TARGETED INTERVENTIONS FOR HIGH RISK GROUPS (HRGs)

OPERATIONAL GUIDELINES
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INTRODUCTION

The purpose of these guidelines is to ensure the delivery of quality HIV prevention interventions through the Targeted Interventions (TIs) under the National AIDS Control Programme (NACP III) in India. The guidelines outline standardized operational procedures for implementing comprehensive HIV prevention services.

According to the framework of NACP III, prevention strategies will have a three-pronged approach:

1. **High Risk Groups (HRGs):** There are three HRGs, otherwise referred to as HRGs (HRGs) in order to reduce stigma towards them. These HRGs are female sex workers (FSWs), high-risk men who have sex with men and transgenders (MSM and TGs), and injecting drug users (IDUs). Through the TIs under NACP III these populations receive a comprehensive package of preventive services. State AIDS Control Societies (SACS) will be expected to saturate coverage of these groups before moving on to cover other groups.

2. **Bridge populations with particular focus on Clients of Sex Workers:** Clients receive a combination of services including condom promotion, referrals to clinical services for STI management and behaviour change communication (BCC). Specific strategies have been outlined to approach two major populations within the bridge population: truckers and high-risk migrants.

3. **Other Vulnerable Populations:** Risk groups in rural areas, HIV affected children, youth 15-19 years old and women receive a package of services delivered through a more extensive mechanism – that of link workers. This is discussed in the section on link workers within the Project Implementation Plan (PIP) (Chapter 5) and the NACO Operational Guidelines for Link Workers.

This document is an operational guideline for Targeted Interventions (TIs) with HRGs under NACP III (approach no. 1 above).

**Chapter 1:** A definition of TIs and an overview of the three HRGs that are to be targeted.

**Chapter 2:** How to configure and initiate TIs at the state level. For:
- State AIDS Control Societies (SACS)
- Technical Support Units (TSUs)
- District AIDS Prevention and Control Units (DAPCUs)

**Chapters 3, 4 and 5:** How to develop and scale TIs for FSWs, IDUs and MSM (including additional tools and documentation where relevant). For:
- NGOs/CBOs funded to implement TIs
- Programme managers
- Frontline health workers such as Peer Educators and outreach workers

**Chapter 6:** How to develop CBOs

**Note:** Please bear in mind while reading these guidelines that all the chapters are interrelated, and no single chapter should be considered in isolation.
CHAPTER 1

Introduction to
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1.1 RATIONALE FOR AND DEFINITION OF TARGETED INTERVENTIONS (TIs)

It is estimated that more than 90% of HIV transmission in India is related to unprotected sexual intercourse or sharing of injecting equipment between an infected and an uninfected individual. Not everyone in the population has the same risk of acquiring or transmitting HIV. Much of the HIV transmission in India occurs within groups or networks of individuals who have higher levels of risk due to a higher number of sexual partners or the sharing of injection drug equipment.

These high risk groups (HRGs) of individuals who are most at risk include:
- Female sex workers (FSWs)
- High-risk men who have sex with men (MSM), and trans-genders (TGs)
- Injecting drug users (IDUs)

The broader transmission of HIV beyond these HRGs often occurs through their sexual partners, who also have lower-risk sexual partners in the “general” population. For example, a client of a sex worker might also have a wife or other partner who is at risk of acquiring HIV from her higher-risk partner. Individuals who have sexual partners in the highest-risk groups and other partners are called a “bridge population”, because they form a transmission bridge from the HRG to the general population. This is illustrated in Figure 1, which shows how HRG members or HRGs have many sexual partnerships with different bridge population members, who in turn have at least one partner in the general population.

Figure 1. Illustration of an HIV Transmission Network

Given this pattern of epidemic transmission, it is most effective and efficient to target prevention to the HRG members to keep their HIV prevalence as low as possible, and to reduce transmission from them to the bridge population.
1.1.1 Female Sex Workers (FSWs)

FSWs have many sexual partners concurrently. Generally, full-time FSWs have at least one client per day, or at least 30 clients per month, and nearly 400 per year. Some FSWs have more clients than others, having several clients per day and 100 or more clients in a month. The higher risk of FSWs is reflected in a substantially higher prevalence of HIV among them than in the general population. In India, sentinel surveillance data has shown that the HIV prevalence is generally 10-20% or more, which is more than ten times higher, among FSWs than among pregnant women attending antenatal clinics.

The relative importance of FSWs as a HRG can be summarized by estimating the number of sexual contacts occurring between FSWs and clients. Within one year, 1,000 FSWs will have sexual contact with 300,000 to 1,000,000 clients. In contrast, 1,000 “high-risk” men who have 6-12 sexual partners in a year will have a total of 6,000-12,000 sexual partners in a year. Since the HIV prevalence is much higher among FSWs, a higher proportion of their sexual partnerships could result in HIV transmission. As illustrated in Figure 2, the number of HIV positive sexual contacts for 1,000 FSWs is much greater than for the same number of high-risk men. This demonstrates the strategic importance of focusing prevention programs on FSWs.

Figure 2. Number of HIV Positive Contacts for 1,000 FSWs and “High-Risk” Men
1.1.2 Men Who Have Sex with Men (MSM) and Transgenders (TGs)

MSM/TGs are another important HRG who are highly vulnerable to HIV and are also a strategically important group for focusing HIV prevention programs. It is important to know that not all MSM have many sexual partners, and are therefore not at a substantially increased risk for HIV compared to others. However, there are MSM sub-populations which do have high rates of partner change as well as high number of concurrent sexual partners, and those that often engage in anal sex with multiple partners are at particularly high risk since HIV is more transmissible through anal sex than by other sexual practices. Members of the transgender population who have many male partners are also at high risk since many of them engage in anal sex. Since many men who have sex with high-risk MSM and transgendered individuals also have other partners, both male and female, targeted interventions for these HRGs are strategically critical to controlling the HIV epidemic.

1.1.3 Injecting Drug Users (IDUs)

IDUs are a third HRG for which targeted interventions are of critical importance. HIV is highly transmissible through the sharing of needles and other injection equipment, so it can spread very rapidly within networks of IDUs who share injecting equipment with each other. Once HIV prevalence is high in the IDU population, it can expand quickly into their sexual networks. Some IDUs are also sex workers, which can quickly link HIV transmission in the IDU networks to transmission in the larger high-risk sexual networks.

It is important to recognize that like sexual transmission of HIV, HIV is essentially preventable among IDUs and their sex partners too. Effective interventions that are implemented early (HIV prevalence <5% among the IDUs) are most effective in halting the spread of HIV epidemic among the IDUs. HIV interventions targeting the majority of the injecting drug users can stabilize and even reverse the escalating HIV epidemic among IDUs. HIV positive IDUs receiving opioid substitution treatment (OST) not only helps them to avoid injecting but also to adhere to anti-retroviral treatment (ART) as well as other treatments.

In summary, the HIV transmission dynamics in India are such that unless effective targeted HIV prevention saturates the most at-risk HRGs of FSWs, MSM/TGs and IDUs, the epidemic will not be controlled. But the positive implication of this is that if HIV prevention is successful in these HRGs, the epidemic will be substantially curtailed.
1.2 HIGH RISK GROUPS – DEFINITIONS AND TYPOLOGIES RELEVANT FOR INTERVENTIONS

1.2.1 Typologies of Female Sex Workers (FSWs)

For the purpose of TIs, a female sex worker (FSW) is an adult woman who engages in consensual sex for money or payment in kind, as her principal means of livelihood.

In any given geography, sex workers are not a homogeneous group. Sex workers can be categorised into 6 main typologies, based on where they work and more specifically on where they recruit or solicit clients and not where they live or actually entertain the clients. The major typologies of FSW in India are described below. The accompanying chart shows the distribution of these typologies among sex workers in southern India.

1. **Street-based** sex workers are those who solicit clients on the street or in public places such as parks, railway stations, bus stands, markets, cinema halls. They may live in a brothel and may entertain their clients in a lodge, car, truck, hotel room, at the client's home, in a cinema or in a public place.

2. **Brothel-based** sex workers are those whose clients contact them in recognised brothels, that is buildings or residential homes where people from outside the sex trade know sex workers live and work. These includes sex workers in Kamathipura in Bombay and Sonagachi in Calcutta, and also smaller scale brothels in districts such as Sangli, Bagalkot and Guntur. Typically, a brothel is a place where a small group of sex workers is managed by a Madam (Gharwali) or an agent. Usually the sex worker pays a part of her earnings to the Gharwali.

3. **Lodge-based** sex workers are those who come and reside in what is known as a lodge (a small hotel) directly and their clients are contracted by the lodge owner, manager or any other employee of the lodge on the basis of sharing the profits. These sex workers do not publicly solicit for clients.

4. **Dhaba-based sex workers** are those who are based at dhabas (roadside resting places for truckers and other long-distance motorists) or road-side country motels. Like lodge-based sex workers, these sex workers do not publicly solicit clients, but rather are accessed by clients who come to these locations. In some cases, dhaba-based sex workers are also contracted by the dhaba owners and could move from dhaba to dhaba based on their contracts.

5. **Home-based** or “secret” sex workers operate usually from their homes, contacting their clients on the phone or through word of mouth or through middle-men (e.g., auto drivers). Generally, they are not known to be working as sex workers within their neighbouring areas. In fact, they could have an entirely different “public” identity – e.g., housewife, student. While many sex workers operate “secretly” given the level of harassment, violence and stigmatisation they experience from the police, the rowdies and the members of general public, for the purpose of TIs, the term “secret” sex worker refers to a specialised category of sex workers, as explained above. They are only “secret” or “anonymous”
in terms of their identity in their immediate context (e.g. family, neighbourhood) – not in terms of accessibility to programmes or their clients.

6. **Highway-based sex workers** are those who recruit their clients from highways, usually from among long distance truck drivers.

There are other sex workers whose primary occupational identity may vary, but a large proportion of their occupation group, *but not all*, often engage in commercial sex regularly and in significant volumes. Bar girls, Tamasha artistes, Mujra dancers, come under this category.

The categories used here are often overlapping and fluid. For example, a sex worker may be street-based for some time and then go into a contract with a lodge owner to become-lodge based. Or a brothel-based sex worker may move to another town or city temporarily and work as a street-based sex worker. **For the purposes of mapping and designing TIs we must categorise sex workers according to their primary identity and terms of engagement in the sex trade.**

### RISK VARIES WITH TYPOLOGY
It is important to note that certain typologies (brothel- and lodge-/dhabha-based sex workers) tend to have higher client volumes than home-based sex workers, and they therefore have a higher risk profile, requiring special focus even within the category of female sex workers. New entrants into these categories also warrant special focus.

#### 1.2.2 Typologies of High-Risk Men who have Sex with Men (MSM) and Transgenders (TGs)

The term “men who have sex with men” (MSM) is used to denote all men who have sex with other men as a matter of preference or practice, regardless of their sexual identity or sexual orientation and irrespective of whether they also have sex with women or not. Coined by public health experts for the purpose of HIV/STI prevention, this epidemiological term focuses exclusively on sexual practice. This term *does not* refer to those men who might have had sex with other men as part of sexual experimentations or very occasionally depending on special circumstances. It should be noted that all who engage in male-to-male sex do not necessarily identify themselves as homosexuals or even men.

There are several sub-groups among MSM. For the purposes of TIs, these groups are defined as below.

- **Hijras**: Hijras belong to a distinct socio-religious and cultural group, a “third gender” (apart from male and female). They dress in feminine attire (cross-dress) and are organised under seven main *gharanas* (clans). Among the hijras there are emasculated (castrated, *nirvan*) men, non-emasculated men (not castrated, *akva/akka*) and inter-sexed persons (hermaphrodites). While one sub-set of hijras is involved in blessing and gracing during births, marriages and ceremonies, another is involved in begging, and a third group is involved in sex work. For the purposes of TI, hijras are covered under the term “transgenders” or TGs.

- **Kothis**: The term is used to describe males who show varying degrees of “femininity” (which may be situational), take the “female” role in their sexual relationships with other men, and are involved mainly, though often not exclusively, in receptive anal/oral sex with men. Some proportion of Kothis has bisexual behaviour and many may marry a woman. Self-identified hijras may also identify themselves as kothis. Many kothis assume the gender identity of a woman.

- **Double Deckers**: Kothis and hijras label those males who both insert and receive during penetrative sexual encounters (anal or oral sex) with other men as “Double Deckers”. These days, some
 proportion of such persons also self-identify as “Double Deckers”. Some equivalent terms used in different states are “Double”, “Dupli-Kothi” (West Bengal) and “Do-Paratha” (Maharashtra).

- **Panthis:** The term panthi is used by kothis and hijras to refer to a “masculine” insertive male partner or anyone who is masculine and seems to be a potential sexual (insertive) partner. Some equivalent terms used in different states to denote masculine insertive partners are “Gadiyo” (Gujarat), “Parikh” (West Bengal) and “Giriya” (Delhi).

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**Not all MSM/TGs are at equal risk**

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**Do MSMs have sex with women?**

Various sexual behaviour studies have shown that MSM are also involved in sexual relationships with women.

- The national BSS study showed that **31% of MSM reported having sexual intercourse with a female partner** in the 6 months prior to the survey, and the mean number of female partners was 2.4.
- Data from Andhra Pradesh (Dandona et al) shows that **65% of MSM had ever had sex with women**, among which 76% was with their wife, 29% with FSW and 13% with wife as well as FSW.
- Community studies from Mumbai (HumSafar Trust) confirm the above findings that the female partners of MSM were primarily their wife, but about **18% had more than one female partner**.
Among those who are defined as MSM, only some MSM are most at risk. In this document, the term MSM will refer only to those high-risk MSM/TGs who are included as HRGs in the TI efforts, i.e. those who may be self-identified and anal receptors with multiple sexual partners. These groups are hijras, kothis and double deckers (not panthis).

1.2.3 Typologies of Injecting Drug Users (IDUs)

IDUs are not injectors at all times in their injecting life-span. They may inject, then fall back into non-injecting (e.g. oral) drug use, or abstinence, and then return to injecting. Thus IDUs are classified in two categories for the purpose of programming:

- **Current injectors:** IDUs are those who used any drugs through injecting routes in the last three months.

- **Shadow users:** When injecting drugs, e.g. opioids (tidigesic), are not available, some IDUs switch over to oral or inhalation drugs or vice-versa. Conversely, when oral or inhalation drugs are not available, some users shift temporarily to injectables. Drug users who have done so in the last six months are called shadow users.

In addition to addressing IDUs, IDU programmes should ensure that they also address the regular sexual partners of IDUs, as many of them are likely to be infected, and some of them may be IDUs too.

It is equally important to remember that some IDUs might be sex workers or MSM, and some of them are also female.
1.3 INTERVENTION PACKAGE FOR HIGH RISK GROUPS COVERED UNDER TIs

Targeted interventions for HRGs offer a “package” of services which are detailed further in the operational guidelines. This package of services varies for each major HRG, but broadly follows the components outlined below.

