CHAPTER–VI

CHAPTER- VI

NGO RESPONSE TO HIV/AIDS IN WEST BENGAL: CASE STUDY OF SELECTED NGOs

The contemporary Indian society is undergoing through rapid changes in all spheres of life. The present society is characterized by many new and complex problems. The new economic policy of 1991 has shown some positive results, but at the same time it has also created too many negative results. It has contributed largely in destabilizing the national economy in terms of high inflation, collapse of large public sector undertakings (PSUs), increasing unemployment, etc. and thereby causing impoverishment of millions of people. Secondly, the revolution of information and communication technology along with its advantages, have adversely affected our traditional culture and value system. Thirdly, the rise of regional forces and their conflict with the federal political structure is hampering the objectives of decentralization of power at the grassroots level, which has been granted through 72nd and 73rd Amendments of Constitution of India. Fourthly, India still continues with the problems of poverty, casteism, religious unrest, illiteracy, gender discrimination, poor health care and so on. On the other hand, we are crazy again for information technology and nuclear energy. Under the above mentioned socio-economic and political context, NGO sector has been working in India. This situation is more bewildering than what we had seen on the eve of our Independence. In spite of the prevailing multidimensional problems, NGOs carry out their programmes for the betterment of the society.

NGOs of West Bengal are no exception. In West Bengal, NGOs work everywhere on various issues. In case of health care, they reach to the remote and distant villages, which are by and large, remain outside the purview of the government's health care services. The previous chapter has described the growth and distribution of NGOs engaged in HIV/AIDS care in West Bengal. But, it did not give details regarding the working of an NGO considering various aspects of programme, staff members, beneficiaries, etc. These information and issues are significant aspects of exploration. The present study intends to focus on NGOs' contribution in HIV/AIDS care in West Bengal. Therefore, the present chapter makes an effort, through case studies of six selected NGOs, to bring out the facts related to NGO's

past background and present activities. etc i.e. profile of the NGOs (Part-I); nature of programme activities (Part-II); staff members' views on different issues related to HIV/AIDS (Part-III) and beneficiaries' perception towards the working of NGOs (Part-IV). This will help to develop an understanding on how much an NGO can contribute in HIV/AIDS prevention, control and care services. These six NGOs are: (i) Society for Community Intervention and Research (SCIR), (ii) Durbar Mahila Samanaya Committee (DMSC), (iii) Bhoruka Public Welfare Trust (BPWT), (iv) MANAS Bangla (MB), (v) Human Development and Research Institute (HDRI) and (vi) Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA). These six NGOs have been selected purposively on the basis of their direct involvement in HIV/AIDS prevention, control, and care and support services for different target groups by keeping in mind the objectives of the proposed study. The methodology chapter has given detail description about the process of selecting these NGOs.

PART-I: PROFILE OF NGOs

A brief sketch of each of the NGO under the study is presented here. The profile of NGOs includes various aspects like background, vision, mission, present objectives, area of operation, target groups, organizational structure, infrastructure, present programmes, staff related information, financial information and future plans.

[A] Society for Community Intervention and Research (SCIR)

Background

Late Sanjay Bhattacharya's initiative lies at the root of the birth of SCIR in 1996. It was in connection with the research activities at the National Institute of Cholera & Enteric Diseases (NICED) that he came in touch with drug users and was motivated into setting up of this organization for sustained work with this community. Initially, the Society was registered as 'Kolkata Taltala Society for Community Intervention & Research' in 1996, but the name was changed as 'Society for Community Intervention and Research (SCIR)' in 2003. SCIR did not receive any fund from external funding agencies for the first two years and managed with donations and subscriptions from the members. In the year 1998, SCIR got its first external fund from SAHARAN.

New Delhi for conducting awareness programmes on HIV/AIDS, Drug abuse, etc. SAHARAN was the only funding agency for SCIR from 1998 to 2001. After receiving fund from NICED and SAHARAN, SCIR started Needle Syringe Exchange Programme (NSEP) in 2002. SCIR for the first time got financial assistance from West Bengal State AIDS Prevention and Control Society (WBSAP&CS) for conducting a 'Need Assessment Study' in 2003. It started Targeted Intervention Project (TIP) for IDUs in the year 2004 with the financial help of WBSAP&CS and has been continuing till today. From June 2006, SCIR started another two TIPs for IDUs at Siliguri (Darjeeling district) and Lalgola (Murshidabad district) respectively.

Vision

A society which respects each individuals self worth and dignity and ensures their empowerment.

Mission

People in society leading a life empowered through befriending, counseling, health care, rehabilitation and job skills training, practicing values and leading a healthy and meaningful life contributing to the upliftment of the community.

Present Objectives

The major objectives of SCIR are as follows: (i) To provide care and treatment services to drug abusers; (ii) To bring about behavioural change among the drug abusers and help them to lead a drug free life; (iii) To improve social status and quality of life of the drug abusers; (iv) To reduce the risk of HIV transmission from drug abusers to their partners and family members; (v) To create an enabling environment for the drug abusers; (vi) To establish vocational training centers for the economic rehabilitation of the ex-drug abusers; (vii) To make an arrangement for the education of the children of drug abusers; (viii) To establish a network with similar organizations; and (ix) To provide legal support to the drug abusers and their family members.

Area of operation

SCIR is presently working in the four districts namely Kolkata, Howrah, Murshidabad and Darjeeling through its three Targeted Intervention Projects. The Kolkata project covers Kolkata and Howrah districts. Lalgola Project covers Murshidabad district and Siliguri project covers Darjeeling district (mainly Naxalbari and Siliguri area). Kolkata Project is having four drop-in centers at Park Circus, Goabagan, Mehdibagan and Buroshibtala.

The areas covered under these DICs are as follows:

(i) Park Circus DIC -- Topsia, Tiljala, Beniapukur, Gobra, and Auddybag.

(ii) Buroshibtala DIC -- Khidirpur, Ekbalpur, Mominpur, Lake Gardens, Kalighat, Tollygunj and Panchtala.

(iii) Mehdibagan DIC – Taltala, Sealdah, Janbazar and Alimuddin Street.

(iv) Goabagan DIC – Bouhazar, Rajabazar, Kashipur, Dalpatty and Kalabagan.

Target Groups

SCIR is only working for the IDUs, their partners and family members. The number of IDUs and Shadow users registered during 2006-07 is 3366 in SCIR's Kolkata Project.

Infrastructure

SCIR is not having its own office buildings. Both Lalgola and Siliguri Project office is operating from rented building. The main office building of SCIR at Tiljala is owned by Railway. It was previously used as GRP office and later on handed over to SCIR for its noble purpose. Each office is well equipped with computer, Internet and telephone connection. While Lalgola and Siliguri Project is running one clinic each, Kolkata Project is running four clinics for health check-up and treatment of IDUs. There is one non-formal school for the slum children located in the first floor of SCIR's main office building.

Programmes

(i) HIV/AIDS intervention Project for IDUs and their partners

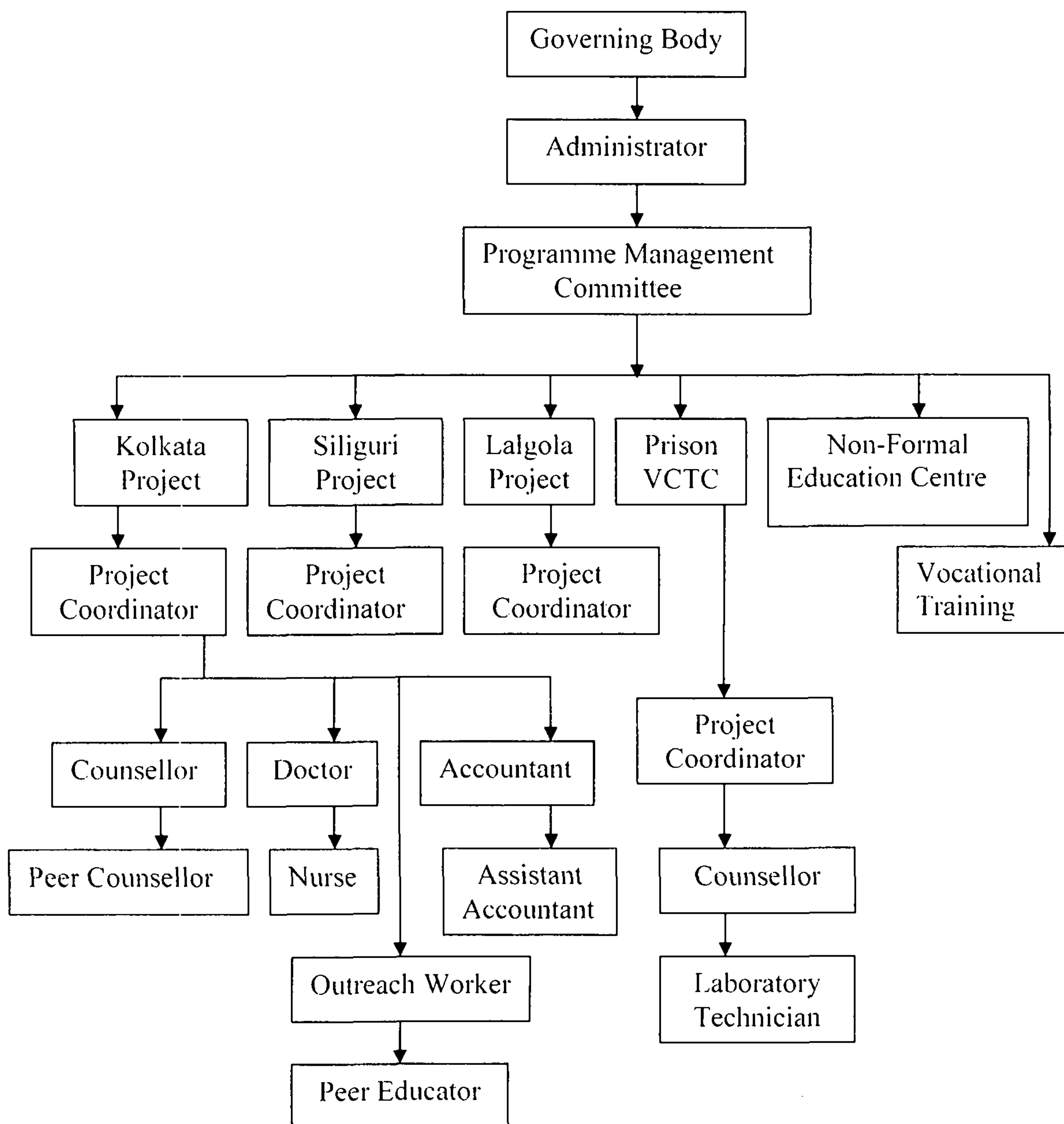
Kolkata project was started from 2004. Before conducting the project, in the year 2003 SCIR conducted a 'Need Assessment Study' with the target groups in Park Circus, Tiljala, Buro Shibtala, Mehdibagan, Sealdah and Tollygunj areas. These areas were profiled and identified as HRB (high risk behaviour) sites. The study revealed that most of the IDUs were injecting drugs more than 2-3 times in a day; sharing needles with others; injecting cocktail drugs and subsequently developed wounds and abscesses and poor treatment seeking behaviour among IDUs. Considering the above findings, Kolkata Project started four drop-in centers at Park Circus, Goabagan, Mehdibagan and Buro Shibtala. The main objective of the Project is to reduce the risk of HIV infection among IDUs their partners and family members. The needle syringe exchange program (NSEP) is a process of befriending, and then through the process of counseling they are motivated to shift to the Oral Substitution Program (OSP). This

program is a rehabilitative process that aims at gradually sending them for detoxification within a period of 4-6 months. The detail of this project is being discussed in Part-II of this chapter.

Based on the experience of its Kolkata project. SCIR started Siliguri Project under Darjeeling district and Lalgola Project under Murshidabad district of West Bengal in 2006. Both the projects were started after conducting 'Need Assessment Study' in the respective project areas. The project components are same as Kolkata project.

Organisational Structure

Chart 6-A: Organizational Structure of SCIR



(ii) Non-formal Education Centre

SCIR is running this centre at its main office for the children of IDUs and local community for their better involvement. Community people are now spontaneously attending Parents-Teachers meeting and are being made aware about the personal health and hygiene. SCIR has also constructed a small garden cum Children Park in front of its main office. The children of the local slum community, who were used to play on dust and garbage for the whole day, are now coming to this Park and enjoying in a child friendly environment.

(iii) VCTC

WBSAP&CS entrusted the responsibility of starting a VCTC to SCIR at Presidency jail, Kolkata. Accordingly SCIR has started it from February'2007 for the prison inmates. From the counseling data, it was found that most of the inmates especially males were exposed to high-risk behaviour before coming to the jail. Some of them are still practicing high-risk behaviours (like anal sex) inside the jail premises. SCIR has already found three HIV positive cases out of 59 prison inmates. It provides both pre and post-Test counseling services, awareness on HIV/AIDS, drug abuse, etc. With the help of another NGO (AWAAZ), SCIR distributed clothes to the inmates of lunatic ward and gifts to the children residing with their mothers in this correctional home.

(iv) Lock-up management

Basically Lock-up is a temporary place used for the detention of those people who are arrested for committing some crime. Lockup Management is one of the key activities of SCIR. The drug addicts are arrested basically for their involvement in petty crime for purchasing drugs or for their abnormal activities when they are under the influence of drugs. But it is observed that the locked-up addicts' cases are totally different from other criminals, as they are the patients of life long disease of addiction. These people are faced the withdrawal pain and at that time their behaviours are quite unnatural and it is difficult for police to manage such situations. SCIR initially started to work with two police stations and provided OST to IDUs. But police officers not agreed with this as they thought SCIR is promoting drug abuse in the jail/custody. After doing a lot sensitization programmes, Kolkata Police HQ gave permission to carry out this programme smoothly. Now 15 police stations are accessing services from SCIR. It has been providing this service for 24 hours.

(v) Vocational Training Unit

SCIR has one printing press and one leather unit where recovering IDUs can take training, if they are willing and interested. These two units were linked up with different organizations for getting orders and supplying the materials successfully. Both the units are running independently as Self-Help Groups.

Staff related information

SCIR is having total 109 full-time paid staff, 4 Part-time staff and one honorary staff. In its Kolkata Project, there are 27 full-time, 2 part-time (Doctors) and one honorary staff. Apart from it, 35 peer educators are working in the Kolkata project and almost similar numbers of peer educators are working in SCIR's Lalgola and Siliguri Project. Majority (80% - 85%) of the staff members are either ex-drug addicts/IDUs or recovering addicts/ IDUs. As far as volunteers are concerned, there is no specific organizational policy to use their help.

The Governing Body of SCIR has developed service rules for its staff. These are discussed here. All the Project Staff will report to the Project Coordinator at SCIR and work under his guidance. (A) Leave Rules: (i) A staff member can avail 20 days casual leave and medical leave as per doctor's advice. No leave will be granted without Permission and intimation for medical leave is compulsory. Medical Certificate is to be attached with medical leave application. (ii) A staff can take maximum 8 days leave at a stretch including Sunday and holidays. Special permission to be taken for leaves beyond 8 days. (iii) The official holidays declared by the organization will be considered as paid holidays. (iv) Three months paid maternity leave at a stretch can be sanctioned to a female employee and ten days Paternity leave to male employee. (B) All appointments are made on temporary and contract basis. Every year contract should be renewed. Continuation service is subjected to availability of fund. (C) Minimum working hour is 7 hours per day and 40 hours per week (6 days in a week). Staff members may be asked for additional working days/ hours as per the requirement of the office. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) The staff can be posted to work in any shift or office of work at any site managed by the Organization. He/She can be deputed to work in any sister concern of this Organization. (F) In case of harmful work against the interest of the organization, the service of the concern employee will be terminated. (G) The Organization will reimburse starting fees for work or job related courses to encourage and motivate its staff. (H) Medical benefit –

up to 50% of medical bills will be reimbursed as per the discretion of the Managing Committee. (I) All staff members will contribute (Optional) Rs. 50/- (fifty rupees only) from their monthly honorarium/salary towards the development, maintenance and functioning of the Staff Self Help Group (Staff Cooperative). (J) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time. (K) SCIR is also having Gender Policy and following the same.

SCIR is arranging training programmes regularly for its staff members. These programmes are organized internally as well as by external agencies. Some of these external agencies are WBSAP&CS, National Institute of Cholera and Enteric Diseases (NICED), Indian Institute of Health Management & Research (Jaipur), Murray Culshaw Consulting (Bangalore), Indian Institute of Bio-Social Research & Development (Kolkata), Hope Foundation (Ireland), etc.

Financial Information

SCIR's financial turn over in the year 2006-07 was Rs. 1,55,92,500/-. All together SCIR received Rs. 17,58,700/- from WBSAP&CS for its three TI Projects at Siliguri, Lalgola and Kolkata. For its Kolkata Project, SCIR has received Rs. 5,55,900/- during 2006-07. During this period, various sources of funds were WBSAP&CS, World Vision, Assembly of God Church, Kolkata Municipal Corporation, AWAAZ, Public donations, etc. SCIR has no specific fund raising policy except for its Printing press and Leather Units. Every year SCIR is facing the financial problem at the beginning of new financial year due to the delay in releasing fund from the WBSAP&CS/NACO. But SCIR manages this situation with the help and full support of its staff members.

In order to manage the financial affairs, SCIR prepares annual budget considering expenditure mentioned in the project proposal, present market price, last year's expenditure, area needs, expected funds to be received, etc. Almost 5 percent to 10 percent money is spent for administrative purpose and 90 percent money used for the programme activities.

Future Plans

SCIR is trying hard to start the following activities in near future: (a) to establish a 'Research Unit' for undertaking research studies on different issues related to IDUs; (b) to start a State Level Resource Centre for helping the NGOs working on the drug addiction; and (c) to upgrade its existing vocational training unit by adding more units

on different trades. But to do all these, SCIR requires more financial support from WBSAP&CS and other funding agencies.

