIs</td>
<td>Recognizes STI symptoms, seeks medical advice from qualified medical practitioners and completes treatment.</td>
</tr>
</tbody>
</table>

The frontline team members – Peer Educators and Outreach Workers (ORW)/Community Mobilizers (CM) will primarily deliver the key messages or provide education for behaviour change. These messages will be delivered through interpersonal communication mostly:

- One to One Communication: Peer Educators or Outreach workers will contact FSW in their place of operation on one to one basis for providing information, services and products.
- One to Group Communication: Peer Educators or Outreach workers will contact more than one FSW at a time for providing information, services and products.

**Delivery Mechanism and Frequency:**

**Peer Education Based:** The education for behaviour change and the entire HIV prevention programme will be Peer Educator based. Peer Educators will be paid volunteers. The key strategy to reaching out to FSWs will be through peers. Hence first point of contact for FSWs will be their own fellow sex workers who have taken up the role of peer educators and will be ably assisted by Out Reach Workers/Community Mobilizers (ORW/CM). The PE along with ORWs/CMs will plan when to reach, whom to reach, purpose, how many times, etc. *(For full details please ref Micro Planning chapter in Set-up Phase)*

**Differential Risk and Differential Messaging:**

Most of the FSW are at risk of contracting HIV if safe sex behaviour is not adopted. However there are few among them who have highest risk of contracting HIV due to their profile such as ‘New Sex Worker’ & ‘Young Sex Worker’.

**New Sex Workers** are those women entered into sex work for the first time in past one month. *(Not new to the place but new to the sex trade)* In normal circumstances these women will have less or no information neither about HIV transmission nor about the ways and means to protect oneself by using condoms correctly. It is also noted that new sex workers are also high in demand among clientele resulting in more number of sexual encounters per day. So, factors such as lack of information about HIV, STI, Condoms and high client volume will result in heightened risk of contracting HIV and STIs.
**Young Sex Workers** are those who are less than the age of 30 years. The client behaviour of seeking young sex workers will raise their demand thereby increasing client volume. The more the client volume more is the risk of HIV infection, given the current safe sex behaviour.

Hence the above two categories of sex workers are at higher risk of contracting HIV than their fellow sex workers. It is important to differentiate risk among FSWs, based on typology and profile. The same needs to be reflected in the outreach planning, STI strategy, condom promotions, vulnerability reduction and in communication strategies.

**Differential Messaging and Community Dialogue:**

The field workers will provide basic information about the following:

- About Self, Organization & Project
- What is HIV? What is AIDS? What is the difference between the two?
- How HIV transmits? How HIV does not transmit?
- What is STI? What are signs & symptoms of STI? STI treatment process and follow-up.
- What are condoms? Different king of condoms? How to use condoms? What kind of lubes can be used with condoms?
- Condom use demonstration & negotiation skills.
- Relationship between substance addiction and HIV? Services available about harm reduction/de-addiction? How to access it?
- How one can know HIV status? Where to get the test done? What happens if one is tested positive for HIV?
- What are the Government schemes on social security? How can one access it?
- What are different services that are available to improve health, livelihood, and income? How to access it?
- What are our rights being citizens of our country? How can we seek justice in case of violation of our rights?

The above list is indicative only; based on the local context and the information needs of individual FSW, the PE and ORWs/CMs needs to plan content for BCC. The above information needs to be delivered in phases. The field staff to ensure that there is no information overload. The field staff may use his or her creativity to deliver the messages by using visual aids, etc.

**Value added messages:** The field workers will plan to deliver messages related to Hepatitis – B, Mental Health and Reproductive health issues. These issues affect the lives of FSW along with HIV and addressing these would add value to the efforts. At the same time the information boredom of listening to only HIV will be addressed and FSW will have something new to look forward when they meet the field staff.
**Addressing boredom and message overload:** One of the key challenges of BCC is that it can get repetitive for FSW who have been with the project for a long time and are aware of most of the issues. The BCC process should not just be information giving systems rather it should facilitate ‘critical thinking’ about lives and livelihood among FSW. For e.g. the education series can discuss the ‘current situation of sex workers and how their quality of life can be improved, or ‘what can be done by sex workers to change the negative perspective about them in larger society’, ‘how can sex workers contribute in reducing trafficking of humans’, etc.

**Regular Contact:**

**Among any FSW:** A visit by PE, ORW/CMs with a definitive purpose of providing information, services & products in the field or in any service centre. The FSW should be met at-least twice in a month.

**New Sex worker & Young Sex Worker:** A visit by PE, ORW/CMs with a definitive purpose of providing information, services & products in the field or in any service centre. The FSWs should be met at-least twice in a month for first one year from the time they got into sex work.

**Quality assessment of project communication including materials developed:**

The intervention will have to put in place a Quality Assurance System (QAS) that will assess field communication by PEs, ORWs/CMs and other communication (flip charts, posters, messages through games, mass media using electronic and print media). Please refer to annexure for field communication checklist and suggested further reading to assess the quality of materials produced.

**Outreach Kit:** Field staff will carry an outreach kit that contains the following but not limited to:

- BCC materials
- Condoms & lubes
- Penis model for condom demonstration
- Referral centers contact details
- Referral slips
- ID Card
- Outreach diary (depending on literacy levels of field staff)
Scope of STI treatment: The Intervention will identify and treat all forms of STIs including syphilis through established norms of Syndromic Case Management. (Refer to National guidelines on case management of sexually transmitted infections, Ministry of Health and Family Welfare, NCASC).

Setting up services and role of community members: The community members will play an important role in setting up the STI services. The concerned NGO Partner will have Focused Group Discussions (FGDs) among various typologies and profile to understand their needs in terms of accessibility, timings, preferred service providers, issues related to confidentiality etc. Based on the findings the NGO partner in consultation with the community will decide on where to locate the STI services. Since most of the STIs services are co-located in DIC, it is important to follow same procedure in identifying location for DIC.

Delivery Mechanism: The NGO Partner will have following options to deliver STI related services. They are,

- **Project Based:** Refers to clinics that are run and managed by the NGO with the help of grant or any other source of fund. The entire medical and Para-medical team is hired by the project who can be on full time or part time basis depending on the traffic to the clinic.
  - Project Static Clinic, will be co-located within the DIC that is near to the majority of sex work sites and ensures comfort and confidentiality.
  - Mobile / Outreach Clinic will cater to the distant and difficult to access sex work site. Here the NGO Partner with a team of essential medical and Para medical team will go to a pre-identified location on a pre determined day and time. The visiting team will ensure they have basic amenities with high priority to issues of confidentiality. The concerned field team on the said day and time will mobilize FSW to seek medical intervention to their problems. The frequency of such clinic will be determined by the field team depending on the demand and the need.