1.3.1 Outreach and Communication

Peer-led, NGO-supported outreach and behaviour change communication.
- Differentiated outreach based on risk and typology
- Interpersonal behaviour change communication (IPC)

1.3.2 Services

Promotion of condoms, linkages to STI (sexually transmitted infection) services and health services with a strong referral and follow-up system.
- Promotion/distribution of free condoms and other commodities (e.g. lubricants for MSM, needles/syringes for IDUs)
- Provision of basic STI and health services (including abscess management and oral substitution therapy for IDUs and also oral/anal STI services for MSM/TG)
- Linkages to other health services (e.g. for TB) and voluntary counselling and testing centres (VCTC)
- Provision of safe spaces (drop-in centres or DICs)

1.3.3 Enabling Environment

- Advocacy with key stakeholders/power structures
- Crisis management systems
- Legal/rights education

1.3.4 Community Mobilisation

Building community ownership of the TI’s objectives (“community” refers here to the HRGs: FSWs, high risk MSM and IDUs).
- Collectivisation
- Creation of a space for community events
- Building capacity of FSWs, MSM and IDU groups to assume ownership of the programme.
1.4 RATIONALE FOR CBOs

The NACP III design aims to strengthen the processes of community-led and community-owned TIs (where “community” refers to HRGs). The rationale for this is based on several observations:

- When the community defines HIV prevention as part of their own agenda, uptake of services and commodities is higher than when services are “imposed” upon them.
- Community-led interventions leverage the existing organic bonding among community members so that individual HRG members take interest in supporting their colleagues in accessing both information and services. This leads to rapid and saturated coverage of the FSW, MSM and TG communities.
- On many occasions, community based organisations (CBOs) are found to be most effective in scaling up HIV prevention programmes. The Sonagachi project started in 1992 and was subsequently handed over to the FSW CBO (Durbar Mahila Samanwaya Samiti, DMSC) in 1999. Soon after that, this organisation was able to expand to 15 red light districts in the state of West Bengal in a span of two years, increasing the coverage of the FSW population in the state to a level of 75%-80%.
- Community-led initiatives allow members of the community to enable HRGs to play the role of a pressure group as consumers to maintain and reinforce quality of services, leading to sustained demand for high quality services.
- Sustainability of a programme depends among other things on the level of ownership by the community. For example, the FSW CBO in Bangladesh, Durjoy, even after the withdrawal of the donor’s support, was able to sustain basic minimum services with its own organisational resource base.

Beyond HIV, there are several other examples of CBOs developing strong scaled programmes. Community mobilisation of poorer women through micro-credit has helped them to gain more control over their own lives (e.g. BRAC and Grameen Bank in Bangladesh, SEWA in India). These organisations have improved the quality of lives of thousands of women, in addition to providing economic security to the family through the process of institutionalisation of community ownership building.

Thus, NACP III offers a set of guidelines specifically to address the strengthening of CBOs and building of new CBOs (both from scratch and from existing NGOs).
1.5 TRAFFICKING AND NACP III

Since its inception, the National AIDS Control Programme (NACP) has accorded priority to preventing and controlling HIV among populations at greater risk, which include inter alia sex workers. Targeted interventions (i.e. provision of risk reduction measures such as information, condoms, treatment for STIs) for high risk groups (FSWs, MSM, IDUs) will remain the mainstay of the response under NACP III. The programme recognises that stigma and marginalisation experienced by high risk groups amplifies risks and limits their ability to protect themselves and others. Therefore, NACP aims to empower high-risk groups to enable improved negotiation and health seeking. Creation of an enabling environment and community mobilisation are the key programmatic strategies to address such vulnerability.

NACP notes that structural determinants such as poverty, gender inequality and lack of viable opportunities compel many persons, particularly girls and young women, into commercial sex. Further, many are forced or fraudulently brought into sex work. NACO and its affiliate State AIDS Control Societies (SACS) cannot and will not support NGOs and CBOs which encourage the compelling of persons into sex work. NACO and SACS affirm the principle of voluntary entry and exit from sex work. NACO, in partnership with other Ministries, will seek to address fundamental conditions that contribute to involuntary entry into sex work. Simultaneously, at project sites, targeted interventions will help institute community mechanisms to prevent involuntary sex work.

For persons in sex work, NACP will promote health and occupational safety by promoting use of condoms, providing access to STI and other treatment and encouraging voluntary HIV counselling and testing. NGOs implementing targeted interventions for sex workers and MSM will proactively assist persons opting out of sex work through collaborative arrangements with women's groups, Women's Commission and the Ministry of Women and Child Development. At the same time, NACP will not interfere with rights of those choosing to remain in sex work. Targeted interventions will promote active involvement of sex workers in all aspects of project development, implementation and evaluation.
CHAPTER 2

Operationalising Targeted Interventions for HRGs:
Guidelines for SACS, TSU and DAPCU
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2.1 MAPPING HRGs – GEOGRAPHIC MAPPING, SIZE ESTIMATION AND SITE ASSESSMENT

2.1.1 Background

2.1.1.1 Mapping in the context of HIV intervention

Mapping, in the context of NACP III TIs (and of this document), refers to the following three exercises:

1. Review of secondary data
2. "Broad mapping" to estimate size, identify HRG typology and locations of risk
3. "Site assessment" to derive basic insights into factors that make HRGs particularly vulnerable to HIV, and to initiate interventions.

HRGs will be "mapped" in each state in two distinct phases:

First Phase
In the first phase mapping is to be carried out:
- Where TIs addressing HRGs are in operation.
- Any other areas where TIs are not in operation but HRGs are known to be present in significant numbers.

Second Phase
The second phase of mapping is implemented when SACS and TSUs identify major geographic areas in the state which have been left out of TI coverage. This could occur through a review of TI data against state geography. The objective of mapping in the second phase is to ensure that such gaps in coverage are "mopped up" through commissioning of new TIs or reconfiguration of existing TIs. Mapping in the second phase will follow the same methodologies as in the first phase.

These guidelines describe mapping in the first phase.

Key terms
- A geographical area demarcated by a definite boundary (e.g. town, city, village) is referred to as a "site".
- Areas within a site where there is significant concentration of HRGs are referred to as "hotspots". Within hotspots, HRGs may solicit, cruise, interact with other HRG members, or have sex or share injecting drugs.

So the overarching goal of mapping HRGs is to put appropriate and effective interventions in place. Therefore it is important to remember:

1. Mapping has to be rapid – as based on its results the TIs have to be designed and services have to reach these populations urgently.
2. Those who are mapping HRGs must know how to find them; be credible and acceptable to them; and most importantly, be respectful towards the norms, practices and rights of HRGs. This is because many of these HRG members are hard to reach or hidden or physically scattered. Moreover, the stigma, discrimination and violence they experience from the mainstream society often make them even more inaccessible, as they are usually reluctant to share personal information with outsiders.
3. Methodologies used must be usable and HRG-friendly.
2.1.1.2 Objectives

1. **Identify or confirm locations within the states and districts where TIs ought to be placed to reach those HRGs who are most vulnerable.** Targeted Interventions will address only those MSM and IDUs who are most at risk, namely kothis, hijras, double deckers, IDUs who share injecting equipment. Therefore only these subcategories of MSM and IDUs will be mapped and not the whole universe of MSM and IDUs.

2. **Validate estimates of size**
   - Generate estimates of the size of HRGs in each site, by different categories
   - Provide locations of hotspots where HIV risk activities predominantly take place
   - Generate information to help understand the mobility patterns of HRGs within and outside the site
   - Explore the HIV/STI risks that HRGs face and the vulnerability factors that exacerbate such risks
   - Characterise the HRGs to facilitate subsequent programming
   - Identify their HIV related needs, existing HIV interventions and key gaps

3. **Begin the process of mobilising HRG groups for HIV/STI prevention**
   - Build awareness of HIV
   - Increase knowledge about risk reduction strategies
   - Increase knowledge about existing HIV/STI prevention interventions for HRGs
   - Build social capital and solidarity amongst HRGs – a collective voice
   - Explore safe and private spaces for HRGs to meet and work together
   - Build a core group of HRG members from the site who will serve as an important resource for project implementation by recruiting and training local HRG members to implement mapping.

2.1.1.3 Guiding principles

1. **Pay attention to definitions of HRGs (including subcategories)**
   We must clearly define the HRGs we are mapping. Otherwise, those conducting the exercise will not know whom to count and whom to leave out. For example, for the purposes of the TI, who is a sex worker, and when is a sex worker classified as street-based? Who are MSM and who among them are kothis (or regular and casual partners of kothis or double deckers)? Whom do we define as an IDU?

   Please refer to Chapter 1 for details on how different HRGs and their subcategories are defined under NACP III.

2. **Use members of HRGs to map**
   - Experience shows that if HRGs themselves are recruited to conduct the mapping the **results will be closer to reality.** It is also important to recruit onto the mapping teams representatives from all subcategories of HRGs that are available in a site – since brothel-based sex workers, whose operations are restricted to a particular brothel in a town, may not know where street-based sex workers solicit their clients. A hijra may not necessarily be able to relate to a kothi. A city-based IDU may not know where IDUs hang out in more rural settings.
   - Since mapping involves getting people to provide sensitive information about their sexual behaviours, their partners, locations, networks, etc., HRG members are more likely to share information without fear or prejudice if it is solicited by people from the same group, who are acceptable and credible to them.
   - When HRG members do the mapping, the **process of mapping becomes an intervention in itself** – it mobilises local HRG communities to understand and address HIV risks and creates a demand for HIV services. So while mapping is going on the intervention simultaneously gets underway.

   Of course, like all other researchers, the HRG members must be trained to do the mapping and will also require administrative and technical support during the entire mapping process. This additional support will be provided by non-HRG members in the mapping team.
Some critical criteria for selecting people who will do the mapping are that they be:

- True peers of and represent different categories of HRGs in the areas being mapped.
- Be acceptable and credible to HRGs.
- Known in the site and know the site well.
- Motivated to work with their peers on HIV/STI risk reduction.
- Available to follow the entire mapping process from training, field level implementation, feedback and analysis of data, to dissemination. This means they must agree to take time off from their regular occupations for a considerable period of time at a stretch, for which they will be financially compensated.

Mapping implementers who are true peers of HRG participants will find the safest space and best time to facilitate mapping activities with them. They also have the necessary acceptability and credibility among HRGs to effectively mobilise them and to generate in-depth, accurate information for project design.

Effectiveness of mapping by HRGs

3. Gather information from multiple sources

Triangulation is a critical component of any mapping exercise. Information gathered from one source needs to be verified against information from other sources. In order to triangulate the data, it is important to have multiple sources of information for mapping:

1. **Primary Key Informants** are members HRGs and their sexual partners. For example, sex workers and their clients, people who inject drugs and their sexual partners, a kothi and his parthis.
2. **Secondary Key Informants** are those who are part of or close to the HRG members’ occupational or sexual lives or their addiction practices. For example, suppliers of injecting drugs and equipment, pimps, agents, brokers, madams, hotel workers, shopkeepers near risk sites, auto rickshaw drivers plying routes near sex sites.
3. **Tertiary Key Informants** are those with a good idea about the HRGs at a town/district/state level. For example, NGOs, government officials, pharmacy owners, local journalists.

It is advisable not to consult groups that are known to have adversarial relationships with the particular HRGs, such as rowdies and goondas, as this might jeopardise local HRG members’ trust in the mapping exercise or cause them actual harm.
A rule of thumb: Although secondary or tertiary stakeholders often know something about HRGs, they never have as full or the same picture as HRGs themselves. Therefore, in any mapping exercise more than 60% of respondents – that is people who are consulted for seeking information – must be from HRGs that are being mapped.

4. Understand the limitations of the mapping process
Mapping is not formal research or ethnographic study. So the information it generates can (a) be limited to informing the design or review of HIV interventions; and (b) be site-specific and therefore not generalisable to other sites. Keep in mind that size estimates are just that – they are not an exact headcount of individual HRG members. There is constant turnover/mobility of some HRGs – estimates arrived at from mapping must be regularly revised and updated through the course of TI implementation.

5. Do no harm – be ethical
As mapping is an integral part of NACP III, it must be implemented in a way that reflects and reinforces the core values and approaches of NACP III, ensuring the well-being and protecting the rights and interests of HRGs. While mapping it is important to remember the secret, socially marginalised, and also formally criminalised status of most HRGs and the practices that they engage in. To protect HRG participants in mapping the following key guidelines are to be followed:

- Do not breach confidentiality of HRG members
- Seek the consent of HRG members before involving them in mapping
- Be prepared to handle negative consequences of mapping for the HRGs – have a harm redress plan
- Do not raise false expectations (e.g. promise services, jobs or remuneration)
Steps to ensure protection of HRGs during mapping

1. Access to the HRGs may require going through various gatekeepers such as employers, brothel owners or suppliers. Mapping teams will hold discussions with gatekeepers and clarify the purpose of the mapping, e.g. size estimation, service providers to HRGs, places where HRG members operate and obtaining information to guide design of HIV interventions or improved implementation of ongoing projects. Gatekeepers will be made aware that all information gathered by the mapping team will be kept anonymous and confidential and will not be shared even with them.

2. Specific efforts will be taken to inform the NGOs working with the populations covered by the mapping, as well as community leaders, about the purpose, risks and benefits of the mapping.

3. The mapping is anonymous. No names or personal identifiers will be recorded. Mapping teams and others associated with mapping will have to ensure that mapping records are kept secure throughout the mapping process and after.

4. Mapping teams will have to take witnessed verbal consent from each participant before they involve her/him in the process. All mapping documents and information will be labelled in such a way that the participants remain anonymous. Prior to implementation of any mapping procedure or method, those who are implementing it will explain the mapping procedures in detail to potential participants, and answer all questions to the full satisfaction of the participants. The mapping team will emphasise that participation is voluntary and should participants decide not to participate or withdraw from the procedure at any time, their decision would not affect any services from the NGO or the clinic that they would normally receive.

5. Mapping teams, SACS, TSU and NACO will closely monitor the consent procedure through spot checks.

6. Discussions will be held between SACS, TSU, NACO, the mapping team and local NGO/CBO staff and community leaders on potential use of information for programming when the mapping is complete or before any dissemination of mapping data.

7. Implementers of mapping will adopt stringent measures to ensure that participation in mapping does not expose HRG members to any risk or cause them any harm. However, it is also essential to spell out what specific steps would be taken to mitigate the harm that HRG participants might still be exposed to, despite such precautionary measures, and how the HRG participants will be supported by the implementers of mapping following such incidence of harm.

These steps are necessary not just to mitigate the harm caused materially (such as money to compensate for loss of work or other support such as legal aid, safe custody, etc.), but also to establish that NACP III respects the rights and entitlements of HRG participants and acknowledges that any harm to them ought to be substantively redressed.
2.1.1.4 Steps

<table>
<thead>
<tr>
<th>Steps</th>
<th>Programmatic Objective</th>
<th>Where to be Implemented?</th>
<th>Output Expected</th>
<th>Timeframe</th>
</tr>
</thead>
</table>
| 1. Review of available information | To determine the sites where mapping will be carried out | At state level | List of sites to be mapped  
  - All sites where there are TIs  
  - Sites where there are no TIs but are obvious and/or reported concentrations of HRGs such as cities/towns, trading centres, religious centres | 2 weeks |
| 2. Broad Mapping and feedback and analysis of data | To determine where to place the TIs (which district) | At site level | List of reported hotspots  
  - Size estimation by subcategories  
  - HIV/STI services available for HRGs | 4 - 12 weeks, depending on size of the state |
| 3. Site Assessment including feedback, data analysis | To determine the site specific design of TIs | Within a site at hotspot level | Confirmed list of hotspots in the site  
  - Fine-tuning of estimated numbers by subcategory in the site  
  - Mobility pattern of HRGs  
  - Availability of HRGs  
  - Risk profile of HRGs | 6 - 12 weeks |

The shaded area represents activities which are a part of TI processes.