In brief, SCIR is mainly working among the IDUs and running its HIV/AIDS programmes for them in Kolkata, Murshidabad and Darjeeling districts of West Bengal. SCIR is reformative in its approach since it has been trying to reduce the risk of HIV infection among the IDUs, their partners and family members. Its approach of getting cooperation from the local community through running the non-formal school for their children is quite successful.

[B] Durbar Mahila Samanwaya Committee (DMSC)

Background

WHO (Global Programme on AIDS) funded National AIDS Control Organization (NACO) in 1992 to undertake a study to assess the prevalence of STD (sexually transmitted diseases) and HIV among sex workers in Delhi, Mumbai, Chennai and Kolkata. In January 1992, Dr. M. Mehret, an AIDS consultant visited Kolkata and approached All India Institute of Hygiene and Public Health (AIIH&PH), a Government of India institution with a proposal for a community based study among the female commercial sex workers (CSWs) in Kolkata. The study was conducted by a team led by Dr. Smarajit Jana, an epidemiologist of AIIH & PH, in collaboration with Society for Community Development (SCD) – a local NGO. The study looked into issues of social demography of the locality, mapped the sexual behavioural practices among sex workers, their clients and partners; and assessed the prevalence of STD and HIV among them. The Kolkata experience proved to be a success because of the close rapport built up between the CSWs and Staff of the study team.

Following the baseline survey in 1992, AIIH&PH started the STD/HIV Intervention Programme (SHIP or popularly known as 'Sonagachi Project') at Sonagachi from September 1992 with the help of WHO and NACO. The word 'Sonagachi' stands out, as symbol of sex trade and it is an oldest as well as the largest red light area in Kolkata, having a population of 5000 CSWs. The 19th Century Bengali literatures on Kolkata's social history frequently referred Sonagachi, which ultimately became a proverbial term in the world of prostitution in Bengal. Kaliprasanna Singha, author of the famous social satire *Hutum Pencher Naksha*

(1862) lamented that in Kolkata there was hardly a locality in which at least ten prostitutes did not stay.

The objective of SHIP was to control the spreading STD and HIV among the CSWs. The Programme incorporated three principal components: provision for health services including STD treatment. IEC and condom promotion and distribution. First a primary health clinic was set up at the Friend's Union Club at Imam Bux Lane. The clinic was later shifted to Rambagan area and finally to the Palatak club at 7/A. Maniruddin Lane, Sonagachi. The programme was put into operation through a network of government and non-government organizations by adopting a strong peer based outreach component. The project recruited sex workers as Peer Educators (PEs) and trained them for door-to-door awareness campaign about STD and HIV/AIDS. Soon. PEs of Sonagachi Project realized that sex workers were vulnerable to STIs and HIV infection not because of unsafe sexual behaviour but rather due to structural barriers that control their everyday lives. These structural barriers comprise of powerbrokers within the sex industry that coerce. exploit and oppress sex workers; mainstream society that stigmatizes sex workers and prevent them from accessing services otherwise freely available; and the law. which criminalises sex work through provisions of the Immoral Trafficking Prevention Act (ITPA).

Sex workers, therefore. realized that to ensure sustained change and safer sex practice. they needed to organize themselves to challenge and change these structural barriers. From this realization. Durbar Mahila Samanwaya Committee (DMSC) - a sex workers' forum. emerged with the direct support from the Project. It became an active partner of the programme (SHIP) on and from 1995. DMSC registered in 1995 with only 13 members. Finally. DMSC took over the management of STD/HIV Intervention Project from the AIIH&PH in the year 1999. Since then. there has been no looking back for DMSC. After taking full control of the programme. DMSC started replication of the basic principles and approach of the 'Sonagachi Project' in other red light areas of West Bengal. It took special initiatives to reach an increasing number of sex workers outside Kolkata.

DMSC rapidly expanded its activities and established different wings to run them effectively. Some of these wings are Usha Multi-purpose Cooperative Society Ltd. (cooperative bank). Komal Gandhar (cultural wing). Binodini Shramik Union (trade union). Srishti (vocation training centre). Shramajeebee Mahila Sangha (SHG). etc. In order to manage all these activities smoothly. a conglomerate of Sex Workers'

Organisations under the name 'DURBAR' was established and all different wings including DMSC are working under it. Recently, to formalize the loose affiliation of all wings, an umbrella institution named as "Durjoy Durbar" has been registered. The word 'Durjoy' in Bengali language means which can't be defeated and 'Durbar' means unstoppable or indomitable. DMSC was running its project office from the head office of Durbar at 12/5, Nilmoni Mitra Street, Kolkata-6. In 2005, DMSC shifted its Project Office from the head office to 44, Balaram Dey Street, Kolkata-6. DMSC today is an organization of 65,000 sex workers with branches in 66 sex work sites throughout West Bengal.

Vision

Durbar seeks a world where all marginalized communities of the world live in an environment with due respect, rights and dignity. We hope for a social order where there is no discrimination based on class, caste, gender or occupation all people live in peace.

Mission

To enhance a process of social and political change in order to establish rights, dignity and improvement of social status including quality of lives of all sex worker communities of the world as part of the global movement to establish rights of marginalized people through:

1. Improvement of image and self-esteem of marginalized communities.
2. Influencing existing norms, policies and practices operating at all levels in the society.
3. Empowering communities through a process of collectivization and capacity building.
4. Addressing power relations within the sex sector and outside.
5. Formal and informal alliances with individuals, groups, institutions and movements.

Present Objectives:

The major objectives of DMSC are as follows: (i) To fight for the recognition of 'sex work' as 'work' and 'sex workers' as 'workers'; (ii) To improve social status, dignity and quality of lives of all sex workers; (iii) To protect legal rights of sex workers and fight social injustices against sex workers; (iv) To reform laws that restrict human rights of sex workers, tend to criminalize them and limit their enfranchisement as full citizens; (v) To improve the image and self-esteem of sex workers; (vi) To empower

and enable the sex workers community to assert their rights; (vii) To solve the social, economic and health problems of sex workers; (viii) To secure social existence of sex workers and their children; (ix) To establish non-formal education centers and vocational training centres for the sex workers; (x) To make arrangement for the education of sex workers' children; (xi) To form alliances with other like-minded organizations; and (xii) To prevent trafficking and entry of minor girls into sex work.

Area of Operation

At present 43 clinics of DMSC offer treatment for general ailments with special emphasis on STD/HIV through out West Bengal. Currently, DMSC is running five STD/HIV Intervention Projects (SHIP) namely, Sonagachi Project, Ganga Bhagirathi Project, Ultadanga Project, North Bengal Project and Cossipur Project. All the first four projects are working among sex workers and Cossipur Project is for truckers. Sonagachi Project covers Sonagachi, Khidderpore, Kalighat, Bowbazar and Lokermath. North Bengal project covers Coochbehar, Darjeeling (excluding Gorkha Hill council Area) and Uttar Dinajpur districts. Ganga Bhagirathi Projects covers Burdwan, Howrah, Nadia, East and West Medinipur, Bankura, Malda and Hoogly districts. Ultadanga Project covers street-based (flying) sex workers and Cossipur Project covers Chitpur and Cossipur area of Kolkata. In general, Durbar is having 66 branches and covering around 65,000 sex workers in different districts of West Bengal.

Target Groups

The target groups of include female CSWs, male sex worker, lesbian, homosexual, transgender., etc. In addition, DMSC through its 43 clinics also serve the customers of sex workers, *babus* (non-paying fixed customers), pimps, etc.

Infrastructure

The head office of DMSC is operating from its own building. The Project Office of DMSC is operating from the rented building, which is owned by its sister organization — Usha Cooperative. Except the North Bengal Project, offices of the other four projects are situated in the same building. Its vocational training centre (SHRISTI) is also situated within its head office. Similarly, the residential schools (Rahul Vidyaniketan and Indubala Abasik Vidyalaya) for the children of sex workers are owned by DMSC. The Mamata Care and Treatment Centre is equipped with modern laboratories and in- house treatment of PLWHA. All the offices are well equipped with modern facilities like computers, telephones, Internet facilities, different audio-

visual equipments, etc. About two-third of the total clinics run by DMSC are functioning from the rented premises. The clinics are well equipped with required facilities in general. But there are few clinics where space is comparatively small. In brief DMSC is having good infrastructure to run its different activities.

Programmes

Durbar is running numbers of different programmes through its different wings. The programme activities of DURBAR are depicted in the Chart - 6B. Some of the major programmes are being briefly discussed below.

(i) Health Programmes

(a) *STD/HIV Intervention Programme*

DMSC runs this programme in five project areas. The details are as follows: is presently running five such programmes through out the state of West Bengal. These projects are Sonagachi Project (since 1992), Ganga Bhagirathi Project (since 2001), North Bengal Project (since 2004), Ultadanga Project (since 2000) and Cossipore Project (since 2006).

Ganga Bhagirathi Project (since 2001) is the one which divided into three zones – namely, Zone-1 (Durgapur under Burdwan district), Zone-2 (Seoraphuli under Hoogly district) and Zone-3 (Santipur under Nadia district). There are three Project Coordinators to look after the functions of three zones respectively. There are five clinics under Durgapur zone. These are: Asansol (Burdwan); Durgapur (Burdwan); Bisnupur (Bankura); Kharagpur and Ghantal (Paschim Medinipur). Similarly, there are six clinics under Seoraphuli zone. These are: Contai (Purba Medinipur), Domjur (Howrah), Uluberia (Howrah), Rajganj, Titagarh and Seoraphuli (Hoogly district). Under Santipur zone, there are three clinics namely at Kalna (Burdwan), Santipur (Nadia) and Malda (Malda district).

North Bengal Project office is situated at Siliguri. There are three clinics under this project. These are located at Siliguri (Darjeeling), Islampur and Panjipara (Uttar Dinajpur district).

Ultadanga Project was started for street based sex workers (flying CSWs) and their clients covering a population of about 20000 CSWs. There are three clinics under this project. These clinics are located at DumDum (North 24 Parganas), Ultadanga and Rajabazar (Kolkata district).

Cossipur Project is for the truckers. All the five projects are funded by WBSAP&CS and having similar components. All the projects are running on the

strong peer based approach. The details about Sonagachi Project are being discussed in Part-II of this chapter.

(b) *VCTC*

DMSC also runs a VCTC in its Mamata Care and Treatment Centre. This Centre provides HIV and VDRL testing facilities, pre-test and post-test counselling, diagnosis and treatment of opportunistic infections (OIs) like TB, etc. and ART to PLWHA. This initiative addresses the needs of PLWHA and their family members to cope with the social and psychological traumas associated with HIV/AIDS. It also provides weekly ration to the PLWHA. Apart from providing these services, the centre also aims at promoting positive attitude towards infected and affected people. DMSC also runs Community Based DOT programmes for PLWHA and CSWs as per Revised National Tuberculoses Control Programme (RNTCP). Because it is difficult for them to access the services from general PHCs as they are discriminated against.

(ii) Educational programmes

(a) *Adult Literacy Programme*

This programme was first started in 1993 in the name of 'KOROK' and 'DIGANGANA' as more than 80% of CSWs were illiterate. This programme has helped DMSC in designing health and other intervention activities including empowerment and community mobilization. Currently 15 adult education centers covering almost 300 sex workers are run in Kolkata and other districts. In 1992, 84.4% of CSWs in Songachi were illiterate, which has come down to 69.9% in 2005.

(b) *Educational assistance for the children of CSWs*

A perennial problem with children of sex workers is questions raised by others about their father's identity. Once their identities are known, they become stigmatized and discriminated against. To address this problem, DMSC has adopted a special approach – 'Berabhenge' (Breaking fences). Basically it has three components viz. special assistance centers for school going children, education centers for school dropouts and special coaching centers for the children of higher classes. Classes are held in the evening, the time when most of sex workers are busy with their work and children have to fend themselves. Currently 15 Berabhenge centers are running in Kolkata and other districts covering almost 500 students. DMSC has started two libraries, one in Kolkata and another in Contai of Paschim Medinipur district.

Organisational Structure

Chart 6-B.1: Organisational Structure of DMSC

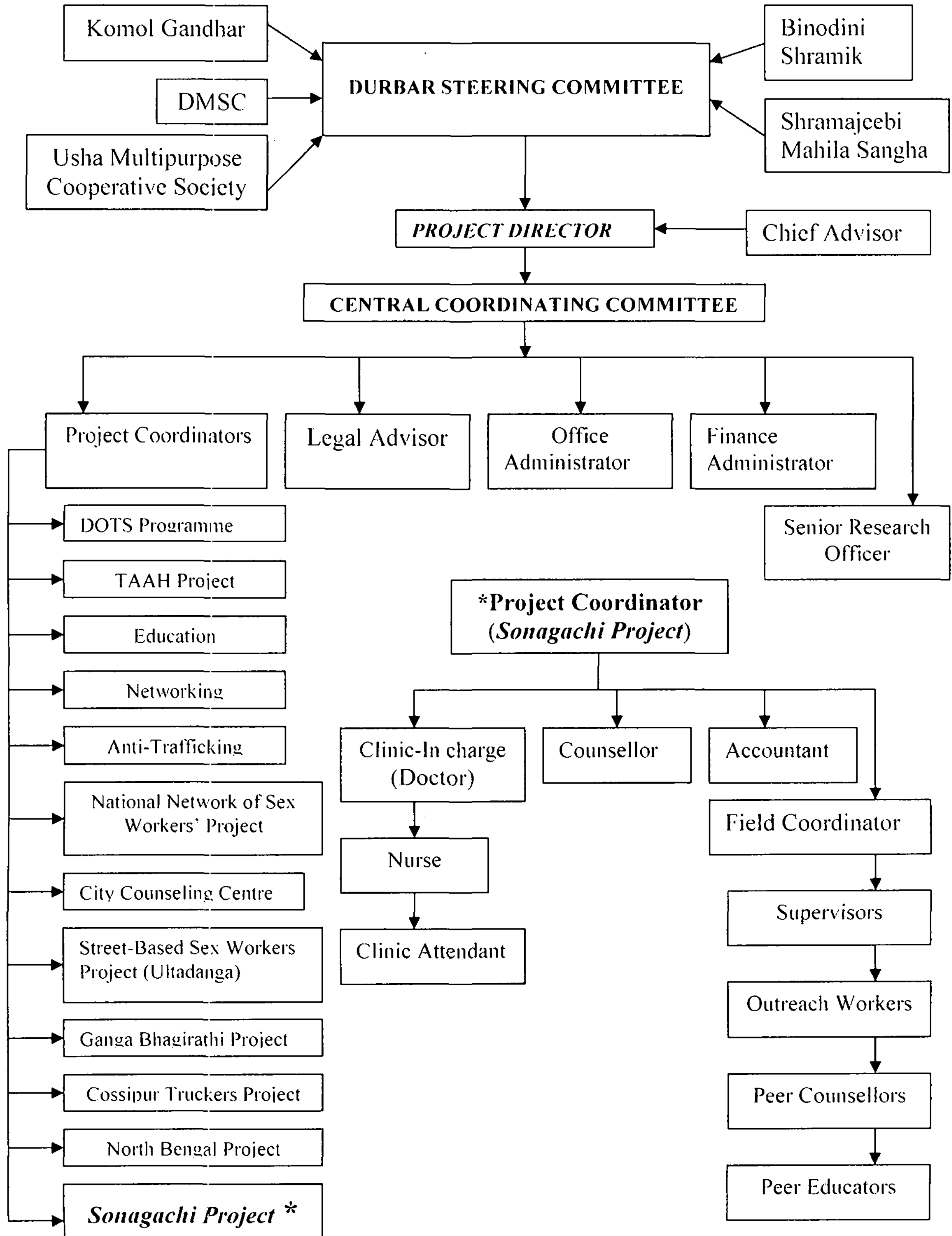
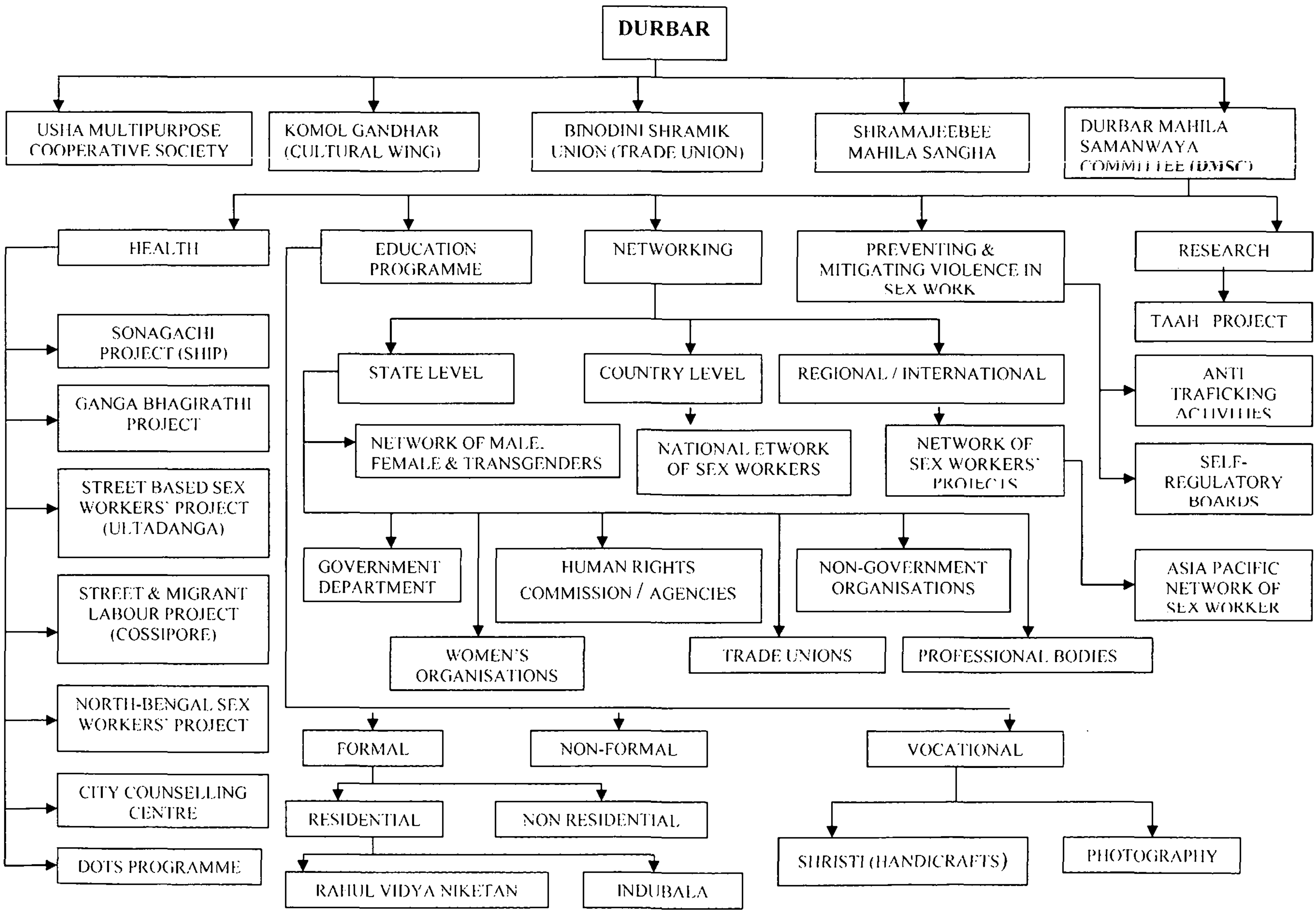


Chart 6-B.2: An Overview of the activities Undertaken by Durbar: A Conglomerate of Sex Workers' Organisations



(c) *Residential Homes for the children of sex workers*

DMSC has established two residential homes. Rahul Vidyaniketan is located at Baruipur. South 24-Pargana district and presently houses 48 school children in the age group of 5-14 years. All boarders of this home have enrolled in local mainstream schools and performing well. A small library was also started in this home. The other home – Indubala Abasik Vidyalaya is located in Ultadanga and presently houses 20 children in the age group of 4-10 years.

