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HIV Prevention in Maharashtra, India

In October 2009 Suhel Jamadar, project coordinator of Muslim Samaj Prabodhan Va Shikshan Sanstha (MSPSS), reflected upon the organization's progress over the past 10 years. In 2004, five years after its inception as a small, grassroots organization working with marginalized women in the district of Kolhapur, MSPSS had contracted with the Bill & Melinda Gates Foundation's Avahan India AIDS Initiative (Avahan) to deliver HIV prevention services in the state of Maharashtra. Since that time, Jamadar had seen his HIV program expand from a small clinic to a prevention model that incorporated a wide range of services and stakeholders.

In 2008, however, the Gates Foundation began a phased transition of Avahan program ownership to the government of India. Avahan would transfer all of its programs in a stepwise fashion to the government by the end of 2013. In line with the plan, the government requested to receive the first 30% of programs by November of that year.

The MSPSS contract was scheduled to be one of the last programs to shift to government control in 2013, accompanied by a 15% decrease in the operating budget, despite an increase in the population it would be required to serve. MSPSS would need to reduce its employees' salaries to match government pay scales; close the program's clinics; and shift the care of its clients from MSPSS clinics to private providers. Jamadar considered how best to keep MSPSS accessible and maintain its quality of services.

The State of Maharashtra

With 1.13 billion people in 2005, India was the second most populous country in the world.[1] The vast majority of the population self-identified as Hindus (80.5%), followed by Muslims (13.4%), Christians (2.3%), and Sikhs (1.9%). The Republic of India was divided into 35 states. There were 15 official languages in India, including Hindi (41%), Bengali (8.1%), Telugu (7.2%), and Marathi (7%).[2]

The state of Maharashtra was located on the western coast of India and was bordered by the states of Goa, Karnataka, Andhra Pradesh, Chhattisgarh, Madhya Pradesh, and Gujarat.[3] Spanning 308,000 square kilometers, almost the size of Poland, Maharashtra consisted of 35 districts and two major cities, Mumbai

Claire Cole, Julie Rosenberg, Joseph Rhatigan, Rebecca Weintraub, and Professor Michael Porter prepared this case for the purposes of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.

(also referred to as Bombay) and Pune. Maharashtra's estimated population of 96.9 million in 2001 made it the second-largest state in the country. The majority of people resided in rural areas. Marathi was the state's primary language.[3]

In 2008 Maharashtra had a GDP of USD 132 billion, the highest of any Indian state.[4] Nearly half of all households were located in urban settings, where wealth disparities were most pronounced. Overall, about 25% of the state's population was living below the poverty line.[5] Just over half of the labor force worked in agriculture, 34% in service, and 14% in industry.[2] Fully 90% of the jobs were in the informal sector.[6] The unemployment rate in 2009 was 9.5% (see **Exhibit 1** for basic socioeconomic and demographic indicators of India).[2]

Health in Maharashtra

The Maharashtra State Ministry of Health and Family Welfare managed Maharashtra's government health system. This included 10,579 sub-centers, 1,816 primary health centers, and 407 community health centers.[5] Per national guidelines, sub-centers served as the first point of contact between community members and the primary health care system. They provided care pertaining to family welfare, maternal and child health, immunization, nutrition, and communicable disease control. For every six sub-centers, one three-person nursing team rotated among them to provide care and refer patients to primary health centers for further needs.[7]

Primary health centers served as the next level of care. They delivered basic preventive and curative care and were typically equipped with four to six beds and a staff of 15, including one physician. Community health centers received referrals from primary health centers and were staffed by a team of 25 that included a surgeon, gynecologist, pediatrician, and general practitioner. Community health centers had 30 indoor beds, x-ray technology, and emergency obstetric and specialist care capacity.[7]

Maharashtra had 23 district hospitals, 55 Ayurvedic (traditional Indian medicine) hospitals, and 45 homeopathic (alternative medicine) hospitals.[5] Most were located in the urban areas of Mumbai, Thane, and Pune. Only two of the district hospitals had at least 60% of critical supplies, and only nine had 60% of critical infrastructure in 2000.[8]

Maharashtra also had a private health care system, which was the largest and most developed of any state in India. These private hospitals and specialty clinics were required by law to provide services at no cost to 20% to 30% of their clients, although these targets were rarely met. The professional medical bodies did not self-regulate, nor did the government enforce the few national rules. This lack of regulation and enforcement was concerning as the private health care sector expanded (see **Exhibits 2 and 3** for health and socioeconomic indicators of Maharashtra).[9] A 2002 study looking at young women's medical expenditures found that 97% incurred expenses when using the private sector, and 71% incurred expenses in the public sector. The average cost per visit in the private sector was USD 1 and in the public sector USD 0.80.[10]

HIV in India

HIV was first discovered in India among a group of female sex workers in the southeastern state of Tamil Nadu in 1986, five years after the first known cases in the United States.[11] In the early years of the Indian epidemic, commercial sex workers and their clients were at the highest risk for contracting the virus. In the 1990s infection rates among Indian injecting drug users rose sharply.[12]

In 1992 the government created the National AIDS Control Organization (NACO) as a division of the Ministry of Health and Family Welfare to implement a national strategy to prevent and control HIV/AIDS. The government's first seven-year plan, the National AIDS Control Program (NACP-I), was launched that year and focused primarily on blood bank infrastructure and establishment of clinics to treat sexually transmitted diseases in district hospitals and medical colleges.

Under NACP-II, from 1999 to 2006, State AIDS Control Societies were created to coordinate activities at the state level. The National AIDS Control Organization's budget directly funded State AIDS Control Societies so they were not subject to state governments' budget allocation decisions.[13]

By the late 1990s, many feared that HIV was spreading beyond high-risk groups to become a generalized epidemic in India. This concern prompted many non-governmental organizations (NGOs) working on HIV prevention to expand efforts to the general population.[14] The National AIDS Control Organization focused on targeted interventions during the NACP-II, prioritizing services for female sex workers, men who have sex with men, injecting drug users, street children, and bridge populations, such as truckers and migrant workers that spread the disease from one group to another as they moved. Program guidelines were implemented at the state level via grants to NGOs operating in each state. The government established voluntary counseling and testing clinics and made antiretroviral treatment free in select public hospitals.[13]

HIV surveillance in India was conducted via antenatal clinic surveillance, using blood samples from the pregnant women to project prevalence rates. In 2000 the government of India began using sexually transmitted disease clinic surveillance to estimate prevalence among high-risk groups.

The third national plan, NACP-III, began in 2006 with the ambitious goal of "halting and reversing the HIV epidemic in India." Under this plan, government focus shifted to the district level, stressing outreach and services for high risk groups in the highest prevalence districts and scale up of interventions for the general population such as counseling and testing or prevention of mother to child transmission.

In 2007 the National AIDS Control Organization launched the Strategic Management Information System, a national computerized system, to coordinate monitoring and evaluation of the country's 35 State AIDS Control Societies. The Strategic Management Information System coordinated surveillance, monitoring, and evaluation nationally and aimed to standardize reporting. Technical Support Units provided capacity building services to State AIDS Control Societies' grantees.[15]

In 2007 new data showed 23% prevalence rates among high-risk groups in some states.[16] In collaboration with a variety of donors and technical groups, the Government of India integrated HIV surveillance into its existing National Family Health Survey.[a] The updated estimates found that about 2.5 million people were living with HIV, a reduction from the previous estimate of 5 million. India still had the third-largest HIV-positive population in the world. Prevalence among adults aged 15-29 was slightly less among females than males. Among females, HIV prevalence was higher in urban areas than in rural ones. Prevalence among injecting drug users was 7.2%, among men who have sex with men, 7.4%, and among female sex workers, 5.1%.[17]

[a] The United States Agency for International Development, the Department for International Development (United Kingdom), the Bill & Melinda Gates Foundation, United Nations Children's Fund, the United Nations Population Fund, and the Government of India provided funding for the third National Family Health Survey (NFHS). The National AIDS Control Organization and the National AIDS Research Institute provided assistance for the HIV component of the NFHS-3 survey. The Joint United Nations Program on HIV/AIDS, the World Health Organization, the US Centers for Disease Control and Prevention, and others were involved in the HIV estimates from the NFHS-3.

Most HIV infections in India occurred through heterosexual transmission. In the northeastern part of the country, however, injecting drug use was the primary cause of infection, particularly in Manipur. In the south, HIV was highest along the routes between Mumbai and its southern bordering state, Karnataka, as well as in coastal Andhra Pradesh and parts of Tamil Nadu (see **Exhibit 4** for states and districts with high HIV prevalence among specific groups.)[18]

HIV/AIDS in Maharashtra

Maharashtra was among the seven states with the highest HIV prevalence in the country, with a 2007 general population prevalence of 0.5% and a high-risk group prevalence of 11.6%, down from 12% three years earlier. HIV prevalence in the districts of Sangli and Mumbai was more than 3%, among the highest in the country.[16] Prevalence among injecting drug users was 24.4%, among female sex workers, 17.9%, and among men who have sex with men, 11.8% (see **Exhibit 5** for the Maharashtra districts with HIV prevalence higher than 15% by high risk group).[17,19]

The Maharashtra State AIDS Control Society (MSACS) coordinated NACP activities in Maharashtra. In 18 of Maharashtra's 35 districts, MSACS contracted with NGOs to deliver HIV/AIDS services, and in the remaining districts, MSACS ran the programs itself (see **Exhibit 6** for MSACS and NGO coverage of districts).[20] MSACS received condoms and other supplies from the National AIDS Coordinating Organization and was responsible for distributing them to the organizations it supported around the state.

Female Sex Workers

Solicitation for sex, exploitation for sex, and profiting from another's sex work were illegal throughout India. The exchange of money for sex was not (see **Exhibit 7** for profile of a commercial sex worker).[21] Domestically, Indian-born women and girls were trafficked between states. Foreign-born women — often from Nepal and Bangladesh — were also trafficked into India, accounting for up to 150,000 new sex workers entering the country each year. Many of these women were taken to work in major red light areas of the country, including Mumbai.[22] Most of these women and men came from impoverished families, had little schooling, and were illiterate.[23]

Sex work in Maharashtra was dispersed throughout the state. Tamasha dancers, part of traditional theatre groups, traveled between districts and did not identify themselves as sex workers for fear losing their partners, whom they relied on for financial security. In Mumbai and the nearby district of Thane, sex workers worked in brothels, bars, or on the street. Brothel-based sex workers were accountable to brothel owners and had to comply with brothel rules and regulations about which clients they could see, times they worked, and whether condoms were available freely on site. Street-based sex workers, dispersed throughout cities, towns, and villages, utilized a wide and varying range of lodges and transport stops as venues for sex. Home-based sex workers practiced sex work secretly, usually to support husbands, families, and children unaware of the source of their income. Like much of the informal sector in India, sex work could be migratory and subject to shifts in client demand. As a result, sex work often was concentrated in the villages and towns located along the national highway system, termed the "Golden Triangle" (see **Exhibit 8** for depiction of the national highway system).

