



*Risk, Morality, and Blame:
A Critical Analysis of Government and U.S.
Donor Responses to HIV Infections Among
Sex Workers in India*

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I – Introduction

India is one of five countries that—along with Russia, China, Nigeria and Ethiopia—were classified by the U.S. National Intelligence Council in 2002 as representing the second wave of the HIV/AIDS epidemic. Current estimates put the total of those infected with HIV in India at 4.5 million, with projections for the number of infections to rise to anywhere between 9 to 25 million by 2010 (NACO 2003; NIC 2002; Rao 2003). Mirroring the global trend, new infections in India are rising rapidly among women ages 15 to 49, who, in 2002, accounted for nearly 40 percent of the total number of estimated cases in the country (NACO Director, July 25, 2003). Surveillance data indicate that HIV prevalence rates among women attending antenatal clinics in several Indian states are well above one percent (NACO 2003). As is clear from these data, HIV infections in India have moved from “high-risk” populations, such as commercial sex workers, into the general population. Yet, not surprisingly, sex workers remain disproportionately affected by the epidemic in India, with prevalence rates among them ranging from 40 to 60 percent in some parts of the country.

The vulnerability of women sex workers to HIV infection in India is best understood through a lens of the “multiple disadvantages” sex workers face in the context of both broad social inequities and specific gender disparities. Despite recent economic progress and the growth of a large middle class in India, gender disparities in education, access to land and property, and other means of attaining economic security persist. These gaps are compounded by cultural practices, such as child marriage and dowry, discrimination based on caste and class, and gender-based violence, all of which, taken together limit women’s livelihood prospects. As a result of these circumstances, millions of women and girls in India—single and married, young and old—live in extreme poverty. Thus, many resort to prostitution¹ as a survival strategy. At the same time, the interplay of household poverty, migration, and the demand for sexual services of young girls have also contributed to coercion of many women and girls into prostitution through trafficking².

Current estimates and future projections of HIV infections highlight the urgent need for India to adopt effective national HIV/AIDS control strategies. The second phase of India's National AIDS Control Program (NACP) will come to an end in 2004, and planning for the next phase is now underway. It is perhaps, the right moment to take stock of whether India's HIV/AIDS control efforts address the needs of the increasing number of uninfected women now at risk, those already infected with HIV, and those who are otherwise affected directly or indirectly by the epidemic.

This paper is part of a larger policy analysis and advocacy effort by the Center for Health and Gender Equity (CHANGE) to promote gender and rights-based approaches to HIV/AIDS prevention and treatment worldwide, by examining the effects of U.S HIV/AIDS strategies, globally and at the country level, on women’s reproductive and sexual health and rights. This work includes conducting research and policy analysis to examine whether and how strategies supported by U.S. bi- and multilateral assistance work effectively to stem the spread of HIV infection among women and girls. Through this research, we seek to identify gaps and develop recommendations for changes in existing strategies for

¹ Prostitution is defined as provision of sexual services by one person, the “prostitute” or “sex worker” for which a second person provides money or other markers of economic value. Exchange of sex for food, clothing, and shelter - known as “survival sex” is also a part of prostitution (Alexander 1998). In most, but not all situations, it involves a third party - broker, brothel owner or keeper who takes a commission from the sex worker’s earnings and facilitates client contacts.

² Trafficking is defined as the recruitment, transportation, harboring or receipt of persons by means of threat or use of force, abduction, deception, and exchange of payments that results in a person having control over another person for purpose of exploitation. Trafficking of women and girls for purposes of sexual exploitation and prostitution is a common form of this phenomenon (Source: Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, article 3(a)). A critical distinction between trafficking and prostitution is that the latter encompasses, but does not equate with trafficking, as it also includes those who *choose* to exchange sex for money (Butcher, 2003).

HIV/AIDS prevention based on approaches consistent with promoting both health and human rights, and to foster accountability of both donor and government policies through evidence-based advocacy.

Rationale and scope

This paper is the second in a series on gender and HIV in India, one among several priority countries currently receiving a large amount of U.S international assistance for HIV prevention. Since 1995, the United States has contributed \$67 million to India's AIDS control program, focusing its efforts on the states of Tamil Nadu and Maharashtra. We examine the scope and effectiveness of strategies being used by the Government of India—with bilateral development assistance from the United States—to address the vulnerabilities of *adult female sex workers* in the commercial sex industry³. Despite nearly 10 years of work in this area, little is actually known about the effectiveness of India's HIV prevention strategy for sex workers. Here we examine whether targeted interventions, the main component of India's NACP, have effectively addressed the HIV prevention needs of women sex workers in Tamil Nadu and Maharashtra⁴ and pose the following questions.

- Are targeted interventions being used in India adequate for and effective in reaching sex workers?
- Do they address the complex set of factors that make sex workers vulnerable to HIV?

Gender inequities play a critical role in fueling the epidemic and need to be addressed in programs and strategies focused on women, including female sex workers. An increasing body of program experience with sex workers reviewed for this analysis highlights the limitations of models that fail to address the broader needs and rights of sex workers as human beings, and by extension to slow the spread of HIV throughout the country. Our analysis of effectiveness is therefore based on the premise that gender and human rights concerns are critical to the success of HIV/AIDS programs and policies and must be integral at all levels of program design and implementation.

Furthermore, this paper responds to two contemporary debates on what constitutes effective prevention strategies for sex workers. On one hand, using models derived from mathematical and cost-benefit analyses, several researchers have argued that targeted interventions—those, for example, that focus on groups like sex workers as vectors for transmission of infection—will have the greatest impact in reducing the spread of HIV infection in India and elsewhere (Potts and Walsh 2003; Nagelkerke et al 2002). Based on recommendations from such analyses, governments and donors in many low-prevalence countries such as India have adopted targeted interventions as a cost-effective and efficient strategy to allocate scarce resources for the control of HIV transmission among "high-risk groups," and as a means to prevent or slow the spread of infection to the general population.

On the other hand, the implementation of targeted interventions within a narrow framework of cost-effectiveness has raised a number of critical questions. Many researchers, advocates, and program implementers have criticized targeted interventions on the basis that these fail to reduce and in many cases actually exacerbate stigma and discrimination against high-risk groups (Thomas and Bandyopadhyay 2003). Evidence clearly demonstrates that stigma and discrimination is counter-productive to HIV/AIDS prevention as it further isolates both those at highest risk and those already infected, leading to denial, avoidance of testing and counseling and fatalism, which in turn undermines adoption of safe sex practices (UNAIDS 2002). And in fact, stigma and discrimination against "high-

³ Our research did not address the specific plight of young girls in the sex industry, nor, despite the increasing attention to sex trafficking worldwide, do we explore the nexus between trafficking, sex work, and HIV. These are critically important topics, but more effectively addressed in a separate analysis.

⁴ While treatment and care strategies for sex workers are equally important, this paper focuses on prevention as no donors include treatment and care as part of targeted interventions at the present time.

risk groups" such as sex workers has worsened with the advent of HIV/AIDS in all affected countries, including India. In 2002, for example, Human Rights Watch documented widespread human rights violations among sex workers, peer educators, and non-governmental organizations (NGOs) implementing targeted interventions in India, including verbal, physical and sexual abuse, arbitrary arrests, and refusal of law enforcement and political authorities to take action against perpetrators of violence and discrimination against sex workers. Based on this and other evidence, many researchers argue that strategies based on "everyone at risk" are more appropriate than targeted interventions in part because such approaches aim to reduce stigma and discrimination. Others have suggested that, in any case, the window of opportunity for targeted interventions in India may have passed, as the epidemic has already spread to the general population (Gupta 2003).

This paper examines these polarized debates, and looks for a third approach, one that merges conventional approaches to HIV prevention among sex workers with those that respond to their health needs and human rights as women at risk. Thus, we also ask the following: What should be the essential elements of a strategy that focuses on sex workers and ensures stigma, discrimination, gender, and rights are addressed simultaneously and as priorities in their own right?

The paper is divided into five sections. The first describes the rationale, scope, background and framework for analysis. The second briefly explains the methodology used to gather evidence. The third examines the main factors underlying the vulnerability of sex workers in India. The fourth analyzes targeted intervention strategies of the National AIDS Control Organization (NACO), United States Agency for International Development (USAID) and NGOs they support, and identifies gaps in their responses to the needs of sex worker needs. And finally, the fifth presents conclusions and offers recommendations for future policy and programs.

India's HIV/AIDS epidemic and responses

Heterosexual transmission is the main mode of transmission in India accounting for 85 percent of cases, except in the northeast where injection drug use accounts for a majority of new infections (NACO 2003). While the national prevalence rate remains below one percent, these numbers mask a complex reality that India has not one but two epidemics in various stages of progression, requiring decentralized responses.

In six states, for example—Maharashtra, Andhra Pradesh, Tamil Nadu, Karnataka, Manipur and Nagaland—prevalence rates have reached well over five percent in "high-risk groups" and above one percent among women attending antenatal clinics, indicating that the epidemic is now established in the general population. In three other states—Gujarat, Goa, and Pondicherry—the epidemic remains "concentrated", with prevalence rates over five percent in "high-risk groups", but below one percent for women attending antenatal clinics. The remaining states are categorized as having a "nascent" epidemic, with prevalence rates below five percent in "high-risk groups" and below one percent in women attending antenatal clinics (NACO 2001).

Tamil Nadu and Maharashtra are the focal states for the rapid spread of HIV among sex workers, with the latter accounting for the majority of cases (Jain et al., 1994). Initial studies conducted in these two states showed an increase in prevalence rates among sex workers from one to three percent in the late eighties to 45 percent by the early nineties (Bollinger et al 1995; Jain et al 1994; Mehendale et al 1995). In 2002, the median HIV prevalence rate among sex workers in Mumbai (Maharashtra) was estimated to be 55 percent (NACO 2003). In a study in Tamil Nadu, close to 60 percent of sex workers were found to be infected with HIV (Babu et al 1997).