- **Referrals Based:**
  - Referral to Private and Public Service Providers: NGO Partner will identify Private and Government medical care centre that have ability and willingness to provide required STI services. NGO Partner should also make careful assessment about right attitude of clinical team, clinic timings (should be open in mornings, or late evenings), about right kind of facilities, accessibility/distance and willing to comply with confidentiality clause. This identification should be done in consultation with the community taking into account their choice and preference. These centers should be in the sex work sites or close to it.
On identification of such service providers, the NGO team will orient the concerned doctors about SCM and record keeping and also will ensure he or she is able to go through a formal training on SCM.

The field team will be aware of functional referral centre and will have with them full details about the Clinic/Hospital, timings, and address with landmark and referral slips. As and when the field team identifies issues with FSW, they are referred to the referral centers.

Criteria for setting up STI Services: The NGO partner along with NTU will be best judge to ascertain which delivery mechanism is beneficial for FSW. There can be combination of above stated delivery mechanisms within a given project. Any decision so taken should justify the following:

- Accessibility, comfort of FSWs
- Cost Effectiveness
- Quality standards

Frequency of Visit to Clinic by FSW:

- Every FSW will have to visit clinic at least once in a quarter
- Every NSW and YNW will have to visit at least once in a month

Package of services provided:  
- Health promotion and STI prevention activities, such as promoting correct and consistent use of male condoms (and female condoms where available) and water-based lubricants and other safe sexual practices
- Provision of free male condoms (and female condoms if available) and lubricants
- Provision of socially marketed condoms
- Immediate diagnosis and clinical management of STIs
- Health education and counseling for treatment compliance,
- Periodic check-ups, syphilis screening
- Partner management programmes (i.e. contact referral)
- Follow-up services
- Referral links to VCTC, HIV care and support, Hep-B management and other relevant services

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Quality assurance: The NGO Partner once in six months will conduct quick dip-stick analysis on quality of STI services provided. The NGO will do the following:

- Exit interviews of FSWs who have sought STI services form project and referrals clinic
- Conduct mystery client visits to referral centers
- Appropriateness of physical infrastructure and convenience
- Conduct regular orientation to all medical and para medical staffs
- Analyze STI data for repeat STIs cases and relapse cases for improving programming (every month)
Condom & Lube Programming

Condom promotion takes a central stage wherein route of HIV transmission is predominantly sexual. Herein too, condoms are positioned as one of the most potent ways to fight against HIV infection among FSW and other MARPs

Principles and Approach in Condom Programming:

- **Free Distribution:** The condoms will distributed free of cost to the MARPs.

- **Adequate:** Condom distribution will take into account the needs of the community and ensures that the demand is met; at no point in time there will be stock out of condoms at central, state or district warehouses or at NGO Partners ends. A steady flow of condoms through a robust supply chain will be adopted and executed.

- **Appropriate:** The condoms so procured by National Authorities and subsequently distributed will be of appropriate quality, length and width. The condoms will be adequately lubricated and adhere to all quality parameter that is currently in practice.

- **Lubes:** Since there is demand for anal sex by clients of FSW, it is important to provide condoms with extra lubes or to provide separate lubes along with condoms. This will reduce the risk of condom breakage and damage to anal tissues

- **Genderization of condom promotion:** While the major focus will on male condoms, the National Policy will take appropriate steps to ensure that women too have options for protection with adequate availability of ‘female condoms’. This will provide an option for FSW in case of client refusal and during cases of violence/forced sex. The LMD will ensure steady supply of female condoms.

- **Menu of options:** Though the emphasis will be on free distribution of condoms including female condoms, appropriate systems will be evolved to provide variety of condoms (flavored, dotted, ribbed, scented….) through social marketing of condoms. The system of social marketing of condoms is not in lieu of free supply but only an option provided for FSW and clients.
Condom Promotion Matrix:

The sole objective of condom promotion is to ensure steady and appropriate supply of condoms; build demand for condoms by addressing lack of information and skill to use condoms; provide enabling environment in which FSW can negotiate for condom use. Thus condom promotion will encompass components related to Procurement and Distribution (supply side), Demand Generation & Condom usage and quality assurance. This system is applicable to both type of condoms – Free supply and Social Marketed Condoms.

Procurement & Distribution:

**Procurement:** The Logistic Management Division (LMD) will procure condoms from appropriate competent manufactures with specification that is most suited to countries context. The stock so procured will be further procured by DPHO from whom the NGOs will get its supply.

**Stocking:** The LMD, DPHO and NGO partner at any given time will have stock to meet the demand for next 3 months. For e.g. if the national demand for condoms is around 2 million pieces per month, the concerned authority will have at least 6 million pieces of condoms in stock. The same is applicable to all those involved in condom distribution.

**Distribution at the Intervention Site:** Two level of distribution of condoms: Direct Distribution and Indirect Distribution:

8. **Direct Distribution:** Peer educators and Outreach workers will distribute condoms directly to FSW during their planned interactions. These distributions can happen in the field or during FSW visit to DIC/Clinic/VCTC/Care Homes.

9. **Indirect Distribution:** Condoms can be distributed trough supervised or unsupervised condom outlets placed in strategic vantage points that are easily accessible to FSW and their clients round the clock. These outlets can be place with a vendor wherein clients and FSW frequent or can be placed with community members from where other FSW can access the condoms when in need.
Demand Side:

Demand Generation will adopt two pronged strategy; one at micro level facilitated by the NGO team and other at macro level by NCASC through IEC officer.

- **Micro Level**: The concerned NGO team through Inter-personal education session will discuss with FSWs the advantages of using condoms in protecting oneself from HIV infection; address all myths related to condoms and its use; provide information about different kind of condom available; address issues related to quality of free supply and commercially available condoms and address any other barriers to use condoms.

- **Macro Level**: NCASC through IEC officer will run national campaign using print and electronic media to address the issues surrounding condoms. It will also direct law enforcement authorities about the condom programme and not to be an obstacle in its promotion. This is necessary since most of FSW have faced harassment by law enforcement authorities on carrying condoms on them.

- **Skill Building**: The skills building for FSW is required at two levels: One - How to use condoms correctly? Two - How to negotiate for condom use in difficult circumstances and with unwilling client including partners?

  - **How to use condoms correctly?** Correct condom demonstration should be part of every inter-personal interaction with FSW. FSW should be encouraged to do condom re-demo to ascertain that they have appropriate knowledge and skills to use condom correctly. During field monitoring by programme managers and others, encourage FSW to demonstrate their skills on correct condom usage.