2.1.1.5 Involvement of TIs

As far as possible NGOs and CBOs implementing TIs should be engaged in the process of mapping: they should understand the process and realise why such close participation of HRG members is critical for successful mapping. Only if they know how and why information is being gathered will they trust the information and use it for shaping their intervention design. In addition, involvement in the mapping process enables NGOs, CBOs or networks running TIs to fully understand the complex realities of the lives of HRG members. Witnessing the competence with which HRG members implement mapping also convinces NGOs of their full potential as partners in interventions.

While TI involvement in mapping is the ideal, TIs are likely to be in different stages of maturity, and coverage of HRGs by TIs may vary from state to state. As a rule of thumb:

1. Where a TI has been in operation for some time and has an extensive and effective intervention programme, the NGO/CBO running the TI should ideally be involved in all steps of mapping. However, it is recommended that HRG members who are not being paid or working with the existing TI (as peer educators, outreach workers or in any other paid or voluntary position) be selected to do the mapping. Of course, if the TI in question has mapped the HRGs they work with with substantive participation of HRGs themselves, and the data they have is reliable and credible, there is no need to do mapping again in their operation site/s.

2. Where TIs have been commissioned but the intervention is new, mapping will be done as the first step of the intervention, and if necessary the design, location or composition of particular TIs will have to be reconfigured based on the mapping information.

3. In areas where HRG presence is reported but TIs are not yet in place, mapping needs to be carried out first, and TIs are then to be contracted depending on the numbers of HRG members present. Since it takes considerable time to advertise for, select and contract TIs, advertisements can be
placed based on the information generated through the Review, and TIs can be selected from those who apply, based on the information from Broad Mapping.

<table>
<thead>
<tr>
<th>Steps</th>
<th>Involvement of TIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review of available information</td>
<td>Existing TIs to be consulted</td>
</tr>
<tr>
<td>2. Broad Mapping</td>
<td>Ideal but not imperative</td>
</tr>
<tr>
<td>3. Site Assessment</td>
<td>Should be closely involved</td>
</tr>
<tr>
<td>4. Feedback and data analysis</td>
<td>Should be closely involved</td>
</tr>
<tr>
<td>5. Report writing</td>
<td>Not necessary</td>
</tr>
<tr>
<td>6. Dissemination</td>
<td>Should be closely involved</td>
</tr>
</tbody>
</table>

Based on information from review numbers of new TIs required can be estimated and accordingly Expressions of Interest can be advertised.

Selected organisation can be involved, and if already contracted can implement Site Assessment as the first step in intervention.

2.1.2 Organisations Involved in Mapping

2.1.2.1 Mapping TRG and NHRGCs

A Technical Resource Group or task force dedicated to mapping (Mapping TRG) at NACO level will provide technical oversight to the whole process of mapping under NACP III. This group of experts will be supported by a cadre of National HRG Consultants (NHRGCs), drawn from members of HRGs with previous experience of implementing mapping in different states.

The Mapping TRG and the NHRGCs have the following roles:

- Build capacity of NACO TI Project and Technical Officers, State AIDS Control and/or Prevention Societies and the Project Support Units (TSUs) in mapping approaches and mechanisms
- Identify and select state- or regional-level organisations that will be responsible for implementing mapping in each state in consultation with State AIDS Control and/or Prevention Societies
- Mapping TRG and NHRGCs orient and train selected state- or regional-level organisations in mapping approaches and methodology, including selection and recruitment of HRG members to implement mapping
- NHRGCs select HRG members to implement mapping in collaboration with selected state- or regional-level organisations
- Mapping TRG and NHRGCs train HRG members they recruit in implementing mapping
- NHRGCs provide hands-on technical and mentoring support to HRG mapping teams
- Provide technical assistance during the field implementation of mapping, feedback and analysis of information, report writing and dissemination
- Intervene in case of any technical dispute or other major crisis
- If necessary, the Mapping TRG will also carry out the Review of available information in consultation with State AIDS Control and/or Prevention Societies

2.1.2.2 State or regional organisations

The broad mapping and site assessments are to be carried out at each state, and within the state at each site identified through the process of review of available information. These activities will be carried out by selected state or regional organisations (either an individual organisation or a group of two organisations, to fulfil the selection criteria given below).
2.1.2.2.1 Role of organisations

- To carry out review of available information in consultation with Mapping TRG and respective State AIDS Control and/or Prevention Societies
- To recruit, contract, train and remunerate HRG members to implement mapping in the state
- To provide administrative and technical oversight to implementation of Broad Mapping and Site Assessment (e.g. hiring field staff to support HRG mappers)
- To provide logistical and administrative support to HRG mapping teams during training, field implementation, feedback and analysis of data
- To take a lead in analysis of data in collaboration with HRG mapping teams
- To compile state-level mapping report

2.1.2.2 Selection criteria

- Institutional capacity (in terms of human resources, breadth of experience, systems in place) to work across a particular state and to work simultaneously at multiple centres in the state
- Financial and administrative capacity to recruit, contract and remunerate HRG members for the duration of the mapping
- Commitment to and proven track record of working with HRGs or other marginalised and stigmatised populations
- Proven track record of delivering on time
- Capacity to implement, or amenability to learn to implement, participatory methods
- Experience of carrying out field-based research and handling data
- Capacity to compile reports to specifications
- Commitment to disseminating results of mapping
- Cost effectiveness

2.1.2.3 Selection and contracting procedure

1. The Mapping TRG will support the NACO TI team in selecting organisations to implement mapping in each state, using the selection criteria given above.
2. A state or regional organisation or groups of organisations can be selected to implement mapping in a geographical region, provided they have the capacity to do so.
3. One organisation will be independently contracted to implement mapping in a state or a region.
2.1.2.3 Summary chart

<table>
<thead>
<tr>
<th>Step</th>
<th>Roles of Different Players in Mapping</th>
<th>Who leads it?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Implementation</td>
<td>Administrative and logistical support</td>
</tr>
<tr>
<td>1. Review of available information</td>
<td>Selected state- or regional-level organisation</td>
<td>-</td>
</tr>
<tr>
<td>2. Broad Mapping</td>
<td>Trained HRG members from the site</td>
<td>Non-HRG field staff of selected state- or regional-level organisation</td>
</tr>
<tr>
<td>3. Feedback and Data Analysis/report writing of broad mapping</td>
<td>Trained HRG members from the site</td>
<td>Selected state- or regional-level organisation</td>
</tr>
<tr>
<td>4. Site Assessment</td>
<td>Trained HRG members from the site</td>
<td>TI NGO/CBO, with support from state level organisation</td>
</tr>
</tbody>
</table>

2.1.3 Methodologies of Mapping

2.1.3.1 Methodology for review of available information

Please note that this step will be skipped for mapping MSM, as a district-wise list of sites to be mapped has already been developed.

2.1.3.1.1 Objective

<table>
<thead>
<tr>
<th>Programmatic</th>
<th>Mapping related</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To determine the sites where mapping will be carried out in a particular state</td>
<td>2. To estimate the time that it will take to implement Broad Mapping in the state</td>
</tr>
</tbody>
</table>

2.1.3.1.2 Who will do it?

- Selected state- or regional-level organisation
- If those organisations are not yet selected, the Mapping TRG at the initial few states to kick-start the process

2.1.3.1.3 Sources of information

1. Secondary sources
   - Published surveys about HRGs in India, including National Survey, Sentinel Surveillance reports
   - Past mapping data for the state available with SACS
   - RCSHA reports, if relevant to the state
- DFID-PMO documentation, if relevant to the state
- Other site estimation reports from local and international NGOs including USAID, Avahan partners, if relevant to the state

2. Consultation with selected key informants
- SACS, TSU (if in place), other government departments, local NGOs working with HRGs, HRG CBOs

2.1.3.1.4 Process
1. The selected state- or regional-level organisation or members of Mapping TRG and selected NACO TI Project and/or Technical Officers collect all existing secondary data available about numbers and location of HRGs in the state.
2. Selected state- or regional-level organisation or members of Mapping TRG and selected NACO TI Project and/or Technical Officers visit the state to be mapped for 2 days.
3. On Day 1 they will review the existing secondary data along with the SACS and PSU staff and compile a preliminary list of sites where there is significant concentration (100 or more sex workers and 50 or more MSM or IDUs in a site) of HRGs.
   - This list will include all sites where HRGs are known or likely to be present in significant numbers, such as big towns, trading towns, religious centres, traditional sex work, existing TI sites, etc.
4. On Day 2 SACS will convene a meeting and ensure participation of:
   - SACS representatives (PD, NGO Advisor and other staff who have been working in the state for more than 1 year)
   - TRU staff
   - Representatives of other relevant government departments in the state who might have knowledge about numbers and distribution of HRGs in the state
   - At least one NGO each with experience of running interventions with sex workers, MSM and hijras, and IDUs
   - Representatives of local HRG CBOs or networks
5. At this meeting in-depth consultation will be held to finalise the list of sites to be mapped in the state from the preliminary list prepared from the review of existing data.
6. The preliminary list will be reviewed at this meeting using the following checklist
   - Which HRGs are reported to be present at the site?
   - Which subcategories of HRG/s are present at the site?
   - What is the reported number of members of each HRG subcategory reported to be present at the site?
   - What explains the estimated number of HRGs? (E.g. it is a trading centre and therefore there is a large turnover of likely clients of sex workers; there is a military camp in the town, therefore there is a concentration of likely sexual partners of kothis and hijras; existence of injecting sharing networks, mapping data suggesting the estimate is not more than 1 year old and is realistic and credible.)
7. At the suggestion of the participants, sites can be added to or deleted from the preliminary list. The following criteria are used to determine if a site will be included or excluded in the final list of sites to be mapped in the state:
   - The reported presence of one or more HRG is significant enough to warrant at least one TI at the site
   - The estimated number can be justified
   - If a TI has mapped the HRGs of the site with substantive participation of HRGs themselves, and the data they have is reliable and credible, the site will be excluded from the final list of sites to be mapped in the state.
8. Once the final list has been compiled and verified at the meeting, the time needed to implementing broad mapping of each site will be estimated, site by site through in-depth consultation with the participants, keeping in mind the size of the site, transportation facilities within the site, law and order situation at the site.

2.1.3.1.5 Expected outputs
1. List of sites to be mapped in the state
2. Time estimate for broad mapping all the sites in the final list
2.1.3.2 Methodology for broad mapping

2.1.3.2.1 Objective

<table>
<thead>
<tr>
<th>Programmatic</th>
<th>Mapping related</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To determine the districts and sites where TIs will have to be located on a priority basis</td>
<td>2. To develop a list of sites where Site Assessment will have to be carried out</td>
</tr>
<tr>
<td></td>
<td>3. To prepare a list of reported hotspots at each site where Site Assessment will be carried out</td>
</tr>
<tr>
<td></td>
<td>4. To estimate the time it would take to implement Site Assessment at each site</td>
</tr>
</tbody>
</table>

2.1.3.2.2 Who will do it?
Trained HRG members from the site, with administrative and logistics support of selected State- or regional-level organisation, mentored and supervised by NHRGCs and with technical oversight by the Mapping TRG and local SACS and PSU.

2.1.3.2.3 Sources of information
1. Primary Key Informants
2. Secondary Key Informants
3. Tertiary Key Informants

For detailed definitions of these informant groups, see No. 3. “Gather information from multiple sources” in Section 2.1.1.3 above.

2.1.3.2.4 Process
1. The Mapping TRG assigns a team of NHRGCs to support the state or regional organisation responsible for implementing mapping in the state.
2. The NHRGC team, in consultation with local SACS and TRU, selects local HRG field researchers to implement Broad Mapping.
3. The state or regional organisation recruits and contracts the local HRG field researchers for stipulated days (for training, field implementation, feedback and data analysis).
4. The Mapping TRG and NHRGCs carry out a Training of Trainers for trainers from the state or regional organisation.
5. The state or regional organisation trains the local HRG field researchers.
6. The local HRG field researchers implement Broad Mapping at every site selected in the state. (See Annexure 1, Tool for Broad Mapping.)
7. During field implementation by local HRG field researchers, the NHRGC team assigned to the state mentors them and provide technical supportive supervision and the state or regional mapping organisation staff provide administrative and logistics support.
8. The local HRG field researchers and the NHRGC team reconvenes for feedback and data analysis workshop facilitated by the state or regional mapping organisation.
9. The state or regional mapping organisation prepares a list of districts where TIs are to be implemented on a basis of priority, based on the data analysis and in consultation with the local SAC and TRU.

2.1.3.2.5 Expected outputs
1. A list of districts and sites where TIs will have to be located on a priority basis
2. List of reported hotspots at each site
3. Size estimate by subcategories
4. HIV/STI services available for HRGs
2.1.3.3 Methodology for site assessment

2.1.3.3.1 Objective

<table>
<thead>
<tr>
<th>Programmatic</th>
<th>Mapping related</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To determine the site-specific design of TIs</td>
<td>6. Not applicable</td>
</tr>
<tr>
<td>2. Initiate interventions</td>
<td></td>
</tr>
<tr>
<td>3. Contact at least 50% of the broad mapping denominator at least once</td>
<td></td>
</tr>
<tr>
<td>4. Build rapport of TI with the HRG community</td>
<td></td>
</tr>
<tr>
<td>5. Identify potential peers</td>
<td></td>
</tr>
</tbody>
</table>

2.1.3.3.2 Who will do it?
Trained HRG members from the site, selected for the purpose with administrative and logistics support of the TI NGO/CBO who will operate in that site, with technical support from the selected state- or regional-level organisation, mentored and supervised by NHRGCs and with technical oversight by the Mapping TRG and local SACS and PSU.

2.1.3.3.3 Sources of information
Members of HRGs and their sexual partners at each hotspot. For example, sex workers and their clients, people who inject drugs and their sexual partners, a kothi and his panthis.

2.1.3.3.4 Process
1. The NHRGCs involved in the broad mapping of the state are available to support TI NGOs/CBOs conducting the site assessments. It is critical to ensure continuity between the broad mapping and site assessment steps.
2. TI NGO/CBO (with support from NHRGCs as needed) select local HRG field researchers as community guides to implement Site Assessment. For details on this selection process, see Chapter 3. The HRG community guides from the site who had implemented Broad Mapping in the state will be included, but depending on the size of the site in question, more HRG community guides will have to be selected.
3. The TI NGO/CBO recruits and contracts the local HRG field researchers for stipulated days (for training, field implementation, feedback and data analysis).
4. The TI NGO/CBO trains the local HRG field researchers to implement Site Assessment and the TI staff to support them.
5. The local HRG field researchers implement Site Assessment at the selected site. (See Annexure 2, tool for Site Assessment.)
6. The local TI NGO/CBO community guides and the NHRGC team reconvenes for feedback and data analysis workshop facilitated by the TI NGO/CBO.