India's response to HIV/AIDS among sex workers is best understood through the framework of targeted interventions, adopted as a central strategy in the second phase of (1999-2004) of the NACP. Since

the first HIV case was detected in 1986, sex workers were seen as the key to HIV/AIDS control efforts in India. Initial efforts to target sex workers were patchy at best and laced with stigmatizing attitudes and discriminatory approaches. For example, in 1989 Tamil sex workers were deported from Maharashtra back to Tamil Nadu and forced to undergo HIV testing. At the time, 800 sex workers were jailed and quarantined by the Tamil Nadu government (Dube 2000, pg 26)⁵.

In 1992 the National AIDS Control Organization (NACO) was established as the main body to implement HIV/AIDS control efforts in India. NACO made a conscious decision to implement targeted interventions through NGOs and community-based organizations (CBOs), which were seen as more effective in reaching vulnerable groups using non-judgmental approaches (Sethi, 2002). More than 700 NGOs and CBOs are currently funded by NACO (as well as bilateral donors and private foundations) to carry out targeted interventions with "high-risk groups" including sex workers, truck drivers, injection drug users, men having sex with men, and migrant workers (NACO 2003a).

NACO's budget for HIV/AIDS in phase 2 of the NACP is approximately \$300 million. Of this, the World Bank contributes \$191 million in soft loans and the Government of India (GoI) contributes \$38 million. The United States contributes the largest amount of bilateral assistance. USAID is spending \$42 million over seven years in Maharashtra on what is known as the AVERT project and \$15 million over five years in Tamil Nadu for the second phase of the AIDS Prevention and Control (APAC – 2) project in addition to the \$10 million already spent on APAC-1 (1995-2002). Other bilateral donors contributing to the NACP in eight other states include the British Department for International Development (DFID), Canadian International Development Agency (CIDA), and the Australian Agency for International Development (AUSAID) (NACO 2003b). In addition, among private donors, the Bill and Melinda Gates Foundation is the single largest contributor to HIV/AIDS control efforts in India, with a recently announced grant of \$200 million over 10 years. Other private foundations including Ford and MacArthur—both with a long history of supporting reproductive health programs in India—are also providing support for HIV/AIDS programs to a select number of NGOs.

Donor approaches to HIV/AIDS prevention among sex workers vary both conceptually and practically. The scope of this analysis is focused primarily on the two largest institutional actors, i.e. NACO and USAID, in part because of the scale of their efforts, and in part because the mandate of the Center for Health and Gender Equity is to foster accountability of both U.S. international policies and funding to reproductive and sexual health and rights, and gender equity.

Framework of the analysis

This paper argues for placing HIV/AIDS prevention strategies targeting sex workers within a health and human rights framework that blends principles of public health and human rights. The rights principles most relevant for this analysis are the a) right to health (including sexual and reproductive health); b) non-discrimination and equality before the law; c) freedom from violence, inhumane, or degrading treatment and punishment; and d) autonomy, liberty, and security of the person (Butcher 2003; UNAIDS 1999). Within this framework, we also examine the concept of "harm reduction," which, although more frequently associated with HIV prevention in context of injection drug use, is becoming recognized as a pragmatic approach to reduce individual and social harms associated with sex work (Urban Justice Center 2003).

The health and human rights framework including the harm reduction philosophy require both a broader understanding of risk than offered by the usual more narrow focus on individual behaviors, and

⁵ These actions were contrary to internationally agreed principles of human rights assuring voluntary testing and informed consent of those affected by HIV/AIDS. They have been shown as counterproductive to HIV prevention in many settings (Wolffers and van Beelen 2003).

a move away from simplistic, stereotypical, and moralistic notions of sex work. For example, sex work is not a binary issue of good or bad (Sangram, Point of View, VAMP 2002). While many women resort to sex work due to a lack of other means to secure a basic livelihood, as well as by outright coercion, not all sex workers see themselves as victims, oppressed, or exploited. Instead, many can and are taking control of their own lives, finding solutions to their problems, acting in their individual and collective interests, and contributing to the fight against HIV/AIDS and public health. Moreover, public health approaches have been dominated by the view that sex workers need to be targeted because they are a hazard to society or vectors of HIV transmission (Wolffers and van Beelen 2003).

Instead of labeling sex workers as immoral, deviant, vectors, or as victims, a health and human rights framework views them as human beings, women, like any other— in need of, and entitled to good health, dignity and a life free from violence and stigma in their own right. Thus, this framework argues for HIV/AIDS strategies for sex workers to:

- a) enable them to exercise their human rights;
- b) respect their choices and realize these choices are made based on rational decisions balancing the need for survival and the reality of risk;
- c) involve them in decision-making; and
- d) make sex work safer and reduce health risks associated with sex work.

II - Methodology

Three sources of evidence inform this analysis. First, policy research was conducted on the ground in two high HIV prevalence states—Tamil Nadu and Maharashtra. Second, HIV/AIDS control program and policy documents of NACO and USAID were reviewed. And lastly, behavioral sentinel surveillance (BSS) and program experiences of sex work projects were examined. The policy research was conducted in February and March of 2003. The focus is on Tamil Nadu and Maharashtra because, in addition to being high prevalence states and contributing the highest number of HIV cases, these are also states where USAID is the primary bilateral donor for HIV/AIDS activities.

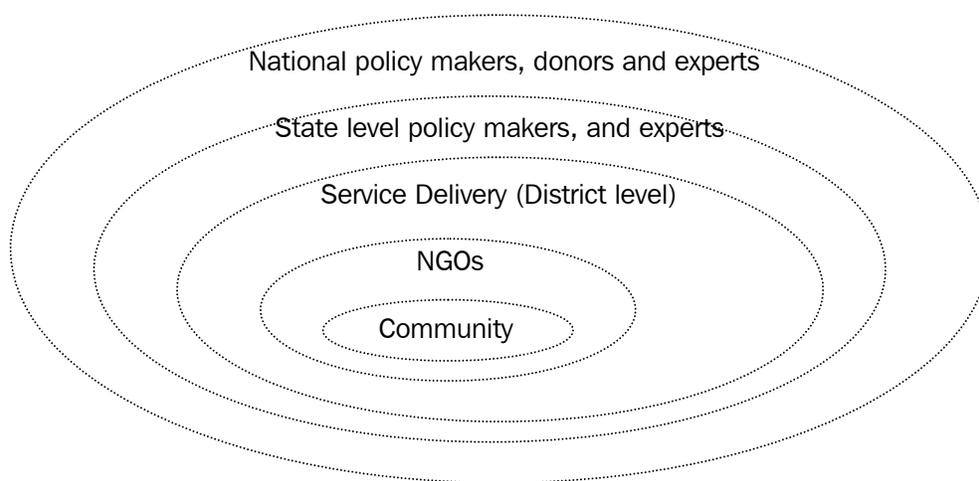
Data were collected at multiple levels (Figure 1) including NGO, service delivery, state and national policy maker, and donor levels. The first level focused on four NGOs implementing targeted interventions with sex workers and truck drivers. The NGOs were purposively selected based on CHANGE's prior contacts with them. Two NGOs from Salem and Namakkal districts in Tamil Nadu and two from Nasik and Sangli districts in Maharashtra participated in the research. The NGOs are implementing their programs in high HIV prevalence districts (NACO 2003). Field visits and interviews were arranged by prior appointments via email. Information was gathered through a combination of participant observations, group discussions, and key informant interviews. The purpose of the visit and interviews were explained to the participants. They were assured of confidentiality of information they shared. Interviews were recorded daily as notes, which were shared with participants to verify accuracy of the information. Permission was sought to use the information for policy analysis.

At the next level, information was gathered on the service delivery context at the district level. Interviews and observations of sexually transmitted infection (STI) clinics, voluntary counseling and testing (VCT) programs, and prevention of mother to child transmission (PMTCT) programs in district hospitals, and with district health officials in three of the four districts were conducted. To provide a policy context to both targeted interventions and service delivery, state and national level policy makers and donors also were interviewed. In addition, a range of experts in VCT, stigma and discrimination, substance abuse, and human rights were interviewed as key informants. Despite best efforts, this framework for data gathering could not be entirely replicated in Maharashtra, due to the inability to

secure appointments with several state-level policy makers. A more detailed description of the sample, field visits and type and number of interviews is included in Appendix 1.

There are two caveats in interpreting the findings of this policy research. First, the sample size in each category of key informants, observations and group discussion is small. Thus, findings cannot be generalized to the situation within and across states. Secondly, there is no intent to offer a comparative analysis *between* Tamil Nadu and Maharashtra. Differences and similarities in risk factor profiles and responses of the two states are noted as observations. The analysis integrates different sources of evidence to provide a more comprehensive picture. Thus, for each theme secondary data are combined with group discussions and interviews from research conducted in the two states. The issue of validity is addressed by gathering perspectives of stakeholders at different levels in program and policy implementation.

Figure 1: Data collection framework



III - Rethinking risk: Factors shaping HIV vulnerability

The vulnerability of sex workers to HIV is shaped by a number of factors. Some of those discussed here include poverty and power in the sex trade, knowledge and risk perception, sexual risk, access to health services, stigma and discrimination, and violence against sex workers both by institutional actors, such as law enforcement agencies, and by clients and partners. The discussion of these as risk factors, framed in the context of gender and social inequities, underscores the need to understand "HIV risk" as more than a narrow set of behavioral and demographic factors. It also underscores the need to avoid "moralistic" approaches to prostitution, because the accompanying blame, labeling, and discrimination against women in prostitution both contribute to and often exacerbate their risk of contracting HIV.