About 26,000 female sex workers were estimated to be working in Mumbai and nearby Thane district, two of Maharashtra's smallest geographic districts. Maharashtra's remaining 33 districts were home to roughly 82,000 female sex workers.[5]

Men who Have Sex with Men

Until July 2009, any form of homosexual sex was punishable by up to 10 years in prison.[24] There was also stigma around homosexuality from widely perceived religious prohibition. Many of the men who have sex with men were married with children and were reluctant to be associated with any services or groups that might affiliate them with homosexual sex. Same-sex behavior was not associated with a distinct gay identity, as in the Western cultures. There was a large underground culture, however, that flourished, consisting of behavior and codes of communication recognized only among men who have sex with men.[25] In large cities the stigma was somewhat lessened,[26] but there were no openly gay restaurants or bars. Sexual intercourse took place in private places or in public places such as public toilets, bus stops, alleys, cinema halls, temples, rail and bus stations, and construction sites. Specific sites would become well-known and used frequently among a particular group of MSM until the police or some other factor forced the group to change venues.[25]

A study of 2,381 men attending sexually transmitted disease clinics in Mumbai found that 66% had sex with females only; 10% had sex with females and *hijras* (transgenders); 13% had sex with males and females; 11% had sex with males, females, and *hijras*; and less than 1% had sex with males only.[27] Another study enrolling 122 men who have sex with men in Mumbai found that most were laborers, with a median of five partners in the last six months. About 44% reported ever having visited a female sex worker.[28]

Thousands of homeless and poor boys and young men, including truck driver assistants, also engaged in sex with men — often their male bosses — in exchange for job security.[29] There were also full-time or part-time male prostitutes who sought male clients by offering massage services in parks, beaches, hotels, and houses. Brothels for men who have sex with men were rare. The Maharashtra government estimated there were 32,000 men who have sex with men in the state.[20]

Injecting Drug Users

A study in Madras found that most injecting drug users were between 25 and 34 years old and were literate; slightly less than half were married.[30] Heroin, buprenorphine, and diazepam were the drugs most commonly injected. Heroin users formed the largest networks.[31] Most drug users were men and lived with their families despite heavy drug use.[30] Injecting drug users often used drugs in chaotic street scenes, abandoned buildings, public toilets, and in the facilities where they purchased them from dealers. Users tended to congregate in these secluded settings, and a study in Southern India found direct needle sharing (69%), as well as indirect sharing (94%; sharing of substances, tools or the drug solution itself), were common.[31]

History of MSPSS

Under Islamic law in India, Muslim men could orally divorce their wives without establishing cause or seeking legal counsel. Because many of these women had children, most were considered unfit to remarry and were thus made permanently dependent on aging parents for security. In 1983, having seen the effects of this practice on his own family, 20-year-old Hussein Jamadar formed a group in Kolhapur to support divorced mothers in building skills to generate income or remarry. The group also created a community kitchen and helped support the women's children. As Hussein Jamadar remembered, "I took care of those children as though they were my own, but it was a very difficult time then. We did not have sufficient resources to fully support all of the women and children who needed our help."

Hussein Jamadar and the 13 founding MSPSS employees applied for charity status with the state government and began advocating for making oral divorce in the Muslim community illegal. Through

this work, Hussein Jamadar developed a rapport with vulnerable community members and came to know many influential individuals in the Kolhapur Muslim community.

In 1999 Hussein Jamadar's son, Suhel, joined MSPSS as project manager of targeted intervention. He had recently completed graduate work on HIV/AIDS and had worked in a STI clinic at a government hospital. He brought doctors from the government hospital's sexually transmitted diseases department into the brothel areas to provide clinical services to sex workers.

MSACS began operating in 1999 and observed a shortage of HIV prevention NGOs working in the state. Thus, MSACS asked MSPSS to submit a proposal for government funding to serve as an HIV prevention service delivery site for brothel-based sex workers in Kolhapur. MSPSS was awarded funding to establish and run a stand-alone clinic to provide sexually transmitted disease syndromic management and treatment services to 600 to 800 brothel-based sex workers. It was also contracted to distribute condoms, raise awareness about sexually transmitted diseases and HIV/AIDS, and create an "enabling environment for safe sex work."

MSPSS began its work by stocking the new clinic with the list of medicines and equipment provided by MSACS, namely sexually transmitted disease medications. MSPSS leaders called upon informal relationships with doctors in the area to find staff. Because MSACS did not provide technical assistance or managerial oversight for grantees, MSPSS had little contact with MSACS or the other grantees and developed its own unique service delivery process. MSPSS was required to report the number of clinic visits and condoms distributed to MSACS. MSACS' supply of condoms and funding was inconsistent, leading to frequent stock-outs at many NGOs. MSPSS leaders felt that clinical services and procurement would improve over time.

MSPSS wanted to find a more comprehensive way to address the diverse set of needs that Kolhapur's high-risk communities were experiencing, but the means to do so was unclear. As Suhel Jamadar reflected, "Whenever the sex workers would have problems or experience violence, they would come to us, but we would tell them they had to deal with the police themselves. If they were doing illegal work, how could we help them? What could we say, and on what basis? That was our thinking at the time." MSPSS wanted community members to learn to better negotiate with clients, rickshaw drivers, pimps, lodge owners, brothel owners, and the shop keepers in front of whose stores they stood, as violence was a common part of these interactions as well. The sex workers were less concerned about HIV than these other immediate threats and the ability to feed their families.

MSACS would not allocate funds to MSPSS for violence intervention or other social services, however, and the MSPSS community kitchen closed. MSPSS staff educated clients about government entitlement programs and encouraged them to apply and enroll for food ration programs themselves. MSPSS also began to advocate for the National AIDS Control Organization to expand the government HIV program to include support for ration cards.

Avahan and the Mukta Project

In 2004 MSPSS received a visit from the Boston-based NGO Pathfinder International, which was seeking a USD 8.5 million grant from the Bill & Melinda Gates Foundation (the Gates Foundation). Pathfinder was trying to identify local NGOs across the state that it would sub-contract if it won the grant. Pathfinder requested MSPSS' accounting processes, qualifications of staff members, governance structure and decision-making processes, and training needs — information it would have to include in its proposal to the Gates Foundation.

The Gates Foundation had launched in 2003 the Avahan Indian AIDS Initiative (Avahan) with initial funding of USD 100 million to "stem the tide" of the HIV epidemic in India within the first five years of

operation through targeted interventions for high risk groups. In its central office in New Delhi, Avahan had a 15-person team from the business and public health sectors that was directed by two former global management consultants.

At the state level Avahan planned to contract national and international NGOs as "state lead partners" to coordinate efforts in each of the six states Avahan operated. With support from their designated program officer within Avahan's central office, they identified organizations with established relationships in hard-to-reach, district-level communities. State lead partners would contract with these organizations to carry out HIV prevention programming in their respective districts and provide them with technical, financial, and logistical expertise (see **Exhibit 9** for Avahan organizational structure).[32]

Pathfinder was designated as one of two state lead partners in Maharashtra in 2005. Pathfinder lacked experience working in Maharashtra but since 1957 had been delivering reproductive health services in resource-limited settings around the world, including Africa and other parts of India. Pathfinder believed that STI clinical services alone were an insufficient HIV prevention model and proposed an integrated approach to HIV services that would acknowledge all of a client's needs and incorporate community participation and mobilization. From its work in other stigmatized communities, Pathfinder knew clients would not wish to be associated with clinics publicly known as STI clinics and especially not as sex worker clinics. Instead, it proposed delivering services under one community-identified, positively-associated program name. Within a few months of operation community members chose "Mukta," meaning "liberation" in Marathi, as the official name of the new Pathfinder HIV prevention project in Maharashtra.

In January 2005 Pathfinder formally opened its Mukta project office. Mukta officially invited local NGOs it had visited to submit requests for funding. MSPSS was invited to submit a formal proposal for funding for targeted HIV prevention services based on its assessment of community needs. The proposal required an estimate of the number of sex workers it would reach and funding needs. MSPSS and its 10 employees were daunted by the complexity of the proposal development process and approached Mukta for help. Mukta staff worked with MSPSS to plan a program and helped shape the proposal. MSPSS planned to target the community of l,015 individuals it estimated needed HIV prevention services.

In selecting grantees Mukta staff prioritized NGOs with established relationships and infrastructure in their respective districts. Mukta believed it could quickly build NGOs' HIV and clinical service capacity and that establishing relationships with vulnerable communities would take time Mukta didn't have. As with other state lead partners, Mukta was under pressure from Avahan's central office to scale its program rapidly, saturating target populations in the state with Avahan services as quickly as possible (see **Exhibit 10** for flow chart for provision of services).

By March Mukta had contracted local NGO grantees, including MSPSS, in 10 districts. Roads in varying states of repair connected the districts, which were spread far apart (around 500 miles) and included a variety of cultural and demographic contexts. Mukta supported its grantees via its five divisions: Community Mobilization, Monitoring and Evaluation, STI and Medical Services, Health Communications, and Finance. Each division had a director and staff of project officers, and the divisions worked collaboratively to identify and address the capacity and training needs of grantees. Per Avahan's program guidelines, Mukta's staff included one advocacy officer, who provided oversight for district-level advocacy activities throughout the state and received reports from all the town advocacy committees (see **Exhibit 11** for the Mukta organizational chart).

With all state lead partners and district-level NGOs Avahan jointly developed a basic package of HIV prevention activities and guidelines called the Common Minimum Program to guide program activities. Beyond the new minimum standards, the Foundation team encouraged and funded state lead partners and their district-level NGOs to innovate as necessary to best meet the needs of their local target

communities. The Foundation team provided state lead partners and NGOs with tools to map their communities and with funding to adapt the tools for illiterate community members. As state lead partners developed new ways to build the technical capacity of their NGO grantees and as NGO grantees developed new ways to help community members engage in HIV prevention, the Foundation team disseminated these lessons across the six states.

MSPSS in 2009

MSPSS received funding from MSACS and Mukta through 2008. The following year its budget was USD 77,436, and its staff size increased to 45, including 26 peer educators and 6 field officers. MSPSS was providing clinical services, peer education, training, and advocacy services in four towns in the district of Kolhapur (see **Exhibit 12** for MSPSS' organization profile and **Exhibit 13** for a map of MSPSS' service area). MSPSS served 1,976 brothel-based[b], street-based, private home-based, and lodge-based female sex workers; Tamasha theatre dancers; men who have sex with men; and transgendered people.

Clinical Services

Mukta expected each contracted NGO to set up approximately one clinic for every 350 targeted community members served. MSPSS had two fixed clinics, located in Kolhapur City and Ichalkaranji, each staffed by a part-time doctor. The clinics offered voluntary STI counseling, behavior change communication, gynecological and anal-rectal exams, and syndromic and presumptive treatment of STIs. In 2008 MSPSS waived the USD 0.20 charge for clinic visits to increase uptake, and MSPSS services became free to patients.

MSPSS' two staff doctors implemented a standard set of treatment protocols from Mukta. In accordance with Mukta's syndromic management flow chart, the doctors asked each patient about the reason for his or her visit, observing visible symptoms and documenting patients' self-reported ailments and incidences of unprotected sex. The doctors then screened for syphilis using a finger-prick blood test and diagnosed other sexually transmitted diseases based on a clinical algorithm. They used the algorithm to determine therapy and dispensed Mukta's pre-filled medication dosage packets for treatment. MSPSS stocked all medicines regularly using active supply chain management and provided them at no cost to patients (see **Exhibit 14** for the syndromic management flow chart for female sexually transmitted disease patients). For all other health-related issues — including HIV and tuberculosis testing; antiretroviral therapy; and primary health needs — MSPSS doctors referred patients to government clinics and hospitals. There, HIV and tuberculosis services were free of charge, and other services incurred a fee.