2.1.3.3.5 Expected outputs
1. Details on risks/vulnerabilities by typology and location for HRG members
2. Validation of broad mapping size and location estimates
3. Initial rapport with at least 50% of the broad mapped HRG denominator
4. Identification of potential peers (among the community guides and other HRGs mapped)

Tools
Annexure 1  Tool for Broad Mapping
Annexure 2  Tool for Site Assessment
2.2 ANALYSING THE COVERAGE AND QUALITY OF CURRENT TIs AMONG HRGS

2.2.1 Analysing Existing TIs

In the State the first priority should be to complete the mapping/assessment (described in Section 2.1 above) for size estimation of HRGs by category.

Based on mapping and size estimation data, a set of analyses can help define the scope and scale of needed TI coverage in the state:

- There should be a physical map of the entire state describing mapping data for each location and site
- The data should include all the detail information collected during mapping (e.g. locations of sex workers, typology, numbers/concentrations by region)
- The map should also include information of existing TIs and their coverage

This geographic picture of the state will highlight gaps in TI coverage. Based on these gaps, TIs can be configured or supplemented as per the criteria below.

2.2.2 Criteria for TI Allocation

TIs should be allocated, or where they already exist, an analysis of whether they are able to saturate coverage of the existing HRGs should be conducted, based on the following criteria:

- Locations where there are no interventions
  - Large pockets of HRGs
  - Smaller pockets of HRGs
- Locations where HIV prevalence rate is higher than other districts
- Locations where sizeable number of HRG exist with some TI but not covering 100% of the HRG
- Locations where TIs exist but coverage (outreach to HRGs on a monthly basis of >80%) is low
- To achieve economic efficiency (TI units of 800-1500 HRG members, with the possibility of one NGO covering multiple TI units, or one TI unit covering multiple HRG groups)
- To achieve 80% coverage of HRGs

2.2.3 TI Unit Size

Evidence shows that for interventions among HRGs to be cost-effective and impact-efficient, each TI unit should aim to provide services to 800-1,500 HRG members (150-1,000 for IDUs).

If a particular NGO or CBO is already working with a larger population of HRGs, and has the necessary capacity to provide the comprehensive package of services to them, they can be assigned more than one TI unit, depending on the actual size of the population they work with.

Similarly, even in areas where new TIs are to be started, an NGO/CBO can be assigned more than one TI unit each covering 800-1,500 FSWs/MSM provided there are such numbers in a particular
geography and the NGO/CBO has the appropriate capacity. For IDUs, the unit size may be smaller – between 150 and 1,000.

In some areas, the size of sex work population may well be smaller than 800. In such instances the TI can address a cross-HRG composite group, that is, a combination of FSWs, MSM and transgenders and/or IDUs so that the total population size addressed by the TI unit is 800-1500.

Thus there are only two possible types of HRG TIs under NACP III:

1. **TIs for only one core group** – e.g. FSW-only TIs, or MSM-only TIs, or IDU-only TIs

2. **Core composite TIs for multiple core groups**: e.g. TIs for FSWs and MSMs in a given geographic area

**Composite TIs for HRGs can be composed only of HRG members, not bridge populations like truckers or migrants.**

### 2.2.4 Geographic Distribution of TIs

Based on HIV surveillance data, epidemiological profile, risk and vulnerability, NACO has classified the 611 districts in the country into 4 categories: A, B, C and D.

<table>
<thead>
<tr>
<th>Description</th>
<th>Category</th>
<th>Number of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>In district in any time in any of the sites in the last 3 years</td>
<td>A</td>
<td>163</td>
</tr>
<tr>
<td>In all the sites during last 3 years associated with more than 5% prevalence in any HRG group (STD/CSW/MSM/IDU)</td>
<td>B</td>
<td>59</td>
</tr>
<tr>
<td>Less than 1% in ANC prevalence in all sites during last 3 years with Less than 5% in all STD clinic attendees or any HRG with known hot spots (migrants, truckers, large aggregation of factory workers, tourist, etc.)</td>
<td>C</td>
<td>278</td>
</tr>
<tr>
<td>Less than 1% in ANC prevalence in all sites during last 3 years with less than 5% in all STD clinic attendees or any HRG or no/poor HIV data with no known hot spots</td>
<td>D</td>
<td>111</td>
</tr>
</tbody>
</table>

Given the variations in risk among districts, Categories A, B and C will receive high priority in scaling up. In category D districts and parts of category C districts, focus will be on awareness-raising strategies for vulnerability reduction, risk reduction, promotion of protective behaviours and data-gathering on the extent of the high risk groups for initiation of TIs.

Scale-up will likely occur in a few stages, based on concentration of HRGs. These stages are usually in the following order of geographical distribution:

- Initially in large cities/towns
- Then peri-urban areas
- Finally in rural areas (to be covered by link worker scheme)
2.3 RECRUITMENT, CAPACITY BUILDING AND PROGRAMME MANAGEMENT

2.3.1 Recruiting NGOs/CBOs/Networks to Implement TIs

Through NACP I and II, the focus has been on implementing TIs through NGOs. NACP III aims to implement through NGOs and CBOs.

To bring about a systematic and transparent process for identification, field appraisal, selection, funding and monitoring of suitable NGOs, CBOs and networks, NACO has developed NBO/CBO Guidelines and Guidelines on Financial and Procurement Systems for NGOs/CBOs. These guidelines:

- Delineate the process involved in calling for applications, partner identification, appraisal and contracting, capacity building of partners, monitoring and evaluation
- Explain the steps in each stage and outline the process
- Enable SACS/TSUs to establish procedures for the various stages by adapting them to specific contexts

Each SACS is to recruit suitable NGOs, CBOs or networks following the processes laid out in the guidelines to implement the numbers of TI units required to saturate coverage of the HRGs mapped and estimated in the state.

Interventions implemented and led by HRGs themselves lead to faster and more effective and extensive coverage than NGO-led interventions. In order to achieve this comparative advantage, CBOs and HRGs require high-quality capacity building. For examples, refer to NACO’s Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III.

There are four possible types of interventions under NACP III:
1. Funding of existing or new NGOs
2. Funding of existing CBOs
3. Funding of de novo CBOs
4. Funding of NGOs with capacity building to help them transition to CBO-led model of intervention, with NGOs continuing to play a role in support and technical assistance.

**Note on CBO selection and transition guidelines**

For details on transitioning to CBOs, refer to the Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III. The CBO guidelines outline the process of CBO formation and development, either as offshoots of NGOs, or de novo (from scratch). It is critical to note that CBO formation takes time, and the percentage of funding expected to go to CBOs may vary based on the stage of existing interventions in states. For example, states with longstanding interventions and existing CBOs may be able to develop CBOs which could be funded before states without long-standing interventions.

This document focuses on the NGO-led model of intervention.

To implement and operationalise the TIs and ensure the quality of their services, the capacities of SACS/TSU and DAPCU, as well as the NGOs, CBOs or networks that will run the TIs, must be strengthened.

**Tools**

- NACO NGO/CBO Guidelines
- Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III
## 2.3.2 Capacity Building Plan for NGOs and CBOs Implementing TIs

Note: The budget for capacity building will be earmarked under the SACS budget. If there is a TSU in the state, SACS will release TI training budget to the TSU on an annual basis (based upon spending against a regular “impress” or “indent”).

<table>
<thead>
<tr>
<th>TI component</th>
<th>Capacity Building on</th>
<th>Objective</th>
<th>For Whom</th>
<th>Type of Training</th>
<th>When</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach/ Peer Education</td>
<td>1. Rationale and design of TIs under NACPIII</td>
<td>To build capacity to support and manage PEs and ORWs</td>
<td>Project Coordinator, Counsellors</td>
<td>2-day orientation training</td>
<td>By the 2nd month of intervention by the TI</td>
<td>TSU with support from state-level capacity building consultants or organisations, including trained trainers from HRGs</td>
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<td></td>
<td>2. Roles and responsibilities of Peer Educators and Outreach Workers</td>
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<td>3. Roles of other TI staff in outreach</td>
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<td>4. Sexual and Reproductive Health</td>
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<td>5. Basics of STI</td>
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<td>6. Basics of HIV</td>
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<td>7. Gender</td>
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<td>8. Sex and Sexuality</td>
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<td>9. Values and attitudes about HRGs and HIV</td>
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<td>10. Structural contexts of HRGs</td>
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<td></td>
<td>11. Community mobilisation and its role in TIs</td>
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<tr>
<td>Outreach planning and</td>
<td>Site Assessment</td>
<td></td>
<td>Project Coordinator, Counsellors</td>
<td>1 day orientation training</td>
<td>By 5th month</td>
<td>TSU with support from state/regional mapping organisation, including trained trainers from HRGs</td>
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<tr>
<td>management</td>
<td>To build capacity to plan outreach and support and manage PEs and ORWs</td>
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<tr>
<td></td>
<td>To build capacity to implement outreach plan (some PEs and ORWs will already be</td>
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<td>PEs and ORWs</td>
<td>4-day training including 2-day</td>
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<td></td>
<td>trained in this during Mapping)</td>
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<td>mentored field practice</td>
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<tr>
<th>TI component</th>
<th>Capacity Building on</th>
<th>Objective</th>
<th>For Whom</th>
<th>Type of Training</th>
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</thead>
<tbody>
<tr>
<td>Communications</td>
<td>Dialogue-based interpersonal communication (IPC)</td>
<td>To build capacity to support and manage PEs and ORWs</td>
<td>Project Coordinator, Counsellors</td>
<td>1-day orientation</td>
<td>In the 4th month</td>
<td>TSU with support from state/regional mapping organisation, including trained trainers from HRGs</td>
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<td></td>
<td></td>
<td>To build capacity to implement dialogue-based IPC</td>
<td>PEs and ORWs</td>
<td>4-day training including 2-day field practice</td>
<td>In the 4th month</td>
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<tr>
<td>STI</td>
<td>STI Management</td>
<td>To strengthen capacity of TI doctors in clinical STI management</td>
<td>TI doctors</td>
<td>4-day training</td>
<td>In the 4th month</td>
<td>TSU</td>
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<tr>
<td>Condom programming</td>
<td>Planning condom programming</td>
<td>To build the capacity of TIs to estimate requirements, stock, distribute and monitor distribution and usage of condoms</td>
<td>Project Coordinator, TI accountants, PEs and ORWs</td>
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<tr>
<td>Counselling</td>
<td>1. Nature and purpose of counselling</td>
<td>To strengthen HIV counselling skills</td>
<td>TI counsellors</td>
<td>6-day residential training</td>
<td>In the 4th month</td>
<td>State or regional counselling training institute accredited with NACO</td>
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<td>2. Counselling skills</td>
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<td>3. Sex and Sexuality</td>
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<td>4. Understanding HRG issues and rights</td>
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<td>6. Counselling sex workers, MSM and IDUs</td>
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<td>1. Sex and Sexuality</td>
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<td>TI doctors</td>
<td>2-day training</td>
<td>In the 4th month</td>
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<td>2. Understanding HRG issues and rights</td>
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</tr>
</tbody>
</table>
| Programme Management      | 1. Importance of programme management
2. Intervention planning
3. Quality assurance
4. Supportive supervision
5. The role of a manager | To strengthen management capacity                                                   | Project Coordinators                                                     | 3-day training     | In the 4th month | TSU with support from external consultants |
| Programme vision and design | Understanding best practices in Focused Prevention among HRGs                      | To strengthen capacity to implement TI creatively and effectively        | Project Coordinators, selected PEs and ORWs                             | Exposure Visits to learning site | In the 7th month | SACS to coordinate                    |
| MIS                       | 1. Understanding the structure of MIS system
2. Indicators
3. Field level formats
4. Peer Cards
5. Data Collection
6. Reporting and documentatio n | To build capacity in monitoring and documentation                                    | 1. Project Coordinators
2. TI accountants
3. ORWs
4. PEs                                             | 4-day training  | In the 4th month | TSU with support from external consultants |
| Finance management        | 1. Account keeping
2. Accounting software
3. Finance Management Statutory Issues               | To strengthen finance skills and systems                                             | TI accountants            | 3-day training | In the 2nd month | TSU with support from external consultants |


<table>
<thead>
<tr>
<th>TI component</th>
<th>Capacity Building on</th>
<th>Objective</th>
<th>For Whom</th>
<th>Type of Training</th>
<th>When</th>
<th>By Whom</th>
</tr>
</thead>
</table>
| Community Mobilisation | 1. Group dynamics and Group cohesion  
2. Ownership of TIs  
3. Rights of HRGs  
4. Understanding power dynamics in lives of HRGs  
5. Specific risk and vulnerability factors of HRGs  
6. Attitude and values towards sex, drugs and autonomy  
7. Legal frameworks affecting HRGs and how to address them | To strengthen capacity to mobilise HRGs for HIV prevention and protection and promotion of their rights | PEs and ORWs | 4-day residential training | In the 7th month | Trained trainers from HRGs |
|               | 8. How it works in reality | Exposure visits to strong CBOs | In the 10th month | SACS to coordinate |
| Enabling Environment | Advocacy | To strengthen capacity for planning and implementing advocacy | 1. Project Coordinators  
2. PEs  
3. ORWs | 3 day training | In the 10th month | Trained trainers from HRGs with support from TSU |
| Crisis management | To strengthen capacity to mitigate crisis | PEs and ORWs + orientation for Project Coordinator | In the 7th month | Trained trainers from HRGs with support from TSU |
2.3.3 Programme Monitoring

The project life-cycle of the TI follows a few phases of scale-up, which should be reflected in the monitoring and management of these TIs:

1. **Scaling coverage**
   a. Mapping of HRGs and defining where interventions need to be launched
   b. Commissioning TIs to ensure saturated coverage of HRGs at the state level

2. **Scaling infrastructure** (0-3 months)
   a. Improving infrastructure in respect to clinics and DIC (Safe Places)

3. **Scaling intensity of service delivery** (3-12 months)
   a. Ensuring regular outreach contacts with >80% of the population on a monthly basis
   b. Ensuring regular STI uptake for the population on a monthly basis
   c. Ensuring condom availability and accessibility
   d. Creation of an enabling environment – crisis response, power structure mapping and analysis
   e. Strengthening community initiatives – formation of community committees, seeding collectives, etc.

4. **Scaling quality of service delivery** (9-18 months)
   a. Improving service delivery
   b. Strengthening monitoring and evaluation of TI
   c. Improving linkages with DAPCU and other local administration
   d. Strengthening fund utilisation
   e. Strengthening referrals to TB units and other OI/VCTC/ART referrals
   f. Building CBO systems

The process of monitoring happens at three different levels:
- National level by NACO
- State level by SACS & TSU
- TI level by NGO implementing the project

Programme monitoring of state performance should assess the performance of the TIs based on the life cycle mentioned above.
- SACS/TSU should be assessed on all four phases
- NGOs/CBOs/TIs should be assessed on phases 2-4
2.3.4 Programme Management

2.3.4.1 Objectives of programme management

- To improve quality and management of TI
- To effectively deliver project services to the HRG
- To increase the coverage of, and uptake of services by, the HRG
- To provide training and hand-holding wherever required
- To identify and effectively fill gaps in TI implementation
- To set up efficient administrative and management systems to support these operations

2.3.4.2 Role of State AIDS Control Society (SACS)

The overall responsibility of implementing NACP III in the state belongs to the SACS. SACS plans, monitors and manages TI through partner organisations. SACS ensures adequate resources to accomplish goals and it will ensure minimum quality of interventions. SACS provides support and necessary mentoring to achieve its objectives. It reviews and monitors all partner organisations to identify gaps in TIs and address them.