Sex trade in Tamil Nadu and Maharashtra

There are an estimated 2.3 to 8 million⁶ women sex workers in India (Murthy, 1999; Nag 1994). They can be broadly classified into:⁷

⁶ The numbers of sex workers are likely to be underestimates, as many women who engage in sex work do not identify themselves as such due to the stigma associated with prostitution.

⁷ This paper is based primarily on discussions and interventions with the first three categories of sex workers.

- a) Brothel-based sex workers in red-light areas and elsewhere, including those who engage in prostitution for economic survival as well as those who have been sold or trafficked into prostitution;
- b) Sex workers of *devdasi* origin. *Devdasi* refers to an ancient practice of dedicating young girls to Hindu temples to provide sexual entertainment to temple priests. The practice, though officially illegal, still persists in some parts of South India. Today, moreover, most *devdasis* engage in general commercial sex work outside the temple—in brothels or streets—using temples as a base for exchanging sex for money or essential goods such as food or clothing;
- c) Non brothel-based sex workers are street-based, floating, or mobile sex workers who operate near highways, industrial areas, tourist spots, railway stations, bus stations, and in lodges, hotels, bars and residential areas. Many are married women seeking to supplement meager household incomes for family survival;
- d) Call girls, who typically have a higher socio-economic profile and provide services to wealthier clients (NACO 1994; Nag, 2001).

In Tamil Nadu, commercial sex work is dominated by non-brothel-based workers. A recent survey⁸ indicates that there are approximately 6000 sex workers in the city of Chennai alone. The majority (70 percent) are "family girls" or "housewives", operating secretly from their homes through a network of brokers in order to earn enough income for survival. A smaller number are street-based, migrant women and brothel-based sex workers (Mujtaba 2003). In Salem and Namakkal districts (our research setting), most sex workers are highway-based, as Salem town is a junction of several national highways and Namakkal is the headquarters of the trucking industry. The Tamil Nadu (BSS) shows that the majority of sex workers have some schooling, are married, have children, and are either living with or separated from their husbands (APAC 2001). Household debt, abandonment by husband and lovers, and responsibility for children are the main reasons that many of the "family girls" or "housewives" find themselves in such a situation (Mujtaba 2003).

In Maharashtra, there is a more equal mix of both brothel and non brothel-based sex work. While clearly defined red-light areas exist in larger cities such as Mumbai, Pune, and Sangli, there is also a large population of non brothel-based sex workers operating both within and outside the red-light areas. There are an estimated 100,000 or more sex workers in the city of Mumbai alone (Friedman 1996). In Sangli and Nasik districts (our research settings), both brothel and non-brothel based sex workers provide services in the context of national highways and industries. In Sangli, which is part of the region where the practice of *devdasi* was common, many sex workers originated as *devdasis*. The Maharashtra BSS indicates that a majority of sex workers are single (either unmarried or separated from husbands) and are not literate (AVERT 2001). In Maharashtra, the interplay of poverty, trafficking, and the system of *devdasi* form the basis for women's entry into sex work.

Various surveys from Maharashtra and Tamil Nadu indicate that sex workers service between 7 to 13 clients a week and earn an average of less than two dollars per day or less than \$100 a month (APAC 2001; AVERT 2001; Mujtaba 2003; NACO 2001a). In Tamil Nadu, a substantial proportion of sex workers have another source of income and engage in sex work to supplement their meager household incomes. They mostly obtain clients through brokers⁹, or independently (Mujtaba 2001). In Maharashtra, brothel-based women work under the control of a network of brothel-keepers, owners, financiers, brokers, and even the police—all of whom play a powerful role in shaping the sex worker's daily life and environment. For example, most sex workers share a significant proportion (up to 80 percent) of their income with brothel owners, brokers, and police (Nag 2001). For many brothel-based

⁸ Survey data refer to specific studies conducted in Tamil Nadu and Maharashtra, state-wise break down of national behavioral sentinel surveillance (BSS) conducted by NACO, and state-specific BSS conducted by the two USAID projects - APAC in Tamil Nadu and AVERT in Maharashtra.

⁹ Intermediaries who procure girls for brothels, facilitate contact with clients, and charge a commission from sex workers' earnings.

sex workers, their ability to work independently of these third parties is constrained by factors including coercion by brothel owners/keepers, harassment by police and criminals outside the confines of brothels, or repayment of debts to brothel owners. Despite these constraints, evidence indicates that many choose to remain as sex workers for reasons that include acceptance of their situation, being ostracized by mainstream society, and responsibilities towards their families (Nag 2001; Sangram 2002; Group discussion participant, CHANGE's research).

Knowledge and risk perception

HIV/AIDS awareness and knowledge is the most widely used indicator of risk, success of programs, and tracking behavior change. Tamil Nadu and Maharashtra BSS data indicate that awareness is almost universal, with more than 90 percent of sex workers having heard of AIDS (APAC 2001; AVERT 2001; NACO 2001a). Knowledge of transmission and prevention methods is also very high (i.e. between 80 to 98 percent). And yet, it is increasingly recognized that while awareness and knowledge are necessary, they are by themselves not sufficient conditions to effectuate sexual behavior change. For example, knowledge of HIV/AIDS without any misconception, including the belief that a healthy looking person cannot transmit HIV, is no more than 50 percent among sex workers in the two states. Likewise, HIV risk perception, a more sensitive indicator of behavior change than knowledge, is also less than 50 percent in both states (APAC 2001; AVERT 2001; NACO 2001a). The Tamil Nadu BSS also highlights sex workers' low risk perception with regular partners (APAC 2001).

Sexual risk

While sexual risk in the form of multiple sexual partners is a fact of life for all sex workers, several factors place them at higher risk for HIV transmission including certain types of sexual relationships, alcohol use, and violence. The Maharashtra BSS shows that brothel-based sex workers have on average a higher number (13 per week) of clients than non brothel-based women (9 per week), suggesting that the former may be at higher risk for HIV, especially if condoms are not used (AVERT 2001). However, BSS data from the two states suggest that non brothel-based sex workers work harder to attract clients, more often have non-paying partners with whom risk perception is low, and find it more difficult to negotiate condom use compared to brothel-based women (AVERT 2001; APAC 2001).

BSS data and discussions with participants of the research conducted by CHANGE indicate that safe sex negotiation by sex workers depends on several factors. For example, in Maharashtra a study suggests that sex workers use condoms intermittently and hope for the best in terms of avoiding infection (AVERT 2001). Alcohol use by clients and sex workers also jeopardizes negotiation of safe sex, with the national BSS indicating that more than 70 percent of clients and 40 percent of sex workers consume alcohol before having sex (NACO 2001a). Interviews and discussions with NGO staff and sex workers also suggested that women's ability to negotiate safe sex is compromised by coerced sex with criminals, drunks, and police.

The vulnerability of sex workers to infection resulting from unprotected sex with regular partners (i.e. husbands, lovers, brothel owners, bar keeps)¹⁰ is an important but largely neglected dimension of prevention. In both Maharashtra and Tamil Nadu, many of the single sex workers have regular partners (AVERT 2001; APAC 2001). The Tamil Nadu BSS (APAC 2001) reveals that condom use with regular partners (40 percent) is lower than with paid clients (90 percent). Sex workers who participated in our field research described the struggle they face in convincing their regular partners to use condoms.

¹⁰ Men who provide companionship and emotional support to the sex worker

We don't accept any client without condoms. No matter how much money they offer - 50-100 or even 500-1000 rupees, we refuse to do it without condoms. The only thing is that we cannot use condoms with our "gharwala" (regular partner)...no, my "gharwala" doesn't like to use condoms. He has told me to stop this "dhandra" (business of sex work). But with our "gharwala", we cannot use any condoms. They chide us saying 'don't you trust me' ("bharosa"). 'You are in this profession with other men, but I am not like that so you have to trust me.' (Group discussion participant, sex worker intervention, Maharashtra)

Several sex workers in this group discussion explained that "trust" and a desire for companionship and children make it difficult for them to insist on condom use with their regular partners. Such narratives indicate that even where sex workers are empowered to demand condom use with clients, they have less power to negotiate safe sex with regular partners. NGO outreach staff from other sex worker interventions that participated in our field research explained that sex workers also have unprotected sex with brokers, brothel owners, and police. Coercion, dominance, and power make it difficult for sex workers to negotiate condom use with such partners.

Health needs and access to services

Sex workers own health needs often go unmet—constrained by the economics of losing wages, inaccessible services, and socialization to prioritize children and partners' needs over their own. If they do seek treatment for their ailments, it is usually as a last resort and through private providers that include quacks and neighborhood clinics and doctors (Sangram 2002; Evans and Lambert 1997). Our group discussions with sex workers and interviews with NGO staff revealed that public sector facilities, even though free, are not used by sex workers because of inconvenient hours offered, perceived and actual poor quality of care, and discriminatory treatment by providers.

Moreover, access to condoms is increasingly unpredictable and inadequate. National BSS data indicate that in Maharashtra approximately 50 percent of sex workers gain access to free condoms through NGOs. In Tamil Nadu sex workers mostly rely on clients for condoms, or purchase them from chemists (NACO 2001a). In our field research, some NGO staff revealed that access to free condoms from the government and donors is declining, and NGOs working with sex workers increasingly find it a struggle to procure condoms for distribution to sex workers. An NGO outreach worker from Maharashtra described acute shortages of condoms in their area, leading the NGO to cease community-based distribution, causing conflicts among sex workers, and forcing sex workers to purchase condoms from the market. Sex workers from another intervention in Maharashtra, citing the importance of access to free condoms, argued that the costs of paying for condoms would undermined consistent use.