(d) *Vocational Training Programme*

SRISHTI (Creation) is a vocational training centre started by DMSC with a view to initiate some productive engagement for aged sex workers and for the sex workers' children. Training as well as production of handicraft goods (terracotta toys. soft toys. jute objects. badges. etc) is undertaken in this centre. The unit is housed in the office premises of DMSC. SRISHTI markets its products through different sales outlets in Kolkata. At the end of 6 months training programme, DMSC offers certificates to the trainees.

(iii) Anti-Trafficking Activities

Since 1997. DMSC decided to develop strategies to stop the trafficking of women and children into sex work. To address this critical issue. DMSC felt the need to constitute Self Regulatory Boards (SRBs) in the sex work sites. First SRB was started in Tollygunj and subsequently demands for more SRBs were coming from other sex sites of West Bengal. By 2006. SRBs operate in 33 sex work sites through out West Bengal and out of these 8 SRBs located in Kolkata. SRBs are running as a double check (1) to prevent entry of minor girls and unwilling adult women into sex work. (2) to control the exploitative practices in the sex sector. (3) to regulate the rule and practices of the trade and (4) to institute social welfare measures for sex workers and their children. Initially. there were resistance from *malkins* (madams of sex workers who keep sex workers and take share from the sex workers' earnings). pimps. local clubs and the local police. But this problem was overcome by frequent meetings with the concerned persons. SRBs also play the role of arbitrator in respect of disputes. which may occur between CSWs and madam or between CSWs and local inhabitants. police and others. SRBs are constituted by the sex workers. representatives of other concerned non-government organizations and

government departments like Health, Labour, Social Welfare, Police, etc. During 1997 to 2007(June), DMSC had rescued 419 under age girls (below 18 yrs) and 86 unwilling women. These rescued girls and women were either sent to Government approved shelter-homes or to their respective families. DMSC teams also follow up these cases by visiting them. DMSC has collaborated with BPWT, UNDP and CARE-Bangladesh to address the issues around cross-border trafficking and established three SRBs at Hilly (Dakshin Dinajpur district), Changrabandha (Coochbehar) and Basirhat (North 24-parganas). The percentage of minor girls in Sonagachi reduced from 25.29 percent in 1992 to 3.12 percent in 2001.Recently, DMSC has developed a detailed terms of reference for the constitution of SRBs at state, district and local level.

(iv) Research activities

Sonagachi Project was initiated following a community-based research study conducted in 1992 by AIIH&PH under the auspices of WHO and NACO. The project was unique as it inducted sex workers as peer educator. In 1998-99, Horizon (Population Council) sponsored a research project to enquire about community mobilization activities of DMSC and Sonagachi Project. A selected group of peer educators and sex worker activists were trained in conducting field interview and data entry. The success of this experience was overwhelming, but not sustained once project ended. Theory and Action for Health (TAAH) Group in collaboration with DMSC conducted a 3 years (2003-2006) Research Project. The objectives of this study are (1) to evaluate the social approaches that worked successfully in Sonagachi project, (2) to document the success, (3) to develop a model of the Sonagachi Project and (4) to develop learning resources for sex workers' groups, donor agencies, community leaders and policy makers at local, national and international level. DMSC-TAAH Project identified numbers of core values embedded in DMSC's programmes.

Following the first National Conference of Sex Workers in 1997 and global recognition of Sonagachi Project as 'Best Practice Model' by UNAIDS, DMSC, its sister organizations and sex workers became the 'subject' of research of by groups of film makers, researchers and many others. All of them were not completely satisfactory experiences as some of them failed to protect the rights, dignity and privacy of sex workers. DMSC felt an urgent need to set up norms and ethics of research on sex

workers. Accordingly, the Ethical Review Committee on Research (ERCR) was born in DMSC for protecting the civil and human rights of sex workers who agreed to participate in research conducted by external researchers. Based on Helsinki Declaration, ERCR developed protocol that is needed to be adhered to by the willing researchers. For the present study, the researcher also had to go through ERCR of DMSC.

Staff related information

DMSC is having total 302 full-time paid staff, 37 Part-time staff and 400 Peer Educators who work on fixed honorarium as per WBSAP&CS rules. In its Sonagachi Project, there are 105 full-time and 15 part-time (Doctors) staff members. Apart from it, 232 peer educators are working in the Sonagachi project and remaining 168 numbers of peer educators are working in other four Targeted Intervention Projects of DMSC. As far as volunteers are concerned, there is no specific organizational policy to use their help. There are 80% to 85% staff members from sex workers' community including the Project Director. Most of them are working at different levels of the organization i.e. from Peer Educator to Project Director.

The Central Coordination Committee of DMSC has developed service rules for its staff. These are discussed here. All the Project Staff will report to the Project Coordinator at DMSC and work under his guidance. (A) Leave Rules: (i) A staff member can avail 18 days casual leave (12 days casual leave for peer educators) and 8 days medical leave in a year. No leave will be granted without permission and intimation for medical leave is compulsory. Medical Certificate is to be attached with medical leave application. (ii) A staff can take maximum 2 days leave at a stretch and special permission to be taken for leaves beyond 2 days. (iii) The staff members of DMSC enjoy almost all national holidays like government employees and the list of such holidays declared at the beginning of every year. The official holidays declared by the organization will be considered as paid holidays. (iv) Three months paid maternity leave at a stretch can be sanctioned to a female employee of DMSC. (B) All appointments are made on temporary and contract basis. The contract should be renewed on half-yearly basis. Continuation of service is subjected to availability of fund. (C) The working hour is 10.30 am to 6.00 pm for all staff except Peer educators who work from 10 am to 2 pm. Staff members may be asked for additional working days/ hours as per the requirement of the office. The staff

members enjoy Compensatory Leave if they work on holidays, but it can be availed only with prior permission from the Project Director of DMSC. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) The staff can be posted to work in any office or at any site of the particular project managed by the Organization. He/She can be deputed to work in any other projects also after getting his/her consent and approval of WBSAP&CS. (F) In case of harmful work against the interest of the organization; the service of the concern employee will be terminated. (G) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time. (H) DMSC is also having Gender Policy and following the same.

DMSC is arranging training programmes regularly for its staff members. These programmes are organized internally as well as by external resource persons/agencies. There are two Training Officers apart from other key staff who impart internal training. Some of these external agencies are WBSAP&CS, CINI, etc. DMSC also sends its staff members to attend different seminars, workshops in different places within the country as well as in abroad too.

Financial Information

DMSC's financial turn over in the year 2006-07 was Rs. 5.0 crores (approximately). Sonagachi Project (SHIP) received Rupees 1,77,18,424.00 during 2006-07 from WBSAP&CS. All the five STD/HIV Intervention Projects are funded by WBSAP&CS and renewed annually. During this period, it received funds from various sources like WBSAP&CS, TDH, Action Aid, Clinton Foundation, Bill & Melinda Gate Foundation, UNAIDS, Kolkata Municipal Corporation, Public donations, etc. In spite of receiving fund from different funding agencies, the organization still feels that fund is inadequate to meet their requirements. DMSC has no specific fund raising policy. But keeping the interest and objectives of the organization in mind, DMSC approaches different funding agencies. Every year DMSC is facing the financial problem at the beginning of new financial year due to lack of timely disbursement of fund from the WBSAP&CS/NACO. But DMSC manages this situation with the help and full support of its staff members.

In order to manage the financial affairs effectively, DMSC prepares annual budget based on previous experiences, expenditure mentioned in the project proposal, present

market price, last year's expenditure, area needs, expected funds to be received, etc. Almost 5 percent to 10 percent money is spent for administrative purpose and 90 percent money used for the programme activities.

Future Plan

Being a large organization, DMSC has a number of future aspirations. Some of them are: (i) to set up a Day Care Centre for the HIV positive people; (b) to establish a Home for elderly and retired sex workers; (c) to start Educational and Vocational Training Centres in all sex sites of West Bengal; and (d) to register each Self Regulatory Board (SRB) as a separate body.

In brief, various types of programmes are run by DMSC. Few of them are welfare oriented; some programmes focus on relief services and the rest are having developmental and right-based approach. This kind of plurality in approach has emerged as a result of diversified needs and issues related with the sex workers' community. But, whatever may be the approach; DMSC becomes a best practicing model for its community mobilization activities in the world and UNAIDS recognizes its 'Sonagachi Project' as model Project.

[C] Bhoruka Public Welfare Trust (BPWT)

Background

Late Shri Prabhu Dayal Agarwal established Bhoruka Public Welfare Trust (BPWT hereafter) in 1979. It was an initiative from the Transport Corporation of India (TCI) as a part of Charitable Trust. Shri P.D. Agarwal took birth in Bari Nangal – a small village in Rajasthan and shifted to West Bengal at the age of 13 years in search of earning a livelihood. He started his first job as a record-keeper and ultimately became the owner of a big diversified business empire through his hard work and vision. His job was to weigh and record the tea leaves plucked by the workers in Red Bank Tea Garden under Jalpaiguri district of West Bengal. His monthly wage was eight rupees only. His life story is no less interesting than a novel. Shri P. D. Agarwal established a number of trusts to carry out the social welfare activities throughout the country. The Indian Institute of Health Management, Jaipur is also under one such trust established by him. To him, "life

means one long opportunity to be good and to do good: if that is religion, I practice it most ardently every moment'.

Initially, BPWT started with an aim to improve quality of life of general population by mainly promoting public health related issues. In the beginning, BPWT started its office in Transport Corporation of India's office at 'Foodnani Chamber' Kolkata. Later on, it shifted and started its independent office in its own building from January 1996. The head office of BPWT is located in its own building at 63.Rafi Ahmed Kidwai Road, Kolkata-16. Initially, it managed its activities with the financial assistance from TCI Foundation only. In 1982, Bhoruka Research Centre for Haematology & Blood Transfusion (popularly known as Bhoruka Blood Bank) was established by BPWT. Gradually, BPWT expanded its activities in different other fields with the help of different external funding agencies. Gradually, it has also extended its area of operation. Some of the major programmes of BPWT are HIV/AIDS intervention project for truckers, anti-girl trafficking project, RCH project, child watch project, HIV/AIDS infected and affected children's project, etc. Now BPWT is working in the States of Assam, Orissa, Bihar, West Bengal and Andhra Pradesh.

Vision

We BPWT, provider of health care service to the society, are committed to build and sustain the organization as welfare oriented innovative service unit wherein QUALITY is the hallmark of every activity achieved through the teamwork and involvement of all employees in pursuit of excellence in all our endeavours.

Mission

BPWT seeks to improve the health status of the people in the society through providing quality blood and blood components efficiently; encouraging rationality in the use of blood; improving the quality of life by addressing the health needs and developing human resources for sustained quality services.

Present Objectives

The major objectives of BPWT are: (i) To improve the quality of life by addressing the health needs of the vulnerable section of the community; (ii) To reduce the incidence of HIV/AIDS among truckers; (iii) To develop a resource centre for PLWHA for providing technical assistance and capacity building of the positive networks in the different

districts of West Bengal; (iv) To provide support to HIV/AIDS infected and affected children and their families; (v) To provide maternal and child health services to the poorer section of the society; (vi) To bring sustainable improvement in TB control activities at the community level; (vii) To provide healthy and congenial environment for the street children through drop-in-centres; (viii) To provide quality blood and blood components efficiently; (ix) To create an enabling environment for the adolescent girls and women to reduce their vulnerability of being trafficked; (x) To develop human resources for sustained quality services; and (xi) To undertake research on different health related issues.

Area of Operation

BPWT has been working in the five states namely Assam, Andhra Pradesh, Bihar, Orissa and West Bengal. In West Bengal, it covers Kolkata, Howrah, North 24 Parganas and Darjeeling district. The districts covered under other four states are Guwahati (Assam), Srikakulam (Andhra Pradesh), Ganjam (Orissa), East Champaran and Araria (Bihar).

Target Groups

BPWT has been working with the diversified group of people. Its HIV/AIDS intervention Projects are covering truck drivers, helpers and through them to their family members and sex workers. PLWHA and their networks are covered under its Resource Centre for PLWHA. It is also providing services to the street children and children infected and affected by HIV/AIDS. Adolescent girls and women are helped under the Anti-Trafficking projects. It also covers different categories of industrial workers through its Work Place Intervention project. BPWT provides services to all general people through its Blood bank.

Infrastructure

The head office of BPWT is operating from its own building. Its Blood Bank is also situated within its head office. Similarly, its other units like home for HIV/AIDS infected and affected children (*Snehneer*) and Resource Centre for PLWHA (*Bhalobasa*) are also located in its own building. Truckers' Intervention Project offices at Petrapole and KPT are running from rented building. The laboratory of BPWT is equipped with all modern equipments and machineries and has received ISO 9001 certificate. All the offices are well equipped with modern facilities like computers, telephones, Internet facilities, and

different audio-visual equipments. The clinics and offices of truckers' intervention projects are comparatively small. Similarly, children's home (*Snehneer*) and care & support unit of PLWHA (*Bhalobasa*) are well furnished with all required facilities. There is one good library in its Resource Centre for PLWHA, which is operating from *Bhalobasa*. In brief, BPWT is having good infrastructure to run its different activities.

Programmes

BPWT is running different programmes in the five states of India. Some of the major programmes are being briefly discussed below.

(i) Reproductive and Child Health Programme

BPWT is running this programme in the states of Assam, Bihar, Orissa, Andhra Pradesh and West Bengal. The project activities include information and awareness, training of the field workers and community health volunteers (CHV), activation and networking with existing service providers, organizing need based health camps and technical support to health care service providers. The RCH project is designed as a participatory intervention programme, where the target group will participate directly in the programme. Community Health Volunteers are working in the preventive aspect by creating enabling environment, promoting positive health seeking behaviour and smooth service access for the people.

(ii) HIV/AIDS Programmes

(a) *HIV/AIDS Intervention Project for truckers*

Truckers are vulnerable to STIs and HIV infections by nature of their job. They used to stay away from home for a long period and many of them visit sex workers to meet their sexual needs. Thus they are unknowingly getting infected with STIs and HIV infections. BPWT was one of the few organizations that initiated intervention among truckers in Uluberia check post in 1993. From the very beginning, BPWT is implementing the programme in Kolkata Port Trust (KPT) area. Currently, BPWT is running four such intervention projects in Guwahati (Assam), Ichchapuram (Andhra Pradesh), Raxaul (Bihar), Petrapole and Kolkata Port Trust (West Bengal). Respective States' AIDS Control Society financially supports these programmes. These projects are located at terminal points of highways or major transshipment centres, where trucks stop and wait for considerable amount of time. At every project, BPWT runs drop-in-centres cum

clinics. These clinics offer a range of services: qualified doctors treat STIs and common ailments; counsellors help them recognize and assess their risks; various types of IEC materials and condoms are distributed. Apart from it, outreach workers and other field staff are regularly interact with the target group at the field to make them aware about STIs, HIV and AIDS and refer them to the clinic if needed. The details about the West Bengal project are discussed in Part-II of this chapter.