2.3.4.3 Role of Technical Support Unit (TSU)

The TSU implements TI in the respective state along with SACS. TSU follows NACP III guidelines developed by NACO and facilitate its implementation along with partner organisations. The TSU facilitates the designing, planning, implementation and monitoring of sexual health interventions in the states on behalf of the respective SACS, and provides management and technical support to the SACS.

The TSU makes supportive visits to partner organisations and provides coaching and mentoring to NGOs and TI staff. It participates in periodic reviews of all partner organisations and provides necessary inputs. TSU staff includes project officers who visit TIs on a regular basis to assess quality of STI services, outreach, and M&E.

2.3.4.4 Role of Non-Governmental Organisations (NGOs)

NGOs implement TI in their respective project areas and achieve objectives laid out by the project plan. The implementation of TI follows the guidelines of NACP III. All NGOs report to SACS/TSU and can seek support wherever required. Each NGO prepares a project implementation plan along with its respective SACS/TSU. NGOs will liaise with DAPCU, local health authorities and other NGOs while implementing TI. They will work towards forming a CBO of HRGs and strengthen it so as to transfer their project to the CBO at the end of year five.

BEING IN THE FIELD

The key to successful programme management of TIs is field-level presence: TSU project officers should spend at least three weeks in a month visiting TIs to provide hands-on capacity building and problem solving support in three key programme areas: STI, M&E and outreach/community mobilisation.
2.3.4.5 Principles of CMIS for TIs

Because of the scale of TIs and the importance of information gathering, analysis and use by the project, NACO has developed a Computerised Management Information System (CMIS). The meaning of CMIS and its uses should be understood clearly by the community, partner NGOs/CBOs and SACS/TSU. CMIS:

- **is not** a means to find faults in the implementation process
- **is not** gathering of information to be used only for research purposes
- **is not** gathering of quantitative information only
- **is diagnostic**, i.e. to identify opportunity gaps in the project implementation
- **is supportive**, i.e. to help bridge opportunity gaps for optimum implementation of the project
- **is participatory**, i.e. the community, NGOs/CBOs and SACS/TSU are equal partners in monitoring

2.3.4.6 Timelines and key indicators

Programme management occurs at the levels of the SACS, TSU, JAT, and TI/NGO. Teams from each of these groups play a role in monitoring project progress against indicators.

The attached annexure 10, *Tool for Programme Management*, lays out the inputs, outputs, timelines, and monitoring guidelines for each of the programme areas.

An example of the programme management framework – Master Plan for TIs – is outlined below. This is for the programme component of BCC. Each other programme area (e.g., mapping, STIs, condoms, community mobilisation, peer engagement) has its own table like the one below.

<table>
<thead>
<tr>
<th>Programme Component</th>
<th>Behaviour Change Communication / Interpersonal Communications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prerequisites</strong></td>
<td>1. TI coverage area and denominator fixed</td>
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<tr>
<td></td>
<td>2. TSU contracted and fully staffed</td>
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<tr>
<td></td>
<td>3. NGO contracted and funded as per NACO guidelines</td>
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<td></td>
<td>4. NGO outreach staff (esp. project coordinator, outreach workers, advocacy officer) recruited to cover intervention area as per staffing guidelines</td>
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<td></td>
<td>5. Site validation process completed</td>
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<td>6. Peer educators from HRG recruited to cover all sites as per peer selection guidelines</td>
</tr>
<tr>
<td><strong>Input</strong></td>
<td>1. Annexure 6a, <em>Tool for Dialogue Based Interpersonal Communication (IPC) By and With HRGs</em></td>
</tr>
<tr>
<td><strong>Output</strong></td>
<td>1. IPC packages for risk reduction</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Activities</th>
<th>Primary responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapt IPC and BCC toolkits for local use</td>
<td>SACS</td>
</tr>
<tr>
<td>Train NGO staff and peer educators on IPC methods - especially the value of analytical thinking and problem solving among community members to arrive at local solutions to HIV/AIDS risk and vulnerability issues</td>
<td>SACS</td>
</tr>
<tr>
<td>Train NGO staff and peer educators on strategic planning for BCC message development</td>
<td>SACS</td>
</tr>
<tr>
<td>Review NGO-developed BCC materials and NACO/SACS materials for message consistency / message reinforcement</td>
<td>SACS</td>
</tr>
<tr>
<td>Conduct IPC capacity standards jointly with NGO staff and peer educators every six months to assess quality of IPC and identify areas for improvement</td>
<td>SACS</td>
</tr>
</tbody>
</table>

**Tools**

- Annexure 6a *Tool for Dialogue Based Interpersonal Communication (IPC) By and With HRGs*
- Annexure 10 *Tool for Programme Management*
2.3.5 Financial Management

Available funds should be used in accordance with plans and proposals given to SACS/NACO/TSU. Proper accounting systems should be in place and all the necessary records should be maintained for internal/external auditing. For details, see the NACO NGO/CBO Guidelines.

Tool
NACO NGO/CBO Guidelines
Guidelines on Financial and Procurement Systems for NGOs/CBOs, NACO, March 2007
NACO STI Guidelines
CHAPTER 3

Targeted Intervention Guidelines for Female Sex Workers, Men who have Sex with Men and Transgenders
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Site assessment

Establishment of basic services

Peer Educator (PE) selection

Scaling up services

Outreach planning

Community mobilisation

Enabling environment

Linkages to other services

Programme management
3.1 INTRODUCTION: NEW INTERVENTIONS

These guidelines are designed for NGOs/CBOs starting a new targeted intervention (TI) to female sex workers (FSWs), men who have sex with men (MSM) and transgenders (TGs) or scaling up an existing intervention. Where an intervention already exists, the process can be modified as discussed briefly in Section 3.5.

The guidelines assume that a desk review and/or broad mapping of existing TIs on the ground has been completed by an external agency, and that the number and location of sites, and an estimate of FSWs/MSM/TGs by typology, are available.
3.2 PHASE 1 OF INTERVENTION: START-UP

Phase 1 of the Targeted Intervention comprises four major steps: staff recruitment (except for Peer Educators) and training, site assessment, hiring of Peer Educators and establishment of basic services.

3.2.1 Step 1: Recruitment and Training of Staff (other than Peer Educators)

3.2.1.1 Hiring outreach workers and other TI staff

NACO staffing guidelines for TIs stipulate that one outreach worker should be hired per 250 HRG members. The NGO should plan its own selection methods, e.g. group discussion, written examination and interview. Peer educators from other existing projects or CBO members can be part of the interview process. Outreach workers should have the following profiles:

- Non-judgmental attitude and willingness to work with FSWs/MSM/TGs. A good understanding of the community mobilisation process is also a plus.
- Previous experience of working with the same or any other HRG is desirable but not essential.
- FSWs/MSM/TGs or their children should be given equal opportunity and priority if they meet the defined guidelines (e.g. educational and or other qualifications, reporting skills).
- Strong facilitation skills.
- Knowledge of local languages.

3.2.1.2 Capacity building of TI staff

Trainings should be conducted for the new staff on the following:

a. Basic induction on HIV/AIDS and understanding the FSW/MSM/TG community and the dynamics of sex work.

b. Skills in identifying and building rapport with FSWs/MSM/TGs and methodology of site validation.

3.2.1.3 Hiring and capacity building of community guides

Any intervention for high risk behaviours requires the active involvement of members of the community from the beginning. Guides selected from the community can help the field team gain access to the vulnerable group, identify locations, help to estimate the size of the group, collect data for the initial survey and assist the investigator throughout the assessment. This also establishes as a norm the involvement of the community in making decisions for all activities concerning them.

Guides’ compensation can be used from the ‘Peer educator’ line item within the TI budget.

Potential guides can be identified quickly among the following groups: risk assessment contacts who were from the community; referrals from peer educators from other existing FSW/MSM/TG TI projects; and recommendations from project staff with site experience. Select guides who meet the following criteria:
a. Available for the programme in terms of time
b. Keen to work in the programme
c. Representative of and accepted by the community
d. Representative of multiple “social networks” from different locations/sites
e. Knowledgeable of the local context and setting

Based on the staff induction training package, conduct a simple training for guides on HIV, the intervention and the process of site validation.

If a broad mapping was conducted with the assistance of NHRGCs, these NHRGCs can be leveraged by the NGO/CBO to identify potential local HRGs or community guides.

---

**Why not hire Peer Educators immediately?**

When a project starts, the TI staff may not know all the existing social and sexual networks. Selecting peer educators before understanding these networks can result in a skewed representation of the community. For example, an FSW programme hired 10 peers only to find that their total contacts did not exceed 100 FSWs. Upon investigation, they learned that all 10 peers were from the same social network and had overlapping contacts. This limited the extent of the intervention. Thus it is important to select peers from different social and geographic networks (at the 1:60 NACO recommended ratio).

---

### 3.2.2 Step 2: Site Assessment

The methodology of site assessment is referred to in Chapter 2.1.3.3 above, and described in detail in the [Annexure 2, Tool for Site Assessment](#). The assessment is conducted by trained members of the local HRG group, who conduct a series of interactive exercises with members of their community, using visual tools (drawings and maps) to solicit information.

The objectives of the site assessment are to determine the site-specific design of TIs through:

- Validation of broad mapping size and location estimates
- Contact with at least 50% of the broad mapping denominator at least once
- Gaining details on risks/vulnerabilities by typology and location for HRG members
- Initiating interventions

Apart from the quantitative information gained in the assessment, there are qualitative outcomes:

- Establish contact with community – the site validation helps the project to meet at least 50% of the estimated population in a given location on a one-to-one or group basis
- Generate interest and curiosity about the project
- Dispel myths about the intervention before it even begins, and communicate correctly the project’s scope and plans, avoiding false promises
- Identify potential peer educators for future hiring

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**Tool**

[Annexure 2 Tool for Site Assessment](#)
3.2.3 Step 3: Establishment of Basic Services

In order for the community to have faith in the project and see early signs of benefit from the project, basic prevention services (as per TI guidelines for FSWs/MSM/TGs) should be in place as early as possible. The basic services that can be established quickly are:

- Referral systems for treatment of STIs
- Availability of free condoms (and lubricants) through the project/staff/guides
- Setting up of a drop-in centre (DIC) (also known as a safe space)

3.2.3.1 Tips for planning services

It is important to get the FSW/MSM/TG community involved in the planning of all basic services. The FSW/MSM/TG community will be able to indicate what types of services they need beyond the project-driven ones. Use the following approach:

- Talk to the community in a group setting and make a list of all required/requested services
- Differentiate between services the project can offer and those for which linkages/referrals need to be established
- Explore with the community how project-driven services (condom promotion and STI services) can be incorporated

3.2.3.2 Safe spaces: Drop-in centres (DICs)

“Safe spaces” are critical in the early phase of service delivery, especially for street-based populations.

- Public sites such as streets, parks, etc. do not allow much contact time for outreach workers or peers, so the creation of DICs as safe spaces is important.
- At DICs, FSW/MSM/TGs can interact with each other, rest, seek advice, share information, approach someone in case of a crisis, or pick up condoms.
- Other popular DIC activities are teaching self-defence, literacy classes and rotational savings schemes trainings.
- Counselling and/or STI services can be provided at the DIC through counsellor and/or doctor visits on certain days/times. Referral to satellite services such as de-addiction, crisis response, social welfare schemes and services can also be provided through at the DIC.
- DIC should ideally be located close to the sex work sites or hotspots. The choice of the centre location will be dictated by availability and the preference of the community as to whether the centre should stand out or be relatively anonymous.
3.3 PHASE 2 OF INTERVENTION: FROM PEER EDUCATOR RECRUITMENT TO SCALE-UP

3.3.1 Step 4: Peer Educator Selection and Training

3.3.1.1 What is a Peer Educator (PE)?

A peer educator (PE) is a person from the HRG who works with her/his colleagues to influence attitude and behaviour change. PEs are responsible for providing information on HIV/STIs and harm reduction, and promoting condom use among colleagues/peers, which ultimately results in peer pressure for behaviour change. They can also distribute condoms, lubes, needles and syringes. They also provide basic data for monitoring the project. A PE is paid an honorarium as per NGO/CBO costing guidelines for her/his contribution to the TI project.

The PE to FSW/MSM/TG ratio is set at 1:60 – one PE for 60 FSWs/MSM/TGs

3.3.1.2 Why peer education?

Peer education enables members of a given group to effect change among other members of the same group. It is considered to be one of the most effective and sustainable tools for changing group behaviour. Peer educators play an important role in TI implementation as they can:

- Help to build trust and establish credibility with the vulnerable group
- Provide a vital two-way link between the project staff and the community
- Provide important information about the vulnerable group to other stakeholders and the wider community
- Reach a large number of people effectively
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility)

3.3.1.3 Role of PE

- Conducting outreach: this includes identifying new FSW/MSM/TGs as well as maintaining regular contact with her/his own network of 60 FSWs/MSM/TGs. This might entail contacts on a weekly or bi-weekly basis within any given month.
- Able to meet all her/his contacts minimum once in 15 days
- Providing dialogue-based IPC to FSWs/MSM/TGs
- Encouraging service and commodity uptake - motivate FSW/MSM/TGs to come to DIC, distribute condoms, make referrals for sick FSWs/MSM/TGs
- Advocacy with the known power structure
- Training of new PEs from within the project and outside
- Maintaining the DIC
- Generating demand for Welfare Programme and facilitating identification of beneficiaries
- Regular visit to condom service centres to gather information and to improve service
- Building skills of priority groups in understanding and assessing high risk behaviour, and in condom use, condom negotiation, identification of STIs, etc.
- Attending review meetings
- Preparing and presenting the daily reports to ORWs
- Report preparation for activities implemented
- Attending all trainings, workshops and seminars
A good peer educator maintains her/his social network with a great deal of effort. When new entrants into sex work enter her geographic/peer network, a FSW PE should be able to identify them and introduce them to services as soon as possible.

A PE should also be able to identify and segment her/his portfolio to identify and serve those FSWs/MSM/TGs with the highest risk profile (high volume, low condom use, new and young FSWs/MSM/TGs, those with a high volume of anal sex transactions).

### 3.3.1.4 PE selection criteria

- Available for the programme in terms of time
- Committed to the goals and objectives of the programme
- Representative of, and accepted by, the FSW/MSM/TG community
  - Representative of multiple “social networks” from different locations/sites
  - Representative in terms of age of their social network
- Knowledgeable of the local context and setting
- Sensitive to the values of the community, and able to maintain confidentiality
- Values accountability to her/his FSW/MSM/TG community and not just to the project
- Tolerant and respectful of others’ ideas and behaviours
- Good listening, communication, and inter-personal skills
- Demonstrates self-confidence and show potential for leadership
- Potential to be a strong role model for the behaviour she/he seeks to promote with others
- Willing to learn and experiment in the field
- Committed to being accessible to her/his peers in times of crisis

### 3.3.1.5 Process of PE selection/recruitment

**Informal approach to selecting potential PEs**

a. Treat community guides as potential PEs during qualitative and quantitative surveys or when getting to know the community (see Section 3.2.1.3).

b. Give priority to existing guides and key informants if they are suitable to join training for peer education. Ask them if they are willing to work as PEs.

c. Explain why you want to work with them.

d. Tell them how much time they will need to spend working as peer educators.

e. Explain the method of selecting PEs (i.e. training, assessment, etc.)

f. Work out a possible strategy for a peer outreach cycle in collaboration with selected peers.