Violence of stigma, criminalization, and abuse

Violence is one of the more dire realities confronted by sex workers in India and elsewhere. A number of studies underscore how violence undermines the safety and survival of sex workers, as well as their ability to participate in HIV prevention programs and protect themselves from infection (Alexander 1998; Longo and Telles 2001; Carrington and Betts 2001; Overs 2002). In India, violence against sex workers is not only widespread, but ranges across the spectrum of labeling, stigma, discrimination, verbal, physical and sexual abuse, and denial of rights to those who demand justice for themselves. One study revealed that 70 percent of sex workers from 13 districts in Tamil Nadu had been beaten by police, and more than 80 percent had been arrested without evidence (Sangram, Point of View and VAMP 2002). In our field research, several NGO outreach workers described a pattern of harassment, arrests, and coercion by police as a major barrier to their prevention work with sex workers. For example, a key informant described the problems faced by NGOs due to police harassment.

The police book sex workers on illegal charges because they have to fulfill their quotas of cases in a month - so they arrest sex workers. Then in exchange for releasing the sex workers, the police demand that sex workers give them sex for free, or for not getting them arrested or booked on some charges. The "rowdies" (criminals), who harass not just sex workers, but others as well, never get booked or disciplined by the police. The police also create problems for AIDS NGO staff and harass and threaten us. (Outreach staff, sex worker intervention, Tamil Nadu)

Key informants and group discussion participants reported that a large part of the violence against sex workers is explained by prejudicial public and institutional attitudes. For example in a group discussion, sex workers protested against being branded as "AIDS carriers" by the media, policy makers, and program staff. In several instances, NGO staff themselves labeled sex workers as "immoral", reflecting societal attitudes towards them. Such attitudes have also influenced the implementation of policies and laws governing the rights of women in sex work.

The Immoral Trafficking Prevention Act of 1986 (ITPA or PITA) provides an ambiguous framework for criminalization of sex work in which, prostitution is not criminalized per se, but the procurement of sex workers and establishment of brothels are listed as criminal activities. This law is frequently used by police to arrest sex workers and to mount rescue and rehabilitation raids in brothels, with the aim of rescuing young girls in prostitution (Lawyers Collective 2003; Sangram, Point of View and VAMP 2002a). In reality, the nature of these arrests, rescue, and rehabilitation efforts are often arbitrary, repressive, and lead to gross human rights abuses against both adult sex workers and minors. For example, rescue and rehabilitation efforts, involving both adult sex workers and minors, do not taken into account sex workers' wishes of whether they want to be rescued or not, nor do they protect them from physical or sexual violence perpetrated by police themselves. The raids often involve manhandling, beating, sexual coercion, and extortion of sex workers (Sangram, Point of View and VAMP 2002a).

IV - Targeted interventions: An examination of responses to sex worker needs

The premise of a targeted intervention strategy is that in a low-prevalence country like India, the HIV/AIDS epidemic can be most efficiently stemmed from spreading to the rest of the population by focusing prevention efforts in high-risk groups such as sex workers, truck drivers, and others. Both NACO and USAID focus on targeted interventions as their main prevention strategy, with NACO spending between 15 to 20 percent of its total budget in 2002-2003 for targeted interventions (NACO 2003c). NACO has established State AIDS Control Societies (SACS) in every state, union territory, and in several metropolitan municipalities. The SACS directly receive and disburse funds for HIV programs to other organizations.

Operational structures and strategies of NACO and USAID

In Tamil Nadu, the State AIDS Control Society (TANSACS) and the Chennai District AIDS Control Society (CDACS) implement HIV/AIDS programs as per NACO's guidelines, supporting up to 150 targeted interventions—at least a third of them for sex workers¹¹ (NACO 2003d; Appendix 2). The APAC project is a tripartite agreement between USAID, NACO, and Voluntary Health Services (VHS)—a leading health services institution in Tamil Nadu (APAC 2003). APAC has supported close to 50 NGOs

¹¹ The number of targeted interventions and proportion of sex worker interventions in the two states have been calculated from list of NGOs supported by NACO and USAID between 1997 and 2003 that was issued by NACO in 2003. This list provides state-wise information about type and population covered by the targeted interventions (NACO 2003d)

- nearly half of them for sex worker interventions (NACO 2003d; Appendix 2). Both TANSACS and APAC work separately, but collaboratively.

The Maharashtra State and Mumbai District AIDS Control Societies (MSACS and MDACS) have been implementing HIV/AIDS programs in the state since 1999. They support approximately 65 NGOs—approximately 30 percent of them for sex worker interventions (NACO 2003d; Appendix 2). The AVERT project has recently begun to support NGOs and is expected to continue until 2007. AVERT is registered as a separate entity and is responsible for administrative and strategic planning functions of the project. The first round of grants were made in 2002-2003 and about 4 out of 15 interventions were for sex workers (NACO, 2003d; Appendix 2).

NACO has decentralized NGO selection, training, monitoring, and evaluation to the SACS. The SACS appoint an NGO advisor who is expected to develop a portfolio of targeted interventions. The guidelines for selection of NGOs, costing of interventions, core components, and curriculum are provided by NACO, with the SACS given the primary responsibility to disburse funds according to NACO guidelines. In addition, NACO has supported the formation of technical resource groups to assist in NGO training and capacity building. NGOs are expected to submit coverage, output and financial indicator reports to SACS. External consultants appointed by the SACS conduct evaluations of NGO projects (NACO 2003e).

USAID's APAC and AVERT projects have separate guidelines for selection and funding of targeted interventions. APAC¹² has developed intervention packages for each target group including the Women in Prostitution (WIP) and the Prevention along the Highway (PATH) for truck drivers and sex workers. NGOs participating in these models share their experiences, lessons and strategies to improve project implementation. Training and capacity building of NGO staff is conducted through demonstration centers supported by APAC. Monitoring and evaluation, conducted by consultants, is based on monthly reports, bi-annual site visits, and a mid-term evaluation. In addition, APAC conducts operations research to improve technical assistance and develop new strategies for HIV prevention. APAC along with TANSACS has conducted BSS in Tamil Nadu since 1996 to measure the impact of statewide efforts on behavior change among high-risk groups (APAC 2003).

Key components of NACO (i.e. SACS) and USAID's (i.e. APAC and AVERT) targeted intervention strategy include:

- a) Information, Education and Communication/Behavior Change Communication strategies.¹³ These include communicating information about STI, HIV, AIDS and prevention methods in ways that seek to inform and catalyze changes in behaviors;
- b) Education and referral on sexually transmitted infections (STIs), including communicating information about STI symptoms and appropriate modes of action as well as referral to a trained provider;
- c) Condom promotion, including distribution of both free condoms and those made available through social marketing programs;
- d) Creation of enabling environments, including building liaisons and STI and HIV education of gatekeepers and opinion leaders who are likely to influence target groups in adopting safe sex.

These strategies are to be implemented through peer education where NGOs are required to train a cadre of outreach workers and peer educators in communication, counseling, HIV/AIDS and STIs, and

¹² Unlike the APAC project, which has been operational for 8 years, AVERT only recently started program assistance. Therefore, operational modalities for AVERT have not been documented, and hence not described here

¹³ IEC - Information, Education, Communication; BCC - Behavior Change Communication

in cultivating relationships with gatekeepers and opinion leaders in the vulnerable community (NACO 2003e; APAC 2003). In addition, table 1 summarizes differences between NACO and USAID strategies. In our field research, key informant interviews with NGO staff and USAID program officers indicated that APAC and AVERT emphasize interpersonal communication as part of BCC whereas, the SACS are relying on the traditional IEC approach with emphasis on mass media for HIV/AIDS education. For STI and VCT services, SACS are supporting government health services at the district level whereas USAID projects (in particular APAC) are training and supporting private sector providers in syndromic treatment for STI and counseling services. Likewise, NGOs funded by the SACS obtain condoms through the district health services, whereas, NGOs supported by the USAID projects are encouraged to engage in social marketing of condoms (Table 1).

Table 1: A comparison of NACO and USAID strategies for targeted interventions

Priority strategies	NACO	USAID
IEC/BCC	Mass media	Interpersonal communication
STI referral	District hospitals	Private providers
Condom promotion	Free distribution, supplies obtained from government sources	Socially marketed, supplies obtained through private manufacturers and retailers

Gaps in targeted intervention strategies

This analysis identifies several gaps in NACO and USAID's targeted intervention strategies for sex workers. The following sections are organized by themes that emerged from discussions with key informants as some of the more critical issues undermining the effective implementation of targeted interventions for sex workers.

Coverage

Several key informants noted that targeted interventions cover only a small proportion of sex workers at risk. NACO's BSS data also reflect poor coverage of sex workers by prevention programs. Here, coverage is evaluated based on assessment of indirect indicators obtained from the national BSS: the proportion of sex workers approached with STI/HIV information and education; and the proportion of sex workers attending HIV meetings in a 12 month period (NACO 2001a). These data, summarized in Table 2, underscore several points.

Table 2: Coverage indicators for targeted interventions and sex workers

Sex Workers Participating in BSS Surveys	Maharashtra ¹⁴	Tamil Nadu ¹⁵	National
Share of Sex workers approached with HIV/AIDS information	73 brothel-based	58	62
	29 non brothel-based		37
Share of Sex workers participated in HIV/AIDS program meetings	38 brothel-based	52	30
	9 non brothel-based		21

¹⁴ Source Maharashtra BSS (AVERT2001)

¹⁵ Figures for coverage in this column and the last column in the table are from National BSS (NACO 2001a). State level statistics for coverage were not collected by APAC's BSS

First, Tamil Nadu has a better record of reaching sex workers than Maharashtra (NACO 2001). This may, in part, be explained by Tamil Nadu's longer (since the early nineties) and stronger history of implementing targeted interventions compared to Maharashtra. As noted earlier, TANSACS, CDACS, and APAC have collectively supported more than 200 interventions in Tamil Nadu—between a third and a half of them for sex workers (NACO 2003d; Appendix 2). Whereas, in Maharashtra MSACS, MDACS, and AVERT have supported less than 100 interventions and less than 30 percent of them for sex workers (NACO 2003d; Appendix 2). Second, in Maharashtra, coverage of brothel-based sex workers is significantly higher than that of non brothel-based sex workers. This gap highlights not only the latter's vulnerability, but also the difficulties of reaching non-brothel based sex workers in an environment where soliciting in public is punishable by law. For example, a key informant noted the difficulties of identifying sex workers.