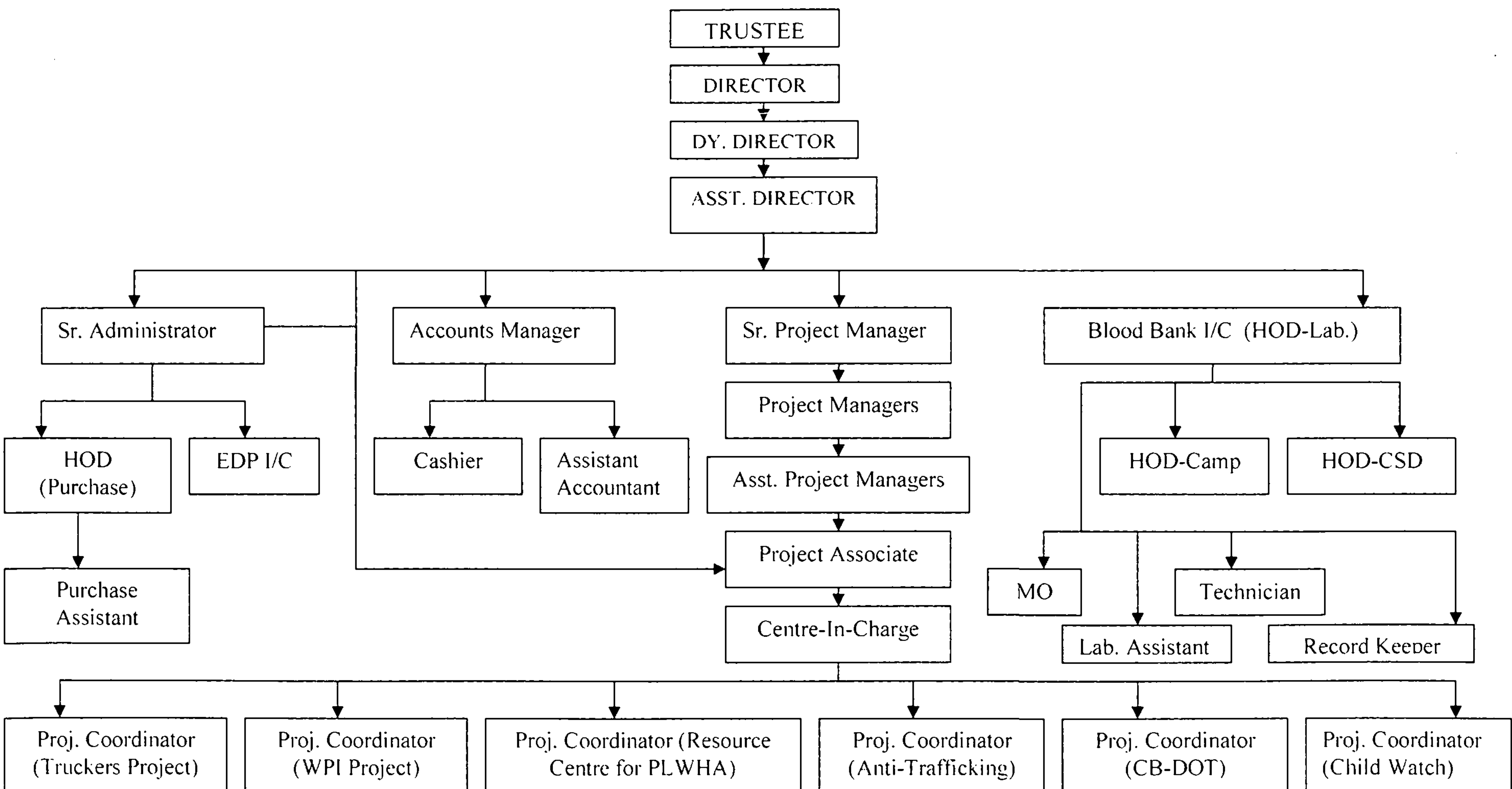
(b) *Workplace Intervention Project among industrial workers*

The prevalence of HIV/AIDS is increasing day by day among the working population. Relatively high mobility and prolonged absence from family and social support network may be partly responsible for it. BPWT has been running this project among the workers in different organizations of Kolkata with the financial support from WBSAP&CS. The main objective of the programme is to make the industrial workers aware about STD, HIV/AIDS and safer sex method. It also motivates the management to create a company policy regarding HIV/AIDS especially to avoid discrimination of positive people at work place. The project is now being implemented at the offices of Central Industrial Security Force, Food Corporation of India, Hindustan Jute Mill, ABC India Ltd. and Kolkata Port Trust (KPT) area.

(c) *Resource Centre for PLWHA*

WBSAP&CS has selected BPWT to act as a Resource Centre for providing technical assistance and capacity building of positive networks in all districts. It is felt that these network people need to build their capacity in terms of knowledge, information and technical know- how to fight against the disease more efficiently and effectively. The capacity building needs of network people are identified through Capacity Need Assessments. Since its inception in 2005, the Resource centre is actively involved in empowerment process of HIV positive people in West Bengal. It is imparting training to the PLWHA as well as those organizations that are extending services for positive people. It has completed capacity building process of PLWHA networks so far in eighty percent of districts in West Bengal.

Chart 6-C: Organizational Structure of BPWT



(d) *Shelter home for children infected and affected by HIV/AIDS*

This home is known as 'Snehneer'. It is established under the project "Care and Support for the Children infected and affected by HIV/AIDS in Kolkata and suburbs" supported by The Hope Foundation. Ireland to ensure rights of these most vulnerable children. It is a 25 bedded home and two housemothers look after the residents. It provides nutritional. educational and psychological support to the children. There is also arrangement for medical facilities. The services are not limited to the children. but also provided to their families. BPWT provides treatment facility through OPD and organize family training on monthly basis.

(iii) Anti-Girl Trafficking Programme

BPWT has started this anti-trafficking programme at Indo – Bangladesh and Indo – Nepal border. At present BPWT is running three anti-trafficking projects. In West Bengal there are two projects namely Panitanki Project under Darjeeling district and Petrapole Project under North 24-Parganas district. Jogbani Project is under Araria district of Bihar. Both Panitanki and Jogbani Projects are functioning near Indo-Nepal borders and Petrapole Project is near Indo-Bangladesh borders. The main aim of the project is to create an enabling environment for adolescent girls and women to mitigate the factors that reduce their vulnerability to trafficking. For successful implementation of the Project. BPWT has constituted numbers of Village Vigilance Committee as fundamental component. It is a community led effort to combat the problem of trafficking. BPWT has also trained the members of SHGs. Mahila Samity and local youth clubs. It has also developed a strong network with BSF and local Police personnel. BPWT is running a Shelter Home at Panitanki. which provides short stay services to the rescued victims of trafficking.

(iv) CB-DOT Programme

BPWT. since 2005. has been implementing Community Based DOT (Direct Observation Treatment) Programme in Bongaon under North-24 Parganas district. The project sensitizes the people on tuberculosis and tries to increase the treatment compliance rate. BPWT has adopted community based partnership strategy to support the patients in completing their treatment. The project is working as a part of Revised National Tuberculosis Control Programme (RNTCP). The project reaches out to the beneficiaries through different IEC/BCC activities such as community sensitization meeting. kiosk programme. talking doll show. etc. A group of Community Health Volunteers (CHVs) is formed and trained. who work as a programme wheels in the

community. The programme also sensitizes PRIs. CBOs. SHGs and other community stake holders.

(v) Blood Bank

Bhoruka Blood Bank is the first private blood bank in Kolkata aims to provide quality blood to the needy and promote blood donation. BPWT, at present. has been collecting nearly 10000 units of blood in partnership with nearly 180 NGOs. CBOs and Youth clubs. It has a very good laboratory and initiated screening of HIV. Hepatitis C. VDRL, Hepatitis B. etc. To ensure rational use of blood. BPWT has been preparing and supplying blood components to the patients requiring blood transfusion. The blood bank always gives emphasis on quality and has received ISO 9001 certificate for maintaining its quality system. It offers door steps services.

(vi) Training and Research activities

BPWT is having a training unit, as it requires trained personnel for its diversified activities. This unit has also been imparting training for the staff of other organizations on various issues like counseling. BCC. HIV/AIDS. home-based care and support of PLWHA. RCH. gender sensitization. etc. Besides this. the unit has developed a number of manuals on AIDS and other health related issues. BPWT has also engaged in research activities and conducted studies on different issues. Currently. it is conducting a study to evaluate the impact of the use of Female Condom by CSWs and their clients in West Bengal. BPWT has also published few books/reports on PLWHA. Call girls. Trafficking. Stigma. etc. to disseminate its experiences. BPWT is providing human resources for laboratory services for running the VCTC/PPTCT centres across the state of West Bengal.

(vii) Child Watch

BPWT initiated its project for the street children in 2005. The Child Watch programme was started in 2006 with the children of Sudder Street. Royd lane. Rafi Ahmed Kidwai. Nonapukur. Marquis Street. etc. All children up to the age of 18 years are included in this project. The goal of this project is to protect children at high risk; to provide nutritive food and health support to street children in pursuance of minimizing the exploitation of this vulnerable population and thereby bringing about a positive change in their behaviour and attitude. One Drop-in Centre has been made in BPWT (*Bhalobasa*) where they spend considerable time and get all supports like food. life skill training, counseling. etc. The project also makes them aware regarding health and hygiene. HIV and AIDS.

Staff Related Information

BPWT has total 155 full time paid staff including 29 technicians of Blood Bank in West Bengal. In its Truckers' Project, there are 25 full-time and 3 part-time (Doctors) staff members. Apart from it, 21 peer educators are working in the Kolkata Port Trust (KPT) area and 24 peer educators are working in Petrapole area. As far as volunteers are concerned, there is no specific organizational policy to use their help in BPWT.

The Trustee of BPWT has developed service rules for its staff members. These are discussed here. All the Project Staff will report to the Project Coordinator at BPWT and work under his guidance. (A) Leave Rules: (i) A staff member can avail 10 days Casual Leave, 30 days Earned Leave and 5 days Medical Leave as per doctor's advice. In addition to above types of leave, staff are also entitled to 6 national holidays and 4 days optional leaves as per their conveniences. No leave will be granted without permission and intimation for medical leave is compulsory. Medical Certificate is to be attached with medical leave application. (ii) Staff are also entitled for compensatory leave if they work in holidays or Sundays. But this compensatory leave must be taken within that month only. (iii) A staff can take maximum 10 days leave at a stretch with permission. The service of a staff will be discontinued if s/he avails more than 7 days leave without permission. (iv) The official holidays declared by the organization will be considered as paid holidays. (v) Three months paid maternity leave at a stretch can be sanctioned to a female employee. (B) All appointments are made on temporary and contract basis except few staff members of Blood Bank. Every year contract should be renewed. Continuation of service for the Project staff is subjected to availability of fund. (C) Minimum working hour is 8 hours per day i.e. 9 am to 5 pm (6 days in a week). Staff members may be asked for additional working days/ hours as per the requirement of the office. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) The Centre In-Charge only can be posted to work in any site managed by the Organization. The project staff are generally not transferred to other project areas. (F) In case of harmful work against the interest of the organization, the service of the concern employee will be terminated. (G) The project staff members are not entitled to any medical benefit. But the direct staff of BPWT are entitled to Mediclaim and Accidental benefits. (H) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time. (I) BPWT is also having Gender

Policy like recruiting male and female staff at 50:50 ratio, rules to prevent the sexual abuse of female employees a work place, etc.

BPWT is arranging training programmes regularly for its staff members. These programmes are organized internally as well as by external agency like WBSAP&CS. It also organizes exposure visit for the staff members to other related NGOs.

Financial Information

The financial turn over of BPWT in the year 2006-07 was Rs. 2.67 crores. Its blood bank is running independently without any financial assistance. The State AIDS Control Societies of Assam, Andhra Pradesh, Bihar, Orissa and West Bengal are providing financial assistance for the truckers' projects of BPWT. Apart from it, BPWT also receives fund from European Commission, UNODC, TCI Foundation, Elton John AIDS Foundation, Care India, UNDP, Resource Centre for Sexual Health and AIDS (RCSHA/DFID) and International Commission on Research on Women (ICRW).

In order to manage the financial affairs, BPWT prepares annual budget through its competent Accounts section. Annual budget is prepared after considering the expenditure mentioned in the project proposal, last year's expenditure, expected fund to be received, present market price, etc. BPWT earmarks majority of funds for programme activities in its budget.

Future Plan

BPWT has a plan to start following activities in near future: (a) to expand its area of work and serve every individual infected and affected by HIV/AIDS all over the eastern part of the country; (b) to start a one year course on Blood Banking Technology; (c) to introduce modern techniques for screening the transmissible viruses in the blood more efficiently; and (d) to campaign more among the doctors regarding 'rational use of blood' in West Bengal.

In brief, BPWT runs various types of programmes in the states of Assam, Andhra Pradesh, Bihar, Orissa and West Bengal. It has been working to serve the different categories of people like women, adolescent girls, children, truckers and PLWHA. Most of its programmes are health oriented. BPWT is having both institutional and community based services. It also assists other NGOs and CBOs through its Resource Centre for PLWHA. BPWT is also famous for research activities and therefore, has undertaken and completed many research projects with the support

from UNDP, DFID, International Commission on Research on Women, UNIFEM and other such agencies.

[D] MANAS Bangla (MB)

Background

NACO started the Phase-I of National AIDS Control Programme (NACP-I) in 1992. Accordingly all State AIDS Control Societies started to implement the Targeted Intervention Project for different high-risk vulnerable groups through NGOs. WBSAP&CS has also started many such projects for different vulnerable groups. But there was no project for males who have sex with males (MSM). In West Bengal, there were few NGOs were working with the MSM population in a scattered way with their limited resources. New Alipore Praajak Development Society (1994), Kolkata is one of the first agencies in West Bengal to focus on sexual health services for MSM. This NGO conducted a need assessment survey among MSM population. Later on, Palm Avenue Integration Society (another NGO) conducted similar survey in 2001. But findings of these surveys were confined to the respective NGOs only. Apart from these two NGOs, few other NGOs like PRANTIK, PRATYAY, SWIKRITI Society, AMITIE, etc. are also working with MSM. In the year 2003, one incidence took place, which triggered the formation of MANAS Bangla. Two outreach workers of an NGO working with MSM in Kolkata assaulted in a cruising area by local youth on 7th January 2003. The local police failed to take action. The NGO posted the news of assault on several e-mail forums. After one week, members of several other NGOs working with MSM in West Bengal had conducted a meeting and planned joint action in support of the aggrieved NGO. The idea of starting a network was also discussed in this meeting. During the Naz Foundation International's MSM Sexual Health Conference in New Delhi on 5th April 2003, several NGOs keen to form network, organised a meeting and set deadline for launching the MSM network. Finally, AMITIE (NGO), Chandannagar hosted first formal meeting of the network on 4th May 2003. MANAS Bangla (MB) – the first network of MSM in West Bengal started with seven constituent member NGOs. The names of these partner NGOs are: (1) AMITIE (Hoogly district); (2) ASTITVA (South 24-Parganas); (3) DumDum SWIKRITI Society (Kolkata); (4) PRANTIK (North 24-Parganas); (5) MITJYU (Darjeeling); (6) The Pratyay Gender Trust (Kolkata); and (7) Swapnil (Burdwan).

The entire partner NGOs are CBOs i.e. started and managed by MSM themselves. Each of these NGOs has their own goals, activities and strategies. But they have realized the need for a greater level of commonality in policy and action. The network has been formed with the aim to coordinate and enhance their efforts in promoting health and general well being of MSM community. Initially, there was no office. Prof. Rajarshi Chakraborty – the General Secretary and one of the Key promoters of MB used his residence as office for time being. Later on, Praajak Development Society allowed MB to use its office, computers, etc. At the beginning, MB managed its activities with membership fees and later on SAATHII (an international NGO working on HIV/AIDS), Kolkata Branch provided support to it. Formally MANAS Bangla got registered under Society Registration Act in February 2004. In the later part of 2003, MB and Praajak Development Society jointly conducted a 'Need Identification Survey' among MSM population in west Bengal, with the financial support of WBSAP&CS. The findings revealed that about 10% of MSM are suffering from STIs. MB submitted a proposal of Targeted Intervention Project for MSM to WBSAP&CS. Finally, the proposal was approved and MB started *Male-to-Male Sexual Health Promotion and HIV Control Programme* w.e.f. July 2004. It is the first such intervention project for MSM in West Bengal as well as in the whole Eastern and North-Eastern India. The registered office of MB is located at 75, Jawpur Road and its Project Office is now located at E-31, Sreenivas Apartment, Rajdanga Nabapally, Kolkata-700107. MB is affiliated with Indian Network for sexual Minority (INFOSEM) of Humsafar Trust and with Naz Foundation Partners' Network.

Vision

The vision of MANAS Bangla is to coordinate and enhance the efforts of organizations working to promote the health and general well being of MSM population in West Bengal.

Mission

With a primary focus on males who have sex with males (MSM), MANAS Bangla's mission is to empower socially excluded and disadvantaged males to secure social justice, equity, health and well-being for themselves.

Present Objectives

The broad objective of MB is to focus on the health concerns of MSM as a broader issue, inclusive of not just physical health, but also psychological and social health aspects. The major objectives of MB are as follows: (i) To run, maintain, manage and

carry on the society for the welfare of the people of the localities; (ii) To promote awareness programmes on HIV/AIDS and sexual health among the people of localities; (iii) To prevent the spread of HIV/AIDS and other sexually transmitted diseases: (iv) To aware the people about their health and to arrange for free medical treatment to the needy patients by the qualified doctors; (v) To ensure proper sexual health services and facilities for those who require them; (vi) To provide advice regarding all aspects of sexual health by the qualified doctors; (vii) To print, publish, and distribute journals, periodicals, leaflets for the promotion of the objects of the society; (viii) To give necessary relief to the affected in times of flood, famine and other natural calamities; (ix) To impart and develop social awareness among the illiterate women and men by organizing awareness camps from time to time: (x) To improve the social and cultural life of the people by organizing various social and cultural programmes from time to time; and (xi) To engage and assist in all other philanthropic activities as may be deemed appropriate by the Executive Committee of the Society

Area of Operation

Being a network of CBOs, MB covers all parts of the West Bengal through its different partner organizations. It covers seven districts under its project of WBSAP&CS on 'Male to Male sexual Health Promotion and HIV control Programme'. Currently, MB has been running 8 Drop-in- Centres (DICs) at Baruipur (South 24-Parganas district); Bangaon (North 24-Parganas); Srirampore (Hoogly); Siliguri (Darjeeling); Kasba, Kadapara and DumDum (Kolkata) and Burdwan (Burdwan district). Srirampore DIC also covers Howrah district. It is also running partial DICs in the districts of Howrah, Nadia, and Jalpaiguri. Besides it, MB has been providing outreach services in Murshidabad, Coochbehar, Purba and Paschim Medinipur districts. It has also networking with different NGOs working with MSM in the districts of Malda, Birbhum, Bankura, Purulia and Uttar Dinajpur. MB has been covering around 9000 MSM population through this project in different districts of West Bengal.