  - **How to negotiate for condom use in difficult circumstances and with unwilling client including partners?** Besides providing the above skills, the field staff should train FSW in “Condom Use Negotiations” (CUN). These trainings can be done in one to one and one to group interaction. For e.g. the field team can adopt role play method, case study discussion and just sharing success stories by fellow sex workers. It is important that the field team is well trained on these aspects so that transference of the same will be effective.

**Demand Assessment**: The demand for condoms among FSW can be assessed in the following way.

\[
\text{Demand} = \text{Number of Female Sex Worker (FSW)} \times \text{Average Number of Sexual Encounter per Day (SW)} \times \text{Average No of sex work day per month} - \text{condoms}
\]
brought by clients and minus condoms purchased by FSW. The below table illustrates the formula for reference.

**Demand Assessment Matrix for free supply:**

<table>
<thead>
<tr>
<th>Formula</th>
<th>D</th>
<th>N</th>
<th>En</th>
<th>Ds</th>
<th>CbyC</th>
<th>CP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand for free condoms</td>
<td>D</td>
<td>Number of female sex worker in the project area</td>
<td>Average number of sexual encounter per day</td>
<td>Average number of sex work days in a month</td>
<td>Number of condoms brought by clients</td>
<td>No of condoms purchased by FSWs</td>
</tr>
<tr>
<td>e.g.</td>
<td>171085</td>
<td>851</td>
<td>8</td>
<td>27</td>
<td>6% (11029)</td>
<td>20% FSW 10 per month (1702)</td>
</tr>
</tbody>
</table>

The NGO team will have to do this calculation in each sex work site and then consolidate at the project level to get the overall demand for condoms. Such calculation needs to be done in the beginning of the project and once every six months.

Following needs to be taken care while arriving at condom needs:

- The client volume differs from typology to typology, hence typology wise sexual encounters and number of day of sex work per month needs to be determined separately.
- Based on typology the client profile also varies and this influences condom uptake i.e. some client profiles carry their own condoms; hence this needs to be assessed separately for each typology of sex work. The same is also true for FSW purchasing condoms. An operational research study can be executed to assess the actual status of these indicators.
- Also it is important to top up the total condom requirement (based on calculation) by 10-20% keeping in mind that there will some wastage of condoms and some will be used for demonstration.
- CbyC and CP columns needs to be filled once in a years based on the findings of rapid assessments.

**Quality and Usage:**

**Quality Assessment:** The NGO team will regularly carry out checks on the stock received for breakage of package, expiry date and lubrication. Designated person will also carry out inspection of condom outlets for its appropriateness (location, away from direct sun, protection from wind, out of reach of children), privacy and IEC materials popularizing the outlet.

**Condom Usage Assessment:** The project team will carry out a field study to assess condom usage among FSW at least once in a quarter. This study will provide appropriate representation to the typology the project is working with. The study along with current practice will also assess barriers for condoms uses, their changing...
preferences for condoms, condom breakage and reasons for the same. Based on the findings the team will revise condom promotion strategy and share with their reporting Organization.

Social Marketing of Condoms (SMC)

Depending on the demand and the local realities, NGO will initiate social marketing of condoms. For the purpose of facilitating an understanding among the NGOs, the below section details out four key steps in setting up SMC. This section is borrowed from USAID’s Nepal Social Marketing and Franchising Project and modified to suite the context.

This framework is called the 4Ps approach and follows:

**Needs Assessments or Diagnostic Study:** Use primary and/or secondary data to understand the needs and requirement of MARPs. Also look for current condom buying ability and behaviour, key players in the market, brand preference, etc. This will help in configuring SMC as per the needs of MARPs.

**P-1: Define and identify “Product”:** NGOs based on the data generated will zero in on a product or slew of products that will address their current needs and gaps. The product so identified must meet the quality standards and should be culturally acceptable to MARPs.

**P-2: Define” Place” or ”People”:** The initiative will identify typology of MARPs who prefer variety of condoms and lubes. It is not likely that every typology among MARPs would prefer to buy condoms. It is also important to identify sex work sites where condoms can be located and is easy to access as and when needed.

**P-3: Define “Affordable Price”.** The condoms and lubes so offered needs to be affordable and enable the most poorest of MARPs to buy it if preferred. The pricing should not put anybody at disadvantage. The price should be commensurate to the value offered.

**P-4: Determine ways to inform about or ”Promote” the products:** Inter personal communication (one to one, one to group and one to mass) are a great way to promote the condoms. The condoms can also be promoted during community events or any other opportunities where MARPs congregate.

**Output and Outcome Monitoring:** Project team through a robust monitoring framework will monitor the demand and supply of condoms. It will assess the changing needs and preference of condoms and lubes among MARPs from time to time. This framework should also assess the condom usage, condom breakage and barriers which will feed into re-strategizing SMC.
Interventions with intimate/regular partners of sex workers

The client and partners of FSW play a vital role in HIV transmission dynamics. While it is important to work with FSW it is also strategic to have intervention with regular partners of FSW and if possible with larger clientele. However the cost of intervention with clients of FSW is prohibitive. Hence prioritizing and filtering is important to reach the most at risk among client/sexual partners. They are

- Trucking community (Driver & Helper)
- Partners of FSW

The trucking community plays a vital role in HIV transmission. The factors that influences truckers for sexual transactions, long stay away from home/spouse, existence of robust sex work network along the highway, boredom of the work, need for relaxation and entertainment, etc.

The partner of FSW (husband or a male who is co-habiting) also influences the epidemic transmission. Quite often the condom use between husband and FSW and Partner and FSW is low, leading to STI and HIV transmission. While it is a challenge to work with husbands of FSW due to issues of confidentiality/identify being revealed, it is less difficult to work with partners of FSW since in most cases the partner would be aware of her profession.

Given this scenario the FSW projects will work with trucking community and partners of FSW. The following are the minimum package of services to be offered.

<table>
<thead>
<tr>
<th>Minimum Package of Services</th>
<th>Trucking Community (Driver &amp; Helper)</th>
<th>Partners of FSW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BCC</strong></td>
<td>- Information about HIV transmission</td>
<td>- Information about HIV transmission</td>
</tr>
<tr>
<td></td>
<td>- Information and skills to recognize STI symptoms</td>
<td>- Information and skills to recognize STI symptoms</td>
</tr>
<tr>
<td></td>
<td>- Knowledge on protection including condom use</td>
<td>- Knowledge on protection including condom use</td>
</tr>
<tr>
<td></td>
<td>- Improve risk perception</td>
<td>- Improve risk perception</td>
</tr>
<tr>
<td><strong>STI</strong></td>
<td>- Provide treatment for STIs</td>
<td>- Provide treatment for STIs</td>
</tr>
<tr>
<td><strong>Condoms</strong></td>
<td>- Condoms distribution</td>
<td>- Condom negotiations skills</td>
</tr>
<tr>
<td></td>
<td>- Skills in using condoms</td>
<td>- Condom distribution</td>
</tr>
<tr>
<td></td>
<td>- Address barriers for condom use</td>
<td>- Skills in using condoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Address any other barriers for condom use</td>
</tr>
</tbody>
</table>
Counselling

- Risk reduction,
- Motivating for HIV testing
- Partner treatment and notification
- Partner notification in case of STIs or HIV infection
- Dealing with violence
- Motivating for HIV testing

Delivery Mechanism:

A FSW Intervention will offer services to truckers (drivers & helpers) only if the highway is passing through the project area or in case of presence of sizable trucking community in the project area. If none of the above is true the NGO partner need not have an intervention with the truckers.