At the end of each patient clinic visit, MSPSS' staff doctors completed a clinic encounter form documenting the purpose and results of the visit. The forms were kept at MSPSS' offices, where doctors used them to track the clinic attendance and health of MSPSS patients over time (see **Exhibit 15** for the clinic encounter form). MSPSS' staff doctors were paid a nominal salary for the regularly set hours they kept at their clinics and made most of the earnings from their work in other clinics or hospitals.

MSPSS also provided clinical services by contracting with private doctors in Kolhapur City, Ichalkaranji, Hatkanagale, and Jaysingpur. MSPSS' private doctors had to receive approval from the targeted community members before being contracted. Once hired, doctors underwent training on the

[b] In October 2009 MSACS requested Mukta assume oversight of MSPSS' brothel-based clinic in Kolhapur to strengthen the program's capacity in advance of the 2013 transition deadline. In line with the "one donor, one district" rule, MSPSS had not overlapped any Mukta-related funds or protocols to its MSACS-funded brothel-based intervention site up to that point.

needs of their populations. They signed oaths of confidentiality to protect the identities of their new patients and were trained to deliver clinical services to community members using the same protocols as MSPSS' staff doctors. Each doctor received a Mukta binder containing syndromic management flow charts for female sex workers, men who have sex with men, transgenders, and the partners of all groups, who were brought by their MSPSS member partners. Binders also included protocol charts for syphilis screening and testing, condom demonstration, anaphylaxis management, aseptic procedures for cleaning equipment, and post-exposure prophylaxis, as well as forms for equipment and restocking. MSPSS supplied all medicines, creams, supplements, condoms, and antiseptic agents directly to patients. Private physicians did not track the patients they saw and were paid per clinic visit.

Peer educators frequently accompanied patients — particularly female sex workers — on their visits to private doctors. There, peer educators observed and noted the services and protocols used. Those doctors who received complaints from community members or who were called into question by peer educators received specialized attention from MSPSS staff. If necessary, their contracts were terminated.

Peer Educator Program

The peer educator program recruited female sex workers, men who have sex with men, and transgenders who were nominated by the community for their positions. Peer educators were paid an honorarium of USD 33 and travel expenses. They were considered members of MSPSS' staff, receiving training in behavior change communication, condom negotiation, and outreach strategies. In addition to their ongoing sex work, peer educators worked a minimum of four hours every day to fulfill their MSPSS duties. On a quarterly basis, MSPSS' 26 peer educators traveled to large training sessions called peer educator "melas," or gatherings, where they met with other peer educators from across Mukta's implementing NGOs to share new techniques and practices.

Peer educators encouraged the 50 to 60 community members under their care to use condoms, trained them in condom negotiation skills, motivated them to maintain monthly clinical visits, monitored their behavior for risk signs such as alcohol use or regular partners (who often resisted condom use), helped them register for government entitlement programs, distributed condoms and lubricants, and escorted them to and from most clinic visits. They tracked their community members' emotional health, condom acceptance and knowledge of proper condom use, their clinic and community drop-in center attendance, and any referrals given for health needs outside of MSPSS. Peer educators who were female sex workers met with the women under their charge in the neighborhoods and streets where the community solicited for sex. Similarly, peer educators who were men who have sex with men or transgenders met with their target groups in settings that were convenient and confidential, as per their members' wishes.

Mukta developed pictorial tools for peer educators to record data for each communication with the target groups and to remind them of the behavior change communication protocols (see **Exhibit 16** for depiction of a peer educator "micro-planning" tool). The tools were developed specifically for sex workers, who often lacked formal education in reading, writing, and math. On a weekly basis peer educators consolidated the information from their one-on-one meetings into a monthly chart, which aggregated health and risk behaviors from the current month with the data from the last month. Peer educators reviewed each community member's health data, looking for changes over time and determining which individuals needed more support. This data was given monthly to MSPSS staff, who aggregated it for the district using Avahan's computerized information management system and included it in their required reports for Mukta.

Peer educators also were responsible for community mapping. Using poster board and markers, peer educators drew the roads and landmarks of the areas that their community members frequented,

noting "hot spot" sites where the volume of sex workers and sex acts was particularly high. MSPSS set and revised its targets for community coverage using the estimates produced by these mapping exercises.

Community mapping also enabled peer educators to identify and register new sex workers who were often wary of MSPSS' clinics. Peer educators often introduced MSPSS' services slowly. Initially they might invite new recruits to stop by a MSPSS' drop-in center to rest, freshen up, and meet other MSPSS members. As trust evolved, peer educators invited their new contacts to become formal MSPSS members. They filled out registration cards for the community members, keeping one copy and leaving a second with the new recruit (see **Exhibit 17** for explanation of the Mukta identification card). With a registration card, community members could identify themselves as Mukta and MSPSS members to police, prompting better treatment and often quittance. Once new recruits consented, peer educators escorted them to the clinic for an exam, often staying with them through the full visit and even having screening procedures performed on themselves to demonstrate their safety.

Training

Using curriculum tools developed by Mukta, MSPSS held specialized training sessions to sensitize influential society members to the needs of female sex workers, men who have sex with men, and transgendered people. MSPSS showed a film, for example, depicting typical interactions between police and community members in which community members resisted arrest and police officers confiscated sex workers' money or committed acts of violence against them. MSPSS then facilitated discussions between police and target community members about the scenarios and how they could have unfolded differently. MSPSS conducted similar training and dialogue sessions for members of the media, elected officials, shop owners, rickshaw drivers, and the staff of government clinics and hospitals where MSPSS community members received services. MSPSS held celebrations of progress with stakeholders and community members as interactions improved. Many in MSPSS believed the activities were related to improved relations in Kolhapur (see **Exhibit 19** for an image of MSPSS members honoring a female police officer).

Community members were also influenced by MSPSS' trainings. In dialogues with shop keepers and rickshaw drivers, sex workers learned of their concerns about sex work. One peer educator shared that before the training the female sex worker community "didn't know the effects of our behavior on the street. We would fight in the streets, drink in the streets. … It created a bad opinion of us within the larger mainstream society, and we were looked down upon because of it." As a result of these meetings, MSPSS' female sex worker members decided to monitor their community's behavior. They agreed to intervene when other sex workers fought or drew unnecessary attention to themselves in the streets, and they held meetings with local shop owners and neighbors to inform them of their intentions to change. "Mainstreaming," being considered a part of mainstream Kolhapur society, was an important goal for the majority of MSPSS' community members that MSPSS helped them try to meet. By standardizing their behavior and encouraging new MSPSS members to adopt a responsible demeanor when interacting in public, sex workers gained access to public events and, eventually, were invited to participate in other causes in the district.

Building on the trainings, MSPSS staff reached out to local stakeholders to invite them to participate actively in the program's HIV prevention efforts. For example, MSPSS included interested lodge and brothel owners in its condom supply chain and began making regular condom deliveries to improve access for the sex workers. For some, the value of condom distribution was evident. One lodge owner had already watched a family member and a colleague die of what he suspected was HIV; the small expense to keep condoms in his lodge to combat spread of the disease seemed minimal. For others, participating in HIV prevention was a business decision. Sex workers — lodge owners' most frequent customers —

wanted condoms available where they worked. Many brothel owners also came to see the financial benefits of a healthy workforce.

Female sex workers, men who have sex with men, and transgendered people received additional training as well in their roles as peer educators and MSPSS members. MSPSS trained them to identify quality HIV and STI health services, maintain proper nutrition and hygiene, advocate for themselves and their peers, and negotiate condom use. With discretionary funds that Avahan provided to Mukta, MSPSS community members also participated in "exposure visits," traveling to neighboring states to observe and network with other sex workers and men who have sex with men involved in HIV prevention under Avahan. There, members shared advice about organizing and behavior change communication and learned about other groups' organizational structures. These visits were remembered as formative moments in their decision to seek out greater leadership roles on behalf of their community for many MSPSS members.

Advocacy

MSPSS worked through various channels to advocate for its community members both in Kolhapur and its surrounding rural areas. Mukta required every town in MSPSS' coverage area to have its own community-led advocacy committee to mitigate resistance to HIV prevention services. Advocacy committee members intervened in disputes and served as an immediate resource for the street- and home-based female and male sex workers that lived in rural settings. Through meetings with peer educators and reports to MSPSS, advocacy committees were part of MSPSS' everyday operations.

MSPSS' advocacy efforts also focused on crisis response, both in Kolhapur city and rural towns where police beatings, abductions, public altercations, and theft were common occurrences for community members. With community leadership, MSPSS ran a 24-hour response system to address violent events committed against female sex workers, men who have sex with men, and transgenders. Peer educators and other active community members were on call during peak sex work hours to receive information via their cell phones as events occurred. Once the nature of the crisis was understood, crisis team members dispatched help to the area of the event and to local police stations as necessary to remove community members from harm.

Mukta's advocacy officer helped design all crisis response plans for MSPSS and other contracted NGOs. After each crisis call, MSPSS staff completed a report on the nature of the event, including the individuals involved, the state of the community member harmed, and their planned strategy for response and faxed it to Mukta's advocacy officer. Within 48 hours, the officer would respond, providing advice on immediate and long-term strategies for response to the event as needed.

MSPSS community members also participated in a number of advocacy activities seemingly unrelated to HIV designed to reinforce their positive image in Kolhapur and increase acceptance. They took collections for local causes, contributed to other activist events in the area, and responded to local media coverage of their community. Advocacy also proved an important skill for MSPSS members in negotiation of daily interactions. MSPSS members who faced difficulty accessing services often motivated fellow community members to gather outside of the government hospitals or police stations where they sought care, garnering local attention to issues of discrimination. Many MSPSS members believed that their organized approaches to harassment made such events less common.

Sakhi Sanghthan

Sakhi Sanghthan was a sex worker collective in Kolhapur that was formed by MSPSS members seeking to address issues relevant to female sex workers' health, lives, and financial security. Members of

MSPSS — chiefly led by peer educators — created the group in 2008 after a mob committed targeted violence against a community of sex workers in Bihar and set their homes on fire. Many of the sex workers' children had died in the fires, and sex workers who survived were imprisoned by police. MSPSS' peer educators approached the entire local sex worker community to argue the need for a collective to organize for their security.

Using the organic, grass roots mobilization skills MSPSS taught them as part of the community mobilization efforts, sex workers throughout Kolhapur held meetings over the course of a year to discuss the benefits and risks of establishing a collective. Elections were held, complete with joint sessions for candidates to campaign. Community members cast their ballots using pictorial voting guides with photographs of each candidate. MSPSS peer educators counted the ballots in front of their voting community members.

Sakhi Sanghthan's elections were covered by local newspapers, drawing positive public attention to the collective and its members for their professionalism (see **Exhibit 20** for Kolhapur newspaper coverage of the election). When the four winning officers of the collective applied for formal charity status from the state government, they met resistance and delays but used their organizing power to rally for a response to their application. In July 2009, Sakhi Sanghthan became a formally recognized community-based organization and began implementing activities to support the Kolhapur sex worker community. Operations were funded by community members' contributions — a total of USD 796 in 2009. As Sakhi Sanghthan President Jyoti Shete reflected, "Now we have a right to approach donors and other power holders because now we are legally recognized. This will help us advocate for our rights."

Sakhi Sanghthan undertook a wide range of issues, including resolving business disputes between sex workers, enforcing a public code of conduct for members using peer pressure, and seeking relationships with journalists to foster opportunities for positive media coverage. Sakhi Sanghthan improved outreach through its networking and increased female sex worker engagement, instilling a feeling of solidarity. As Sakhi Sanghthan's treasurer, also a peer educator for MSPSS, explained, "We faced problems from police and goons, and sex workers were mobile and hidden because of it. Through the peer educator [gathering] we learned of how we could target the problems of sex workers using our collective, and we held a meeting as soon as we returned to take this on."