Our work leads us to believe that it is very hard to identify sex workers. They are the most stigmatized and have many social and psychological problems. They are the poorest, their occupation and livelihood is the most marginalized. Many of these women have no other options as the women are often abandoned, and once they enter this profession, no amount of effort will integrate them into the community. In Chennai it is more difficult, because many of the sex workers here are "flying sex workers". They are migrant sex workers and follow up is a huge problem. (NGO director, truckers and sex workers intervention)

Strategic planning and guidelines

Key informant interviews shed additional light on poor coverage of sex workers noted in the previous section. As suggested by comments of a key informant, a program officer of a Canadian funded technical agency, targeted interventions are hampered by a lack of strategic planning. The key informant noted that NACO's guidelines for targeted interventions do not consider which targeted interventions need to be undertaken, how many, under what circumstances, and what are the most effective modalities to reach sex workers.

At the conceptual level, the national-level guidelines are more suited to brothel-based sex worker projects. They miss the mark on the type of sex work in Southern India, which is not brothel-based. This has two impacts. The first is that there is a constraint on programs imposed by SACS. They will not support proposals outside these guidelines. Secondly, a more subtle impact is that it has encouraged NGOs to fudge the nature of their project. I have never seen a collection of sex workers in these projects that didn't go in multiples of 500. The funding model is based on reaching 500 sex workers and you will not get funded if you don't reach 500 sex workers. The program guidelines are based on a formula and result in a shadowy dance between the NGOs and donors. It is not in the interest of either to try new approaches. Therefore we need new approaches. (A program officer of a Canadian funded technical agency)

Another key informant noted that rigid application of national guidelines in terms of fixed targets, amounts, and activities has resulted in a "cookie-cutter" approach, with little room for innovation.

NACO's whole approach to targeted interventions needs to be revisited. The model has outlived its utility. When they started, they had no idea what to do so they came up with a model for funding NGOs. Now there are lessons learned and they really need to revisit their approach from their lessons. They have a boxed-in approach. They have a fixed amount--Rupees 200,000 per year per NGO--in which the NGO is supposed to do fixed things—provide condoms, IEC and refer STI cases on fixed targets. Now you have to assess the epidemic across the state and country. Where the need is greater, there needs to be some flexibility to the approach. You also have to understand the dynamics of transmission in that

state or city before you apply this formula approach. Even their IEC strategy is based on mass media—we know that is not sufficient for behavior change. We also know that we have to do interpersonal counseling for behavior change, but that NACO is not willing to support. They will only support NGOs that are willing to formulaic things. (A program officer, USAID project)

A key informant, the director of an NGO in Tamil Nadu, noted that both USAID and NACO funding for targeted interventions are "project-driven," with no linkage between the objectives of targeted interventions being run by NGOs or the planning for other health and sector activities (e.g. education) at the sub-district, district, and regional levels. This, according to the key informant, is undermining the success of HIV prevention beyond the narrow confines of the health sector. According to this key informant, such planning would require drawing up of strategic plans for HIV prevention at the regional, district, and sub-district levels, with active donor sponsorship and resource allocation for such an endeavor. This type of strategic planning would not only result in greater ownership of targeted interventions by NGOs, but also facilitate better coordination of different HIV prevention projects in a particular region.

The comments of various key informants suggest that the lack of strategic planning, the project-driven approach to funding, and the formulaic application of guidelines leave little room in the present approach to address the broader context of sex workers' vulnerability discussed earlier. Moreover, they speak to the lack of epidemiological assessment and planning at the decentralized and local levels of the SACS, districts, and sub-districts, reflecting a top-down approach to planning. These insights reflect the absence within current top-down targeted interventions to incorporate the voices, perspectives, experiences, and needs of those working at the ground level, including sex workers themselves, which in turn undermines the success of these approaches overall.

Service delivery context

CHANGE's research also shows that on the "supply" side, targeted interventions are being undermined by a poor, ineffective, and discriminatory service delivery context at the same time that they are creating a "demand" for STI and VCT services through IEC, STI education, and condom promotion. A key informant, a program officer of a Canadian funded technical assistance agency noted that targeted interventions are carried out in isolation of other components of the NACP-2, such as strengthening STI, VCT, and care services in the public health infrastructure. Instead of planning for combined delivery of targeted interventions and services at the district level, areas with targeted interventions lack access to STI and VCT services and vice-versa. Moreover, despite the NACO's efforts to strengthen and provide STI and VCT services in the district hospitals, the public health services at the state level have not been able to provide quality and non-discriminatory STI and HIV/AIDS services. For example, one key informant described the "concentration of apathy" in the government health services.

There is a concentration of apathy in the government health services. We really need to make the government services accountable, because in the private sector, providers are refusing HIV positive patients. People after being turned away in the private sector are knocking on the government health services door for care and treatment for AIDS only to be turned away by the government or to be ill-treated by government health services. I worry about government apathy towards AIDS because they are the only institutions that have the resources and infrastructure to reach out to the maximum number of people. Primary Health Centers (PHC) provide maximum access for poor people in rural areas and yet people in these areas are accessing PHCs that are understaffed, ill equipped and staff is insensitive. They just don't care. They reckon that those who are at risk for AIDS —sex workers and the likes are going to die anyway. They tell sex workers that "you are going to die anyway and no

one will even give you a body bag for your funeral". (NGO director, sex worker intervention, Maharashtra)

These comments speak to the implications of inadequate government HIV/AIDS services on equity in health care and on government responsibility where the private sector has failed in providing HIV/AIDS prevention, treatment and care services. Reinforcing the above comments, another key informant, director of an NGO in Tamil Nadu, described the poor quality of HIV services as part of a larger ethos in which there is a lack of public service ethics. He explained that health service providers in both the public and private sectors trample upon not only the rights of sex workers, but also on patient rights more broadly. Other key informant interviews revealed that the lack of female providers and the indignities women suffer at the hands of providers simply because they are sex workers discourages them from attending public facilities for treatment. Interviews with donors also revealed how their own programs are hampered by rules that prohibit funding of services and the poor quality of public health infrastructure. For example, a key informant noted the limitations of not being able to fund condoms and STI services.

The other problem we are facing is that USAID has rules saying they will only fund condom promotion programs, but not condom procurement. They will only fund referrals to STI services, but not fund improvements in STI services including supplies of drugs. So you tell me how is one suppose to run programs where we cannot fund supplies and services, but we are supposed to create behavior change. You tell me where will people go if they want STI treatment. The SACS are supposed to improve services for STI treatment but the quality of services in the public facilities is very poor. So we are stuck with getting people referred but with nowhere to go. So the SACS tell us we know that we are supposed to provide drugs and condoms, why are you telling us this when you will not provide the drugs or condoms. They tell us why don't you provide the condoms and drugs instead of just telling us and telling people that they are supposed to change their behavior. So this is the problem we are faced with. (A program officer, USAID project)

These comments highlight the acute need for government and donors alike to focus on improving HIV services both technically and in terms of sensitivity and non-discrimination towards all those affected by HIV, but especially women and sex workers. They also suggest the need for closer examination and modification of donor and government rules and guidelines that fail to address expanded access to services that would ensure that the behavior changes sought in at-risk individuals are met with a steady supply of condoms, appropriate diagnosis, and STI drugs.

Conceptual understanding of gendered approaches

Discussions with key informants indicated that many policymakers and donor representatives demonstrate a limited understanding of how to implement gender-sensitive HIV prevention strategies. A review of NACO's policy statements indicates that targeted interventions strategies are to be based on principles of freedom from discrimination and stigmatization, and a concern for human rights of target groups. Moreover, NACO policy includes official recognition of gender as a factor in women's vulnerability to HIV (NACO 2003e). In reality however, there is a gap in translating this rhetoric into tangible strategies. For example, a key informant notes that gender issues are accorded a low priority in programmatic and policy approaches.

The HIV/AIDS policy on paper is very good, but on the issue of rights and gender, they have not put their money where their mouth is. Gender is not even an issue in most people's mind when it comes to HIV/AIDS. They are not able to think about giving human dignity to women as part of their interventions. The orientation of policy makers and those involved in

AIDS prevention is that sex workers are seen as vectors so they are not treated with dignity.
(NGO director, sex worker intervention, Maharashtra)

An interview with a USAID program officer reveals a limited focus on HIV knowledge and condom promotion in absence of a more concrete understanding of what a gendered strategy entails.

Well, we don't have any separate strategy. But our work with sex workers is to "empower" them through knowledge on health, STI, and HIV. So that is our gender approach—empowerment through knowledge. Otherwise, we don't have any special or separate strategy.

Prevention messages

CHANGE's interviews with NGO staff and observations of peer communication, VCT and STI services revealed that communication to sex workers ranges from messages conveying blame on sex workers for spreading infection and moralistic messages about sex work, to messages that offer sex workers practical skills to protect themselves. There is an increasing recognition that prevention messages need at minimum to avoid exacerbating or reinforcing negative gender, sexual, and other stereotypes, and to instead work pro-actively to reduce such stereotypes (BRIDGE 2002). The premise of developing prevention messages that are sensitive to gender and human rights concerns is to ensure that, at a minimum, the language and tone of information conveyed to target audiences does not contribute to increased stigmatization of vulnerable groups. Yet interviews with various NGO staff indicated that in several instances prevention messages conveyed judgment of what are moral and immoral behaviors, blame, and a fear of consequences in addition to the technical aspects of HIV prevention—in effect directly placing and reinforcing blame for the spread of infection on sex workers as though in a vacuum. For example, in a group discussion two outreach staff from an NGO described the content of their communication and counseling.