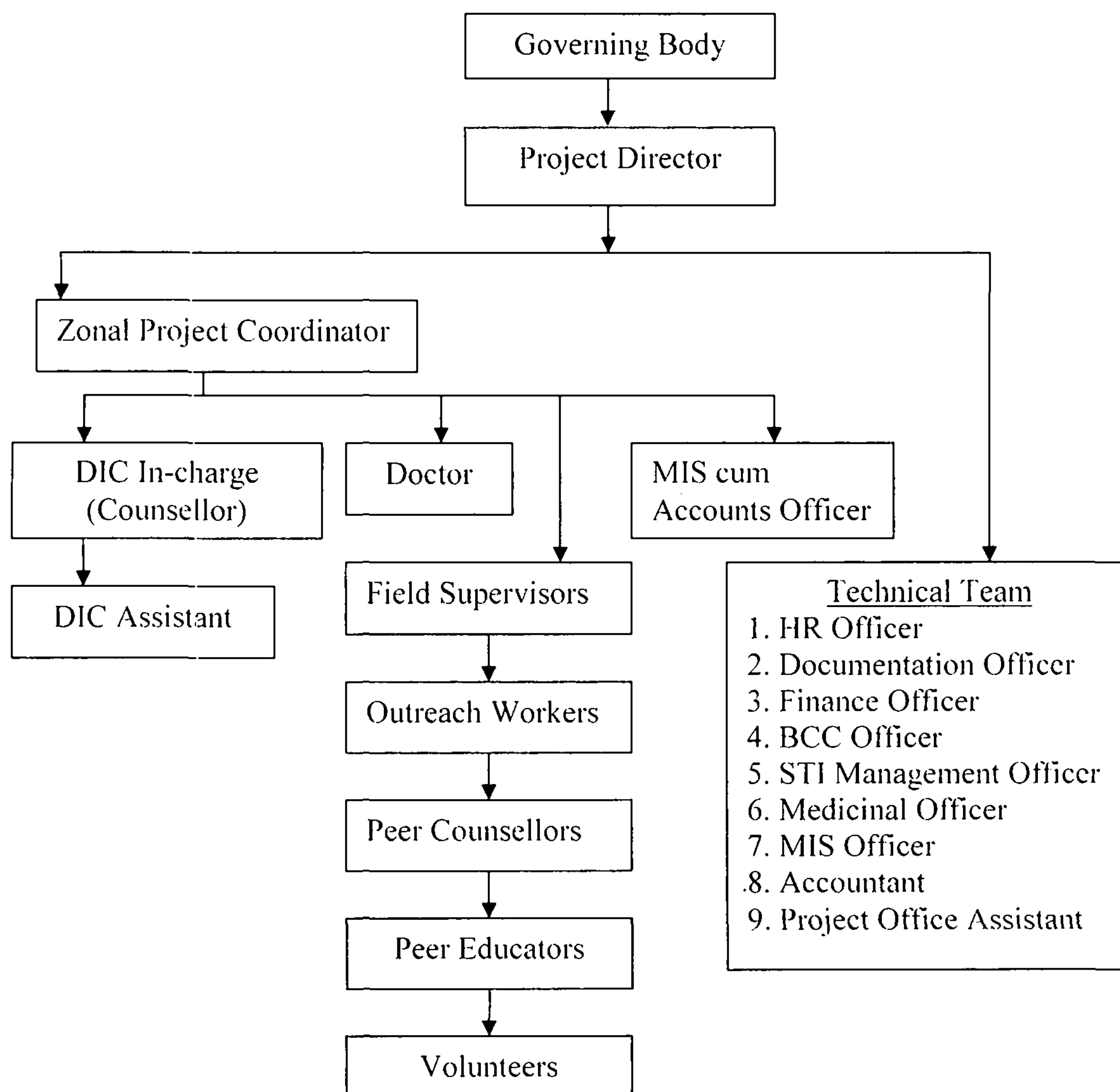
Target Groups

Within the framework of MSM, there is a range of diverse sexual/gender identities, communities, networks, and collectivities like *Koti, Parikh, Dupli, Hijra,* Gay, Bisexual, married and single MSM, Male sex workers, etc. as well as just behaviours without any sense of affiliation to any identity or community. MB covers all these

categories through its project. Apart from the MSM, non-MSM community members both males and females also come to DICs for counseling and treatment.

Organisational Structure

Chart 6-D: Organisational Structure of MB



Infrastructure

MB is not having its own office building. Its registered office is actually the residential address of its General Secretary, Prof Rajarshi Chakraborty. Its Project Office and all DICs are operating from the rented building. The Project Office of MB is well furnished with modern office equipments like computer, phone, Internet, library, etc. It is an ideal office accommodation for the Project Office. The DICs are comparatively having less space, but otherwise fit for running office as well as clinics.

Programmes

(i) Male-to-Male sexual Health Promotion and HIV control Programme

This is the only major programme run by MB since July 2004. This project is the only project under WBSAP&CS for MSM population in the state. MSM people are already stigmatized for their sexual behaviour as society yet to accept as normal sexual behaviour. And MSM who is infected by HIV is actually doubly stigmatized. Therefore, it is very challenging field to work. Presently, the project has been providing services to 9000 MSM through eight clinics in different districts of West Bengal. The details about the programme are discussed in Part-II of this chapter.

(ii) Income Generating Programme

MB has received financial support from the Social Welfare Department, Government of West Bengal for running an Income Generating Project. Its project duration is 6 months only. Under this project, MB has organized and imparted training programmes on two trades i.e. Tailoring and Beautician courses for the willing MSM community members. The main purpose of this project is to help these people to start their own business after the completion of the training programme and lead an economically independent life. MB is in constant touch with these trained people.

Staff related information

MB is having total 50 full-time and 10 part-time paid staff members. Out of the 10 part-time staff members, there are eight doctors, one STI Management Officer and one Counsellor. Apart from it, 100 Peer Educators are working in this project. As far as volunteers are concerned, there is no specific organizational policy to use their help. Generally volunteers participate in event-based programmes (for example street play, etc.) of different DICs. Most of these volunteers regularly visit the DICs. In general, 80-85 percent staff members are from MSM community.

The Governing Body of MB has developed service rules for its staff members. The HR Officer in the Project Office looks after the staff related matters. At the DIC level, all staff members report to DIC in-charge who is working under the respective Zonal Project Coordinator. There are five Zonal Coordinators who work under the guidance of the Project Director. The service rules are discussed here. (A) Leave Rules: (i) A staff member can avail 14 days casual leave and 7 days medical leave as per doctor's advice. No leave will be granted without Permission and intimation for medical leave is compulsory. Medical Certificate is to be attached with medical leave application. (ii) The official holidays declared by the organization will be considered

as paid holidays. (iii) Compensatory leave is given if any staff works on holidays or weekly holidays (B) All appointments are made on temporary and contract basis. Every year contract should be renewed. Continuation service is subjected to availability of fund. (C) Minimum working hour is 8 hours per day and 40 hours per week (5 days in a week). Staff members may be asked for additional working days/ hours as per the requirement of the office. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) In case of harmful work against the interest of the organization, the service of the concern employee will be terminated. (F) The Organization will reimburse starting fees for work or job related courses to encourage and motivate its staff. (H) Medical benefit – there is no medical benefits. Staff can consult the doctors of clinic at free of cost. (I) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time.

MB regularly arranges training programmes for its staff members. These training programmes are organized internally as well as by external agencies. Some of the external agencies are WBSAP&CS, Samikshani, Health Vision Research, DMSC, etc. MB used to organize centralized training programmes separately for its Peer Educators, Peer Counsellors, etc. with the support of WBSAP&CS. It also arranges exposure visits for its staff members to other organizations. Some of the staff members attended different seminars/workshops in India and abroad too.

Financial Information

MB's financial turn over in the year 2006-07 was Rs. 46.64 lakh approximately. Out of this, MB received Rs. 39,85,162.00 from WBSAP&CS and MB shared Rs. 6,78,961.00 as its contribution in the project. The project is funded by WBSAP&CS and renewed every year. Apart from WBSAP&CS, during this period MB has also received fund from Naz Foundation International; Social Welfare Department, Government of West Bengal; public donations and from internal sources. Internal sources include membership fees, registration fees at the clinics and social marketing of condoms and lubes. Naz Foundation assists in terms of supplying Lubes. MB has no specific fund raising policy. But keeping the interest and objectives of the organization in mind, it approaches different funding agencies. Delay in releasing fund from WMSAP&CS, inadequate clinical equipments, and no provision for traveling allowances for Peer educators, etc. are few major problems presently faced

by the MB. However, it manages the situation with the help and active support of its staff members.

MB prepares annual budget in order to manage financial affairs smoothly. The Project Director prepares the budget with the help of other staff and submits it to the Managing Committee/Governing Body for approval. Annual budget is prepared on the basis of terms and conditions of funding agency, previous year's experience, present market price, etc. MB has to arrange different budget for its technical team for whom WBSAP&CS has no financial provision in its project for MSM.

Future Plan

Being a network of CBOs, MB has number of future plans. Some of them are: (a) to bring more districts especially rural areas under its coverage; (b) to initiate efforts for changing the traditional public notions on gender and sexuality; (c) to give more emphasis on psycho-social i.e. mental health aspects of MSM population; (d) to develop an enabling environment for MSM through income generation programmes; (e) to empower MSM community members to exercise their rights related to their identity and sexuality; (f) to work out a common policy for all member organizations on advocacy, outreach activities and referral system; (g) to frame guidelines and undertake research on sexual health related issues of MSM; and (h) to give more emphasis in developing network with other similar organizations at the national and international level.

In brief, MB runs only Male-to-Male Sexual Health Promotion and HIV control programme. It has adopted rights-based approach, which has emerged as a result of diversified issues related with MSM community. MB is the only organization, which has been running HIV/AIDS programme among the MSM community in West Bengal.

[E] Human Development Research Institute (HDRI)

Background

Dr. D.P.Mallick, the present secretary and promoter of the organization is a medical practitioner by profession. Since his student life, Dr. Mallick was interested to do something for the betterment of the deprived section of the society. After the completion of his study, Dr. Mallick took up job and served many organizations. But he never forgot his desire to serve the people. During 1980s, drug addiction became a

major problem in our country and Kolkata was not an exception in this regard. Dr. Mallick felt that something is to be done for these drug addicts, as there was no organization to deal with them in Kolkata at that time. Initially, HDRI was not a registered body. But later on, it was felt that without a registered organization, it would be difficult to work in the field of drug addiction. Accordingly, HDRI was registered in the year 1985. At the beginning, there was no office building. It was working from the residence of Dr. Mallick and sometime from the residence of Dr. S. Sinha who was president of the organization. HDRI first started a Day Care Centre for the drug addicts at the University Institute Hall, Kolkata. Initially there was no financial support from any external agency; HDRI managed its activities with donations from public and members of the General Body. For the first time, it has received fund from the Ministry of Social Welfare, Govt. of India in 1989 for running the project for drug addicts/dependents. Then HDRI opened its project office along with the clinic and detoxification centre at Bidhan Sarani, near Hatibagan, Kolkata-11. Gradually, HDRI expanded its activities in other fields also. Later on, it has been registered under the Foreign Contribution Registration Act also. At present, the head office of HDRI is located at 45, Beniatola Lane, Kolkata-9. It has been running its full fledged 'Recovery De-addiction Centre at 43/C, Nimtolaghat Street, Kolkata-700006. Its old office of Hatibagan is now working as the project office for STD/HIV/AIDS Targeted Intervention Project for migrated labourers. Presently, HDRI is having a good reputation in West Bengal as well as in India.

Vision

HDRI seeks to enable the drug addicts to achieve total abstinence and to improve the quality of their lives by helping them and to give proper sexual health education to the target groups.

Mission

The mission of HDRI is to: (1) treat and rehabilitate the chemical dependents through psychotherapeutic programme; (2) provide and instill sexual health education to the chemical dependents as well as IDUs and migrated labourers; (3) treat and counsel STD cases along with general treatment; (4) provide good quality condoms and to facilitate them for safer sexual practice; and (5) perform networking and advocacy.

Present Objectives

The major objectives of HDRI are as follows: (i) To carry out sexual health education programmes among the migrated labourers, truckers and drug dependents; (ii) To

provide STD treatment along with general health care services to the migrated labourers, truckers and drug dependents; (iii) To provide physical and psychological treatment for the drug dependents including vocational guidance and rehabilitation services; (iv) To reduce the incidence of STD and HIV infection among the migrated labourers, truckers, drug dependents and their family members and sex-partners; (v) To provide networking and advocacy at different levels of society; (vi) To promote sustainability at different components of existing intervention programmes; (vii) To prevent drug abuse among the students through school based primary intervention programme; (viii) To create awareness about drug abuse, HIV/AIDS among the general people of the society; and (ix) To undertake different community development programmes for the upliftment of poor and backward section of the society.

Area of Operation

HDRI is currently working in the four districts of West Bengal namely Kolkata, Howrah, Hoogly and Burdwan. It has been running STD/HIV/AIDS intervention programmes for truckers and migrated labourers at Kolkata district. Similarly it has been running its drug de-addiction programme at Howrah, Central and North Kolkata. Its school-based drug abuse prevention programme has been in operation in the five schools of Howrah, Hoogly, Burdwan and Kolkata. Its community development project is also being run in the Monteswar Block of Burdwan district.

Target Groups

HDRI has been covering 25000 migrated labourers under the Targeted Intervention Project in different areas of Kolkata. Similarly through its truckers' intervention project, HDRI has been covering 10000 truckers at Burrabazar, Kolkata. It is also covering IDUs and other drug dependents, their family members and sex-partners through its de-addiction and HIV/AIDS prevention programmes. HDRI is also running community development programme for the rural poor people and school based primary drug abuse prevention programme for the School children.

Infrastructure

The head office of HDRI is well furnished and equipped with all modern office equipments like computers, fax machine, telephone, Internet facility, etc. Fifteen-bedded 'Recovery De-addiction Centre' is well equipped with required infrastructure and manpower. The project office for migrated labourers is comparatively small in terms of space, but equipped with required infrastructure and manpower. The after

care home run by HDRI for the recovering addicts. is also fit for use. Excepting the head office, all other offices and clinics of HDRI are operating from rented buildings.

Programmes

HDRI is implementing numbers of programmes through its different wings. Some of the major programmes are being briefly discussed below.

(i) Programmes for drug dependents

(a) *Recovery De-addiction Centre*

This centre has started its journey with the support of Ministry of Social Justice and Empowerment. Govt. of India since 1993. It aims to help the addicts to achieve total abstinence and also to improve quality of their lives. Main objective of the centre is to treat and rehabilitate the drug abusers through psychotherapeutic programme. Major activities of the centre are: physical and psychiatric assessment. detoxification. psychological testing, psychotherapeutic programme (meditation, yoga. relaxation, counseling, etc.), awareness programme. vocational guidance. aftercare and rehabilitation. Total number of patients treated during 2006-07 is 1235 (old - 797 and new - 438). Every year this centre celebrates International Day against Drug Abuse on 26th June through meeting, seminar, street drama, audio-visual show, etc.

(b) *G-86 Project*

This project is being run for community empowerment to prevent drug abuse and HIV infection under the sponsorship on UNODC.HDRI carries out awareness generation. home visit. referral services, peer training, counseling, formation of SHG for women empowerment, etc. under this project. Besides it, school based primary prevention activity is also carried out by HDRI as a part of this programme. Group sessions are conducted among students, teachers, parents and community people. Preparation of slogan, quiz contests, etc are arranged for the students under this programme.