The collective wanted to re-open the community kitchen that MSPSS had once run. It hoped to build a more formal program to educate, feed, and clothe the children of sex workers in Kolhapur and to care for the sick and elderly sex workers who could no longer work. Finally, Sakhi Sanghthan's members hoped to open services to help people living with HIV/AIDS in the district learn how to care for themselves and monitor their health and nutrition.

Sakhi Sanghthan became a government-recognized learning site for democratic community-based organization formation processes and was funded by MSACS to educate HIV prevention groups throughout Maharashtra who sought to acquire formal charity status. Groups interested in HIV prevention throughout the state came to Kolhapur to observe Sakhi Sanghthan and receive training in the unique community-based organization development protocols. Sakhi Sanghthan trainers received a small stipend for their work — between USD 6.78 and USD 11.3 per presentation. A portion of the income went to the collective and through that and the meeting space that MSPSS offered in its drop-in center, Sakhi Sanghthan sustained itself financially.

Measurement and Reporting

The Foundation team required state lead partners to meet quarterly to share NGO and state-level performance information along with data on new initiatives that went beyond the Common Minimum Program's standards. Monthly, the Foundation team required state lead partners to aggregate and analyze the data on outreach and service utilization across its NGOs. Mukta gave feedback to its district implementing NGO partners within 48 hours, responding to their monthly technical reports with analysis via email and following up by phone as needed. Mukta field officers then conducted monthly in-person meetings with the NGOs under their care, making up to 32-hour drives every month to reach them. Field officers addressed capacity building needs and fulfilled the various requests of district staff and peer educators while there. Assisting in a range of roles, field officers helped peer educators with difficult recruiting issues, supported NGOs' advocacy and outreach efforts to local power brokers, and provided support and advice requested by their district-level implementers. As new issues or needs arose among community members, field officers conveyed these developments back to their division directors, who could then issue discretionary funds to help the NGO address that need.

On a quarterly basis, each of Mukta's 10 NGOs met for review meetings. NGO staff and leadership presented their technical reports for the quarter to their peers. Together, Mukta's NGO grantees identified their performance issues, sharing resources to address the challenges they faced in implementing their tailored versions of the Mukta program model.

Preparing for Transition

By 2008, Avahan had charged itself with "telling the world" that large-scale HIV prevention was possible and announced its Phase II transition plan: to transfer all of its programs in a stepwise fashion to the Government of India by 2013. In line with the plan, MSACS requested to receive the first 30% of Mukta programs by November 2008. Mukta had to help its grantees align their budgets and salary scales with MSACS requirements. MSPSS had time to prepare, as it would be one of the last to transition in 2013.

Meanwhile in 2009, in Pune, Mukta's director was working to convey the intricacies of Mukta's model to the MSACS Director. After meetings with MSPSS' Suhel Jamadar and staff from other Mukta NGOs, Mukta's director sought to explain the most important aspects of her grantees' programs to MSACS' leadership and to build MSACS' capacity to maintain the progress achieved by MSPSS and other implementing NGOs. She worried that MSACS might not appreciate the importance of Mukta's non-clinical services. MSPSS, in particular, faced significant challenges to maintain the set of activities that had bolstered participation in HIV prevention programs and the community's care-seeking behaviors. MSPSS had reported 578 sexually transmitted disease consultations in October 2009 alone.

Upon transitioning to MSACS control, the 15% budget cut would end MSPSS' community mobilization and advocacy activities, and MSPSS would have to downsize its space. MSPSS would also have to decrease staff salaries to match the government pay scales. Peer educators would receive 20% less for their work, and field officers' pay would be cut by half. One field officer had already quit. Additionally, as MSACS did not fund clinics for fewer than 1,000 target population members, MSPSS was preparing to close both of its clinics and transition fully to a private physician model. All physicians would be paid Rs 30-50 (USD 0.64 - 1.07) per patient visit for sexually transmitted disease services and would not be reimbursed for care provided beyond a patient's initial visit.

While Jamadar knew that maintaining quality and scope of service delivery following the budget cuts would be difficult, he believed that a successful transition was possible. Putting on a hopeful face for

his community members, Suhel Jamadar was decidedly optimistic in his message about the transition: "We can't know how well the community will take to the new model, but I think we will work it out."

Exhibit 1 *Basic Socioeconomic and Demographic Indicators of India*

INDICATOR		YEAR
UN Human Development Index ranking	134 out of 182	2007
Population (thousands)	1,130,618	2005
Urban population (%)	28.7	2005
Drinking water coverage (%)	88	2008
Poverty rate (% living under USD 1.25 per day)	41.6	2000-2007
Gini index	36.8	2004-2005
GDP per capita in PPP (current international dollar)	2,780	2008
GDP per capita in constant 2000 USD	724	2008
Literacy (total, female, male)	66, 54.5, 76.9	2007

Source: Compiled by case writers using data from: United Nations, UNICEF, United Nations Development Program, World Bank World Development Indicators, International Monetary Fund, and the United Nations Educational, Scientific and Cultural Organization.

Exhibit 2 *Basic Health Indicators of Maharashtra*

INDICATOR		YEAR
Infant Mortality (per 1,000 live births)*	42	2010
Life Expectancy	68.19 (F), 65.31 (M)	2000
HIV Prevalence Rate in High Risk Groups (%)	10	2006
HIV Prevalence in General Population	.75	2006

* Female children ages one to four had 61% higher mortality than males.

Source: Compiled by case writers using data from the Government of India's 2001 Census, the Government of Maharashtra's 2002 Human Development Report, and World Bank findings.

Exhibit 3 *Socioeconomic and Demographic Indicators of Maharashtra*

INDICATOR		YEAR
Population (thousands)	96,878	2001
Urban population (%)	42.4	2001
% Population between ages 0-6	14.1	2001
GDP per capita in USD	800	2010
% Living Below Poverty Line	25	2009
Literacy (total)	77	2001
Work Participation Rate (Total, Male, Female)	42.5, 53.3, 30.8	2001
Average Household Size	5.0	2001
Contribution to India's Industrial Output (%)	15	2001
Contribution to India's GDP (%)	12	2001

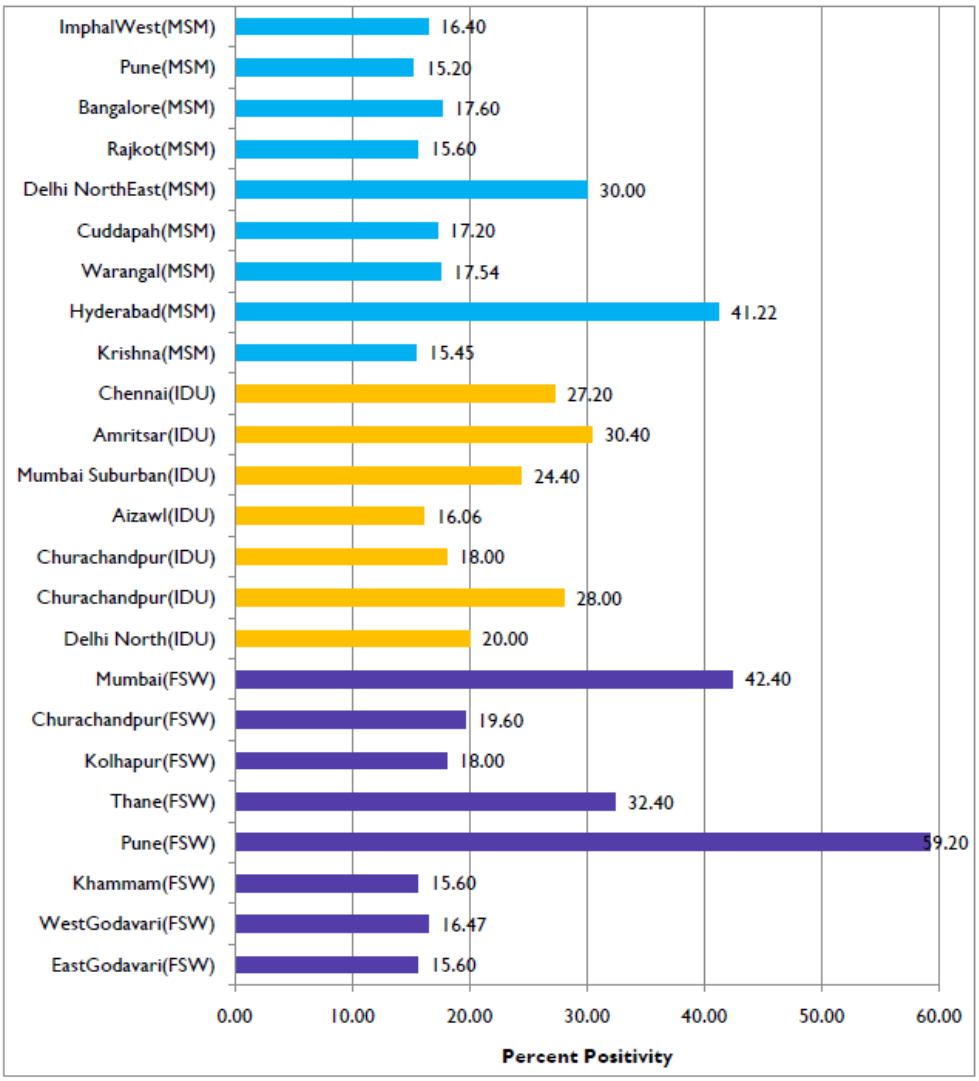
Source: Compiled by case writers using data from the Government of India's 2001 Census and World Bank findings.

Exhibit 4 *States and Districts with High HIV Prevalence by Group, 2007*

States with high HIV prevalence among IDU	Maharashtra (24.4%), Manipur (17.9%), Tamil Nadu (16.8%), Punjab (13.8%), Delhi (10.1%), Chandigarh (8.6%), Kerala (7.9%), West Bengal (7.8%), Mizoram (7.5%) & Orissa (7.3%)
Number of Districts with >5% HIV prevalence among IDU	23 out of 49 districts with IDU sites
Number of Districts with >15% HIV prevalence among IDU	7 out of 49 districts with IDU sites
States with high HIV prevalence among MSM	Karnataka (17.6%), Andhra Pradesh (17%), Manipur (16.4%), Maharashtra (11.8%), Delhi (11.7%), Gujarat (8.4%), Goa (7.9%), Orissa (7.4%), Tamil Nadu (6.6%) and West Bengal (5.6%)
Number of Districts with >5% HIV prevalence among MSM	21 out of 40 districts with MSM sites
Number of Districts with >15% HIV prevalence among MSM	9 out of 40 districts with MSM sites
States with high HIV prevalence among FSW	Maharashtra (17.9%), Manipur (13.1%), Andhra Pradesh (9.7%), Nagaland (8.9%), Mizoram (7.2%), Gujarat (6.5%), West Bengal (5.9%) & Karnataka (5.3%)
Number of Districts with >5% HIV prevalence among FSW	47 out of 129 districts with FSW sites
Number of Districts with >15% HIV prevalence among FSW	8 (FSW sites in Pune, Mumbai and Thane have shown > 30% HIV prevalence among FSW)

Source: HIV Sentinel Surveillance and HIV Estimation: A Technical Report. National AIDS Control Organization, Delhi 2008.