R1: We tell them how to behave properly, how to show good behavior in society and we tell them about joining with bad people. We tell them about discipline.

R2: First we ask them about what they know of AIDS. We then give them information about AIDS and then we do our level best to change the mindset on AIDS. And if they cannot change their mindset about sexual behavior then we insist on condom use. With sex workers, they tell us that they have no choice so what to do, we know it affects everyone. So they only tell us give us condoms and we will protect, but we cannot stop this business.

R1: We tell them about the problems this behavior will cause in their family, but the sex workers are aware. They say what can we do, we are willing to use condoms. Suppose the men are not willing to use condoms. The sex workers insist that the men beat them. We tell them that what you say is okay. When you work and are getting money for this work, you should also think of disease spreading. We tell them "you are looking after your family, but spoiling 100 other families and ruining their future". We tell them to think what the consequences of their actions might be on the society. We tell them that they will ruin an innocent housewife's life. We give them examples of how this disease is spread and what are the dangerous consequences of this disease. We tell them "what will you achieve even if you earn some money". (Two NGO outreach staff, truckers and sex worker intervention)

Communication materials used by NGOs focused on the technical aspects of HIV (APAC 2003a). For example, brochures and posters demonstrated how HIV is spread, symptoms of STI and appropriate action, how HIV can be prevented, and how to use condoms. However, as the above comments demonstrate, an exclusive emphasis on technical messages fails to address underlying judgmental beliefs, prejudices, and inequitable norms towards women, sexual behavior, and prostitution held by

many including those implementing programs, and thereby, contributes to increasing stigma and discrimination against sex workers.

Stigma and discrimination

Our research indicates that HIV/AIDS prevention efforts have not addressed the widespread stigma and discrimination experienced by sex workers. In the way they are currently defined, implemented and perceived, targeted interventions have contributed to increased stigma and discrimination of sex workers. Official NACO policies and parlance for targeted interventions are only recently evolving from using terms such as "vectors" or "core transmitters" that attribute blame to a more sensitive parlance of "vulnerabilities" and "marginalized groups". NACO's recent guidelines on ethics and human rights make the distinction between targeting for program purposes and describing sub-populations to media and general public as "high-risk groups" (NACO 2003e). However, changes in guidelines have yet to be accompanied by concrete efforts to change the mindset of those implementing the programs. For example, the comments of a district health officer highlight the stigmatizing attitudes of those implementing HIV/AIDS programs.

Q. What do you say in your TV messages about AIDS?

A. We clarify doubts. People call and ask or say such shocking things. I think some things have to be frankly said even though the Dean [i.e. of the district medical college] told me not to say such things. For example, one sex worker revealed that she had unprotected sex with a youth because he refused to use condoms. I told her that she has committed a "grave sin" because she should starve rather than ruin a young man's life. (Interview with the district nodal officer for AIDS, Tamil Nadu)

Likewise, interviews with NGO staff indicate that stigma and discrimination in the health care settings including STI and VCT services have discouraged sex workers from seeking treatment even when referred by outreach workers. For example, a key informant described the use of foul language by providers when talking to clients.

The hospital is there, but have you seen the kind of treatment they give there. They are so insensitive. They have the VCT center, but the counselor is a male and he is hardly there. And when he is there he uses such foul language with patients "*Kya randi ke paas gaya tha*" (you went to a whore or what)? This is for those who test positive. For the STD clinic, it is also there, but again the staff is very insensitive. Our sex workers don't want to go there because the doctors ask questions about sexual habits—questions like "did you do it from the top or bottom, front or behind?" So the sex workers tell us that they don't want to go to the government hospital because they don't like the doctors asking such questions. (NGO director, trucker and sex worker intervention, Maharashtra)

Sexuality

In our research we found, as others have, that the failure to openly discuss sexuality is another critical factor contributing to ineffective implementation of targeted interventions in India. In interviews with NGO outreach staff, they mentioned receiving sexuality training. In reality, only some reported being able discuss sex and pleasure in relation to condom use with target groups. A key informant, an expert who conducts training in counseling, clarified that sexuality training is limited to a few hours and does not challenge, clarify, or address underlying values of outreach staff or counselors for them to overcome sexual taboos. Thus, as another key informant noted, prevention messages are boxed into a moral framework or message—"abstain," "use condoms"-- without consideration or discussion of safe sex in context of sexual pleasure.

The problem is that the agenda for sex and sexuality in India is not there. A lot of people are working on targeted interventions, but sex and sexuality is hidden. At the moment we have only two tools in prevention "don't do it" which is a moralistic stance and "do it safely" which complements the condom promotion effort. There is very little romance around sex and sexuality. It is seen as a straight-jacketed process, which translates into dictates of "do this" or "don't do this". There is little consideration for gender disparities and structures around it. So, how can condom promotion in a singular sense work? (An expert on substance abuse and HIV)

Law, human rights and policy

Even where targeted interventions gain the highest political support, many have yet to come to terms with the idea of stigmatized groups such as sex workers being entitled to human rights. This is perhaps a key stumbling block in implementation of targeted interventions. On one hand, government and donors recognize the importance of focusing on sex workers and recruiting them as peer educators. Moreover, a conference (July 26-27, 2003) on HIV/AIDS held in New Delhi, that included policy makers, politicians and bureaucrats across all political spectrums, indicated an emerging political will to address the HIV/AIDS epidemic in India (SAATHI July 27, 2003). On the other hand, under ITPA (Prevention of Immoral Trafficking Act), sex workers continue to be either harassed or not protected by law enforcement agencies when other members of the society (e.g. local thugs) harass them.¹⁶ Several key informants described the challenges of reducing the misuse of ITPA and protecting sex worker rights. For example, a key informant articulated the moral ambivalence or reluctance to granting sex workers certain rights.

I am most amused by how this epidemic has brought out concepts of rights and participatory approach. A lot of politically correct concepts are thrown around, but actually if you go to implement them, then there are limits. Even this concept of patient rights is only in terms of HIV programs. So the rights of women in prostitution is not because they as citizens have rights, but because from a HIV programmatic point they have to have a few rights to enable them to use condoms, but no one wants to address their rights as individuals. So there is this compartmentalization. There is a reluctance to accept a rights approach. These ideas are being bandied around—more as rhetoric. Very little really gets translated into practice. (An expert/trainer for VCT services)

Another key informant, a director of an NGO in Tamil Nadu, noted that the lack of sex worker rights need to be understood as part of a larger apathy towards protecting a continuum of human rights including the right to health, patient rights, civil, political, and economic rights of sex workers and the rights of women more broadly. Thus, to even talk about sex worker rights within a narrow framework of targeted interventions is meaningless unless there is a consensus that includes health and other institutions (e.g. legal, political) to protect not just sex worker rights, but a collective set of health and human rights. A third key informant noted that vested economic interests prevent efforts to stem police misuse of ITPA and protect sex worker rights.

See, sex workers are being regularly harassed and raided. Off the Rupees 1000 they earn a day, the bulk of their earnings go to pimps and police. The police like the fact that prostitution is criminalized, because it gives them control and opportunity to make money. No one wants ITPA to be abolished, because it is in his or her own interest to let sex work remain criminalized. (An expert on the law and HIV/AIDS)

¹⁶ Several recent incidences of violence, harassment and eviction from their homes highlight the ongoing human rights violations against sex workers in different parts of India (Sangram, Point of View and VAMP 2002a; AIDS-India September 15, 2003)

Even where NACO has developed guidelines to protect rights of vulnerable groups in the context of HIV/AIDS, there is unwillingness on part of other government departments, especially at the state level in implementing these policies. For example, despite guidelines on voluntary testing and informed consent, in 1998 the government of Maharashtra attempted to amend the Maharashtra Protection of Commercial Sex Worker's Act of 1994. This amendment included clauses requiring compulsory medical checks for STD and branding with indelible ink those sex workers suffering from STDs (Dube 2000 pg. 30; Mohan 1998).

The negative impact of repressive policies against sex workers has been clearly documented in both India and many other settings. For example, police and criminal harassment, physical, mental or sexual abuse, forced HIV testing accompanied by quarantine—all of these prevent sex workers from negotiating safe sex, accessing health and other welfare services, and participating in prevention programs. They also contribute to sex workers suffering from psychological stress, trauma, injuries, and infections (Alexander 1998; Human Rights Watch 2002). In the case of rescue and rehabilitation of sex workers by the law enforcement agencies described previously (i.e. section on violence), such attempts have separated sex workers from their livelihood, families and forced them into desperate situations. The conditions of rehabilitation homes are usually very poor, with women being kept under lock and key and forced to undergo HIV testing. Some sex workers have died in rehabilitation homes, many become careless about their own health, and others live and operate in fear of being rescued (Sangram, Point of View and VAMP 2002a).

NGO case study: identifying elements of a gender and rights-based approach

This analysis also sought to understand how a gender- and rights-based approach could be implemented in a practical setting by examining the approach of one NGO in Maharashtra that participated in the research. The NGO was formed to respond to the needs of women in prostitution. Starting from an initial focus on improving the lives of sex workers through participatory and peer-driven strategies, the NGO now implements several programs including an advocacy campaign to improve accountability of the primary health system in providing HIV services and an intervention with truckers. The sex worker intervention has a peer education strategy that includes one-to-one counseling, condom distribution, and referrals to health facilities for STI and other health problems. The most distinguishing characteristic of their approach is its emphasis on participatory processes in developing and managing the interventions. The director of the NGO described their approach as the following:

We are firm believers in the participatory approach. Our approach with the sex workers has been to develop their capacity and make them the primary focus in everything. I insisted that there would only be sex workers for project coordination and as outreach workers. I would rather have the sex workers as outreach workers in their own communities than have outsiders working with the community. In keeping with the principles of our participatory approach, we insisted that the project coordinator and outreach workers be from the community, get paid the same amount, and have the opportunity to be promoted. From the very outset, we decided not to see sex workers as vectors or victims of the disease, but as agents of change. Our aim was not to target sex workers in order to stop transmission to clients or their spouses. Instead our aim was to get the sex workers to protect themselves and their lives. Their [i.e. sex worker's] needs placed first. Therefore, our approach has worked. Otherwise everyone else's approach has been that sex workers need to be targeted because they are doing the society a favor by protecting their clients from HIV. Here we tell the sex workers to put their life and that of their children first, before anyone else. The other NGOs haven't been able to negotiate spaces and also negotiate with providers, the government, and donors as we have done. From the very outset, I was very clear that prostitution was not a moral issue for me. They are doing work, performing a service like any

other person in society. That is why I was able to make the kind of inroads I did into this community. The problem is that sex work is never part of the mainstream, so sex workers are very suspicious of those people who want to work with them. Therefore, when working with the sex workers, you have to first address that. Improving their image and acceptance in the mainstream is important.