**Formal selection process**

The formal selection process should be clear and transparent to all FSWs/MSM/TGs in the area. The peer selection process should be well publicized within FSW/MSM/TG networks so that all those potentially interested in being peers can be considered for selection.

a. Conduct basic interviews to rank the candidates based on the criteria listed in Section 3.2.2.1.3 above.

b. Conduct a Contact Mapping exercise, facilitated by ORWs, to determine the size of the potential candidate’s social network and whether she/he is well networked within her/his community (for details, see Section II of Annexure 5, Peer-Led Outreach and Planning).

c. Consolidate the lists from all peers to assess the overall contacts. Discuss with them to understand the duplication of contacts. If there is duplication, discuss who knows the duplicated FSWs/MSM/TGs better.

d. Ask each potential peer to bring her/his contacts to the project office. Organise a meeting with them to assess her/his contacts/rapport with the group.

e. Discuss with the group and find out whether they will accept/nominate her/him as a PE.
f. Discuss and establish systems for monitoring the PE’s performance by the community as well. Community members should able to contact the project if they have any issues related to the PE.

g. Select the PEs based on the above consultations.

3.3.1.6 Capacity building plan for PEs

As with other staff, PEs require support and training from the programme/NGO in several key areas:

- Sex and sexuality
- Sexual and reproductive health
- STI and peer role in STI management
- Basics of HIV/AiDS
- Condom promotion
- Negotiation skills
- Self esteem
- Care for PLWHA
- Peer-led monitoring
- Advocacy
- Community mobilisation

For details, see Annexure 3, Tool for Peer Education.

3.3.1.7 Review and Rotation of PEs

Every six months, the performance of PEs must be reviewed against indicators spelled out in Chapter XX. Since all key components fo TI are led by PEs, this review is critical to keep track of quality of the intervention.

PEs should be selected for a period of 12 to 18 months. The peer selection process described above should be repeated after 12 to 18 months to ensure that the PEs in the network are “active” peers, and not PEs whose social networks have eroded/changed. This method also provides opportunities to more FSWs/MSM/TGs to participate and develop second-line leadership.
3.3.1.8 PE progression pathways

Providing clear progression pathways for PEs is critical. The table below indicates the types of growth and positions PEs can attain. It should be noted that the progression pathways and positions shown are indicative only and not watertight compartments, and they may vary according to realities on the ground.

<table>
<thead>
<tr>
<th>Growth Progression</th>
<th>1st Stage (Initial)</th>
<th>2nd Stage (Growth)</th>
<th>3rd Stage (Growth)</th>
<th>4th Stage (Mature)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizontal growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>within project</td>
<td>Community member</td>
<td>Active member</td>
<td>Peer Educator</td>
<td>Coordinator of committees</td>
</tr>
<tr>
<td></td>
<td>Peer volunteer</td>
<td>Community guide</td>
<td>Core Committee</td>
<td>Advisory group member</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Educator</td>
<td>member</td>
<td>Peer mentor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer co-worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vertical growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>within project</td>
<td>Community Volunteer</td>
<td>Peer Educator</td>
<td>Sub-Committee</td>
<td>Coordinator of Core committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer volunteer</td>
<td>member</td>
<td>Team member</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer co-worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Across boundaries</td>
<td>At project /</td>
<td>Between projects</td>
<td>At programme level</td>
<td>At programme level</td>
</tr>
<tr>
<td></td>
<td>programme level</td>
<td>Peer Educator</td>
<td>Sub-Committee</td>
<td>Coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Core Committee</td>
<td>Member</td>
<td>Program Mentor</td>
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<td></td>
<td></td>
<td>member</td>
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<tr>
<td></td>
<td></td>
<td>Community consultant</td>
<td>Advisor-</td>
<td>Advisory group member</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>community development</td>
<td></td>
</tr>
</tbody>
</table>

For details on vertical growth within the project, see Annexure 4, *Peer Progression Pathways*.

**Tool**
- Annexure 3: *Tool for Peer Educator Training*
- Annexure 4: *Tool for Peer Progression*
- Annexure 5: *Tool for Peer-Led Outreach and Planning*

3.3.2 Step 5: Scaling Up Services

3.3.2.1 STI and other clinical services

3.3.2.1.1 Planning and mode of service delivery
Planning for STI services should be done with the FSW/MSM/TG community. It is important to gather the following information:

- Preferred list of physicians
- List of current barriers to accessing STI services
- Ways in which STI services can be made accessible and acceptable to FSWs/MSM/TGs in terms of location, operating hours, etc.
- Best mode of delivering STI services, e.g.: 
- **Intervention site based clinic:** This ensures confidentiality, less marginalization and better quality of care. Easy to follow up but difficult to sustain.
- **Referral to the public sector:** Services can be free but lack confidentiality, quality of services cannot be predicted and marginalisation of FSWs/MSM/TGs is unavoidable.
- **Referral to the private sector:** This ensures confidentiality and services can be sustained, but quality and costs are difficult to predict.

Once this information is gathered, health care services can be established through the preferred mode of service delivery. Special attention should be paid to ensuring **community-friendly STI service delivery** options:

- Clinicians with the right attitude towards the community
- Availability of services as per the needs of the community, e.g. late-night access
- Accessibility of services at optimal location (i.e. not too far from the major sex work sites, not requiring an auto ride)
- Basic infrastructure facility (facilities should be maintained at the standards stipulated by the NACO STI guidelines)
- Confidentiality between the clinic team and the community need to be maintained

Effective prevention and treatment of STIs among FSWs/MSM/TGs requires attention to both symptomatic and asymptomatic infections. The prevention and treatment of STIs in FSWs/MSM/TGs at NGO clinics should have the following two components:

a. **Management of Symptomatic Infections** – Using NACO syndromic management flowcharts and laboratory diagnosis where available

b. **Screening and Management of Asymptomatic Infections** – Quarterly history taking, physical examination and simple laboratory diagnostics (where available);
   a) Treatment for asymptomatic gonococcal and chlamydial infections at the first visit and repeated every six months; and
   b) Semi-annual serologic screening for syphilis.

The packages of STI/STI services to be provided are (see NACO STI Guidelines):

- 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.
- Immediate diagnosis and clinical management of STIs.
- Provision of STI medicines and directly observed therapy for single dose regimes.
- Health education and counselling for treatment compliance, correct and consistent use of condoms and regular partner treatment.
- Periodic check-ups, syphilis screening and treatment of asymptomatic infections.
- Partner management programs (i.e. contact referral).
- Follow up services.
- Counselling support for seropositive persons.
- Prophylaxis and treatment of simple Opportunistic Infections (OIs).
- Referral links to VCTC, HIV care and support and other relevant services.
- Strong linkages with outreach activities targeted at FSWs/MSM/TGs and their regular partners.
- STI surveillance as requested.

As per the NACO STI procurement guidelines, all STI drugs are to be procured by SACS/NACO. No drugs for STIs are to be purchased by NGOs.
### 3.3.2.1.2 STI management strategy and implementation approaches for FSWs/MSM/TGs

**Management Strategy**

<table>
<thead>
<tr>
<th>Technical Strategy</th>
<th>Role of NACO</th>
<th>Role of SACS/TSU/SSC</th>
</tr>
</thead>
</table>
| Accessible and acceptable TI static and outreach clinics | • Develop Clinical Operational Guidelines and Standards on  
  o STI management  
  o STI and HIV counselling  
  o Syphilis screening and laboratory quality assurance  
  o Establishing referral network | • Facilitate implementation of the clinical operational guidelines and standards |
| Adequate clinical services to provide effective STI services for FSWs/MSM/TGs (syndromic management of symptomatic STIs, regular screening and treatment of asymptomatic STIs for FSWs/MSM/TGs) | • Capacity Building of SACSs/TSU/SSC  
  o Training  
  o Regular technical support | • Capacity building of NGOs  
  o Training  
  o Adequate technical staff to provide regular technical support  
  o (this is defined as quarterly field visits to each TI to assess quality of STI services - see below for details) |
| Syndromic management of male clients | • Develop tools for clinic service monitoring (STI services, counselling including process, outcome and quality of services  
  • Monitor process and outcomes – clinical services  
  • Evaluate effectiveness of STI services | • Develop referral network for HIV testing, treatment and care  
  • Monitor STI referral services |
| Counselling on HIV risk reduction and informed choice on HIV testing | | |
| Utilization of strengthened strategic government facilities for STI services, HIV testing and treatment, TB treatment – upgrading of strategic government facilities | | |
### Implementation Approach

<table>
<thead>
<tr>
<th>Technical Area</th>
<th>Implementation Details</th>
<th>Lead</th>
<th>Timeline and Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective and quality provision of STI services</strong>&lt;br&gt;that are acceptable and accessible: syndromic treatment of FSWs/MSM/TGs, regular screening (speculum and proctoscopic exam wherever necessary) and treatment of asymptomatic STIs including syphilis screening, STI services coordinated with outreach, ensuring condom promotion and community involvement</td>
<td>• TI-owned clinic established where cost-effective (≥ 1,000 FSWs/MSM/TGs/site or high risk)&lt;br&gt;• TI-owned outreach clinics (fixed day, fixed site) established to reach smaller number and most at risk FSWs/MSM/TGs&lt;br&gt;• For smaller groups of FSWs/MSM/TGs (≤200) , establish linkages with strengthened STI government facilities or trained preferred service providers (private practitioners)&lt;br&gt;• Adequate and quality STI services, STI HIV counselling for FSWs/MSM/TGs&lt;br&gt;• Adoption of the NACO operational guidelines for STI management&lt;br&gt;• Ensure involvement of community members in clinic operations, including hiring and training of FSWs/MSM/TGs in clinic operations and management and quality monitoring&lt;br&gt;• Community members take ownership of the clinic – NGO supports community members to establish and design clinical services and to plan, manage and monitor them&lt;br&gt;• Adequate number of qualified, trained and supervised staff (MBBS physician) and counsellors to provide monthly STI screening and clinical services&lt;br&gt;• Adequate resources and commodities to provide free STI drugs, condoms and to implement operational guidelines and establish referral network&lt;br&gt;• Regular coordination of clinic staff and outreach/peer education</td>
<td>TSU/SACS/NGO</td>
<td>Clinic established within 6 months of NACP III&lt;br&gt;Outreach clinic established within 12 months&lt;br&gt;Established by 18 months&lt;br&gt;SCM by 1st year&lt;br&gt;Asymptomatic treatment by 2nd year&lt;br&gt;Universal regular STI check-ups by 3rd year&lt;br&gt;Community ownership of clinic: ongoing</td>
</tr>
<tr>
<td><strong>Referral Network for HIV prevention and care continuum</strong></td>
<td>• Identification of referral organisations with the community, documentation and follow-up of referrals, organise meetings on referral mechanisms&lt;br&gt;• Establishment of formal referral mechanism to quality HIV testing and counselling. HIV testing and counselling referral facility should be sensitive to FSWs/MSM/TG special issues and have a strong referral mechanism to HIV treatment, care and support and other related services. If referral mechanism is not present, clinic to establish its own.&lt;br&gt;• Establishment of formal referral mechanisms for management of complex OIs, TB and ART, including follow-up management&lt;br&gt;• Establishment of linkages to community care and support and self-help groups&lt;br&gt;• Clinic maintains a referral directory, documents referrals and ensures follow-up</td>
<td>TSU/SACS/NGO</td>
<td>Clinic with established referral linkages by 9 months&lt;br&gt;Full referral network functional by 3rd year</td>
</tr>
<tr>
<td>Technical Area</td>
<td>Implementation Details</td>
<td>Lead</td>
<td>Timeline and Frequency</td>
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</tbody>
</table>
| Broader referral systems for additional services as necessary (TB management, STI complications, medical care, social support, legal support, IDU services) | • Establishment of other referral linkages based on community-identified needs and available service in the community.  
• Clinic maintains referral directory of other services, documents referrals and ensures follow-up of referral services                                                                 | NGO            | Referral directory developed within 6 months of establishing clinic  
Referral mechanism established                                                                 |
3.3.2.2 Condom programming

Ensuring availability, accessibility and correct and consistent usage of condoms by HRGs is a core imperative of NACP III. Free condoms for FSWs/MSM/TGs will be sourced to meet their expressed needs, e.g. condoms with extra lubrication and length.

Free condoms for FSWs/MSM/TGs (and also for MSMs) will be designed to meet their specific needs. Prior experience shows that both FSWs/MSM have expressed need for condoms with extra lubrication and length, and MSMs in particular express interest in free condoms of extra thickness.

### 3.3.2.2.1 The basics of free condom programming for FSWs/MSM/TGs

- Ensuring availability alone is not enough – distribution does not equal usage
- Ensuring accessibility is not enough – access does not equal usage
- The goal is increased correct and consistent USE of condoms by FSWs/MSM/TGs

**Address barriers to condom usage** – It is important to understand various aspects related to condom usage among the FSW/MSM/TG population at the site level before initiating condom programming. Considerations may include:

- The barriers to condom usage, e.g. alcohol intake, “difficult clients”
- Misperceptions and myths regarding condom usage, e.g. not required for anal sex
- Condom availability in the area
- Condom accessibility – are condoms available at the point of sex (or does FSW/MSM/TG have to travel to procure the condom) and at the time of sex (often in the evening/at night)
- Creating demand for condoms (see guidelines for Condom Social Marketing)

**Assessing the condom requirement at any given site of intervention** is critical in order to ensure condoms are not being “dumped” or stock-outs are not occurring. Ultimately, condom availability depends on the risk profile of the individual site and cannot be averaged/aggregated at the state level.
The following formula can be used to calculate condom requirement for a FSW at a given site:

\[ D = (S \times I \times N) - C \]

where
- \( D \) is the condom requirement
- \( S \) is the number of FSWs operating in the area
- \( I \) is the number of sex acts per day
- \( N \) is the number of days that a sex worker is “active” in a given month
- \( C \) is the number of condoms brought by clients from other sources

\( S, I \) and \( N \) can be determined through the processes of site assessment and outreach planning. \( C \) can be determined by local SMOs, through special surveys of FSWs. If such surveys have not yet been carried out, the NGO/CBO can estimate the proportion of condoms brought by the clients by polling a random sample of FSWs.

Establish distribution channels – Key channels for ensuring condom distribution to FSWs include:
- **Direct distribution** – Condoms given directly to FSWs are more likely to be used and less likely to be wasted.
  - Distribution by PEs and ORWs in the field
  - At the DIC
  - At the STI clinic
- **Indirect distribution** – Locations should be chosen carefully to minimise wastage or the chance of the condoms being sold.
  - Condom outlets (e.g. public toilets, petty shops, tea shops, lodges)
  - Condoms stockists from the sex circuit (e.g. lodges, bars, brothel Madams, brokers, auto drivers)

Monitoring condoms occurs at three levels:
- **Monitoring distribution/availability** – This can be done at the PE level to ensure that all high-risk acts are covered by distribution channels. Availability of condoms at hotspots, especially beyond 9:00 p.m., should be measured by state by an independent research firm. The target is to ensure over 80% availability.
- **Monitoring accessibility** – This can be done in a variety of ways, including condom depot monitoring and individual tracking through PEs (see Annexure 5, Tool for Outreach Planning and Management).
- **Monitoring usage** – This can be done through PEs, used condom depot (counting used condoms at sex work sites and matching with estimated sex acts), peer counsellors at the clinic.