Exhibit 5 *Districts with HIV Prevalence above 15% among High Risk Groups*

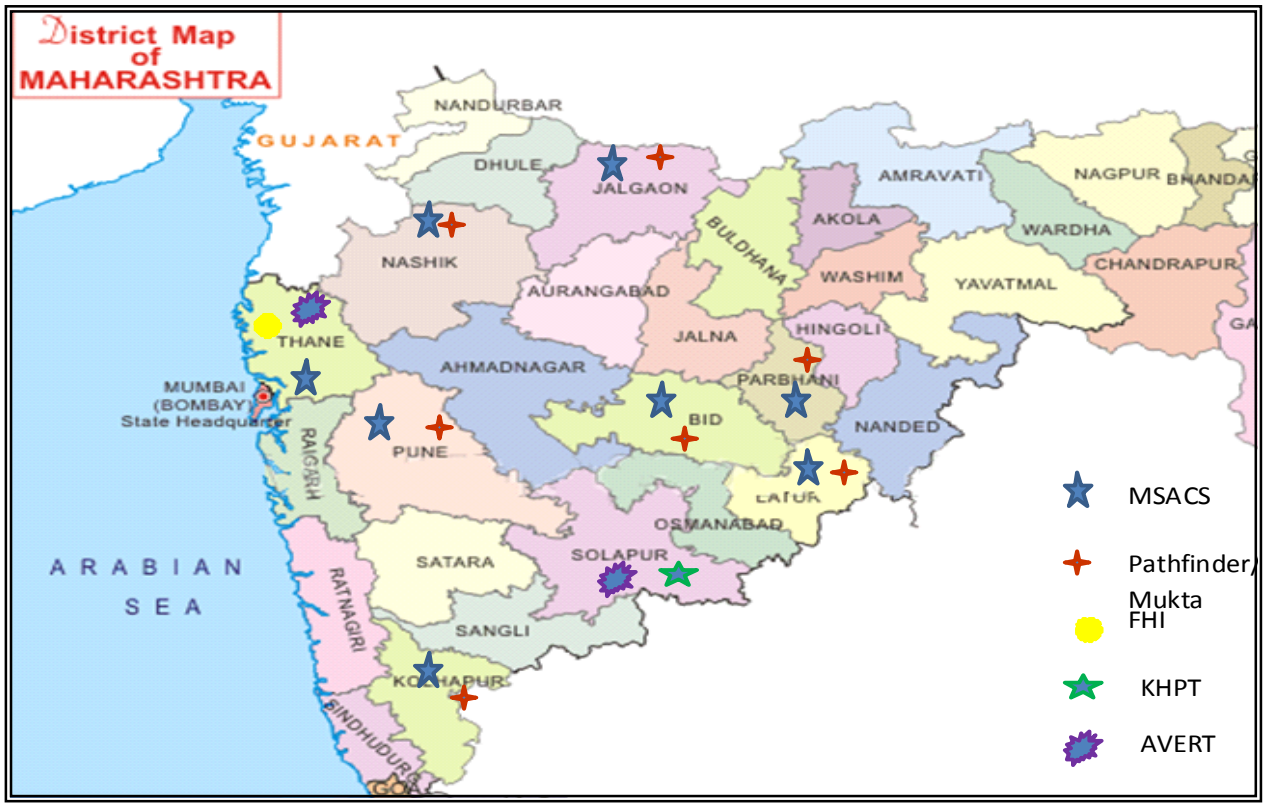


Maharashtra districts listed:

- *Kolhapur*
- *Mumbai*
- *Mumbai Suburban*
- *Pune*
- *Thane*

Source: HIV Sentinel Surveillance and HIV Estimation: A Technical Report. National AIDS Control Organization, Delhi 2008.

Exhibit 6 *MSACS Distribution of Coverage by District and Partner*



Source: Maharashtra State AIDS Control Society.

Exhibit 7 *Profile of a Commercial Sex Worker*

Praveena had been a sex worker for 10 years. She grew up in a rural village outside of Kolhapur city. Her father passed away when she was 15. Her mother was not able to make enough to support the family on her own, so Praveena began to look for work. At first, she pieced together small jobs selling vegetables and wares in the village, but this income was not enough to feed Praveena, her mother, sisters, and brother. She knew that the city had many more customers who could buy from her, and so she began traveling to sell her goods. For several months, Praveena sold her vegetables in Kolhapur during the day and returned to her village on the bus every night.

While working in Kolhapur, Praveena met an older woman who suggested that Praveena stay in Kolhapur for extended amounts of time to bring more money home to her family. Praveena started spending nights in Kolhapur and returning to her village every eight to 10 days. When selling her wares failed to bring in the money she had hoped, she learned from the woman that there was another way to make even more money but that she would need to go with a man and stay with him overnight. Praveena agreed and stayed with a man whom the woman introduced her to at a lodge. He paid her 50 Rupees to have sex just once — enough money to buy at least two meals. Praveena began to see this man regularly, and stood on the street to solicit more clients in the evenings, as she had seen other sex workers do.

On the street one night, Praveena met another young woman from her village who introduced her to a group of friends who were also sex workers. Together they drank and celebrated their earnings, and Praveena found that drinking made the evenings more fun and made it easier to see clients. Many of these women also supported families with their income. Like Praveena, they kept the source of their income secret. Praveena continued to visit home to share her earnings with her family, but when her uncle began to act suspiciously about her work in the city, she began to visit home less and less. Eventually, she came to live in Kolhapur permanently and practice sex work every night. To earn more money from clients, she promoted herself as willing to have sex without a condom. A few times, clients stole from her or would not pay after sex, but she never called the police because she knew they would only force her to have sex with them and take her money. Besides, the police were often as violent as the local gang members, who she knew would sometimes abduct sex workers, rape them with their friends, and then leave them in far away villages to find their way home. She tried to stay out of their way and ran whenever she saw them. Sometimes that wasn't enough.

Praveena began drinking more with her clients and other sex workers and eventually stopped saving money for her family to pay for her increasing appetite for alcohol. She knew that drinking was an expensive habit, but she didn't see much reason to stop, as she had lost touch with her family and felt less lonely when she was drunk. There were down sides to her drinking — forgetting to save enough money for her own meals or being too drunk to negotiate with clients with whom she felt she should use a condom. Drinking helped her get through the nights, though, and she didn't want to stop.

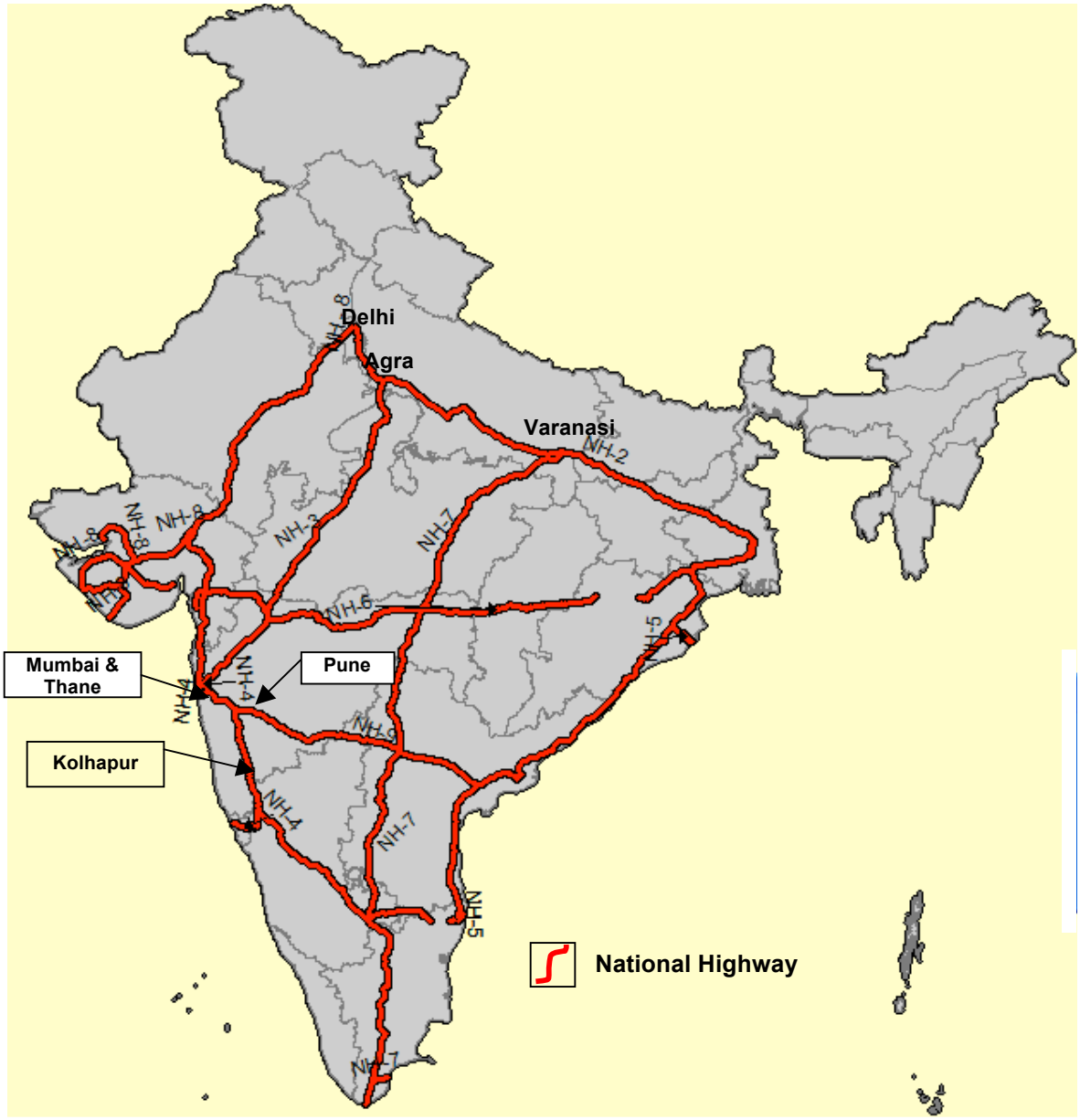
Several months later, Praveena was standing on the street soliciting when she was approached by a sex worker wearing a gold and yellow sari. Praveena had noticed her before while they were both working. The woman introduced herself as a sex worker and chatted with Praveena. She knew that the woman had introduced one of her friends to a place where she could go to freshen up and rest between clients, but she had also heard rumors that the organization the woman worked for stole sex workers' organs to sell them for money. Praveena wasn't sure what to think at first, but as she saw the woman more and more, she began to trust her. The woman asked about Praveena's life and told her about things she could do to keep herself healthy as a sex worker.

Eventually, the woman asked if Praveena would go with her to see the drop-in center and clinic that her organization ran. She said she was a peer educator for an organization called MSPSS and that in addition to being a sex worker she earned a small amount to help other sex workers stay healthy. Praveena went with the woman to the drop-in center and found that the staff there was friendly and helpful. She started going regularly to meet other sex workers, and she enjoyed their discussions about how to improve conditions for themselves in Kolhapur —particularly how to stop acts of violence against their community. After meeting other sex workers who visited the clinic every month and seeing how many of the sick women seemed to get better, Praveena agreed to visit the clinic. She received a gynecological exam, and the doctor answered her questions and referred her for HIV testing. Eventually, Praveena agreed to go. The peer educator went with her, and when Praveena learned that she was HIV positive, the peer educator counseled her on how to get treatment. Praveena learned that she needed to maintain good nutrition if she was going to take the antiretroviral drugs provided by the government clinic and that she would need to end her addiction to alcohol if she was going to stay healthy.