The project will offer services to partners of FSW and will be responsible for outputs as stated in the above matrix.

Voluntary HIV / AIDS Counseling and Testing - VCT

HIV testing and counselling will be part of prevention package offered to FSW. This service will improve the effectiveness of HIV prevention. Some of the strategic advantages are:

- Early detection leading to initiation of Positive Health, Dignity and Prevention programmes which includes ART support, Care services and other supports.
- Early detection will help project to facilitate intense behaviour change programme among those FSW who are tested positive.

Key Outputs:

- NGO Partner will ensure FSW are tested for HIV status one in every six months.
- All such tested will be done by professional and certified HIV testing centers.
- All FSW who are being tested for HIV will undergo pre and post test and all other norms that is stated in National HIV Testing Guidelines

To increase Accessibility and Acceptability VCT services should be:

- Welcoming and friendly environment,
- Privacy and confidentiality are respected
- Hours of operation are conducive for target population
- Waiting time and delays are minimized
- Test results are provided immediately
- Blood collection is made less painful and invasive (e.g., finger-stick blood).
- Counseling provided for specific groups,
- Services are offered in non traditional settings (i.e. community or outreach settings)
- Services tailored for vulnerable groups.

Source: National Guidelines for VCT, 2007

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**Delivery Mechanism:**

- Project Linked Voluntary HIV / AIDS Counselling Centre (VCT).
- Referrals to Government VCT

**Project Linked ICTC:** A project working with over 1000 FSW can apply for VCT centers which can be located in such a manner that it caters to the testing of general population along with FSWs. This will ensure that there is adequate client flow to the centers and there is meaningful return on investment.

If there is functional VCT centre in the project area, then the NGO Partner will have to mobilize FSW for testing to that centre.

**Referrals to Government VCT:** NGO Partner will identify VCT in and around the project area. Based on the feedback from FSWs such centre will be made part of the referral network. A sensitization programme will be conducted with the VCT team about issues surrounding FSWs, the need for confidentiality of highest standard and stigma free service.

NGO Partner will also print referral slips to tract the flow of FSWs and to generate data for monitoring and planning.

**Flow Chart for Testing:**

![HIV Counselling & Testing Flow Chart](image)

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Counseling in VCT: 10

HIV/AIDS counselling / education is a confidential dialogue between Client (herein FSW and or FSW partner) and a counsellor aimed at providing information on HIV / AIDS, to jointly assess the risk behaviour, identify problem together and to assist client in taking appropriate decision regarding HIV testing.

The purpose of counseling in VCT is to: 11

1. Ensure an understanding of HIV transmission and the risks
2. Ensure an understanding of the benefits and risks of HIV testing
3. Facilitate a decision whether to undergo an HIV test
4. Ensure that HIV positive persons have access to prevention, care, support and treatment
5. Ensure that HIV negative persons have access to the means of prevention and to remain HIV negative

Steps in HIV Counselling

- Pre Test Counselling
  - Basic Information on HIV / AIDS
  - Risk assessment
  - Prepare the client for outcome of HIV test results

- Post Test Counselling
  - Help cope client with the test results
  - If Positive: Implication of the test, behaviour modification, life after being HIV positive, information about services available, linkages & networking
  - If Negative: Reiterates information about HIV transmission, behaviour modification and motivates to come back again for testing (can be negative due to window period...)

- Follow-up Counselling
  - Reemphasis on adoption of safe sexual behaviour
  - Help cope with any mental stress
  - Establish linkages with referral networks, ART centers, access to nutrition supplements, referrals to positive networks, etc

Strategies for Improving demand for HIV Counselling & Testing:

The NGO Partner will put in place a robust demand generation mechanism that ensure adequate number of FSW are motivated to seek HIV testing and counselling services. The following steps needs to be followed but not limited to:

**Understand the barriers for low/no service uptake:** NGO Partner will hold community consultation to understand the barriers in accessing VCT services. It will explore the dimension of distance of testing centre from sex work sites, timings of the centers, waiting time, confidentiality issues, time taken to deliver the report, attitude of service providers, etc. This process will be repeated one every year. Based on the findings further planning and tweaking of strategies should be done by NGO Partner.

**Build community motivators and catalysts:** NGO Partner will identify community leaders who can influence the behaviour of fellow FSW. The identified community leaders will be trained on messaging and about the importance of HIV testing. The community leaders will be encouraged to get themselves tested for HIV. The identified motivators will be encouraged to speak about their experiences with fellow sex workers (herein the results will be not shared) and in turn motivate them to know their HIV status.

**Configure Service to communities time and convenience:** The HIV testing centre will make efforts to suite the requirement of FSW in terms of hour of operations (total hours of operations), time of operations (early morning, late evening…), waiting time, time taken to deliver reports, etc. While all requirement may not be taken care but efforts needs to be made towards configuring services as per the needs of the community.

**Community feedback:** Once in a quarter community feedback will be solicited to understand the responsiveness, comprehensiveness, adequacy and other aspects. This process can be done through focused group discussion or through informal feedback mechanisms.

**Life after being Positive – Positive life:** The project will provide comprehensive information about life after being HIV positive. It is vital for FSWs and other to understand that life does not end after being HIV positive. In most cases this understanding is key barrier for HIV testing since they feel what the point in getting tested… NGO Partner will have to make efforts to identify HIV positive speakers to speak about life after being HIV positive. This may motivate few to come forward to for HIV testing and will provide confidence to those who are already positive.
Services for FSW IDUs.

As per the IBBS 2009, 9.8% of FSW respondents reported to have tried some type of drug at least once. The study does not specifically states what type of drugs and mode of consumption. The field experiences of IDU projects & anecdotal references states that many of female IDUs are involved in sex work to finance their drug purchase.

The heightened vulnerability of FSW to HIV infection due to intoxication is an established fact beyond any doubt. Given this, the NGO partner will plan and implement programmes to address the needs of FSW IDUs.

Package of services to be offered to FSW IDUs:

In addition to the services offered to FSWs, following services will be offered to FSW IDUs.