As one measure of success of this NGO's unique approach, it has resulted, albeit not without considerable struggles, in the development of a collective—a community of sex workers, leaders, volunteers who have formed a community-based organization (CBO) to run interventions for their own community and represent their interests in various ways including lobbying with the police and helping sex workers access government services. Some of the elements of a gender-sensitive strategy based on this NGO's approach include:

- viewing sex workers as agents of change instead of passive target groups, deviants or victims;
- giving priority to their needs;
- respecting their choice to continue in sex work;
- improving their own image and acceptance into the mainstream;
- facilitating their empowerment to demand rights and justice; and
- building linkages and negotiating with health care providers, government and donors to increase their access to services and prevention methods, and to ensure their safety.

Other lessons learned included the importance of programs to a) build capacity of sex workers to run their own programs; b) develop their identities as peer educators; and c) develop their collective strength in mobilizing to improve their work and living conditions.

V - Conclusions

We offer two central critiques of current approaches to HIV prevention among sex workers in India. First, the nature of HIV risk faced by sex workers is more complex than is presently understood and addressed in the context of conventional program approaches. The paper identifies five components of risk faced by sex workers—from the environmental or contextual to the individual. Contextual risks such as poor access to services and information; stigma and discrimination; and violence and human rights abuses both create and exacerbate individual risks including the lack of accurate and complete knowledge, sexual and other risk behaviors.

Second, the strategies of the two primary institutional actors examined in this paper—NACO and USAID—are based on narrowly construed approaches to individual behavior change that fail to address the context in which women in the sex industry in India experience and respond to their risks of HIV infection. In addition, operational shortcomings of these approaches such as the lack of strategic planning are further undermining the very goals of these interventions.

Our analysis, for example, reveals that a significant proportion of the sex workers surveyed by the national BSS have both misconceptions about HIV transmission and a low perception of personal risk. These findings challenge the premise of current approaches to reduce risks simply through raising awareness and knowledge. Our findings also indicate that sexual risk, when seen from the perspective of sex workers, has far more to do with their lack of power and inability to negotiate condom use in specific situations and with different types of partners. Thus, while some sex workers are willing to insist on condom use with clients, it is in the context of sexual coercion by the police, brothel owners, criminals and others that there is a greater risk for HIV as they are unable to negotiate safe sex. Moreover, our research also highlights sex workers' inability to negotiate safe sex with their regular partners due to the perception that insisting on safe sex constitutes a breach of trust. Placed in the broader context of women's inability to negotiate safe sex with long-term, regular or marital partners,

our research underscores the need to ensure that women in general, and sex workers in particular, have access to existing female-controlled prevention technologies.

Perhaps most importantly, the paper highlights the broad institutional and community failures to address the needs of sex workers as human beings, thereby exacerbating the spread of HIV. On one hand, lack of access to health services and persistent condom shortages increase the risk of infection overall by undermining the ability of sex workers to seek treatment for STIs or to negotiate condom consistent condom use with clients and partners. These constraints are in turn made worse by the stigma, harassment, and abuse heaped on sex workers from numerous sources including by law enforcement. For example, violence against sex workers ranges from arbitrary arrests, beatings, extortion, sexual coercion, and forced rescue and rehabilitation of women in brothels through violent means. In the words of one sex worker, *"Police harassment is our biggest problem. They trouble us. They beat and lock us up"*. We strongly assert, as others have, that violence and stigma against sex workers pose a daily and constant threat that undermines their ability to practice safer sex and make their own health a priority.

Several pieces of evidence support our critique of targeted intervention strategies. The strategy has been translated into individual behavior change efforts focusing on providing education and in some cases interpersonal counseling around technical aspects of STI, HIV and AIDS prevention. However, such efforts fail to address the social stigma against sex workers, not to mention legal, economic and social discrimination. Linked to this limitation is the failure of the current strategy to address the beliefs and prejudices towards prostitution among program planners and implementers, service providers, and community members. Our analysis highlights that from the policy to program level, the parlance of "vectors" and "high-risk groups" has contributed to branding of sex workers as "AIDS carriers". Moreover, this approach has failed to give priority to sex workers' own needs for protection and their right to health and well-being. Thus, implemented in a context where discourse and attitudes round sex work were already framed in "moralistic" terms, the limited focus of India's targeted intervention strategy has contributed to increased stigma against sex workers.

Sex workers do not operate in isolation. If one sex worker in a community decides in isolation to insist on condom use with clients, the client will go elsewhere, representing a critical loss of income. Despite this reality, our data on the content of prevention messages suggest that current behavior change communication efforts are focused largely on the individual as a sole actor, and fail to address the critical factors of sexuality and the need for sex workers to earn a living. For example, current strategies fail to teach sex workers skills in offering sexual pleasure to their clients through non-penetrative and safer sexual practices. This limits the choices of sex workers to either insist on condom use and thus risk losing the client or have unprotected sex and risk infection. Moreover, with a few exceptions, the absence of community mobilization and empowerment strategies has further limited sex workers' options to negotiate safe sex by not creating opportunities for them to collectively advocate for their rights and demand clients to use condoms. To promote both harm reduction and human rights, new approaches are needed that expand options for sex workers to practice safer sex, earn a sufficient income, and become empowered both individually and collectively in order to protect their own interests and contribute to the fight against HIV/AIDS. Moreover, it is only in this context that efforts to build bridges for sex workers to other means of economic survival will succeed in the long run.

In the same vein, discussions with key informants indicate that the individual behavioral approach of targeted interventions has not been complemented by efforts to create an enabling environment for sex workers. Specifically, both the health of sex workers and the effectiveness of programs are being undermined by the lack of access to services, the poor quality of care offered in government facilities, and the discriminatory treatment given to sex workers by providers. Evidence also indicates that targeted interventions are not linked with service delivery, creating a mismatch between "demand" and

"supply" of services. Thus, both on ethical as well as practical grounds, government and donors have an obligation to ensure functioning and sensitive services to target populations, if HIV/AIDS prevention efforts are to succeed in India. Most significantly, our findings show that there is both reluctance and ambivalence around changing and enforcing existing laws and policies related to sex work, which contribute to the persistent violence, stigma, and discrimination aimed at sex workers. At the same time, there is clear and mounting evidence from India and elsewhere that repressive laws and policies towards sex work and targeted interventions that inadvertently increase or fail to reduce violence, stigma and discrimination against sex workers counteract each other and are counterproductive to HIV prevention.

Additionally, targeted interventions in India are hampered by poor coverage and are being undermined by gaps in the program planning process. The poor coverage of sex workers highlights the challenge of estimating and mapping with any degree of certainty the numbers of sex workers in an environment where sex work is stigmatized and criminalized. It also highlights the challenge of reaching a large target population (estimated to be from 2.3 to 8 million) with a strategy that is more suited to smaller, well-defined target groups. Part of the problem of both coverage and effective strategy is the lack of strategic and top-down planning. For example, intervention models are driven by narrow, short-term project objectives that are unconnected to analysis of the local dynamics of HIV transmission specifically, or to strategic plans for health and other sectors at the local level. Moreover, the targeted intervention guidelines have a "one size fits all" approach—not suited for non brothel-based sex workers. Real efforts to address gender disparities are displaced by simplistic targeted interventions strategies that are framed by a narrow understanding of how to encourage lasting changes in behavior. It is widely recognized that knowledge and awareness are "necessary", but "not sufficient" for HIV prevention and yet, translation of the rhetoric around gender disparities into concrete strategies is not made a priority.

Our findings from Tamil Nadu and Maharashtra have broader implications for targeted interventions as a policy and programmatic strategy of governments implementing HIV/AIDS programs in low HIV prevalence settings. The main rationale for targeted interventions has been based on the cost-effectiveness argument. Moreover, using India as a case study, translating targeted interventions into operational strategies often stems from a narrow conception of public health. Our research suggests that as such, targeted interventions for sex workers fail to effectively address their needs by a) ignoring gender inequities and human rights concerns; and b) not addressing the social, legal and occupational environment in which sex workers experience daily life and HIV risks associated with their occupation, and thus fail in the ultimate goal of protecting both individual and public health. Instead of continuing to pursue these approaches, we argue for a paradigm shift in the way targeted interventions are conceived and implemented.

Recommendations: moving towards a rights-based approach

First we propose, as have many others, that current approaches be transformed from a purely epidemiological rationale of preventing infections from core transmitters to the general population to approaches based on the promotion of human rights and social justice. Thus, a focus on targeted interventions for sex workers should stem not from the view that they are vectors or a potential hazard to society, but because they have the same rights to health and well being as any other individual (Overs 2002, Butcher 2003; Wolffers and van Beelen 2003). In the same vein, there is also a need to extend the locus of responsibility for prevention exclusively from sex workers to include all those who participate in the sex trade including clients, regular partners, brokers, brothel owners, keepers, and police. As Overs (2002) argues, sharing responsibility is less stigmatizing as it redistributes responsibility for prevention disproportionately borne by sex workers to others who, in fact have much greater control over condom use than do sex workers.