Today, Praveena still drinks but does so less frequently. She uses condoms and meets with other sex workers who are living with HIV for support and friendship. She knows that she can have a full and healthy life with HIV. She is glad about the community she gained through MSPSS. Praveena hopes to be a peer educator one day so that she can help others in her community improve their lives. She believes that sex workers have rights, and she knows that a better life for herself and her community is possible if they stay together and stay organized.

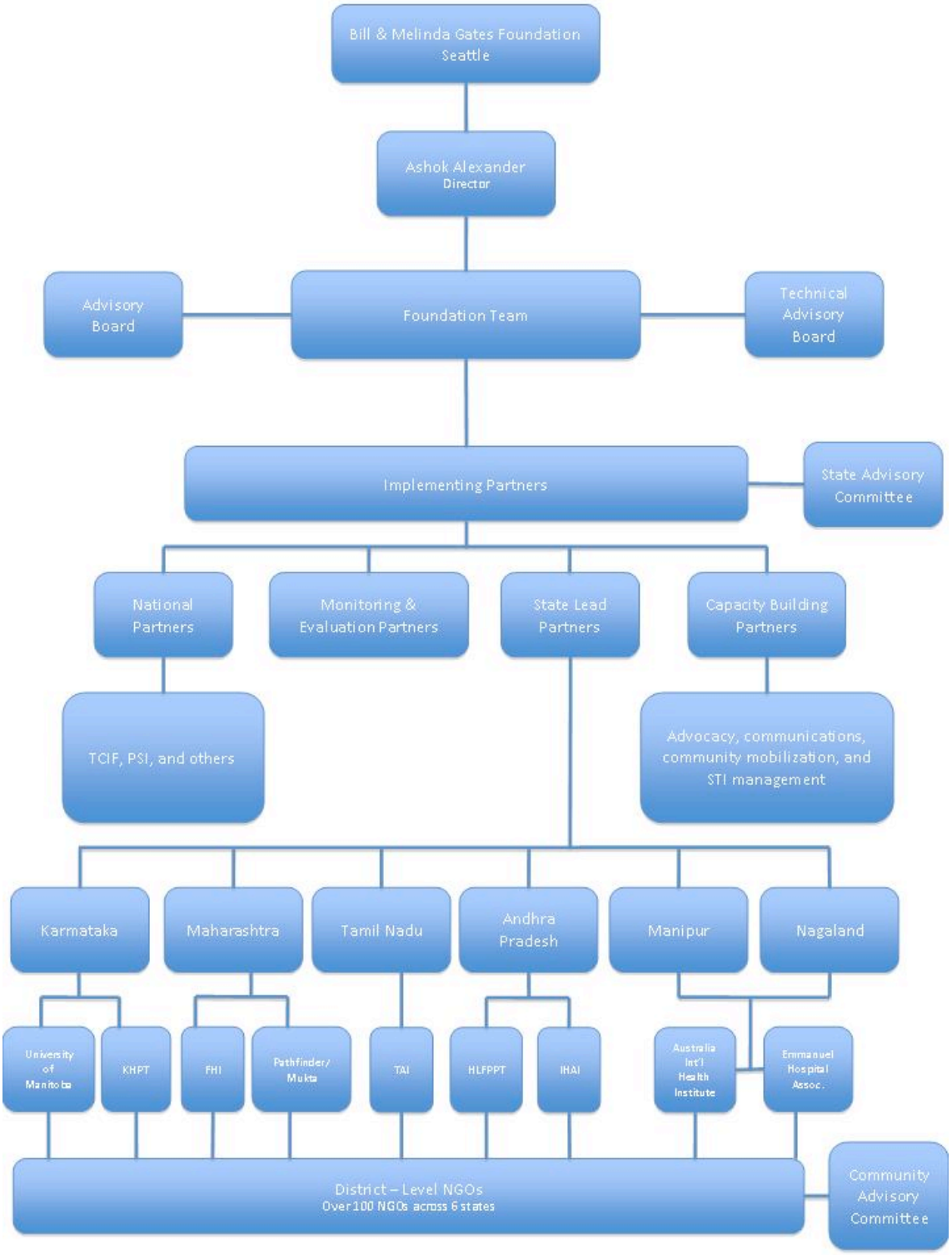
Source: Compiled by case writers.

Exhibit 8 *The Golden Triangle- India's National Highway System*



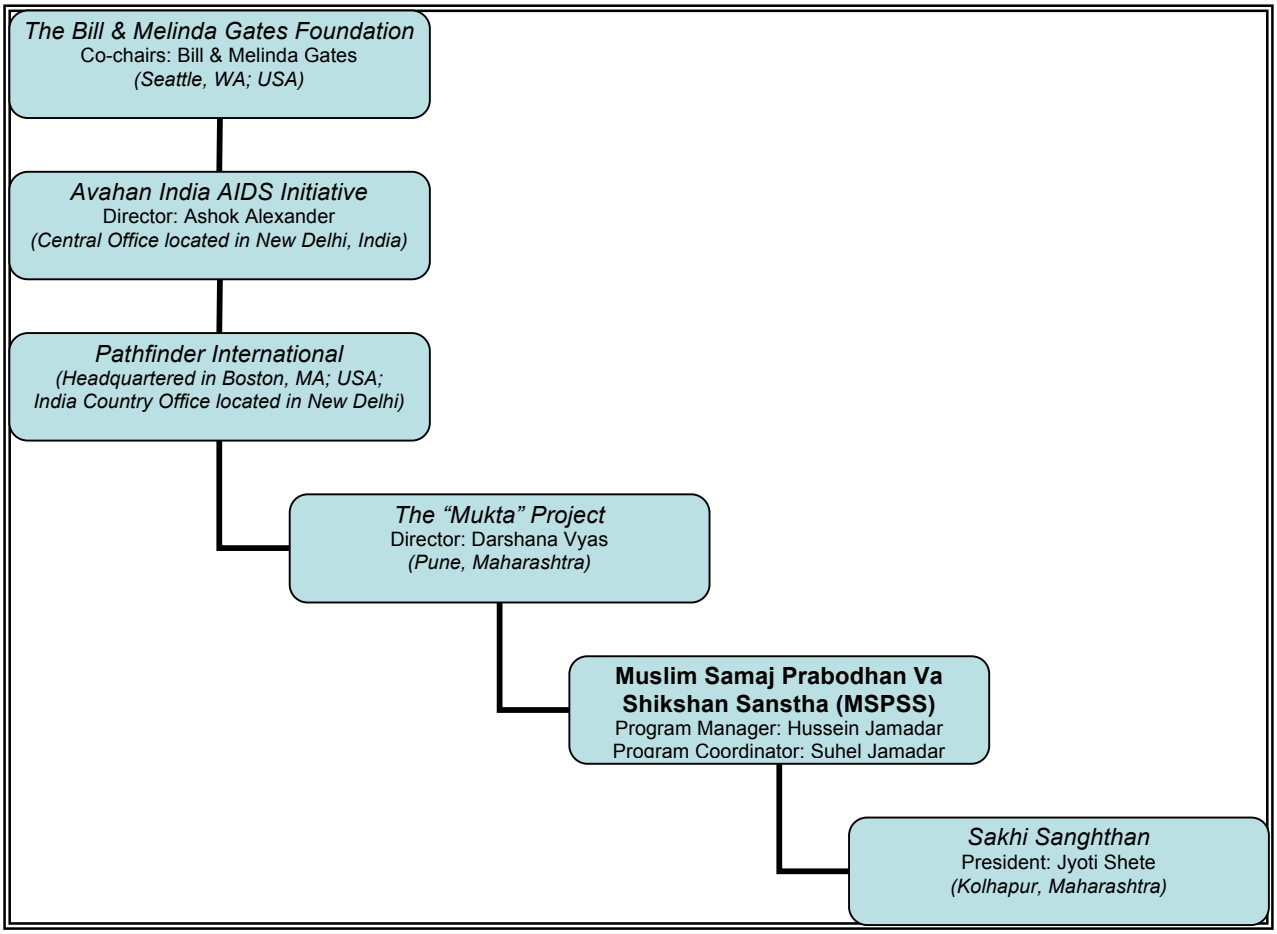
Source: Avahan.

Exhibit 9 *Avahan Organizational Structure*



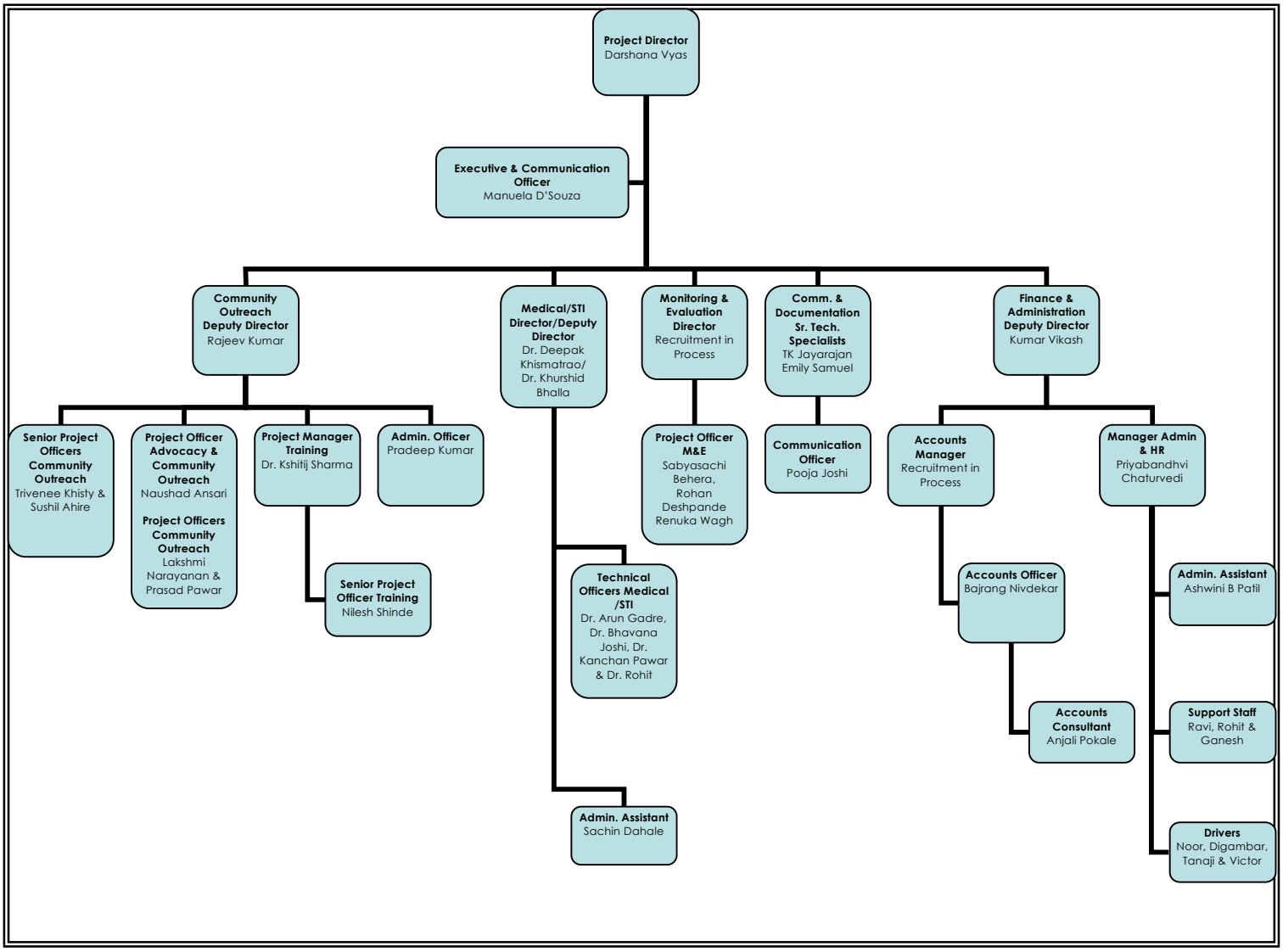
Source: Created by case writers using documents from Avahan, the Gates Foundation, and publicly available data.