<table>
<thead>
<tr>
<th>Additional package of services for FSW IDUs</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle and Syringe Exchange Programme</td>
<td>Provide clean and sterile injecting devices (needles and syringes) thereby reducing harm from needle sharing and reusing of injecting devices.</td>
</tr>
<tr>
<td>BCC</td>
<td>Additionally, the focus will be on creating awareness about NSEP, about ill-effects of needle sharing and reusing it.</td>
</tr>
<tr>
<td>Counselling</td>
<td>Risk assessment related to injecting behaviour, risk reduction (safe practices), linkages and follow-up</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>Identification &amp; treatment of abscesses, wounds, drug overdose, pain management, vein collapse, etc</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Focus on re-integration of drug user into mainstream society with adequate socio-economic skills, provide skills for gainful employment.</td>
</tr>
</tbody>
</table>

Please refer to Guidelines for IDU intervention for more details.

Following are steps to set-up and integrate programme for FSW IDUs:

Identification: The project will identify FSWs who are IDUs through risk assessment process carried during field visits. The project can draw upon the experience of other NGOs who have experience of working with IDUs to identify FSW who are IDUs.

Capacity Building: The capacities of FSW project team needs to be strengthened to deliver services related to IDUs. For this, specific capacity strengthening plan to be developed and executed. Herein experiences of IDU project can be drawn from time to time.
**Service Configuration:** Based on the magnitude of the problem the services can be configured within the existing project service delivery. The DIC can start NSEP, primary care and counselling. The BCC content needs to be tweaked to suite the requirement of FSW IDUs. Alternative the project can link FSW IDUs to the projects that works on similar issues. Care needs to be taken to ensure issues of distance, time taken to travel, cost of reach, etc. The project will have to take decision on service delivery based on the convenience to the community.

**Referrals Services:** The project will develop appropriate referral services to cater to the needs of FSW IDUs. Any services that cannot be offered to the FSW IDUs or the distance is an issues the project will identity players to can fill the gap. The project will have to develop referrals for rehabilitation, primary care, advanced psycho-social counselling, oral substitute therapy, etc.
Positive Health, Dignity and Prevention (PHDP) is a more comprehensive term used to address the needs of People Living with HIV (PLHIV). PHDP does not myopically look only at prevention or physical needs of PLHIV but rather looks at “overall health and well being, dignity and respect of individuals including prevention”.

Why PHDP: PHDP is more a need than an exception, since world over there is a recognition of the role PLHIV can play in furthering their own health and well being along with contributing to HIV prevention efforts. The network of positive groups have played a pivotal role in carving policies and programme that contribute to overall wellbeing and towards reducing impact of HIV infections.

FSW who test positive can make a difference to the epidemic prevalence levels. It can be achieved by providing them holistic health care, empowering them to have control over their lives and livelihood and by enabling them to practice safe sex behaviour with their clients.

PHDP programme to be effective needs to incorporate and enshrine in its approaches the following principles:

**Community Participation:** FSW PLHIV will have key role in conceptualizing, designing and implementing including monitoring of programme along with experts from the field. PLHIV will have definitive stake in key decision making platforms. Special focus needs to be given to those FSW who are HIV positive and their needs to be taken in account.

**Rights and Dignity Oriented:** FSW PLHIV to be treated as equal stakeholders than being treated as beneficiaries. The programme will focus on ensuring rights as enshrined in the law of the land; the programme will uphold basic human rights and individual dignity.

**Shared Responsibilities:** PLHIV will be responsible for their own health and well being including prevention of HIV, with appropriate support from stakeholders. The PLHIV will not solely be responsible for HIV prevention; it is also the responsibility of others to modify their behaviour appropriately.

**Universal Access:** Appropriate policies and programmes will be implemented so as to provide universal access to HIV prevention, treatment, care & support.

**Diversity in strategies:** The needs of FSWs PLHIV vary from location to each location and typologies; hence the programme so formulated will be responsive to the diverse needs and accordingly tailor made.
What are the basic services offered under PHDP?

The services can be categorized under following headings:

Under **Access to critical health promotion & care services** following services need to be provided:

- Anti-Retro Viral Therapy; treatment adherence, travel support & counseling
- Health Education for maintaining overall health and well being.
- Counseling services to promote positive mental health and other issues
- Preventing disease progression and further infections/prophylaxis for tuberculosis (TB) and opportunistic infections (OIs)
- Palliative care
- Nutrition support through provisions supplementary nutrition diet
- Health Insurance trough Private Public Partnership. (Optional; EDPs can explore on line with "India Star Insurance for PLHIV model")

**Sexual & Reproductive Health and Rights services include:**

- Providing basic sexual and reproductive health information, access to reproductive services such as medical termination of pregnancy, etc.
- Maternal and Child care related information for positive women (FSW) who are pregnant or have delivered; motivation for institutional delivery, education about breast feeding, etc
- Family planning services to positive couples (FSW and her husband / partners) to remain sero-discordant
- Prevention and treatment of sexually transmitted infections(STIs), including hepatitis B and C
- Sexual health education including providing information about low risk behaviour, use of condoms and regular health check-ups
Prevention Services includes

- Education about transmission dynamics includes how HIV does not transmit
- Prevention from Parent to Child Transmission
- Harm Reduction programme for FSW IDUs

Livelihood Promotion Services: On being diagnosed for HIV, in most cases, it impacts their earning opportunities and impacts on the size of earnings. Given this scenario, NGO Partner should provide linkages to CBOs/NGOs/other Institutions for alternative and diversified livelihood programmes. EDPs to dialogue and work together at national level on livelihood programmes/schemes for MARPs.

Vulnerability Reduction services consists of

- Providing services related to reduction in stigma and discrimination. Stigma reduction includes both self and external stigma. At the same time services will have to aim at enhancing self-esteem and self–worth.
- Crisis Response / Violence Redressal: PHDP programme should include systems for addressing and reducing violence among PLHIV. Please read annexure for more details on how to set-up systems for addressing violence
- Legal Aid Services: PLHIV faces issues related to property disputes/rights, denial of right to work, etc. The programme will put in place an appropriate system through network of private lawyers to extend legal aid services.
- Access to Social Entitlements: The NGO Partner will provide information about existing social security and entitlement schemes and facilitate access to same based on the eligibility criteria’s.
- Working with Children of FSW PLHIVs: The NGO Partner will develop appropriate linkages and networking with NGOs/CBOs and other Institution to extend health, education and recreational services.