Second, targeted interventions need to integrate efforts to address and mitigate stigma and discrimination against sex workers and other such target groups. For this to happen, norms, beliefs and notions of morality and immorality associated with sex work need to be addressed at all levels of society including policy, media, program, health care, legal, law enforcement, and community.

Another proposed paradigm shift is to place sex work in the context of occupational safety and health hazard (Alexander 1998). As discussed earlier, in context of poverty, prostitution is a livelihood/survival strategy for many sex workers. Seen from that perspective, prostitution is an occupation—no different from any other traditional source of work (Sangram 2002). It is the negative value, blame, violence, and other conditions in which they work that simultaneously traps sex workers and affects their health and well-being. An occupational safety perspective would enable programs and policies to focus on improving conditions and situations that deprive sex workers of the right to live and work safely (Overs 2002; Bastow 1996; Alexander 1998). There is also a need for recognition that HIV is often not the primary concern of sex workers who have critical needs for information and services beyond HIV, including legal assistance, welfare of their children, and future security. To address these needs, targeted interventions must shift from a focus on current individual behavior-change models to a focus on environmental and structural determinants of sex workers' risk for HIV, in the context of their broader vulnerability. This includes interventions that aim to change policies, laws, improve access to health care services, and reduce violence against sex workers.

Lastly and most importantly, targeted interventions need to be accompanied by planning processes and programs that move away from approaches that are largely "expert-driven" and determined by outsiders to those that engage sex workers in prevention efforts as equal partners in planning and implementation (NSWP 2003). As the NGO case study described in this paper and other internationally recognized sex worker interventions such as the Sonagachi project¹⁷ have shown, with the right inputs, capacity building, and an approach that considers sex workers to be part of the solution, targeted interventions can be much more effective (Overs 2002). A participatory approach, one that mobilizes sex workers and develops their collective strength around issues of their health and well-being, creates social capital¹⁸, and recognizes their potential to contribute to public health goals instead of seeing them as passive victims or deviants are recommended as key to a successful targeted intervention strategy.

The following are recommendations to transform targeted interventions in India's HIV/AIDS prevention program to a more gender and rights-based approach. Specifically, the recommended strategies speak to expanding targeted interventions from a "behaviorist" focus to support a range of "enabling strategies". These recommendations are directed toward both the government as well as USAID.

Recommendations:

- 1) Develop guidelines and budgets to support advocacy, training, legislation, and enforcement mechanisms to protect sex workers from arbitrary and unlawful harassment, arrests, physical, verbal and sexual abuse, and denial of justice when they are subjected to such discrimination. Facilitate and develop linkages between targeted interventions and local institutions such as public health facilities and the police to protect sex workers from discrimination and abuse.

¹⁷ The Sonagachi project started in the early nineties as a project to reduce STI and promote condom use among sex workers of the red light district of Sonagachi, Calcutta, India. It evolved to a peer education, participatory effort that focused on sex worker's overall health, social and economic wellbeing. Today, it has the largest network of sex workers and peer educators who focus on HIV and improving their peer's lives through mobilization around sex worker rights and access to economic and welfare services

¹⁸ The term social capital is defined here as building networks and creating a community identity as peer educators or in some other capacity

- 2) Integrate gender and sexuality sensitization and training as part of program implementation.
- 3) Support advocacy and discussions on ITPA and options for decriminalization of sex work.
- 4) Develop strategies to improve how sex workers are viewed by society to reduce the acute stigma and discrimination faced by them. For example, sensitize media to portray sex workers in a non-judgmental manner and report on violence and discrimination faced by them.
- 5) Design communication materials and counseling messages that minimally avoid negative stereotyping of sex workers and optimally tackle biases and prejudices against sex workers with more positive attitudes, beliefs, and images.
- 6) Develop strategies to a) link targeted interventions to provision of STI and HIV/AIDS services; b) improve quality of STI and VCT services, especially in the public sector facilities; and c) reduce stigma and discrimination in health care settings.
- 7) Use the HIV prevention platform as an entry point or opportunity to advocate for changes in the public health system to address a) standards of health services; and b) patient or user rights, especially to quality services as these are integral to improving access of sex workers and other target groups to HIV/AIDS services.
- 8) Improve access to condoms for sex workers.
- 9) Expand options for sex workers to negotiate safe sex with clients who refuse condom use by a) integrating a "sexuality approach" to enable women to negotiate non-penetrative, less risky sexual acts; and b) introducing female condoms as a female-controlled prevention method.
- 10) Modify current costing and program guidelines for targeted interventions to be more flexible in allowing, selecting, training and funding NGOs to undertake innovative approaches. For example, instead of setting rigid quantitative targets for reaching sex workers, offer support for mechanisms to identify and reach non brothel-based sex workers.
- 11) Support targeted interventions with guidelines and training to undertake capacity-building of sex workers to organize, mobilize, make decisions, and participate in program planning and decision-making of targeted interventions.

This analysis uses a specific programmatic strategy of the Government of India and its donor partners to tackle India's HIV/AIDS epidemic to make two final points. First, integrating human rights and gender issues are integral to any HIV/AIDS prevention strategy. This includes combining known best practices in prevention including behavior change communication, STI reduction and condom promotion with changes at the level of laws and policies. The latter are critical to creating enabling environments for change. They require strong political commitment and action, advocacy, and resources.

Second, prevention efforts that are implemented in a climate of punitive measures against sex workers or measures such as the recent U.S. legislation and policy on trafficking and the U.S. Global AIDS policy that require groups funded by the U.S. to certify that they do not "promote" prostitution are likely to be counterproductive to HIV prevention efforts in large part because many of the most successful strategies needed to empower and mobilize sex workers—and which we argue need desperately to be expanded and replicated—are themselves defined as efforts to "promote" prostitution. Instead, we urge U.S. donors and the Government of India to broaden the scope of targeted interventions to protect the human rights of sex workers as integral part of their strategy.

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Appendix 1: Summary of interviews, group discussions and observations

Stakeholders	Tamil Nadu	Maharashtra	National
1) NGO interventions with truck drivers and sex workers	Interviews with 1 director, 3 project coordinators; 2 group discussions with field staff, 1 with truck drivers; 1 Participant observation with peer educators on highway truck stops	Interviews with a director, 2 project coordinators, and 3 field staff; 1 Participant observation with peer educators on highway truck stops	
2) NGO interventions with sex workers	Interviews with 2 project coordinators, 2 field staff, 2 peer educators and a sex worker	Interviews with a director, 3 project coordinators; 1 group discussion with 8~10 peer educators, 1 with 5 sex workers; 1 participant observation of a sex worker meeting	
3) District Health Services	STI clinic observation and interview with doctor; 2 VCT clinics observations and interviews with counselors	PMTCT program interview with counselor; VCT clinic interviews with counselors	
4) District health officials interviews	Dean of hospital; Director of District Health Services	Medical counselor of district hospital	
5) Policy maker interviews	Secretary, Department of Health and Family Welfare; Project Director, State AIDS Control Society		3 NACO Officers
6) Donor interviews	Program officer of the USAID project	Program officer of The USAID project	Program officer of a USAID Cooperating Agency (CA); Program director of a CIDA CA
7) Other Stakeholder interviews	NGO director for projects with children of sex workers	Trainer and expert on VCT; Consultant and expert on AIDS, law & human rights; Researcher on HIV stigma and discrimination	NGO director and consultant to NACO and UNAIDS on substance abuse and HIV/AIDS care

Appendix 2: Number of targeted interventions supported by NACO and USAID in Tamil Nadu and Maharashtra

Donor Institutions	Maharashtra ¹⁹		Tamil Nadu		National
	MSACS+ MDACS	AVERT ²⁰	TNSACS+ CDACS ²¹	APAC	NACO ²²
# Total targeted interventions from '97-'03 ²³	65	15	146	48	734
# Targeted interventions for sex workers from '97-'03	19 (29%)	4 (26%)	51 (35%)	25 (52%)	157 (21%)

¹⁹ Data for Maharashtra are from 1999-2003, as MSACS, MDACS started in 1999 (NACO 2003d)

²⁰ AVERT made the first round of grants only in 2002-2003, so figures are only for that year (NACO 2003d)

²¹ Data for CDACS are from 2000-2003 (NACO 2003d)

²² NACO's presentation to the new Minister Of Health and Family Welfare in 2003 obtained through the NACO office (NACO 2003c)

²³ Compiled from the list of NGOs covered by SACS, AVERT, APAC issued by NACO in 2003 (NACO 2003d)

Appendix 3: Glossary of acronyms

APAC	AIDS Prevention and Control Project
AUSAID	Australian Agency for International Development
AVERT	HIV/AIDS Prevention and Control Project for Maharashtra
BCC	behavior change communication
BSS	behavioral sentinel surveillance
CBO	community-based organization
CDACS	Chennai District AIDS Control Society
CHANGE	Center for Health and Gender Equity
CIDA	Canadian International Development Agency
DFID	Department for International Development (United Kingdom)
GoI	Government of India
HRW	Human Rights Watch
IEC	information, education, and communication
ITPA/ PITA	Immoral Trafficking Prevention Action
MSACS	Maharashtra State AIDS Control Societies
NACP	National AIDS Control Program
NACO	National AIDS Control Organization
NGO	non-governmental organization
PATH	Prevention Along the Highway
PHC	Primary Health Center
PMTCT	prevention of mother to child transmission
SACS	State AIDS Control Societies
STI	sexually transmitted infection
TANSACS	Tamil Nadu State AIDS Control Society
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAMP	Veshya AIDS Muquabala Parishad
VCT	voluntary counseling and testing
VHS	Voluntary Health Services
WIP	women in prostitution