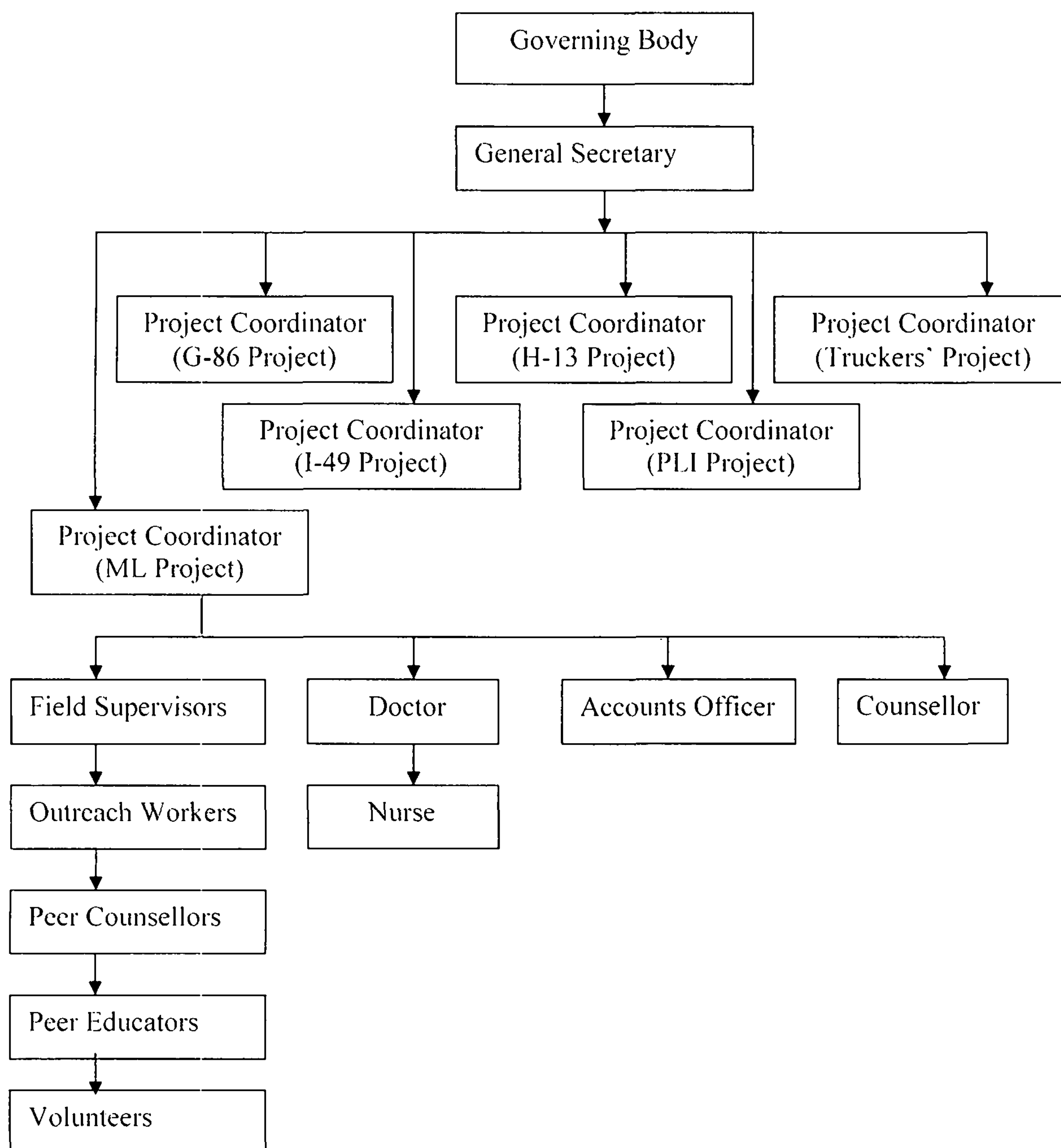
(c) *H-13 Project*

Prevention of transmission of HIV among drug users in SAARC countries Phase-I Extension has been launched on November 2006 under the sponsorship of UNODC. The main goal of this project is to promote HIV/AIDS prevention; and care and support programme through comprehensive package approach. The comprehensive package includes referral services like STD treatment. low cost community based treatment camp. health check-up camp. Mid Day meal. volunteers' meeting. spouse meeting. safer injection training at DIC (Drop – in - centre) and other field area. abscess management at road side and at clinics. One such DIC was established at

Shibpur. Howrah and providing all the above mentioned services. An Advocacy Forum was also formed in this regard.

Organisational Structure

Chart 6-E: Organizational Structure of HDRI



(d) *I-49 Project*

This project is in operation especially for the women with the support from UNODC. As a Part of activity. data were collected from 60 women (10 female drug users and

50 female partners of drug abusers). Four women groups with a purpose of group sessions were formed. They were made aware about drug related HIV/AIDS, safer injecting practice, negotiation skill, STD and general health care, etc.

(e) *PLI Project*

This project is being implemented with the collaboration and under the sponsorship of DFID. Target areas of the project are Armenium Ghat and Sovabazar (Dalpatti). A base line survey was conducted among the drug users of the said areas. Target group was made aware about STD/HIV/AIDS, negotiation skills, effects of drug abuse, safer sex practice, etc. Group sessions and referral services are other important activities of the project.

(f) *HIV/AIDS Prevention Programme*

This programme among chemical dependents goes on with the support of Ministry of Social Justice and Empowerment and different activities are carried out in areas of Howrah, North and Central Kolkata which are risk prone. Major activities include awareness generation, STD treatment, condom promotion, abscess management, counseling, follow up, networking and referral services, etc.

(ii) HIV/AIDS Targeted Intervention Projects

(a) *HIV/AIDS Targeted Intervention Project for Truckers*

HDRI has started this project from June' 2006 with the support from WBSAP&CS. This project is covering two main halting points namely at Balughat and Poddar Court. The target population to be covered under this project is about ten thousand. Truckers are migrant from Bihar, Orissa, Punjab, Rajasthan, Andhra Pradesh, Haryana, Tamilnadu, Uttar Pradesh and interior districts of West Bengal, etc. Major components of the project are: awareness generation; capacity building; counseling; STD treatment; condom promotion; networking and advocacy; referral activity; etc.

(b) *HIV/AIDS Targeted Intervention Project for Migrated Labourers*

In 1992, on the recommendation of WHO, All India Institute of Hygiene and Public Health (AIIH&PH) started STD/HIV Intervention Programme at Sonagachi— the largest red light area of South East Asia. For this purpose, AIIH&PH developed a conglomerate of NGOs and HDRI was part of this. During this work, it was learnt from the sex workers that a large number of migrant populations used to visit them. Thus, they also become vulnerable for STD/HIV infection. In this perspective, HDRI started intervention programme for migrated labourers with the help of DFID (UK) in 1997. Later on the project was handed over to WBSAP&CS in 2001 and HDRI has

been continuing the project. Now this project is covering 25000 migrant labourers of Burrabazar. Posta. Jorabagan. Mechua. Sovabazar and Ahiritola. By occupation. they can be classified as Sardars. Porters. Handcart pullers. labourers and others. There are five static clinics are operating at different target areas to serve the community people. The details of the project are being discussed in Part-II of this chapter.

(iii) Community Development Programme

HDRI has been running its community development programme in rural areas of Monteswar Block under Burdwan district for last 20 years. Patients having different problems have been provided treatment. Camps and awareness programmes on social menace like drugs and AIDS as well as other issues like family planning. leprosy. tuberculosis. etc. are organized for rural people. Besides rehabilitation programme for recovering addicts. HDRI has been helping rural poor through various programmes like primary health care. water treatment. fishery. improving agricultural outputs. etc.

Staff Related Information

HDRI is having total 66 full time paid staff members. There are seven part time paid staff. all of whom are doctors. There is no honorary staff in HDRI. The organization is having many volunteers. but exact number is not available. So far volunteers are concerned; HDRI is having a policy of using the services of volunteers. As per this policy. volunteers are selected on the basis of following criteria: (a) sobriety in case of ex-addicts; (b) concern volunteer's influence in the community; (c) his dedication and commitment; and (d) he is suited to HDRI's mission and vision.

The Governing Body of HDRI has developed service rules for its staff members. These are discussed here. All the Project Staff will report to the Project Coordinator at SCIR and work under his guidance. (A) Leave Rules: (i) A staff member can avail 12 days casual leave. There is no fixed number of days of medical leave. only if required as per doctor's advice. No leave will be granted without Permission and intimation for medical leave is compulsory. Medical Certificate is to be attached with medical leave application. (ii) Staff are entitled to 15-20 days national holidays and the list is prepared and intimated by HDRI at the beginning of the year. (iii) The official holidays declared by the organization will be considered as paid holidays. (iv) Three months paid maternity leave at a stretch can be sanctioned to a female employee. (v) The procedure of availing leave is different for the 'Recovery De-addiction Centre' as it works 24 hours like any hospital. Its staff can't take leave without alternative arrangement of duties. (B) All appointments are made

on temporary and contract basis. Every year contract should be renewed. Continuation service is subjected to availability of fund. (C) Minimum working hour is 7 hours per day and 40 hours per week (6 days in a week). Staff members may be asked for additional working days/ hours as per the requirement of the office. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) The staff can be posted to work in any site of the same project managed by the Organization. (F) In case of harmful work against the interest of the organization, the service of the concern employee will be terminated. (G) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time

HDRI is regularly arranging internal as well as external training programmes for its staff members. It also arranges induction training programme for the new staff. The staff members are also time to time trained by the funding agencies and other external agencies. Some of these agencies are WBSAP&CS, NACO, UNODC, etc. Besides these, HDRI is also arranging exposure visit to other organizations for its staff members.

Financial Information

HDRI's financial turn over in the year 2006-07 was around one crore. It has received Rupees 34,89,026.00 (Rupees thirty four lakh eighty nine thousand twenty six only) from WBSAP&CS during 2006-07 for its HIV/AIDS intervention project for migrated labourers. During this period, it has also received funds for its other projects from various sources like WBSAP&CS, UNODC, DFID, Ministry of social Justice and Empowerment, Govt. of India, public donation, internal resources, etc. In spite of receiving fund from various funding agencies, HDRI still feels that fund is inadequate to meet the various requirements of the organization. Irregular flow of fund especially from the government funding agencies – is one of the problem faced by HDRI. Currently, HDRI is not having any specific fund raising policy. But considering the needs and objectives of the organization, HDRI approaches different funding agencies.

HDRI prepares annual budget in order to manage the financial affairs smoothly. It prepares annual budget on the basis of previous years' experiences, expenditure mentioned in the project proposal, last year's expenditure, expected fund to be received from the funding agencies, etc. But HDRI gives main emphasis on the terms and conditions of funding agencies in this regard.

Future Plan

Being an old and big organization. HDRI has a number of future plans. Some of these are: (i) to act as a Nodal Agency in the field of HIV/AIDS; (ii) to establish a Research Institute for undertaking different research projects on drug abuse and drug dependents; (iii) to establish a Regional Institute and offer regular Counseling courses on drug abuse to produce capable staff in this field; and (iv) to empower and hand over the project to community people to sustain the level of participation.

In brief. HDRI runs various types of programmes. Majority of these are on HIV/AIDS and Drug abuse. It has also few programmes for school children and rural poor people. HDRI has adopted developmental as well as right-based approach because of the diversified issues involved with migrated labourers. truckers and drug dependents. HDRI has got a good recognition for the services that it has been rendering since 1985 especially in the field of drug and chemical substance abuse.

[F] Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA)

Background

In the late 1980s, a group of children and young adults with hemophilia (a genetically determined blood-clotting disorder) in West Bengal contracted HIV through transfusion of contaminated blood and blood products. The treatment. care and support needs of these youths remained un-addressed for long in the shadow of successful targeted HIV intervention projects for other population groups at risk in the state. No self-help group even existed till before 1998 although reported number of AIDS cases from West Bengal at that time was approximately 200. In the year 1994. Dr. Samiran Panda, one of the founder members of SPARSHA, was attached to ICMR and in 1997 he joined a research NGO named Society for Applied Studies in Kolkata. From these organizations, he used to treat and advice people living with HIV. These people with HIV, their friends and family members along with some more people from different walks of life joined hands to form a group in 1998 to reduce social discrimination and facilitate HIV/AIDS care and support. which ultimately culminated in the birth of SPARSHA later on. In this group, there were also people living with hemophilia who contracted HIV through blood transfusion. The group was started with 15 members only. Some of the key founder members of

SPARSHA are Dr. Dilip Mahalnobis. Dr. Samiran Panda. Shri Umesh Kakarania. Shri Soumitra Poddar and Shri Apurba Mitra. Their active participation in forming the basic nucleus of SPARSHA and multifarious activities thereafter has been enormous. This was a pioneering effort. which was initiated in 1998 and paved the way for greater involvement of people living with HIV/AIDS (PLWHA) in West Bengal. The group eventually widened its platform for anybody living with HIV/AIDS irrespective of the way one got infected. Initially, there was no office premise. Sometimes. the offices. residences. etc of the above mentioned promoters were used to run the activities of this support group. There was no external funding support from any agency; the group managed its activities with the membership fees and donations from few well wishers. Finally. this group consolidated into a registered body named Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA) in November 2001 under the West Bengal Society Registration Act 1961. It started working on the creation of a supportive environment. to spread awareness and provide HIV/AIDS care and Support through networking. SPARSHA received its first funding support from the Australian Agency for International Development (AusAID) for a project entitled "Creation of a Support Network for People Living with HIV in West Bengal" in 2001 under the Indo-Australian Community Assistance Scheme (IACAS). Its participation in the Kolkata Book Fair in 2001 and 2002: and sensitization of journalists at Kolkata Press Club exemplify such initiatives. It is worth remembering that SPARSHA pioneered HIV care in West Bengal during a time when more emphasis used to be given to HIV prevention and awareness than on treatment.

In 2003, a small research project was entrusted to SPARSHA by WBSAP&CS on "Lessons learnt from HIV/AIDS Awareness Programme in Schools of West Bengal". The financial support for this activity came from the DFID. UK via Resource Centre for Sexual Health and AIDS (RCSHA). New Delhi. Within a short period of time. another project was entrusted to SPARSHA by the Government of West Bengal to assess the needs of HIV infected and affected families. Being satisfied with the result of these assessment studies, WBSAP&CS approved Care and Support Programme for PLWHA to SPARSHA in January 2004. In addition to it. currently it has been running different other programmes related to HIV/AIDS. HIV non-infected people remained as integral part of this movement since beginning of its formation that helped in effectively reducing stigma and discrimination against HIV/AIDS in the

state. SPARSHA is presently run by a group of 'People Living with HIV/AIDS and Their Friends' (PLWHAF) and provides a platform where research as well as care needs with regards to physical, social, psychological and economic aspects of PLWHA are addressed.

Vision

We must ensure our next generation flying high in a world, free from fear and discrimination against HIV/AIDS.

Mission

Creation of enabling environment for HIV prevention, care, research and fulfillment of basic human rights with active participation of people living with HIV and those who are not infected with the virus is our mission, where engaging women and children will remain central.

Present Objectives

The major objectives of SPARSHA are as follows: (i) To provide care and support services to PLWHA; (ii) To facilitate HIV voluntary confidential testing and counseling; (iii) To disseminate information on HIV/AIDS and issues related to sex and sexuality; (iv) To provide counseling services with regard to stress management, ART, etc.; (v) To provide free anti-HIV medicines to reduce transmission of HIV from parent to child; (vi) To provide low cost clinical care including ART through referral network and lobbying with various pharmaceutical companies marketing Anti Retroviral medicines; (vii) To provide subsidized ART to a few HIV infected children belonging to impoverished family; (viii) To reach out to PLWHA in need of home-based care; (ix) To start income generation activities for women infected with HIV/ or affected by presence of HIV in someone in the family; and (x) To create awareness in the community to reduce stigma and discrimination against HIV/AIDS and physician's orientation programme for HIV/AIDS care and management.

Area of operation

Under the HIV/AIDS Care and Support programme of WBSAP&CS, SPARSHA started three Drop-in Centres (DICs) and one Community Care Centre (CCC) – one each in the four districts of West Bengal. These DICs are located namely at Kestopur in North 24-parganas district, at Sonakhali in Paschim Medinipur district, at Nandakumar in Purba Medinipur district, and only CCC at Uluberia in Howrah district. Apart from current projects, earlier (2003) SPARSHA conducted study entitled ' Lessons learnt from HIV/AIDS awareness programme in Schools of West

Bengal' in Coochbehar, Bankura, Jalpaiguri and Darjeeling districts with an intention to assist future programme planning and development of School curriculum. Later on in 2004, SPARSHA conducted similar studies in Assam and Nagaland on the request of UNDP and UNICEF to assess the School AIDS Education Programme (SAEP).

Target Groups

SPARSHA is mainly working with the people living with HIV/AIDS (PLWHA) and their family members since 1998. It has also given special focus on Women and Children infected with and / or affected by HIV/AIDS. Apart from it, SPARSHA has been conducting awareness programme on HIV/AIDS for general people.

Infrastructure

SPARSHA is not having its own office building. The head office is located at Kestopur and Kestopur DIC is also running from the same office. The head office and other three DICs are operating from the rented buildings. The Project office is well equipped with modern office equipments like computer, telephone, Internet, etc. The Uluberia CCC is having a 10-bedded hospice and also equipped with doctor, nurse and other necessary infrastructure. Similarly, the DICs of Sonakhali and Nandakumar are also fit for the project activities. SPARSHA is not having any official car, but got an ambulance from the Health and Family Welfare Department, Government of West Bengal for serving the general public of Habra-1 Block of North 24-parganas district.

Programmes

(i) STD/HIV/AIDS Care and Support Programme

SPARSHA has been running the programme since January 2004 with the support of WBSAP&CS. The project is running through three DICs and one CCC located in the four districts of West Bengal namely at Howrah, North 24-parganas, Purba and Paschim Medinipur. Since 2004, the client base of SPARSHA has gone up from 152 to 1336 in 2007. The details of the programme activities are being discussed in Part-II of this Chapter.

(ii) Community Support and Advocacy Programme (CSAP)

The Save the Children (UK), Kolkata office, funds this project. The programme is meant for the HIV infected and affected children and is implemented in three villages of Paschim Medinipur district. The names of these villages are Guchhati, Ajurya and Khatbarui. As the fear of stigmatization and discrimination still persists in the communities, it is decided to embrace all children irrespective of their HIV status in this project. This would serve as a good example of non-discriminatory practice in

front of the whole community for positive support. In addition to medical treatment, this approach would facilitate better psychosocial development of the children. Before the starting of intervention, SPARSHA carried out a rapid base line survey visiting more than 800 households. This has generated a good qualitative database for measuring the expected change that would result from the intervention. The project has been started in 2006.