Mobilization & Collectivization of communities for results:

- Provide appropriate Organizational Development services to PLHIV Institutions to strengthen systems, process and procedures including governance mechanisms.
- Leadership development with accountability among key FSW PLHIV
- Build advocacy and campaign skills among group of FSW PLHIV for highlighting their issues and the needs
- Strengthen FSW PLHIV on issues surrounding project management that includes basics of identification of problem, basics of planning, designing small programmes, etc
Delivery Mechanism:

Where there is a strong PLHIV network with adequate experiences of managing projects, the NGO Partner should link with the network and allow it to take the lead in delivery of services. In the absence of such a network, the implementing lead NGOs should take the lead in providing above mentioned services.

The NGO Partner will over a period of time build and strengthen PLHIV Networks for programme transition after careful assessment of its capacities to manage and deliver results.

In both the delivery mechanism referral and linkages with other Organization is critical since all above stated services cannot be provided by NGO Partner or the PLHIV Networks alone.
The Need:

Violence and harassment is an everyday experience of the sex workers. The FSWs face innumerable hardship at the hands of their immediate family members, neighbors, fellow sex workers, pimps/brokers, goons, law enforcement authorities and others. Most FSW face the violence in the form of physical, psychological and sexual violence including, blackmail, arrest on false charges and commercial exploitation.

Any form of violence and harassment of FSW will negatively impact the HIV prevention efforts. Violence and harassment will weaken the position of FSW to negotiate form the point of strength. Most often, they are in no position to practice learnt safe sex behaviour, be it condom use, regular visit to clinic to get their STIs treated or to seek legal support for the injustice they experience.

The experience of violence will leave a deep scar further affecting her self-esteem and self-worth. It is seen world over when violence increases most of the FSW go underground / become inaccessible. This will lead to denial of key HIV prevention services including access to condoms thereby affecting the ability to protect oneself form HIV infection. The level of trust among FSW diminishes if the NGO Partner is not addressing violence but just providing HIV prevention services.

Given the above scenario all HIV prevention project will extend “Crisis Prevention & Response Services”. (CPRS)

Objective of Crisis Prevention and Response Services:

- To build and strengthen capacities of FSW to protect from all forms of violence; and improve her ability to seek justice.
- To develop and implement a community response systems that address all forms of violence;
  - Also provide appropriate medical and psychological aid, legal support and any other services that alleviate the conditions of the victim.
- To sensitize key stakeholders about issues surrounding violence and its impact on the HIV prevention and exhort their role in creating enabling environment.

Setting up CPRS:

- **Site Assessment**: A thorough site assessment to be done to determine the extent of violence and key players who contribute to the situation. The study should be part of the SNA process. The study also should determine the kind of profile of sex work and typology of sex work that is most affected. The trends in violence such as normal time of the violence (day or night), what time of the month, place of violence, etc. This exercise should also identify sex work sites
that are more prone to violence and which requires special attention from the CPRS team.

- **Recruitment of Team:** Willing and able team to be recruited from among the community and supported by non-community members. It is important to state in clear terms the risk involved working for CPRS and the incentives. It is vital to have additional personnel’s recruited to deal with sudden drop-out so that operations do not get affected.

- **Capacity Building and Strengthening:** The CPRS team will be oriented about the needs, objectives and process of prevention and response. It will be adequately trained on legal aspects, first aid; will know where to refer in cases of emergencies, etc. Such trainings will be conducted at least once in a quarter or as per the need.

- **Demand Generation:** The CPRS team along with larger project team will put in place a system to popularize the CPR Services. It will use one to one, one to group and one to mass communication techniques to herald about existence of such services. NGO Partners can also use ‘Chain Card’ with has key information about ‘help lines’; important phone numbers, emergency services, etc. These cards can be given to FSW who in turn are requested to pass it on to their contacts. NGO Partner can have information campaign, events around CPRS and to use any other platforms such World AIDS Day, National Condom Day, International Candlelight Memorial, etc.

- **Help lines:** The CPRS will have at least one helpline number listed out in vantage points or through appropriate communication materials (for e.g. chain card). The helpline will be functional 24/7.

- **24/7:** CPRS services will be 24/7. Any cases that are reported irrespective of time and day, the CPRS team will have to respond. It is important to take adequate precautions in dealing with difficult cases. The team to use its discretion as to what resources to be taken along to deal with such cases effectively.

- **Legal Aid:** CPRS team will provide legal aid to victims through expert lawyers based on the needs and intensity of violence and more importantly what the victim decides to do. These lawyers can be hired on ‘retainer ship basis’ and can be called in as and when needed. All support so extended should be in line with local laws and policies. No legal aid will be provided in cases that ‘threaten national security or in contravention with prevailing local/international laws.

- **Referral Services:** Women needing short stay facility (overnight) or for few months will be referred to NGOs that offer such services. Periodic reviews and follow-up will be done by NGO partners along the referral NGOs for further plan of action.
• **Creating Enabling Environment:** CPRS team along with key staffs of TI project will identify key stakeholders who could influence the situation positively. They will be oriented about the project and the role they can play in order to reduce the violence and harassment meted out to FSWs. Such trainings and orientations/sensitization will be conducted at least once in a quarter.

• **Monitoring & Reporting:** All cases reported and all cases responded will be documented in the prescribed format. The report will be shared with concerned programme team. The report will be further analyzed to advocate with policy makers and other key stakeholders.

  o Quality Assurance: 10% of cases responded will be randomly selected for assessment in a quarter. This assessment will cover response time, ability to respond appropriately, team’s communication skills, adequate and appropriate knowledge, attitudes, etc.

  The coordinator will also conduct one to one interview (in-person or over the phone) with victims/those who availed CPRS. 5% of monthly cases will be randomly selected for the assessment.

**Composition of team:** *(For a denominator of 1000 FSW)* – Additional team will be viable in the case of a metro project. In smaller projects, this should be planned within the existing structure.

  • Rapid response team consisting of three persons with primary role of addressing cases in the field.

  • One Crisis Response Coordinator with key role of providing leadership, directions and implement advocacy efforts with key stakeholders beside monitoring and reporting.
Process of Response:

All cases reported but not responded and all cases reported and responded, will be documented as per the format (annex) These formats will be filled by the person who handles the case and will be approved by the coordinator. These documents will need to be preserved & filed systematically. With data generated the NGO Partners will be able to launch an effective advocacy with stakeholder. A monthly summary report will be prepared by Coordinator. (Please refer annexure for details)
Access to social entitlement programmes.

The Need:
Access to social entitlement/social security (SE/SS) programme play a vital role in improving quality of lives of FSWs and indirectly help in winning their confidence on the project. These programme often provide additional support like free medical care for key illness, scholarship to children for pursing primary and higher education, travel allowances etc. Providing such access to schemes will reduce the stress on FSWs to earn more there by providing her much needed ‘fall back’ strategy. In the absence of such provisions, FSW will be under compulsion to earn more by servicing more clients increasing their vulnerability to HIV. Thus providing access and facilitating consumption of SE / SS will reduce FSW vulnerability and strengthen her position to negotiate for safer sex and improved quality of life.

