Overview

How did the government of India tailor its HIV/AIDS program to the needs of one particularly high-risk group—female sex workers—and effectively deliver services? In two states hard hit by the epidemic, Andhra Pradesh and Karnataka, the government’s AIDS program included specific targeted interventions: outreach, condom promotion and distribution, clinical services, and community mobilization and social support. Over time, the program evolved to better meet the needs of these women, who have gradually taken on more responsibilities within the program. Between 2003 and 2011, the prevalence of HIV/AIDS among the female sex workers declined from 20 percent to 7 percent in Andhra Pradesh and from 15 percent to 5 percent in Karnataka. This improvement has played an important role in slowing the epidemic among India’s general population. The story of progress continues today and holds lessons for other countries in the region and around the world.

Key contextual conditions: included reaching the female sex workers, which was difficult: some lived in rural areas, they were not organized in groups, violence against them by police and family members was very high, they faced extreme stigma and discrimination, and many were illiterate. Yet reaching them was critical to reducing and controlling HIV/AIDS, given that these sex workers were at a high risk for contracting and spreading the infection.

Key stakeholders: were the National AIDS Control Organization; District AIDS Prevention and Control Units; the Department of AIDS Control; the Ministry of Health and Family Welfare, India; the National Blood Transfusion Council; the State Blood Transfusion Council; the Karnataka State AIDS Prevention Society, the Society for Peoples Action for Development; the Andhra Pradesh State AIDS Control Society; Integrated Rural Development Services; the Center for Advocacy and Research; CARE; the Development Action for Rural Development; the Bill and Melinda Gates Foundation; the UK Department for International Development; the Christian Association for People’s Medical Development Society; District AIDS Prevention and Control Units; and the World Bank.

Lessons Learned

- Mapping exercises helped provide reliable estimates of the size of female sex workers at intervention sites; set goals for outreach and coverage; and generated essential data for designing the targeted interventions.
- Understanding the needs and challenges of the female sex workers was critical in designing effective educational materials; for example, because these women were often illiterate, written instructions were not as useful as pictorial presentations.
- Adapting the program to the priorities of the women was important for buy-in and for better results; overall, the women were less concerned with HIV/AIDS and other sexually transmitted infections than with the social stigma and violence directed against them.
Creating targeted interventions is more effective when good data—preferably from several sources—are brought to bear in the planning stage. Periodic surveys and assessments, annual sentinel surveillance, and routine data collection created feedback loops that enabled rapid course correction and informed the many adaptations and refinements during implementation.

Using peer educators was helpful in bringing about behavioral change; they became an indispensable means of reaching out and communicating with these women.

Development Challenges

- India’s HIV/AIDS epidemic had to be brought quickly under control.
- To slow and contain the emerging HIV/AIDS epidemic, the government of India needed to reach groups at high risk of contracting and spreading the infection; female sex workers were a key group since most infections were spread through heterosexual contact.
- To be successful, AIDS prevention and control programs needed to create awareness of sexual health, promote condom use to reduce vulnerability, and encourage referral of sex workers with suspected symptoms of sexually transmitted infections to clinics.

Delivery Challenges

- Identifying and reaching the female sex workers (and other high-risk groups): identifying the sex workers entailed literature review, data gathering, and field observations.
- Promoting proper use of condoms: Once demand had been created by educating at-risk populations, the next challenge was ensuring that condoms were available and promoted in ways that addressed barriers to use, such as lack of knowledge. They were distributed to high-risk groups, using illustrations of correct use. Later delivery efforts incorporated gap analysis to ensure that condoms were available where needed.
- Expanding the clinical services for sexually transmitted infections and HIV testing from stand-alone clinics to government facilities: To better serve clients and rationalize resources, the program linked two types of clinical services: the screening, diagnosis, and treatment of sexually transmitted and reproductive tract infections; and the provision of voluntary counseling and testing.
- Reaching female sex workers in remote areas: As more female sex workers were identified, particularly in remote areas, an exclusive mobile integrated counseling and testing facility was introduced to increase HIV testing among high-risk groups in rural and hard-to-reach areas.
- Stigma and discrimination against female sex workers: A series of campaigns to improve the context for provision of services to female sex workers addressed the problems of stigma and discrimination.