(iii) Situation Assessment Research (SAR)

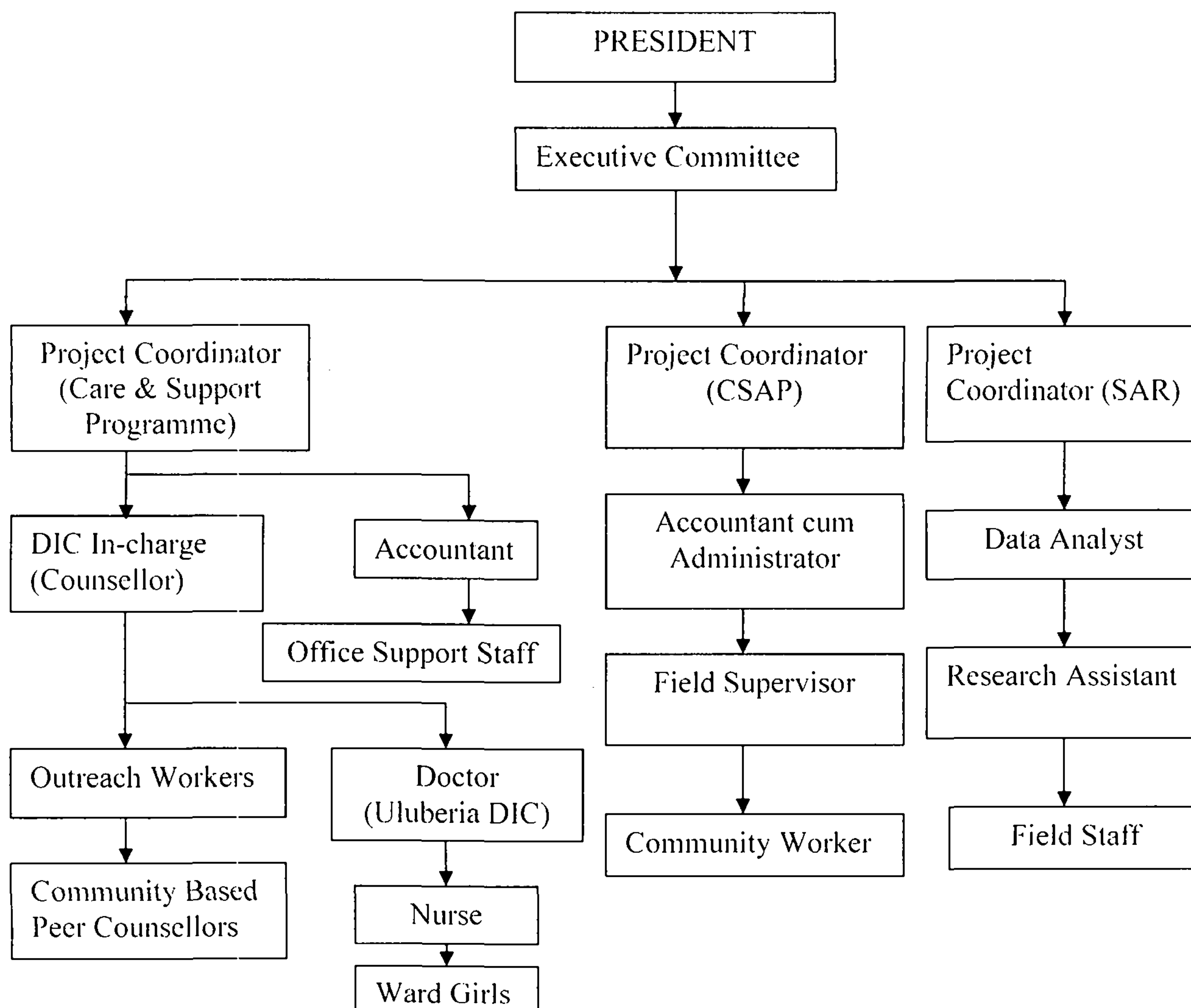
Since July 2006, SPARSHA has started a research project entitled "Assessment of the Situation of Women and Children Infected with and / or Affected by HIV/AIDS" in West Bengal funded by DFID (UK) via Resource Centre for Sexual Health and HIV/AIDS (RCSHA). The project was implemented in Howrah and Paschim Medinipur districts. The study was of 8 months duration and ended in February 2007. It is found from the study that there was lack of income generation support for HIV infected women (many of whom had lost their husbands to AIDS) and affected families; and inadequate focus for children infected with HIV. Community at large was seen at places to mount strong discriminatory responses against people living with HIV and their families. Risk perception of HIV test uptake by women having spouses working as migrant labours was found to be low in this study.

(iv) Child Development and Care Centre (CDCC)

Dr. Bibhat Mandal and Ms. Cynthia Mandal from Manchester, UK floated the idea of sponsoring HIV positive children during their visit to SPARSHA. They publicized the sponsorship proposal widely in England through their contacts as well as articles published in R G Kar Ex-Students' (UK) Scientific Brochure. The aim of this programme is to provide developmental, material, medical and nutritional support for their children. Soon responses came forward for the three children and sponsorship programme began in October 2006. The sponsors are paying 250 pounds sterling per year for each child. A woman living with HIV from nearby village has been appointed as Childcare Community Worker to ensure appropriate care is provided to these children.

Organisational Structure

Chart 6-F: Organizational Structure of SPARSHA



(v) Income Generation Initiatives

The women who lost their husbands to AIDS and those who are living with their ailing husbands are in abject poverty. Many of them had children, some of whom are HIV infected as well. SPARSHA has decided to augment their earnings through income generating initiatives by giving them vocational training. With this end in view, the first item selected was '*mangalsutra*' (a sacred necklace worn by married women). A team of five members living with HIV (one male and four female) was chosen for the training. After receiving training for three months in the beginning of 2006 in Sonakhali DIC, four team members (unfortunately the male member died in the meantime) began working. Since then programme is running smoothly and the

beneficiaries claim that they are self-employed. Based on the same principle and approach, training was also given to four HIV positive women and one male HIV person in Uluberia DIC for '*zari*' work (silver or gold coloured thread work) on *sarees* during the last quarter of 2006. These women are fully skilled and started to enjoy the financial benefit from the programme. Both the above training programmes were financially supported by WBSAP&CS and the micro credit was supplied by SPARSHA's sister concern AASHA (Association for Acquiring Self-reliance through Handicrafts). In addition, training was also given in the making of jute and terracotta products to a number of the members of SPARSHA-family by Small Industry Service Institute (SISI). Government of West Bengal granted necessary permission to AASHA to produce and sell jute products in various fairs.

(vi) Ambulance Services

To meet the local needs of the people in Habra Block-1 of North 24-Parganas district, SPARSHA has started ambulance services. The Department of Health and Family Welfare, Government of West Bengal has provided the ambulance in December 2006. It runs on the basis of 'no loss, no profit basis'.

Staff related information

SPARSHA is having total 42 full-time paid staff, one part-time staff (Doctor) and one honorary staff. Out of these staff, 30 staff members are working in HIV/AIDS Care and Support Programme of WBSAP&CS. There are no volunteers in SPARSHA except the interns of different universities including foreign universities, who visit for short-time assignments. There is no specific organizational policy to use the services of volunteers in SPARSHA.

The Executive Committee of SPARSHA has developed service rules for its staff members, which are discussed here. All the project staff will report to the Project Coordinator and work under his guidance. (A) Leave Rules: (i) A staff member can avail 15 days casual leave, 10 days privilege leave and 15 days medical leave in a year. No leave will be granted without permission and intimation for medical leave is compulsory. Medical Certificate or prescription or medicine bill is to be attached with medical leave application. (ii) A staff can take maximum 2 days casual leave at a stretch. Special permission to be taken for leaves beyond 2 days and it will be treated as medical leave. (iii) The official holidays (national holidays) declared by the organization will be considered as paid holidays. The number of such holidays is 15 days and intimated about the dates of these holidays to the staff at the beginning of

every year. (B) All appointments are made on temporary and contract basis. Every year contract should be renewed. Continuation service is subjected to availability of fund. (C) Minimum working hour is 8 hours (10 am to 6 pm) per day. Except 2nd and 4th Saturday, SPARSHA is working 6 days in a week. Staff members may be asked for additional working days/ hours as per the requirement of the office. (D) The appointment is terminable on either side by one month's notice or salary in lieu thereof. (E) The staff members are selected and posted to work from the local area as SPARSHA works on community based approach and their jobs are not transferable. (F) In case of harmful work against the interest of the organization, the service of the concern employee will be terminated. (G) If required, any staff can stay and avail the treatment at short stay home of Uluberia DIC at free of cost. (H) The prescribed Staff Regulations in force will govern and they may be amended and altered from time to time.

SPARSHA regularly arranges training programmes for its staff members. These training programmes are arranged internally as well as by the external agencies. Some of the external agencies are WBSAP&CS, Kolkata Medical College and Hospital, RG Kar Medical College, School of Tropical Medicine, SAATHII (Solidarity and Action Against The HIV Infection in India), etc. SPARSHA also sends its staff to attend seminar and workshop in abroad too.

Financial Information

Total financial turn over of SPARSHA was Rupees 49,14,417.00 in the year 2006-07. The turn over for its HIV/AIDS Care and Support Programme was 29,05,605.00 during 2006-07. During this period, SPARSHA has received fund from WBSAP&CS, Save the Children (UK), RCSHA (DFID, UK), public donation from within the country as well as from abroad, membership fees, beneficiaries contribution (1/3rd of cost) to avail ART for the children at subsidized rate, etc. SPARSHA has no specific fund raising policy. But keeping in the interest and objectives of the organization in mind, it approaches different funding agencies. Along with inadequate fund, lack of timely disbursement of fund from WBSAP&CS is one of the problems faced by SPARSHA.

In order to manage the financial affairs effectively, SPARSHA prepares annual budget based on the previous year's experiences, last year's expenditure, present market price, current needs of the organization, expected funds to be received,

etc. Generally, SPARSHA considers 10% hike from the previous year's expenditure for preparing current year's annual budget.

Future Plan

Some of the major future plans of SPARSHA are: (i) to start a full fledged Research Centre for undertaking research on different issues related to HIV/AIDS in general and to PLWHA in particular; (ii) to establish a full fledged Child Development and Care Centre equipped with educational, nutritional, play and recreational facilities for HIV infected and non-HIV infected children; (iii) to bring more PLWHA under its Care and Support Programme; and (iv) to form more SHGs of PLWHA especially for women and start income generating programmes for them.

In brief, SPARSHA runs various types of programmes and majority of them are for people living with HIV/AIDS. It has also given more emphasis for HIV infected with and / or affected women and children. SPARSHA has adopted developmental as well as right-based approach because of the diversified issues involved with PLWHA. Though small, but its initiative for the economic development of PLWHA through SHGs is a unique effort.

In order to conclude, this chapter will summarize all the parts separately. This section (Part-I) is a discussion of different aspects (such as past background, objectives, organizational structure, infrastructure, present activities, future plan, etc) of six selected NGOs. It is found that DMSC, BPWT and HDRI are comparatively bigger organizations than SCIR, MB and SPARSHA in terms of financial turn over and volume of activities. Out of these six NGOs, DMSC and SPARSHA are CBOs and MB is a network of CBOs. The target groups for the HIV/AIDS programmes of SCIR, DMSC, BPWT, HDRI, MB and SPARSHA are respectively IDUs, CSWs, truckers, migrated labourers, MSM and PLWHA. The promoters/chief functionaries of these NGOs are adequately experienced and interested to serve the society through their respective target groups. All the selected NGOs have multi-dimensional programmes and HIV/AIDS is an important aspect under their wide spectrum of activities. Despite of having many difficulties, NGOs of the present study are eye opener and pathfinder for the neglected, marginalized and poor masses. All of them have unique approach and are reformative in operation.

PART- II: PROGRAMME ACTIVITIES

In this Part, initiatives have been taken to understand the nature and extent of services provided by the six selected NGOs under the study. The programme activities are being discussed separately covering the different aspects of the programme. These aspects are: (a) objectives, (b) components of the programme, (c) programme execution process, (d) people's participation, (e) monitoring and evaluation, (f) sources of funding, (g) innovative components, and (h) local cooperation. Now programmes under each NGO are being analyzed below.

[A] Society for Community Intervention and Research (SCIR)

At present SCIR is running three HIV/AIDS Intervention Projects for IDUs at Kolkata, Siliguri and Lalgola. Out of these projects, Kolkata Project was purposively selected, as other two projects were comparatively new and just started.

(a) Objectives of the programme

The broad objective of the programme is to contribute to the reduction of HIV/AIDS incidence among IDUs, their partners and families and reduces the pool of infection. This will in turn contribute to increase the quality of life for IDUs in Kolkata and suburbs. The specific objectives of the programme are: i) to provide risk reduction services to IDUs, shadow users and partners; ii) to bring about Behaviour Change by switching from needle sharing to safer injecting practices and from injecting drug use to Oral Substitution Therapy; iii) to reduce the transmission of HIV from IDUs to their partners, offspring and the wider community by concerted condom promotion activities; iv) to create an enabling environment for PLWHA; and v) to empower and mobilize the community so as to ensure project sustainability.

(b) Components of the Programme

This programme has following major components: (i) counselling for blood testing at VCTC; (ii) counselling for PLWHA; (iii) Awareness for IDUs; (iv) awareness for vulnerable groups like slum dwellers; (v) awareness for college students and youth; (vi) condom distribution; (v) advocacy for protecting human rights of the PLWHA; (vi) making arrangement for Antiretroviral therapy (ART); (vii) referral services to other organizations; (viii) home visit and counselling of family members; (ix) awareness among neighbours to remove stigma and prevent social boycott; (x)

imparting training to volunteers and staff of other organizations; (xi) organizing health check up camp; (xii) regular permanent clinic; (xiii) mobile clinic; and (xiv) treatment for STDs.

(c) Programme execution process

The Kolkata Project is having four (4) drop-in centers (DIC) – namely, Park Circus DIC, Goabagan DIC, Mehdibagan DIC, and Buroshibtala DIC. Different types of staff execute this programme. For instance, Project Coordinator (PC) →DIC In-charge (Counsellor) →Outreach worker →Peer Counsellor →Peer educators →Volunteers. Apart from it, there are Accountant, Asst. Accountant, MIS Officer, Doctor and Nurse. As per WBSAP&CS, there are no posts of Assistant Accountant and MIS officer; but SCIR appointed some ORWs and Office Support Staff in these posts for effective implementation of the project. At the grass root level, Peer Educators (PEs) with the help of Outreach workers (ORWs) and volunteers organize awareness camps; distribute condoms and IEC materials as per the pre-planned schedule. Other staff members also help the ORWs. In every DIC, clinics are held thrice in a week and attended by the doctor, nurse and counsellor. The DICs/Clinics offer counselling services for: (i) motivating the target group to comply with treatment (i.e. to complete the full course of medicine); (ii) abstaining from sex until recovery and proper condom, syringe and needle usage; (iii) treatment of their partners to prevent further infections; and (iv) exploring individual problems and helping them to develop safe health seeking behaviour. Park Circus DIC is located at the office of SCIR. All the doctors are working on part-time basis. Total 30 staff members (i.e. 2 Project Coordinators, one MIS officer, one Finance Administrator, 3 nurses, 4 counsellors, 4 peer counsellors, 10 ORWs, one accountant, one assistant accountant, 2 Doctors and one Consultant,) are involved in this project. The doctors and the consultants are part-time staff. Apart from it, 35 peer educators are also working in this project. Feedbacks of beneficiaries or field level staff reach to Project Coordinator through proper channel. Regular staff meeting is another platform to discuss about the plan, programme, progress and other related issues. Generally staff meetings are held twice in a month at the DIC. Meeting of all the project-staff are held at the HQ of SCIR once in a month. Besides it, meetings are held as and when required. SCIR is having one Core Committee to run the project effectively. This committee consists of PC, Counsellor, MIS Officer, Accountant, Counsellor, Peer Counsellor, Nurse, ORW (one) and Peer Educator (one).

(d) People's participation

Beneficiaries (IDUs) of this programme are mostly selected through the referral. They are referred by the existing beneficiaries (recovering IDUs), volunteers, peer educators, police and community members. In SCIR, planning is done at the NGO level and before finalizing the plan; staff members were consulted in the staff meeting. Beneficiaries don't participate in planning, but their opinions are obtained through FGD/GD before implementing the plan. Apart from the staff, peer educators and volunteers actively participate in the programme implementation. It is noticed that beneficiaries received treatment in the clinic at free of cost. Recovering IDUs pay one rupee per day only if they are willing to take tea and lunch from SCIR. But it is optional, not compulsory. Considering the nature and personality of the IDUs, SCIR did not allow them to participate in monitoring and evaluation. Beneficiaries do not contribute any financial resources, but give physical labour in organizing awareness camps, putting up exhibition stall, etc. Thus, we find that beneficiaries participate in beneficiary's selection and programme implementation. But, they do not have any right to participate in programme planning, monitoring and evaluation. Therefore, the situation can be treated as partial participation of the people.

However, people's participation is duly recognized by SCIR. It is done through appreciating them in the meeting, giving them more responsibility and accepting their suggestions. Above all, majority of the existing staff at various levels are selected from among the beneficiaries. Even one Project Coordinator is an Ex-IDU.

(e) Monitoring and Evaluation

The programme is monitored every month as per the monitoring format of WBSAP&CS. The Monitoring and Evaluation Officer (MIS) of SCIR do this in every month. Besides it, the Programme Management Committee regularly monitors the staff members and finances. Financial monitoring is done on monthly basis as per programme budget. This Committee consists of two Project Coordinators, MIS officer, Accountant and Asst. Accountant. Staff members are supervised daily by the DIC in-charges. The Project Coordinator has the overall responsibility of monitoring the staff, programme activities and finance. It is done through monthly staff meeting. In this meeting, various documents (e.g. field visit diaries, etc) of the field level staff are checked and discussed. Besides this, PC sometimes made surprise field visit.

Apart from the internal monitoring, WBSAP&CS and NACO. Delhi also sends their team time to time for monitoring and evaluation of programme activities and performance of SCIR. Thus, it is understood how regular monitoring is done at SCIR's targeted intervention project for IDUs.