3.3.2.2 The basics of social marketing (SM) of condoms

Condom social marketing follows two paths vis-à-vis FSWs/MSM/TGs:
- **NGO/CBO enables availability of socially marketed condoms at hotspots**
  SM aims to make sure that different brands of condoms (preferred choices) are available at/near pick-up points/places of sex (hotspots), including bars and lodges where sex work takes place. The SMO should prioritise all hotspots in towns with over 50 FSWs/MSM/TGs. Only following this should the SMO target urban and semi-urban areas where there are fewer FSWs/MSM/TGs. If the client or FSW/MSM/TG wants a different brand, it should be available within 5 minutes’ walk from the place of solicitation/place of sex. NACO/SACS are collaborating with SMOs to promote SM of condoms. It is suggested that NGOs/CBOs coordinate/collaborate with the SMO within their project area to ensure that condoms are being stocked at hotspots. The role of ensuring that condoms are available at hotspots lies with SMOs. NGOs/CBOs engaged in TIs can enable this by:
- Identifying locations/areas where availability of condoms should be ensured and passing the information to the concerned SMO
- Providing feedback to SMO on a regular basis regarding availability of condoms and incidents of stock-outs in the intervention area
- Sharing information with SMO on newly identified sex work locations and new hotspots as and when identified
- Creating awareness of the availability of condoms among FSWs/MSM/TGs and clients
- Meeting periodically with SMO to share the field realities and for further improvement

b. CBO/collective sells socially marketed condoms to HRGs

In select cases, where established demand from the community requires it, NGOs/CBOs may decide to provide socially marketed condoms to FSWs/MSM/TGs to supplement an SMO’s marketing efforts. It is anticipated that 70%-90% of condoms for FSWs/MSM/TGs will be available for free, and only in select locations (10%-30% of FSWs/MSM/TGs) will condoms be socially marketed.

The following points must be kept in mind when involved in SM of condoms:

<table>
<thead>
<tr>
<th>Dos</th>
<th>Don'ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>SM to FSWs/MSM/TGs should be implemented only if strong demand from the FSWs/MSM/TGs arises, and only if the willingness to pay for condoms is expressed by a large subset of the population.</td>
<td>SM must never be mandatory for NGOs/CBOs – providing condoms for free to FSWs/MSM/TGs is NACO’s policy.</td>
</tr>
<tr>
<td>Even if socially marketed condoms are being made available to the FSW/MSM/TG population, the free supply should not be pulled from the market – those FSWs who cannot afford them should always have access to free condoms.</td>
<td>Staff (e.g. PEs and ORWs) who distribute free condoms during outreach should not be employed to distribute socially marketed condoms, to avoid creating confusion among the FSW/MSM/TG population.</td>
</tr>
<tr>
<td>CBOs should be given preference for SM, rather than NGOs. Profits or subsidies from from SM should be retained by CBOs as development/seed money.</td>
<td>SM and brand promotional activities (e.g. street theatre to promote condoms) should be handled by the SMO, and not by NGOs or PEs.</td>
</tr>
<tr>
<td>SM will only be introduced after careful examination of number of potential sites.</td>
<td>The accounting of SM money should not be mixed up with the TI budget but be handled independently by an external agency.</td>
</tr>
<tr>
<td>Condom gap analysis (as per the section above) should be conducted. The free supply should be mapped against this, and only the gap should be filled by SM.</td>
<td>Fixing of SM targets for NGOs by SACS, or targets for FSWs/MSM/TGs by NGOs, should be avoided, as it creates a disincentive to ensuring free condom supply to those who most need it.</td>
</tr>
<tr>
<td>SMO must deputise its own team to stock and verify the condom availability to the CBOs.</td>
<td>Performance rating of NGO field staff or FSWs/MSM/TGs should not be based on SM performance.</td>
</tr>
<tr>
<td>A separate cadre of FSWs/MSM/TGs should be employed to &quot;sell&quot; these condoms.</td>
<td></td>
</tr>
</tbody>
</table>
3.3.2.2.3 Condom stocking/reporting
- Each implementing NGO should make sure they have an adequate stock of condoms. Reordering is recommended when there is 3 months’ stock in hand.
- NGOs should have adequate storage space for condoms. Care should be taken that they do not get damaged in storage or during transit to outlets.
- Documentation of condom supplies should be ensured. TI partners should be able to provide data on where, when and how many condoms are supplied.
- When assessing condom requirements, one should factor in the condoms required for condom demonstrations and trainings

3.3.2.2.4 Special studies to assess condom use
- Special studies can be carried out regularly to assess the changes taking place among FSWs/MSM/TGs in knowledge, attitude, and practice with focus on negotiation skills about condom use.
- Condom programming should be assessed as part of the annual review/evaluation and appropriate redesigning done accordingly.

Condom breakage during anal sex and the importance of lubricants/lubrication
A common complaint by HRGs is “breakage of condoms”. There are several possible reasons for breakage:
1. Poor quality of condoms
2. Condoms used after the expiry date
3. Incorrect use of condoms
4. Poor lubrication and use of incorrect lubricants

It is important to communicate that reasons 3 and 4 can be avoided by emphasising condom demonstrations and education on use of correct lubricants – water-based, not oil-based.
- Evidence suggests that most MSM use saliva as a lubricant. This is not optimal since saliva dries rapidly, becoming sticky, which thus can increase the level of friction and result in increased damage to the anus.
- Other forms of lubrication that are used include vaseline, ghee, butter or some other oil-based product – these oil-based lubricants can damage the condom (by damaging the latex)

3.3.2.3 Communication for behaviour change
The evolving communication strategies of NACP I and II have contributed to a significant increase in awareness about the infection, but this has not been matched by corresponding behaviour changes regarding safe sexual practices and optimal utilisation of services.

One of the key gaps identified is in the area of helping FSW/MSM/TG groups put HIV/STI prevention messages into practice in their own very local or individual contexts.

A two-pronged approach must be adopted to create behaviour change (see Annexure 6, Tool for Dialogue Based Interpersonal Communication By and With HRGs):
Continue to communicate messages to:
- Create awareness about the imperatives of using condoms for every penetrative sexual act, vaginal and anal, with clients or with regular partners
- Create awareness about utilising the services available for STIs, including the importance of regular screening, as well as other services like (ICTC, PPTCT, ART, partner notification)
- Create demand for services, e.g. condoms, STI services, other health services

Move beyond messages to encourage analytical thinking and problem-solving among individual and small groups of FSWs/MSM/TGs, so that they can arrive at and act on locally appropriate solutions to
overcome their barriers to HIV/STI risk reduction, through peer facilitated, dialogue-based interpersonal communication (IPC).

For a detailed description of condom programming, see NACO Tool for Condom Programming.

### 3.3.3 Step 6: Outreach Planning

The objective of outreach planning is to enable outreach to 80%-100% of the available FSW/MSM/TG population on a regular basis, in order to have maximum coverage and impact on HIV prevention. Outreach planning led by PEs is also a process for their empowerment which increases ownership of the project by the community and peers.

The elements of outreach planning serve the following purposes:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Quantifier</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve quality of outreach</td>
<td>Reach all contacts at least once</td>
<td>▪ Spot analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Contact mapping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Geographic and social networks</td>
</tr>
<tr>
<td></td>
<td>Reach all contacts regularly</td>
<td>▪ Sex work Typology-wise Outreach Planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Site load mapping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Seasonal Calendar</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Force field analysis</td>
</tr>
<tr>
<td>Improve service levels</td>
<td>STI clinic attendance, condom</td>
<td>▪ Preference ranking</td>
</tr>
<tr>
<td></td>
<td>distribution</td>
<td>▪ Peer map for condom distribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ Condom accessibility and availability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ mapping</td>
</tr>
<tr>
<td>Build PE capacity to monitor her/his</td>
<td>Monitors own performance and fills</td>
<td>▪ Peer Education Card</td>
</tr>
<tr>
<td>own performance</td>
<td>gaps proactively</td>
<td>▪ Peer Calendar</td>
</tr>
<tr>
<td>Continuously improve programming</td>
<td>Uptake of services</td>
<td>▪ Opportunity gaps analysis</td>
</tr>
</tbody>
</table>

The attached Annexure 5, Tool for Peer-Led Outreach and Planning, provides details on implementing these processes.
3.3.4 Step 7: Community Mobilisation

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

The following table summarizes the ways in which NGOs can enable the process of community mobilisation and CBO formation.

<table>
<thead>
<tr>
<th>Steps in community mobilisation within an NGO-led intervention context</th>
<th>Major activities</th>
</tr>
</thead>
</table>
| Increasing peer engagement and FSW/MSM/TG involvement in service delivery | • Ensuring peer-led (rather than ORW-led) outreach  
• Sharing of programme budget by NGO with peers and community members  
• Formation of community committees (see below)  
• Ensuring community-friendly services, e.g. FSWs/MSM/TGs involved in selection of doctors or counsellors |
| Networking within the community – moving beyond peers and building “community affinity” | • Conducting community meetings; specific activities can be developed to bring FSWs/MSM/TGs together in small groups initially, e.g.:  
  o Monthly meetings held by each PE with her/his contacts (60 as per guideline).  
  o Every quarter all PEs may bring their contacts together for a one-day event.  
• Involvement of FSWs/MSM/TGs in crisis response and management (see Annexure 7, Crisis Response System).  
• Legal support and literacy support for FSWs/MSM/TGs |
| Increasing community ownership of the programme | • Ensuring peer progression (see Section 3.3.1.8 above and Annexure 4, Peer Progression) |
| Improving governance/initiating CBOs | • Increasing membership of community groups or collectives through democratic processes  
• Capacity building of community groups, e.g. literacy, financial management |

3.3.4.1 Community Committees

Community Committees (CCs) are a model for empowerment of HRGs as well as a key tool for effective provision of services. As such, they should be formed in close consultation with members of the community, and the structures, roles and responsibilities of the committees and their members should be evolved by the NGO/CBO jointly with the community members.

For an overview of CCs and the process for their formation and maintenance, see Annexure 8, Community Committees.
3.3.4.2 Collectivisation and CBO development

Community mobilisation processes should be aimed at developing formal democratic community structures. The processes for transitioning and building CBOs are outlined in the NACO Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III.

<table>
<thead>
<tr>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annexure 4</td>
</tr>
<tr>
<td>Annexure 7</td>
</tr>
<tr>
<td>Annexure 8</td>
</tr>
<tr>
<td>Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III</td>
</tr>
</tbody>
</table>

3.3.5 Step 8: Creating an Enabling Environment

Providing services, supplying condoms and raising awareness may not by themselves result in sustained behaviour change. TIs must also address barriers to change and work towards creating an enabling environment that ensures the right conditions for change among individuals and the community. It is critical to advocate with policy makers, law enforcers and opinion makers to ensure a supportive environment for intervention.

3.3.5.1 What vulnerabilities do FSWs/MSM/TGs face?

FSW/MSM/TG vulnerability can be broadly divided into two categories:
1. Vulnerability within the sex circuit, e.g. violence, exploitation by clients, harassment by police, etc.
2. Broader socio-economic vulnerabilities, e.g. poverty, illiteracy, lack of savings

Both these vulnerabilities need to be addressed in order to enable FSWs/MSM/TGs to negotiate safer sex.

3.3.5.2 Stakeholder/Power analysis

The most important step in creating an enabling environment is a careful analysis of the power structures in which FSWs/MSM/TGs are involved. This analysis must be peer-led in order to be effective. It has to identify, and strategise to address, the various stakeholders who influence FSWs/MSM/TGs, whether directly or indirectly, positively or negatively. These are the people whose support can help to create an enabling environment for the TI.
The following diagram depicts some of the possible different stakeholders for a TI with FSWs.

A stakeholder analysis could use the following table, which indicates the steps in the process leading to a strengthened enabling environment. It will be seen that specific strategies have to be designed for each stakeholder to solicit positive support from them for the TI.

<table>
<thead>
<tr>
<th>Possible Stakeholders</th>
<th>Power/Influence</th>
<th>Expected role in intervention</th>
<th>Planned strategy/Activities</th>
<th>Expected Output</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothel owners</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Brokers</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boyfriend</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Police</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy makers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lawyers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NGOs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom sellers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shop owners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors/Health care Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lodge owners/Boys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td></td>
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</tbody>
</table>

For a detailed tool on power analysis, see Annexure 9, *Tool for Power Analysis*. 
3.3.5.3 Crisis response system

Harassment and violence towards FSWs/MSM/TGs is common and this causes a significant barrier to the HIV/AIDS outreach work of the project. When the obstacle of violence and harassment is removed through timely and proper crisis management and regular sensitisation and advocacy programs, it creates an environment that is conducive to the FSW/MSM/TG, building up their self-esteem, which in turn helps them to focus more on their health specifically in relation to STIs and HIV/AIDS.

As part of a TI, crisis response interventions increase outreach to members of the HRG, thereby strengthening the NGO's or CBO’s relationship with them and gaining their trust. Crisis response also facilitates the establishment of a good rapport between field workers and members of the HRG, which helps communication about prevention and treatments of STIs.

Essential ingredients of effective crisis management include:

- Trained and committed staff members who are willing to be “on call” 24 hours a day and to respond immediately when a crisis happens
- Effective communication mechanisms (i.e. crisis phones) that the community can contact
- Availability of information about crisis response to community members
- Experienced and committed lawyers who are willing to provide assistance 24 hours a day
- Networking, alliance-building, and sensitisation work with local stakeholders (especially the HRG) through regular meetings and education as appropriate. This includes community-level legal literacy sessions.
- Close alliances with other civil society organisations, activists and local media contacts who can advocate on behalf of the community when necessary
- Reflections on crisis management cases to improve and build internal capacities

For a detailed tool for a crisis response system for HRGs, see attached Annexure 7.

3.3.5.4 Police advocacy

Police advocacy is usually a critical component of efforts to create an enabling environment for FSWs/MSM/TGs. It is critical to seek support of the police since their support/hindrance directly or indirectly influences the lives (and therefore risk behaviours) of FSWs/MSM/TGs.