Process:
NGO will make a catalogue of SE / SS programme available with details such as who is eligible, procedure to apply, supporting documents, whom to approach, number of days for realization of schemes, riders, etc. This catalogue will be updated once in six months since programme tends to change and new programme gets added. In summary the scope of SE/SS will be dependent on the schemes available at that point in time by Government Agencies and other CSOs.

Implementing SE / SC: The following are the steps leading to demand generation and realization.

- The PEs and ORWs/CMs will generate list of FSWs who need SE / SC services based on pre determined criteria and inter-personal discussions with FSWs.
- PE and ORWs/CMs will make field visit to provide education about SE / SS using catalogue and other aids.
- Prepare FSW to keep all supporting documents ready; facilitate filling in applications; submitting individually or in groups to appropriate authorities. It is important to ensure FSWs gets an acknowledgement for further follow-up.
- CMs / ORWs will help FSW to make regular follow-up to know the status and to exert pressure for speedy realization.
- NGO can also form group of FSWs who have applied for such schemes; train them to further claim their entitlement through peaceful advocacy.
- NGO team will sensitize the concerned Government agencies and CSOs about FSW issues and the need to access SE / SS schemes.
- NGO will regularly monitor the output and outcomes for further planning and strategizing.
Addressing Stigma among FSWs & FSWs PLHIV

The Context:

The deep rooted negative understanding among majority, regarding sex, sexuality, sex work, caste, race, etc have changed their perspective about people associated with it. This differentiation has contributed in denying them basic right to live with dignity. More so the HIV epidemic has changed the way things are viewed and has changed social cohesion and support structure. This change has led to HIV infected and affected being left with little or no support or social net to fall back.

The above stated scenario is very general in nature and can affect anybody. However given the context of FSWs the situation can be even worse. Firstly, as discussed earlier in the document, women are generally in lower power structure being controlled by many influencers in her life and there are enough anecdotal evidence and studies to prove this. FSWs are often accused of disturbing the social fabric, responsible for broken marriages, HIV infections and also accused of trafficking. While some of these may be true of a few, larger society applies these understanding to all FSWs. This has led to further alienation from mainstream society often denying access to life saving services. Thirdly, when a FSW is infected with HIV she is dismissed summarily and further stigmatized and discriminated. In most cases the families of FSW and FSW PLHIV have to face rejection, harassment and denial of services. This will make FSWs and FSW PLHIV even more vulnerable for further exploitation.

The key reason for stigmatizing is often:

- Lack of awareness, ignorance about the epidemic including transmission dynamics.
- Morality: “PLHIV are sinners, FSW are promiscuous”, etc.

The Effects:

The triple stigma FSW face has led to weakening of HIV prevention efforts in the following ways:

- Inaccessible to TIs to provide education and referral services.
- Low service uptake - STI, OI, & VCT etc
- Voluntary disclosure of HIV status
- Prevents people from caring for people living with HIV and AIDS.
- Prevents community from collectivization
- Preventing affected communities form seeking justice

References: UNDERSTANDING AND CHALLENGING HIV STIGMA: TOOLKIT FOR ACTION, ICRW
In the above context most FSWs face self-stigma and External or Enacted Stigma or Discrimination.

Key Response:

The following are some of the key steps that NGO Partners will implement to set-up stigma reduction programme.

- **Context Assessment:** The NGO will conduct context analysis to assess the extent of stigma and discrimination; who is being stigmatized the most? Who are the perpetuators? What are the other factors contributing to stigma and discrimination of FSWs?

  There are two ways to do this context analysis; one to integrate stigma related queries during the initial site assessment; two, to conduct independent assessment if site assessment is already done. The study needs to be repeated once in a year and should feed into the annual project planning.

- **Strategic Planning:** NGO partner will develop a plan of action that is result based in which key outcomes are evolved and have a system to monitor the same. The plan will also discuss challenges and possible solutions to overcome the same. The project will involve FSWs, FSW PLHIV during the planning, execution and monitoring phases.

- **Capacity Strengthening:** NGO will plan and implement a systematic capacity strengthening plan based on needs assessment. Such plan will cover the following but not restricted to, 'how to identify stigma in community settings, organizational and at individual level, how to confront positively, key campaign techniques, stigma audits skills & counseling,

- **Execution of Plan:** Project partner will prioritize key outcomes and key sex work sites that have experienced maximum incidents of stigma and discrimination. It will then spread its works across the project area. While this is one approach, the NGO may use its discretion to have blanket coverage at one go.

- **Sensitization and psychological intervention with FSWs, FSW PLHIV & Secondary Stakeholders:**
  - **FSW & FSW PLHIV:** It is important to address the issues of self-stigma among the primary group for improving self-esteem and self-worth. This will be done through NGO PartnerC, campaigns & counselling.
  - **Secondary Stakeholders:** Firstly the NGO will identify stakeholders (including media) who are stigmatizing and those who have ability to positively influence the situation. Will develop separate curriculum to orient and to sensitize them on the issues surrounding FSWs and FSWs PLHIV.
The sensitization and orientation can be done through one to one intervention or through formal trainings.

- **Monitoring:** NGO as part of its regular monitoring will look for signs of change at Individual, Group and Institutional level. It will assess performance against each indicator and will analyze possible reasons for low or high performances. The findings will again be fed into planning.

  The systems will monitor key outputs monthly, while outcome indicators will be measured once in six months. Once in a quarter qualitative reports will be submitted by project team.

  NGO will involve FSWs in the monitoring and assessment of Stigma & discrimination.

- **Linkages to CPRP:** The Crisis Prevention and Response Programme will consider stigma as one of the forms of violence and will respond to cases that are reported. Appropriate actions will be initiated including scope for legal course of action.

- **Stigma Audit:** A system needs to be established to audit environment for any stigmatizing behaviours/statement/ from among media, influential leaders & religious institutions. At the same time to analyze public policies, & programmes for stigmatizing approaches. If found appropriate campaigns and advocacy programmes to be implemented.

  NGO will also audit BCC materials, capacity strengthening modules, manuals & field staff communication for stigmatizing statements. It will also audit service infrastructure such as DIC, STI, Care and Support services, etc for stigma free process and systems.

- **Campaigns:** Creative campaign techniques are good bet to highlight the issues of Stigma among policy influencers and others. Some examples of campaigns could be, Signature Campaigns, Shake Hand Campaigns, Bike Campaigns, to identify a celebrity as ambassador, etc.
**Alcohol De-Addiction**

This section details out the need, key strategies and process of integrating alcohol de-addiction services among FSW.