Exhibit 10 *Flow Chart of Primary Characters and Organizations*



Source: Created by case writers.

Exhibit 11 ***Mukta Organizational Chart***



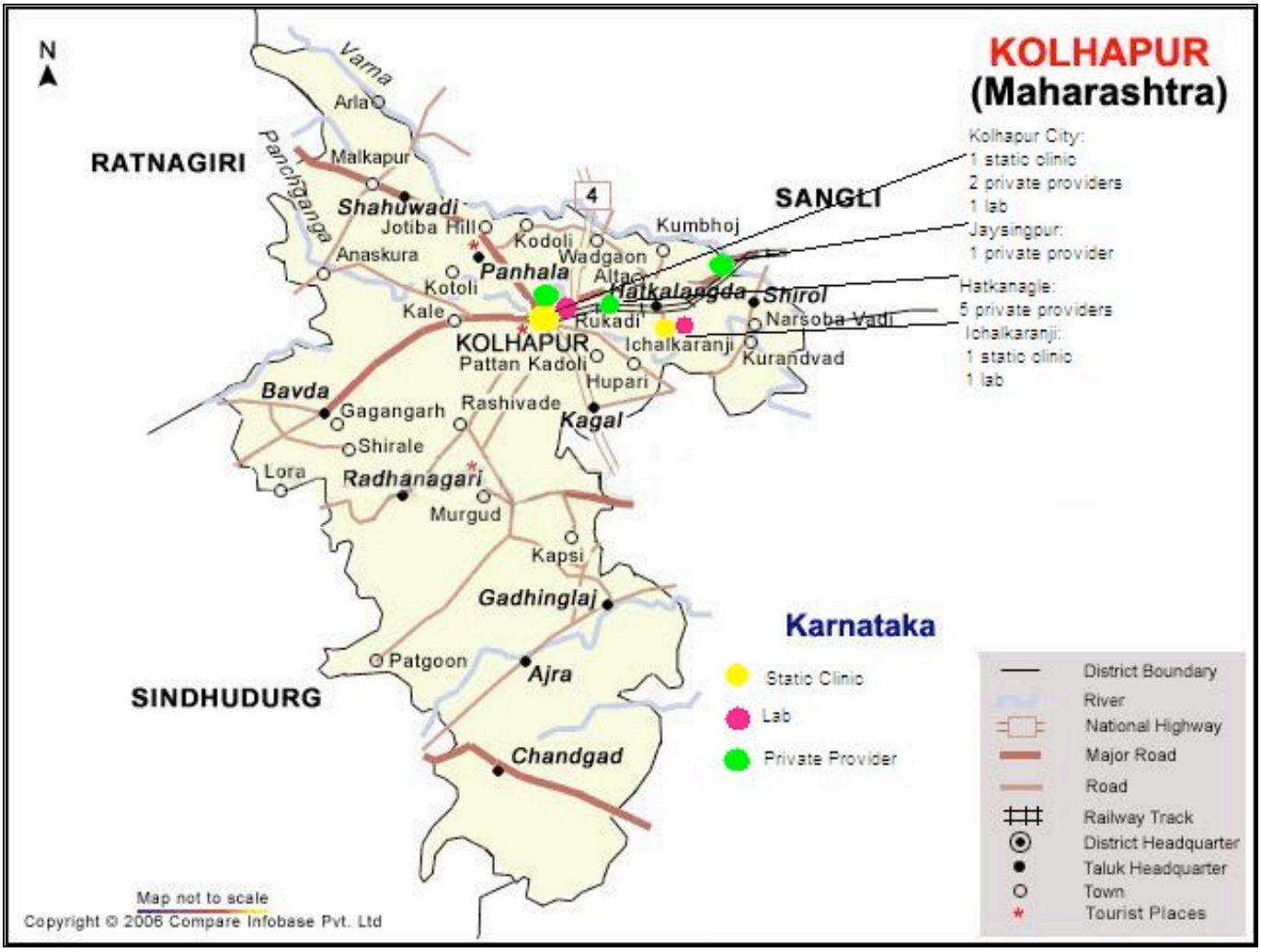
Source: Mukta.

Exhibit 12 *MSPSS Profile of Staff and Service Uptake, October 2009*

MSPSS Staff		
	Number Employed	**Salary/month (if disclosed)**
Project Director (Hussein Jamadar)	1	
Project Coordinator (Suhel Jamadar)	1	USD 270.00 *(INR 13,000)*
Outreach Staff (excluding Peer Educators)	7	USD 220.00 *(INR 10,500)*
Technical Staff (data entry and analysis)	1	
Finance and Administrative Staff	3	
Project Staff Doctors	2	
Other clinical staff	6	
Active, paid FSW Peer Educators	17	
Active, paid MSM Peer Educators	13	
Kolhapur Target Population Estimate		
Total female sex workers	**419**	
Brothel	*10*	
Lodge	*13*	
Street	*261*	
Home/ Private	*60*	
Tamasha dancer	*75*	
Total men who have sex with men	**596**	
Total Individuals Tracked by MSPSS Peer Educators		
Total female sex workers	**1,029**	
Brothel	*174*	
Lodge	*31*	
Street	*383*	
Home/ Private	*218*	
Tamasha dancer	*223*	
Total men who have sex with men	**947**	
MSPSS Service Uptake and Distribution		
Condom Distribution		
female sex workers	73,939	
men who have sex with men	9,915	
STI Consultations		
female sex workers	288 (281 repeat; 7 new)	
men who have sex with men	290 (286 repeat; 4 new)	
Syndromic Treatment Distribution		
female sex workers	32	
men who have sex with men	22	

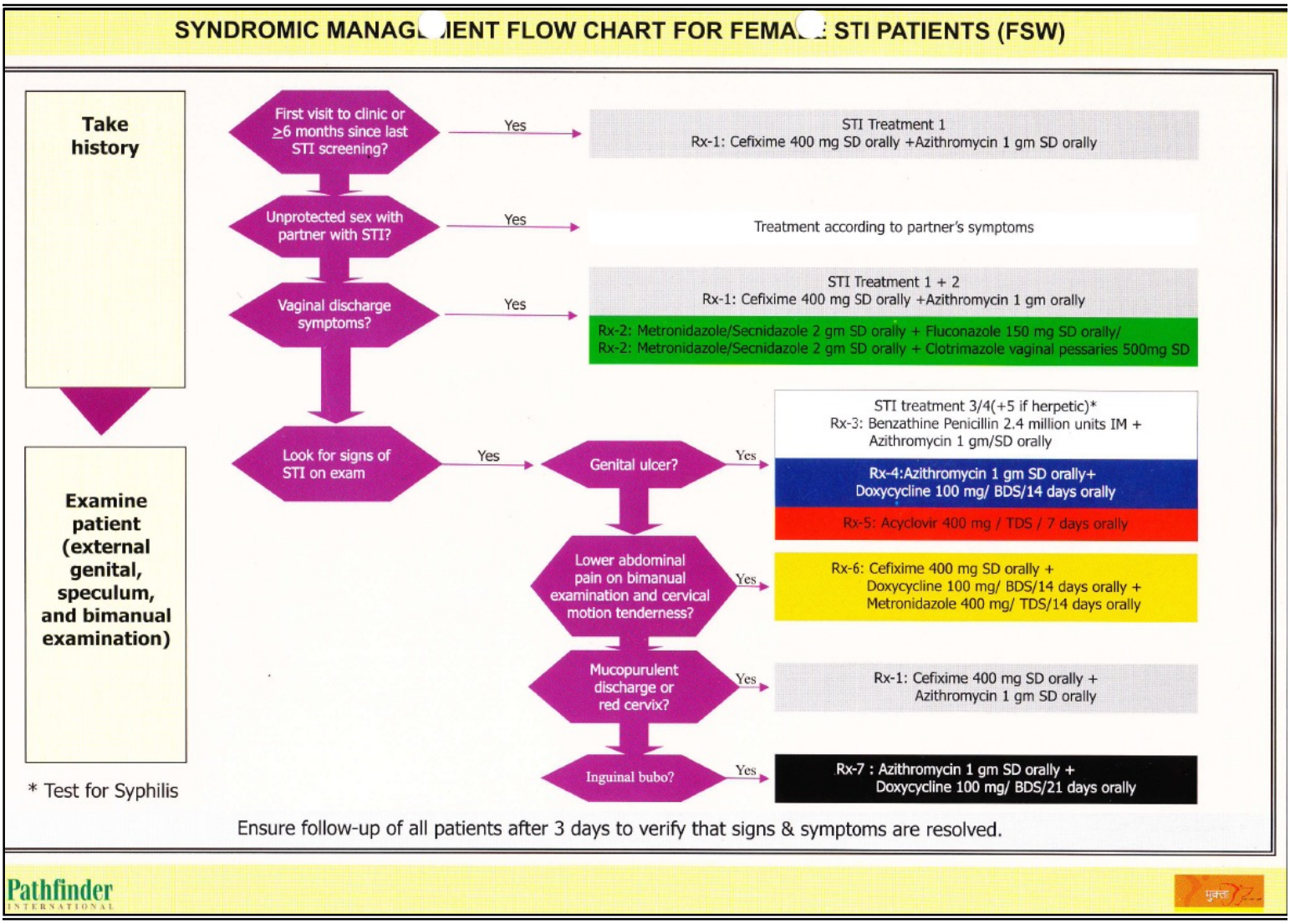
Source: Created by case writers using data provided by the Avahan CMIS and MSPSS leadership.

Exhibit 13 *Map of MSPSS' Service Delivery Sites*



Source: Adapted from Compare Infobase Pvt. Ltd (2006). MSPSS site information provided by Mukta.

Exhibit 14 *Syndromic Management Flow Chart for Female Sexually Transmitted Infection Patients*



Source: Mukta.

Exhibit 15 *MSPSS Clinic Encounter Form*

CLINIC ENCOUNTER FORM Date: / /

Name of Clinic:	**Mukta ID No.:**	**Patient Reg. No.:**
Clinic ID No.:	First Name_____ Last Name _____	
Sex: ☐ Female ☐ Male	Age: ___ years	1st Visit? : ☐ Yes ☐ No

Ref. by: ☐ Peer educator ☐ Field Officer (NGO) ☐ Self ☐ Partner ☐ Other

Beneficiary Category: ☐ FSW ☐ MSM ☐ PE (FSW) ☐ PE (MSM) ☐ Female Tamasha Artist (FTA) ☐ Regular Partner ☐ Client ☐ Other

FSW Typology: ☐ Brothel based ☐ Lodge based ☐ Private ☐ Street based ☐ Slum based ☐ Dhaba Based ☐ Other

Reason for CLINIC visit: ☐ Monthly check-up / Asymptomatic ☐ STI Symptoms ☐ Follow-up for previous STI ☐ Non-STI Symptoms ☐ Only for Counselling

STI Symptoms (Record a maximum of 3 major symptoms as described by the patient)		**Duration:** ☐ <2 days ☐ 3–7 days ☐ 8–14 days ☐ >2 weeks
		Duration: ☐ <2 days ☐ 3–7 days ☐ 8–14 days ☐ >2 weeks
		Duration: ☐ <2 days ☐ 3–7 days ☐ 8–14 days ☐ >2 weeks

Examinations done: ☐ General ☐ Oro-pharyngeal ☐ Abdominal ☐ Speculum ☐ Bimanual ☐ Proctoscopy / PR ☐ Ext. Genital Exam. ☐ Verbal Screening for TB.