The process for police advocacy should follow the following steps:

1. Start from the top if possible, with the SACS/TSU approaching the DGP, ADG (law and order), ADG (training), etc. to explain the HIV situation in the state, why we need to work with FSWs/MSM/TGs and what concrete support we need from the police. The goal is to get facilitating directives from the top police officers at the state level to the district SPs and city Police commissioners to support HIV interventions with FSWs/MSM/TGs, and from the training wing of the police to enable the project to conduct police sensitisations. Facilitating directives can secure district police support along the following lines:
   - Nodal officers from the district police should be designated by the DGP/ADG (training) for each district to be invited to the TOT and coordinate sensitisation training at the district level
   - Ensure signing of ID cards of project staff and personnel by SP
   - If a FSW carries a condom, this should not be considered as a reason to arrest her
   - Take proactive action against perpetrators of violence against FSWs/MSM/TGs (e.g. domestic partners, rowdies)
   - Immediate action on complaints about violence against FSWs/MSM/TGs
   - Ensure humane and friendly attitudes and treatment if a FSW/MSM/TG is arrested/brought to the police station
   - Follow human rights laws/guidelines with FSWs/MSM/TGs
   - Provide necessary support to the project’s crisis response system
   - Be part of the DAPCU and provide necessary support
2. Police sensitisations at the district and town levels are done through a step-by-step approach:
   a. First at the State level through a TOT and then at the district level at the concerned police stations
   b. Involve police proactively in the training so that it does not appear to be just an NGO-led effort,
      e.g. inviting senior police officers to the training for the inaugural, involving trained police officers
      as resource persons for the training
   c. Prepare a multi-disciplinary team of trainers for each district, comprising the trained police
      officer/nodal officer, NGO staff, PEs, lawyers, etc. through the TOT. Interaction between the police
      and NGO staff and PEs is very useful in developing mutual understanding but must be handled
      carefully in the training
   d. The trained multi-disciplinary team to conduct district-level training at identified police stations. It is
      important to try to focus the training on police stations which are in hotspots, especially in big
      cities where there are many police stations
   e. The training must cover general issues of FSWs/MSM/TGs apart from HIV related ones
   f. Advocate simultaneously at the PS, subdivision and district levels for tangible support of the HIV
      programme, e.g. ID cards for the PEs if possible (or recognition of ID cards issued by NGOs),
      request not to arrest FSWs for carrying condoms, support for PEs’ fieldwork, etc.

3. The entire police advocacy should be backed up by the NGO-supported and community-led crisis
   intervention team, including legal support.

4. The DAPCU can also be involved in this effort if the direct approach with the police does not work.

Tools
Annexure 7  Tool for Crisis Response System
Annexure 9  Tool for Power Analysis

3.3.6  Step 9: Linkages with Other HIV Prevention/Care
Programmes Through DAPCUs

TIs should not operate in a stand-alone manner. NACO/SACS are implementing various programs in the
fields of HIV prevention and care at the district level. The District AIDS Prevention and Control Unit
(DAPCU) is a nodal agency at this level.

DAPCU will be an independent body functioning in every district. DAPCU will consist of:

- District health officials
- NGO representation
- Representatives from FSW/MSM/TG community

3.3.6.1  Role of DAPCU in TIs

The objective of DAPCU is to enhance all HIV related activities in the district and increase service delivery
to FSWs/MSM/TGs. DAPCU will provide active support to all TIs in the district. All NGOs implementing
TIs in the district will share their key indicators with DAPCU. DAPCU will be a part of a Joint Assessment
Team (JAT) supportive visit to all TIs. DAPCU will provide district-level insight to all SACS every month
and help SACS in formulating strategies for the district. DAPCU will coordinate between SACS and NGOs
in implementing TIs in the district.

All the feedback given by DAPCU to SACS and TIs will be documented and will be used in implementing
programme related activities in the district. SACS and all TIs will incorporate feedback given by DAPCU
into their activities.
DAPCU should enable intakes/referrals from TIs to other HIV activities in the district, e.g. VCTC, DOTS, ART.

3.3.6.2 Role of the DAPCU in enabling linkages of services

DAPCU operates within the District Health Society, sharing the administrative and financial structures of the National Rural Health Mission (NRHM). While the Unit reports to and works through the Chief Medical Officer of the District for medical interventions, it is also responsible for non-health related activities such as Adolescent Education Programme, supportive supervision of TIs, M&E and mainstreaming. These activities will be carried out through the office of District Collector or Zilla Panchayat.

DAPCU can be leveraged to provide following services to FSWs/MSM/TGs and their families:

- Ration card
- Voter identity card
- Domicile certificate
- Admission to schools for children
- Health facilities without stigma and discrimination
- DAPCU will network with district administration, police, local leaders and community groups to address the issue of harassment of FSWs/MSM/TGs

The category-wise district-level staffing structure proposed under NACP-III is:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Categories of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
</tr>
<tr>
<td>District Programme Officer (HIV/AIDS)</td>
<td>1</td>
</tr>
<tr>
<td>Assistant-cum-accountant</td>
<td>2</td>
</tr>
<tr>
<td>M&amp;E Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Support Staff</td>
<td>1</td>
</tr>
<tr>
<td>Additional Supervisors for NGO and Care &amp; Support Programmes</td>
<td>2</td>
</tr>
</tbody>
</table>
3.4 PROGRAMME MANAGEMENT

3.4.1 Hiring and Training Staff

3.4.1.1 TI Staff Positions

As per the NACO HR policy guidelines for TIs. TIs have the following staff:

- Project Coordinator
- Counsellor
- Accountant
- Office Support Staff
- Doctor (Part-time)
- Outreach Worker
- Peer Educator

3.4.1.2 Assessing attitudes and expectations

Appropriate staff recruitment in terms of attitude, knowledge and experience is essential for a successful project. Working with issues of sex and sexuality dictates that the members of the staff be comfortable with their own sex and sexuality. Sensitivity and understanding towards the targeted population is also essential. Staff recruitment should be balanced with respect to gender and should include professional personnel as well as community persons.

3.4.1.3 Establishing roles and responsibilities

Establishing clear roles and responsibilities will not only minimise confusion but can also add efficiency to outputs. The underlying component to establishing roles and responsibilities is flexibility. Staff should not grow accustomed to routine job duties and should be flexible when needed. As the project grows and intervention processes become sophisticated, staff should be expected to perform varying duties while multi-tasking. As an employer it is equally important to clearly communicate changing roles and responsibilities to your employees. The staff should be aware of what they are expected to do each time new duties are assigned. Furthermore, staff should be clear on the reporting line, that is, knowing who will hold them accountable.

For details on staffing, roles, procedures etc., see the NACO TI HR Policy.
### CMIS indicators for FSWs/MSM/TGs

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicators</th>
<th>Definition</th>
<th>Frequency of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peer engagement</strong></td>
<td>Ratio of HRGs to peer educators</td>
<td>A key measure of adequate resources for peer engagement in outreach. Derived from dividing the size estimation of HRGs into the number of active, paid peer educators.</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Proportion of outreach contacts made by peers</td>
<td>Key measure of extent of peers leading outreach activities. Derived from dividing the number of individuals contacted through peers during the month by the number of individuals contacted during the month.</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of peers receiving STI consultations during the month</td>
<td>Key measure of peers as role models. Derived from dividing the number of peers receiving STI consultations during the month by the number of active, paid peer educators.</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of peers receiving STI consultations who underwent internal/speculum exams</td>
<td>Key measure of peers as role models and early adopters of prevention behaviour. Derived from dividing the number of peers receiving STI consultations who undergo an internal exam with the number of peers receiving an STI consultation.</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>Proportion of peers receiving STI consultations</td>
<td>Key measure of peers as role models and early adopters of prevention behaviours. Derived from dividing the number of peers receiving at least one STI consultation during the quarter, by the number of active, paid peer educators with the program at the end of the quarter.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Service uptake</td>
<td>Denominator: Number of individual HRGs mapped (as per broad mapping estimate)</td>
<td>Total estimate of individual HRGs mapped in a specific geographical coverage area - Methods of size estimation studies include: mapping, PSA, capture and recapture methods. The standardized methodology used to conduct an estimation must be articulated by the group doing the size estimation, and the updated figure should be entered along with target group, source, month, and year of study.</td>
<td>One time</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Proportion of denominator who are being contacted monthly</td>
<td>Measure of proportion of mapped high risk groups who are being contacted by the program (through outreach) - the expectation is that all High Risk Group members should be contacted at least once a month. Derived by dividing the number of individuals contacted during the month by the denominator (the number of individual HRGs mapped by the project as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of monthly risky sexual acts covered by free condom distribution through peers and depots</td>
<td>Key measure for determining coverage of risky sexual acts through free condom distribution, and if free condom distribution matches up with estimated need. Derived from dividing the number of condoms distributed through free condom distribution by the number of estimated monthly sex acts with clients. If there is a particularly high wastage factor in a particular area due to double usage and breakage of condoms, then the demand can be adjusted accordingly.</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of denominator who have ever attended a programme, referral or outreach clinic</td>
<td>Key measure of broad coverage of STI services for HRGs. Derived by dividing the number of high risk group individuals who have visited the all types of clinic (programme, referral and outreach) at least once from the beginning of the program establishment, by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Cumulative</td>
<td></td>
</tr>
<tr>
<td>Metric</td>
<td>Description</td>
<td>Frequency</td>
<td></td>
</tr>
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<td>-----------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>Proportion of denominator who come to the clinic every month</td>
<td>Key measure of monthly coverage of STI services for HRGs. Derived by dividing the number of high risk group individuals who have visited the all types of clinic (programme, referral and outreach) at least once during the specified month, by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of HRGs who come for STI check ups during the quarter</td>
<td>Measure of health seeking behaviour of community with respect to STI care. Derived by dividing the number of high risk group population individuals who received an STI consultation during the quarter, by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>Proportion of HRGs who come for STI check ups during the quarter who were treated (as % of those who came during the quarter)</td>
<td>Derived by dividing the number of high risk group population individuals who received an STI consultation during the quarter and received treatment, by the number of individuals who received an STI consultation during the quarter.</td>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>Proportion of monthly clinic visitors who are 'repeat' (vs. first time)</td>
<td>Derived by dividing the number of clinic visitors who are repeat visitors (not making their first visit) during the month by the total number of clinic visitors during the month (sum of first time and repeat visitors)</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of individuals with repeat STI symptoms who visit with symptom duration of less than 7 days</td>
<td>Individuals making repeat visit for STI symptom (not first time STI symptom visit) who report symptom duration as &gt; 7 days. This is a key indicator for assessing treatment seeking behaviour in the HRG population.</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of HRGs receiving STI consultations who underwent internal exams</td>
<td>Key measure of adoption of prevention behaviour. Derived from dividing the number of high risk group individuals receiving STI consultations who undergo an internal exam by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Enabling environment</td>
<td>Number of reported incidents of rights violations against HRGs</td>
<td>Rights violations include any incident that violates Indian law where one or more community members are subject to extortion, abuse, violence or unlawful arrest by police or goons. This does not include incidents where the police might have acted as per provisions of Indian law. Tracking should be done regularly through peers and consolidated by NGO in a separate register and the NGO should determine, in consultation with community, if the reported incident is a rights violation before reporting it here.</td>
<td>Monthly</td>
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<td>---------</td>
</tr>
<tr>
<td>Proportion of reported incidents of rights violations or violence addressed within 24 hours</td>
<td>Derived by dividing the number of reported incidents of rights violations or violence by those number of reported incidents that are addressed within 24 hours. Addressal of cases means that peers and/or NGO staff should meet with affected community members and the concerned police officials within 24 hours to register a complaint and arrange for appropriate legal help; in case of rights violations by goons a desired action is to get a police case registered within 24 hours.</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of denominator referred to VCTC</td>
<td>Derived from dividing the number of individuals referred to voluntary counselling and testing centres (VCTCs), by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of denominator referred to ART</td>
<td>Derived from dividing the number of individuals referred for provision of antiretroviral therapy (ART), by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Indicator</td>
<td>Description</td>
<td>Timeframe</td>
<td></td>
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<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Proportion of denominator referred to DOTS</td>
<td>Derived from dividing the number of individuals who were referred to TB DOTS centres, by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Number of HRGs who have been assisted by TI to access any government service (e.g., ration card, voter id card, BPL card, school admission, housing, etc.)</td>
<td>Approved government ID cards include ration card, voter ID card, or PAN cards. This is only meant to report cases where the project has directly facilitated the issuance of the ID card - where individuals might have more than one ID card, please count as one. This indicator is to be monitored for increases over time.</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Community mobilisation Number of community groups or SHGs formed</td>
<td>The number of groups primarily organised to address issues important to the community (for example, violence, financial security, education, advocacy, welfare, cultural arts etc). Includes Self Help Groups, Community Based Organisations, and other community committees.</td>
<td>Cumulative</td>
<td></td>
</tr>
<tr>
<td>Number of members who are part of SHGs or community groups</td>
<td>Includes membership of high risk group individuals in various groups that are primarily organised to address issues important to the community (for example, violence, financial security, education, advocacy, welfare, cultural arts etc). Individuals who are members of multiple groups should be counted only once.</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Proportion of denominator who are part of SHGs/community groups</td>
<td>This is a gross indicator for community participation across the entire high risk group denominator. Derived from dividing the number of membership of high risk group individuals in various groups by the denominator (number of high risk group individuals who were mapped as per a broad mapping estimate).</td>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Number of meetings/events held for &gt;50 HRGs</td>
<td>The number of meetings or events held in one month for more than 50 high risk group individuals.</td>
<td>Monthly</td>
<td></td>
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3.5 EXISTING INTERVENTIONS

These guidelines have focused on **new** TIs through NGOs.

The steps for improving scale and scope of **existing** TIs will be slightly different.

For existing TIs, it is suggested that a formal review be carried out by an **Annual TI Evaluation Team** for stocktaking, and where necessary to redesign the TI to achieve maximum output according to NACP III. For details on this review, see the **NACO Annual Evaluation Checklist**.

The review focuses on the level and quality of the following key components and provides inputs into redesigning the programme accordingly:

1. Outreach
2. Programme service delivery coverage/gaps
3. Capacity of the TI team
4. Community mobilisation
5. Programme management systems
6. Financial system

Based on the satisfactory performance of the review, the extension of the TI in that particular project area can be decided upon.

The various tools and techniques suggested in the guidelines can be used to redesign the existing TIs to improve their overall quality.
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## NACO Guidelines and Tools referenced in these Guidelines

NGO/CBO Guidelines, NACO, March 2007
- Section 2.3.1, 2.3.5
- Guidelines on Transitioning, Transferring and Commissioning CBOs in TIs in NACP III
  - Section 2.3.1, 3.3.4.2
- Guidelines on Financial and Procurement Systems for NGOs/CBOs, NACO, March 2007
  - Section 2.3.5
- NACO STI guidelines
  - Section 3.3.2.1.1
- Tool for Condom Programming
  - Section 3.3.2.3
ACKNOWLEDGEMENTS

The following organisations are acknowledged for their work which is quoted or used in adapted versions in the text of the Guidelines and the Annexures.

**FSW/MSM/TG guidelines (Chapters 1-3)**
Avahan, Bill & Melinda Gates Foundation
CARE
Catalyst Management Services
Family Health International (FHI)
Humsafar Trust
INFOSEM (*Strategic Plan for Scaling Up Interventions for MSM and TG Populations*, Naz Foundation India, Humsafar Trust, in consultation with MSM/TG CBOs and community leaders, supported by DfID)
University of Manitoba/Karnataka Health Promotion Trust
Lawyers Collective
PATH
RCSHA
Sangama, Bangalore
SPYM
Tamil Nadu AIDS Initiative, Voluntary Health Services
UNAIDS

**IDU guidelines (Chapter 4)**
Dr. Suresh Kumar
Dr. Samiran Panda
Jimmy Dorabjee
Dr. Arup Chakraborty
SHARAN Project Network
UNODC
ROSA, New Delhi
NACP III Design Documents
Society for Community Intervention and Research Kolkata
The NACO Costing Guidelines,
Rusan Pharma Hand Book for Doctors
DOH International
The Centre for Harm Reduction (Macfarlane Burnet Institute),
Mahesh Nathan and the West Bengal Project Support Unit (A unit of Mott MacDonald India)