**Introduction:** Many studies have shown a relationship between alcohol consumption and HIV infection. One study conducted in Uganda during 1994-2002 finds that consuming alcohol prior to sexual intercourse increases the risk of acquiring HIV by 67% for men and by 40% for women. The study also finds that if both partners consume alcohol, the risk increases by 58% for men and by 81% for women[^13].

Though not all FSWs are alcohol addicts but certain typologies are more vulnerable to alcohol consumption. Empirical evidence concludes that alcohol consumption and alcohol addiction is common among FSWs due to the nature of work they are involved in.

Alcohol addiction among FSWs increases vulnerability to HIV infection in the following ways.

- While intoxicated FSW will have little control over condom use. Given her condition, she may lose her capacity to negotiate for condom use with the client.
- The client can “fake” condom use while FSWs are unable to ascertain the fact due to inebriated condition.
- Increase incidence of violence among alcohol addicted FSW by clients and other.
- Reduced social support resulting in deteriorated fall back systems at time of need resulting in further vulnerability.

Hence it is vital for NGO partner to address the issues of alcohol addiction including any other substance abuse that FSW is addicted to.

The below section details out the key objectives, steps and process of setting up and integrating alcohol de-addiction among FSW in particular and among other MARPs in general.

**Key Objectives:**

The de-addiction programme will have following objectives. (NGO partner has flexibility to add to the below stated objectives)

- To establish alcohol de-addiction model for FSW that is robust, responsive, effective and affordable.
- To improve functionality of FSW related to social, economical, cultural including functionality at workplace and personal space.
- To create an enabling environment that is conducive for FSWs to seek and follow through alcohol de-addiction services.

**Key Steps:**

**Needs Assessment:** NGO partner will conduct needs assessment (*integrate the enquiry/info needs in the main needs assessment of the project. If already done, then have a separate one*) to understand the extent of alcohol addiction among FSWs, which typology or characteristic are more vulnerable for addiction, what are the current barriers for treatment, willingness for treatment, available services in the project areas or elsewhere, etc. This information will form the basis of further planning and execution.

**Identification & Filtering:** NGO partner, based on the needs assessment will develop a checklist that will help in identifying FSW who are in needs of de-addiction services. Even among them (keeping in mind the paucity of funds) further filtering to be done to prioritize service provisions. The criteria for such further filtration can be:

- Young sex worker
- New sex worker
- FSW with high client volume
- Potential to be leader (revered and respected by community and can play a role in alleviation of sex work situation)
- FSW who are Board Members of Sex Workers CBOs.
- FSW who have potential to play a role in Implementation.

**Capacity Strengthening:** Project team through formal and informal platform will need to acquire updated knowledge, skills, attitude and practices about alcohol de-addiction. It will have to train field staffs to identify FSW who are addicted to alcohol not those who consume alcohol but not addicted. NGO will have to develop appropriate BCC strategy including messaging and materials that will be used to provide info.
**Service Set-up:** Alcohol de-addiction services can be offered within DIC services or through referrals. This is dependent on existence of such expertise internally or existence of such services in the vicinity of the Project area/Town/District. Appropriate decision to be taken in consultation with the community and concerned EDPs.

**Demand Generation:** An elaborate plan of action will be put in place to popularize the services. One to one, one to group, one to mass communication techniques will be employed to deliver information and also use counselling services to gain acceptance and to convince the needy to undergo treatment.

**Monitoring:** Key indicators will be continuously monitored to know the efficiency and effectiveness of the programme. Such data will be used to re-strategize and to tweak project design.

**Key Strategies:**

**Address the key drivers:** There could be multiple drivers for alcohol addiction among FSW. While it may be not be possible to address all such drivers, it is important to address those on which NGO have control over and can make a difference.

**Networking & Partnership:** NGO will identify key players who can offer quality alcohol de-addiction services to FSW at affordable cost. It will get into a Memorandum of Understanding (MOU) to provide such services. This will address the issues related to internal capacities and needs to create additional infrastructure.

**Comprehensive & Affordable:** The de-addiction services will adopt comprehensive approach in which medical, psychological, spiritual, life skills, etc. service will be made available and affordable.

**Support Group & Counselling Services:** Support group is a great way to address craving, re-lapse, to instil confidence, provide tips to overcome fear, etc. NGO will adopt this method to build social net around those who are on the road to recovery and integration. The NGO will also enlist support of expert counsellor to address emotional and psychological issues FSW may have.

**De-stigmatizing & Integration:** The Intervention will address the stigma attached to alcohol addicted FSW by way of creating enabling environment around her, both at work and at personal space (where ever possible). The Intervention will also help her to get integrated back with referrals to jobs (depending on her skills and demand for such skills)
Staff Structure

This section details out the staffing structure for HIV Prevention Project – FSW. The basis for arriving at a staffing structure involved many key aspects such as Peer Ratio, Outreach Workers Ratio, Geographical Coverage, Density and Spread of FSWs, etc. The below table details out the same.

<table>
<thead>
<tr>
<th>Position</th>
<th>Geography/Location</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer Educators (PE)</td>
<td>Urban</td>
<td>1PE: 35-40 FSW</td>
</tr>
<tr>
<td></td>
<td>Highway &amp; Rural</td>
<td>1 PE: 25-30 FSW</td>
</tr>
<tr>
<td>Community Mobilizers (CM)</td>
<td>Urban</td>
<td>1 CM: 120 FSW</td>
</tr>
<tr>
<td></td>
<td>Highway &amp; Rural</td>
<td>1 CM: 60-75 FSW</td>
</tr>
<tr>
<td>Outreach Workers (ORW)</td>
<td>Urban</td>
<td>1 ORW: 360 FSW</td>
</tr>
<tr>
<td></td>
<td>Highway &amp; Rural</td>
<td>1 ORW: 240 FSW</td>
</tr>
<tr>
<td>Drop In Centre</td>
<td>Urban</td>
<td>1 DIC : &gt;700 FSW</td>
</tr>
<tr>
<td></td>
<td>Town</td>
<td>1 DIC : &gt;500 -700 FSW</td>
</tr>
<tr>
<td></td>
<td>Rural</td>
<td>1 DIC : &lt; 500 FSW</td>
</tr>
</tbody>
</table>

The below tables details out position granted for a project Urban and Highway & Rural Areas. The number of position depends upon number of FSW / Migrants / IDU’s , MSM to be covered by concern organization)

<table>
<thead>
<tr>
<th>SI No</th>
<th>Positions</th>
<th># of Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Highway &amp; Rural</td>
</tr>
<tr>
<td>1</td>
<td>Peer Educators</td>
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</tr>
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<td>2</td>
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<tr>
<td>3</td>
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</tr>
<tr>
<td>5</td>
<td>Counselor</td>
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