Reasons if Internal Examination not done:

STI-Related Examination / Findings	**STI diagnosis**	**STI Treatment for patients**	**Partner Treatment** Does patient have partner: ☐ Yes ☐ No
☐ TPHA done Result ☐ Positive ☐ Negative	☐ Other STI - Latent Syphilis	☐ Inj B. P ☐ Cap Doxy 100 mg BD x 30 days	** EXAMINE PARTNER
☐ Vaginal Discharge	☐ VD - Vaginal Discharge	☐ Rx-1 ☐ Rx-2	☐ Rx-2
☐ Cervical Discharge ☐ Red Cervix	☐ CD - Cervical Discharge	☐ Rx-1	☐ Rx-1
☐ Lower abdominal pain ☐ Cervical Motion Tenderness ☐ Tenderness in Fornices	☐ LAP (only)	☐ Rx-6	☐ Rx-1
	if ☐ LAP + ☐ VD ☐ CD	☐ Rx-6 + ☐ Tab Flucanazole	
☐ Genital Ulcer	☐ GUD - non-herpetic	☐ Rx-3 ☐ Rx-4	** EXAMINE PARTNER
☐ Genital Ulcer	☐ GUD -herpetic	☐ Rx-5	** EXAMINE PARTNER
☐ Urethral discharge	☐ UD	☐ Rx-1	☐ Rx-1
☐ Anorectal Discharge	☐ ARD	☐ Rx-1	☐ Rx-1
☐ Swelling in Inguinal region	☐ IB	☐ Rx-7	☐ Rx-7
☐ Genital / anal warts	☐ Genital Warts	☐ Podophylline / TCA	** EXAMINE PARTNER
☐ Other STI Findings:	☐ Other STI -Scrotal Swelling/ Genital Scabies/Molluscum	☐ Other Specify	
☐ None	☐ No Syndrome		

Presumptive Treatment : Whether Presumptive treatment given during this visit: ☐ Yes ☐ No
If Yes, is this the first Presumptive treatment given: ☐ Yes ☐ No — ☐ Rx-1

Other specific Findings :	**Non STI Diagnosis:**	**Treatment:**

Referrals: ☐ RPR Testing ☐ ICTC (HIV Testing) ☐ TB-DMC ☐ CD4 Testing ☐ ART ☐ MTP ☐ TL ☐ Other (Specify)

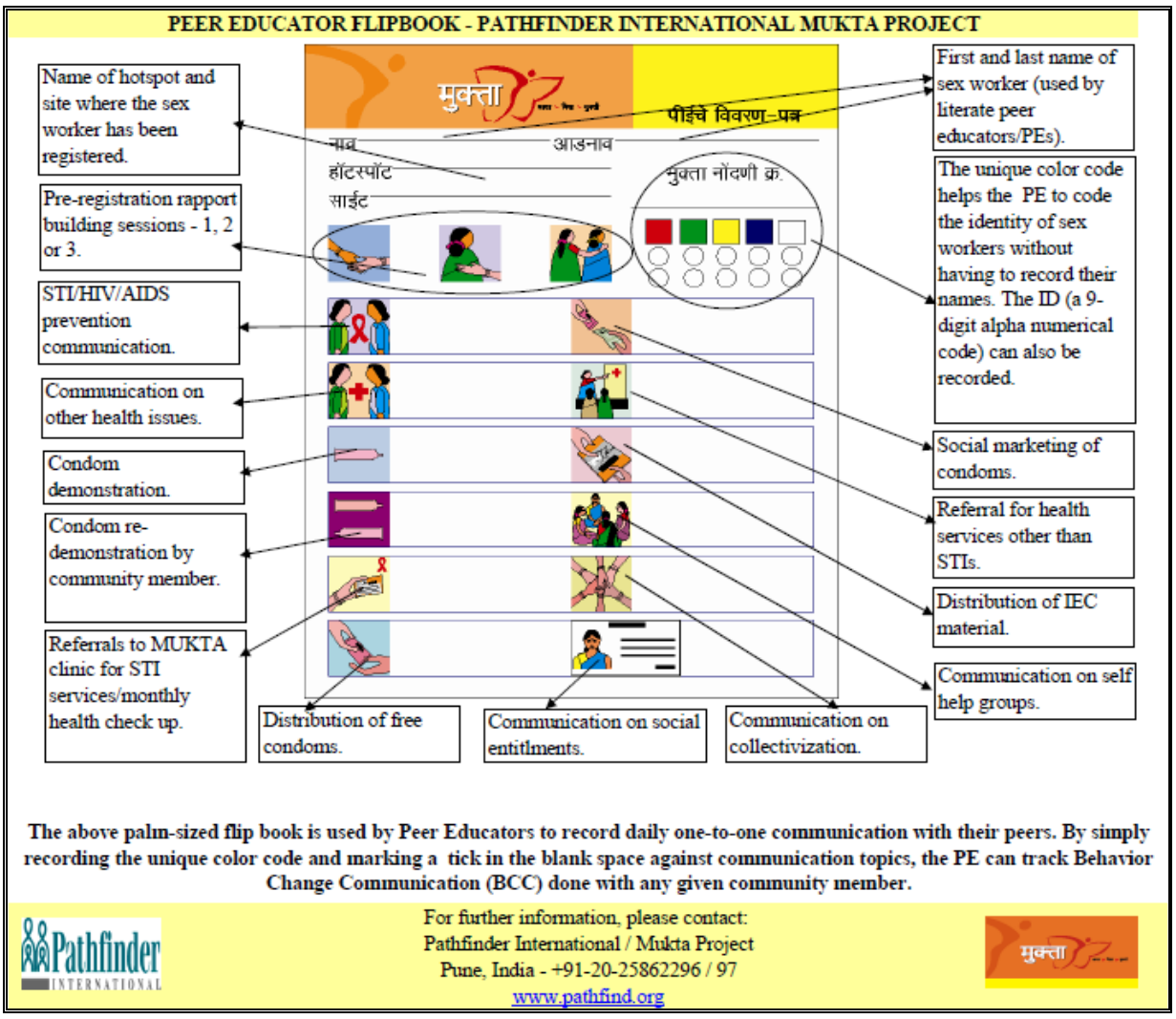
Follow Up Date:	**Comments:**	**Sign:**

Education / Counseling: ☐ STI ☐ HIV/AIDS ☐ Other Ois ☐ TB ☐ ARV ☐ Safe Sex + Condom Demonstration ☐ Partner Treatment ☐ Violence ☐ Nutrition ☐ Addictions ☐ General Health ☐ Family Planning ☐ Positive Prev.

Plan and Comments: Date of next Counseling visit _____ Comments:

Source: Mukta.

Exhibit 16 *Peer Educator "Micro-Planning" Tool*



Source: Mukta.

Exhibit 17 *Mukta Identification Card*

Pathfinder INTERNATIONAL

मुक्ता

Mukta ID Card

The Mukta ID card is a given to each registered sex worker:

1. with whom a Peer Educator has conducted rapport building sessions
2. who is aware about the project objectives (broadly) and able to state at least three project services
3. who is, as per her own will, ready to be a part of the Mukta family

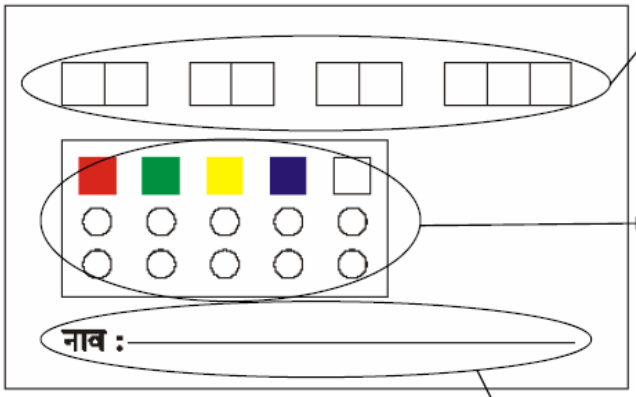
A registration format is available with all district Field Officers to capture vital information about each registered sex worker.

The ID card is explained below:

Front View

The **Mukta logo** is the face of the card. It automatically connects one to the Mukta family.

Reverse View



The following basis is used to form the **registration code**:
Boxes 1 & 2: District code e.g. 01 (Ahmednagar)
Boxes 3 & 4: Hotspot code e.g. 01 (Ahmednagar city)
Boxes 5 & 6: PE code e.g. A0 (for Shobha)
Boxes 7, 8 & 9: Unique sex worker code e.g. 001

Earlier, the PE:KP ratio was 1:50. Based on that, a **colour code** system consisting of five colours and 10 dots was developed to cover all 50 KPs. The colour code corresponds to the unique ID e.g. sex worker 001 would be coded as red-1 dot (R1) or 022 would be yellow-2 dots (Y2).
Even though the PE:KP ratio has reduced to 1:30 for FSWs, the system remains to account for any additional KPs.

Space to write the **name** of the sex

Source: Mukta.

Exhibit 18 *Stakeholder Analysis of the local HIV Prevention Environment*

Source: Avahan.

Exhibit 19 *MSPSS Ceremony Honoring Female Police Officer*

Source: MSPSS.

Exhibit 20 *Kolhapur Newspaper Clipping covering Sakhi Sanghthan elections*

The Indian EXPRESS

Kolhapur prostitutes' exclusive democracy

VIVEK WAGHMODE
KOLHAPUR, AUGUST 27

PROSTITUTES in Kolhapur have formed an organisation of their own, and elected a seven-member committee on Wednesday with Jyoti Shete as president.

Twenty-three members were contesting and 157 prostitutes participated in the elections to the posts of president, vice-president, secretary, assistant secretary, treasurer and two members.

The initiative for forming the organisation was taken by Pathfinder International's Mukta, an NGO working to empower prostitutes and enabling them to improve and gain greater control over their lives

Suhel Jamadar, project coordinator of Mukta, said, "All 380 prostitutes enrolled are part of the organisation. The elected committee will run their democratic organisation. The election symbols were the candidates' own photographs. A team from Ashodaya Samithi, an organisation working for prostitutes in Karnataka, is assisting us in this process. It had helped formed such an organisation in Mysore three years ago."

Rupa (name changed), one of the voters, said, "We have got our own platform now to raise issues that concern us."

Jamadar said, "Our work of NGOs for the cause of prostitutes and their children will continue till they get funding from national and international organisations. Sometimes the work stops after they have started several projects. To sustain the work are forming community-based organisations to enable them to fight for their cause. At the initial stage we will act as a guide and provide technical support. Later they will manage on their own," he said.

Votes were counted in the evening. Manda Chavan was elected vice president, while other members on the panel were Mumtaz Desai, Mumtaz Sheikh, Vimal Pawar, Sadhana Kamble and Surekha Pawar.

Source: News clipping provided by MSPSS.

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