(f) Sources of funding

SCIR has been running this programme for IDUs since 2003-04. This project is funded by NACO through WBSAP&CS and funded annually. Every year SCIR used to give its proposal and accordingly fund is granted by the WBSAP&CS. But this fund is granted for fixed programme components like BCC, cost of service, etc only. But there is no provision for providing food to the recovering addicts who are attending the Day Care Centre regularly. For this purpose, SCIR is getting help from Assembly of God Churches, Kolkata. Similarly except ART, for other medicinal support SCIR is getting 75% financial assistance from WORLD VISION and remaining 25% borne by SCIR itself. Another problem is financial crisis during the gap between the previous and current financial year. Fund is not granted immediately at the beginning of new financial year. During the first few months of every new financial year, SCIR and its staff had to face this problem.

(g) Innovative components

In this project, few innovative components were found and these components helped to execute the programme in a better way. (1) The recovering IDUs who are attending Day Care Centre can get vocational training at free of cost at printing press and leather unit. (2) Primary school project mainly for the children of IDUs and for local slum children helps a lot as most of the IDUs don't have the financial capacity to pay school fees. (3) The strong referral network with different polyclinics helped the client to do the different types of pathological tests at subsidized rate. (4) By linking up with different traders. Printing Press and Leather unit of SCIR are running independently and generating fund. (5) SCIR is providing general health care facilities to the general people of the surrounding community, which helped it to receive active cooperation from the local people. Fund required for this purpose is managed by SCIR only.

(h) Local Co-operation

Out of the 4 DICs. Park Circus DIC is located at the main office of SCIR. The office is located in the slum area. Considering the good motive of SCIR, local people, local Councillor of Kolkata Municipal Corporation, local Police station, Chittaranjan

National Medical College, local clubs, etc. extend their support to this programme as and when necessary. SCIR gets similar cooperation from all concerned in other three DICs. SCIR did not face any threat to carry out this programme from political parties or any other groups whose vested interests are not met. Befriending with the target group and local community is one of components in the targeted intervention project of WBSAP&CS. Thus cooperation of local people is satisfactory.

It is evident from the above discussion that the HIV/AIDS Intervention Project of SCIR under the study suffers from few bottlenecks. For instance, the delay in receiving funds and partial people's participation are the two major problems. At the same time, the programme has some positive and innovative components like committed and dedicated staff members most of whom are from IDUs, school for the children of IDUs, strong referral networking with various GOs and NGOs, etc. There is no alternative source of funding and the programme is totally dependent on the funding agency i.e. WBSAP&CS. So, it is evident that the programme of SCIR is less sustainable.

[B] Durbar Mahila Samanwaya Committee (DMSC)

DMSC, at present, is implementing five STD/HIV Intervention Projects (SHIP) – namely, Sonagachi Project, Ganga Bhagirathi Project, North Bengal Project, Ultadanga Project, and Cossipore project. Sonagachi Project is purposively selected for this study as it is the oldest project (running since 1992) and got global recognition. DMSC started other projects simply by replicating the basic principles and guiding policies of Sonagachi Project.

(a) Objectives of the Programme

The broad objective of the programme is to reduce the incidence of STIs and HIV infections among the sex workers and their partners. The specific objectives of the programme are: (i) to bring about behaviour change for safer sex practices amongst CSWs; (ii) to reduce STI and HIV infection among sex workers; (iii) to prevent the transmission of STIs and HIV from their customers to CSWs and vice-versa; (iv) to provide STIs care and treatment services to CSWs; (v) to create awareness about STIs, HIV/AIDS, etc among sex workers and their customers; (vi) to empower and enable the sex workers' community to assert their rights; and (vii) to provide advocacy services.

(b) Programme components

Major components of the programme are: (i) pre-test and post-test counselling at VCTC; (ii) counselling for PLWHA; (iii) condom distribution; (iv) advocacy for protecting human rights of AIDS victim; (v) assistance for getting ARTs; (vi) referral to other such organizations; (vii) home visits and counseling for family members; (viii) awareness campaign to remove stigma and to prevent social boycott; (ix) mass media campaign; (x) imparting training to internal staff members as well as for the staff of other organizations; (xi) organizing health check-up camp; (xii) regular permanent clinics for STIs care and treatment; and (xiii) running VCTC aided by WBSAP&CS.

(c) Programme execution

The Sonagachi Project is divided into two zones — known as SHIP-1 (North Kolkata) and SHIP-2 (South Kolkata). There are six clinics under SHIP-1 namely (i) Avinash clinic; (ii) Palatak Club clinic; (iii) Rabindra Sarani clinic; (iv) Rambagan clinic; (v) Seth Bagan clinic and (vi) Jorabagan clinic. First three clinics are run 6 days in a week, fourth and fifth clinics function 3 days alternatively in a week and Jorabagan clinic is run 2 days in a week. The timing of all the clinics is 11am to 2 pm except Rabindra Sarani clinic, which runs from 2 pm to 6 pm. Avinash clinic runs also in the evening from 6 pm to 8 pm. Similarly, there are seven clinics under SHIP-2 zone. These are: (i) Bowbazar clinic (4 days in a week); (ii) Kalighat clinic (4 days); (iii) Khiderpore clinic (6 days); (iv) Chetla clinic (5 days); (v) Lakermath clinic (one day); (vi) Ghoradanga clinic (2 days); and (vii) Bandhaghat clinic (2 days). The timing of all the clinics is 11 am to 2 pm. Only Bowbazar clinic also runs in the evening from 5.30 pm to 8.30 pm (2 days in a week).

The programme is executed through a logical process by involving different types of staff members. It is executed through a chain work i.e. Project Coordinator (PC) → Clinic in-charge (Doctor)→Counsellor →Field Coordinator →Supervisor →Outreach workers (ORWs) → Peer Counsellor →Peer Educators. In addition to these staff, there are nurses, clinic attendants, accountants, HR officer, Monitoring and Evaluation Officer, Training Officer, STI Management Officer, Legal Adviser, Finance Officer and Media & Advocacy officer. As per WBSAP&CS, there are no posts of Supervisor, Field Coordinator and Clinic Attendant; but DMSC appointed some ORWs in these posts for effective implementation of the project. The clinics offer counselling services for: (a) motivating the target group to comply with

treatment (i.e. to complete the full course of medicine); (b) abstaining from sex until recovery and proper condom usage; (c) treatment of their partners to prevent further infections; and (d) exploring individual problems and helping them to develop safe health seeking behaviour. At the field level, peer educators visit brothel based sex workers time to time; make them aware about STIs, HIV/AIDS; refer STI cases to the clinic, distribute and do social marketing of condoms, and IEC materials as per pre-planned schedule. DMSC has been using various IEC materials like leaflets, calendars, flipcharts, etc in this programme. All peer educators work in the field from 10.00 am to 1.00 pm and then return to the clinics/office. At the afternoon, they have regular literacy classes, meetings, trainings, etc. The Supervisors, ORWs and other staff help the peer educators in their activities. Generally, CSWs come to clinic in the morning hours and male patients in the evening hours. Apart from STI care, the clinics also provide treatment services for general ailments. Meetings with Police, *Babus*, *Malkins* (Madams who take rented rooms and keep CSWs; and takes shares from the earnings of CSWs), *Bariwalis* (Land ladies), Shopkeepers and Pimps are regularly held as per pre-planned monthly schedule. Regular staff meetings are another platform to discuss about the programme planning, progress, problems, and other related issues. The Clinic Level Committees look after each clinic's function and play an important role for their smooth functioning. This Committee consists of local branch committee members of DMSC along with other project staff. The basic approaches that DMSC adopted can be summed up as three 'R's: ***Respect, Reliance*** and ***Recognition.*** That is, *Respect* towards sex workers; *Reliance* on the knowledge and wisdom of the sex workers' community; and *Recognition* of sex work as an occupation, thereby protecting the sex workers' professional and human rights. In practice, the Project focused on translating this approach through building a relationship of mutual trust and rapport between the community of sex workers and the staff members of the project.

(d) Peoples' Participation

Most of the beneficiaries (sex workers and their customers) are selected through referral services. The existing beneficiaries, community members, peer educators and other staff members of DMSC refer them. Peer educators act as a via between sex workers and DMSC in this programme. In brothel based group meetings, needs and problems are discussed and reported to the NGO. In DMSC, planning is done at the NGO level, but before finalizing the plan beneficiaries' feedbacks were considered

after thorough discussion. Beneficiaries expressed their needs to the peer educators and accordingly reported to the Project Coordinator by the peer educators. What should be the timing of the clinics (morning or evening), place of clinic, etc. were decided only after receiving feedback from the beneficiaries. Each beneficiary contributes Rs. 7/- as registration fee and avail the treatment at free of cost. They do not contribute any financial resources, but physically participate in different activities of DMSC. During brothel based awareness sessions, beneficiaries ensure their involvement by attending the programme, providing physical infrastructure (arranging chairs, etc.), controlling crowd, providing tea, etc. for the staff of DMSC. Beneficiaries also play an active role in monitoring and evaluation through Clinic Level Committee, which is represented by the branch committee members of DMSC. Whenever any external research team or evaluation team comes, beneficiaries extend full cooperation. Without beneficiaries' participation, it is impossible to implement this programme. Thus, beneficiaries' active participation is found in need identification; programme planning and its implementation; and monitoring and evaluation. Therefore, except financial resource contribution the situation can be treated as full participation of the people in DMSC and it is truly a community-based organization (CBO).

People's participation is duly recognized by DMSC. It is done through open appreciation in different meetings, giving them more responsibilities and accepting their suggestions. Above all, except doctors and few such other technical staff, majority of staff members (about 85 percent or more) are selected from among the sex workers and their children at all level. Even the present Project Director of DMSC also belongs to sex workers' community.

(e) Monitoring and Evaluation

The programme activities of Sonagachi Project are monitored every month as per WBSAP&CS's monitoring format. Clinic level activities are regularly monitored and evaluated by the concern Clinic Level Committee. The clinic level meetings are held once in a month and similarly meeting of all the project staff is held at the Project Office of DMSC once in every month. Besides these, need based meetings with different categories of staff are held as and when such need arises. For example, meetings of Peer Educators, ORWs, etc are held separately. The over all responsibility of monitoring the staff, programme activities and finance is rested with the Project Coordinator. It is done through regular staff meetings. In these meetings,

various documents of field-level staff (like field diaries, etc.) are checked and discussed thoroughly. Besides it, the Project Coordinator sometime makes surprise field visit. The Finance Administrator of DMSC does financial monitoring. At the top level, the Monitoring and Evaluation (M&E) Officer of DMSC and Central Coordinating Committee of DMSC regularly monitor all the projects, staff members and finances.

Apart from the internal monitoring, WBSAP&CS and NACO, Delhi send their teams for monitoring and evaluating the programme activities and performances of DMSC. Thus, it is understood that regular monitoring and evaluation are done in the Sonagachi Project of DMSC.

(f) Sources of Funding

The STD/HIV Intervention Project (SHIP) for CSWs is being at Sonagachi since 1992 by All India Institute of Hygiene and Public Health and by DMSC from 1999. The Project is funded by NACO through West Bengal State AIDS Prevention and Control Society (WBSAP&CS) annually and renewed every year after the submission of project proposal. DMSC bears 10 percent of the fund, while WBSAP&CS bears remaining 90 percent of fund in the project. But the fund is provided for some fixed components like Behaviour Change Communication, Programme Management, Enabling Environment, etc. Naturally this is not adequate fund to run the different activities initiated by DMSC. For example, for running Vocational Training Centre, Schools for sex workers and their children, etc. DMSC had to arrange from other funding agencies. Apart from SHIP, WBSAP&CS is providing financial assistance to DMSC for Mamata Care and Treatment Centre (VCTC). Lack of timely disbursement of fund from WBSAP&CS is a problem faced by DMSC. DMSC has no alternative sources of funding for the SHIP and fully dependent on WBSAP&CS. However, since 1992 Sonagachi Project is running successfully.

(g) Innovative Components

In Sonagachi Project, few innovative components were found which helped to execute the programme in an exceptionally better way. For instance, (1) a team of competent, committed and dedicated staff most of whom are selected from the sex workers' community. They are rendering services not as a salaried employee, but more as a community member. (2) Strong networking with different government and non-government agencies is instrumental in its successful advocacy programmes. (3) Vocational Training Centre for the aged and unwilling sex workers. (4) Formal and

Non-formal Education Centres (both residential and non-residential) for CSWs and their children. (5) Linking up the sex workers with Usha Multi-Purpose Cooperative Bank and other sister organizations of Durbar. (6) Efforts for involving pimps, local shopkeepers, clubs, *Babus, Malkins, Bariwalis*, etc. and (7) Self-Regulatory Board for preventing trafficking and entry of under aged (below 18 years) girls.

(h) Local cooperation

DMSC gets active cooperation from all concerned starting from the local MP, MLA, Ward Councillor of Kolkata Municipal Corporation, Police, Health, Social Welfare and other government and non-government agencies. Apart from it, local clubs, shopkeepers, pimps, *Babus, Malkins and Bariwalis* have also been extending all cooperation to field level staff members in executing the programme effectively. Initial threats from the local musclemen, etc. were conquered through DMSC's long and sustained efforts. Being a CBO, DMSC always receives more than required support from the sex workers' community in its different activities. Thus, cooperation of the local people is satisfactory. Being an outsider, the researcher did not face any problem due to good rapport between the project staff and local community.

Having made the above analysis, we understand that Sonagachi Project of DMSC is an integrated programme, not just merely a STD/HIV intervention project. The basic approach of the project is based on giving due respect to the sex workers, recognizing their profession and relying on their understandings. All activities of the programme are designed and implemented accordingly with an ultimate objective to enable and empower the sex workers. Though the main aim of the programme is STD/HIV/AIDS prevention, it has touched a chord deep down within the community of sex workers through multifarious project activities basically to empower sex workers' community. The active support from different sister organizations has made it is possible for DMSC. However, the programme suffers from few problems like irregularity in disbursement of fund and no financial provision for general health care by WBSAP&CS. Except financial resource contribution, there is full people's participation in the programme under the study. However, the programme is fully dependent on the funding agency i.e. WBSAP&CS. Hence, the programme is less sustainable.

[C] Bhoruka Public Welfare Trust (BPWT)

BPWT runs HIV/AIDS Intervention Projects for truckers in West Bengal at two sites – namely at Petrapole (North 24 Parganas district) and Kolkata Port Trust (KPT) area (Kolkata). The KPT area is purposively selected for this Study, as it is the oldest truckers' intervention project (started since 1994) of BPWT and was initially funded by DFID. The WBSAP&CS started funding to this project since 2001. Later on, BPWT started other projects simply by replicating the basic principles of KPT Project.

(a) Objectives of the Programme

The broad objective of the programme is to reduce the incidences of STI and HIV infections among the truck drivers, helpers and indirectly among their family members and sex workers. The specific objectives of the programme are: (i) To empower the truckers against AIDS with satisfactory level of information and awareness towards adoption of safer sexual practices; (ii) To reduce the incidence of STI among truck drivers, helpers and their clients (primarily sex workers) and maintain low prevalence rate among them; (iii) To undertake social marketing of condoms; (iv) To create an enabling environment for the project at a long term basis by sensitizing and involving truckers, transport industry, local people, civic, health and enforcement authorities on various issues related to HIV/AIDS; (v) To provide comprehensive supplementary and referral services to truckers along with HIV/AIDS related services; and (vi) To develop an internal system for monitoring and reviewing the effectiveness and quality of the programme.

(b) Programme Components

Major components of the programme are: (i) Counselling for changing high risk behaviour and blood testing at VCTC; (ii) Counselling for PLWHA; (iii) Awareness for truck drivers and helpers (iv) Condom distribution and social marketing of condoms; (v) Advocacy for protecting human rights of AIDS victims; (vi) Assistance for arrangement of Antiretroviral Therapy (ART); (vii) Referral to other such organizations for treatment, pathological tests; (viii) Awareness campaign to remove stigma and to prevent social boycott; (ix) Mass media campaign to improve the awareness among all concern; (x) Imparting training to internal staff members as well as for the staff of other organizations; (xi) Organizing Health Check-up camp; (xii)

Regular permanent clinics for STI care and treatment; and (xiii) Development and distribution of IEC materials.

(c) Programme Execution Process

The objectives are being achieved through clinic intervention, outreaching, STI case management, counselling and condom promotion. Smooth functioning of the intervention programme is ensured through various components by involving various categories of staff members. The programme is executed through a logical process by involving different types of staff members. It is executed through a chain work i.e. Project Coordinator (PC) → Clinic in-charge (Doctor) →Counsellor →Field Supervisor → Out reach workers (ORWs) →Peer Educators. In addition to these staff, there are Accountant, MIS officer and office assistant. As per WBSAP&CS, there are no posts of Field Supervisor and MIS officer; but BPWT appointed some ORWs in these posts for effective implementation of the project. In KPT Project area, there are two drop-in-centres cum clinics at major parking zones namely at Bhutghat, and Dhobiatala. The KPT area project office of BPWT is located at Bhutghat. The clinic of Bhutghat is open throughout the day and it is located in the Project office itself. Another clinic of Dhobiatala is open up to 1.00 pm. These clinics offer treatment of STI and other common ailments. Clinics provide STI treatment through syndromic approach, which helps to provide quick relief. This approach is adopted because of the low treatment compliance of truckers. Besides it, the clinics also offer counselling services for: (a) motivating the target group to comply with treatment (i.e. to complete the full course of medicine); (b) abstaining from sex until recovery and proper condom usage; (c) treatment of their partners to prevent further infections; and (d) exploring individual problems and helping them to develop safe health seeking behaviour. As per pre-planned schedule, Peer Educators (PEs) and Outreach Workers (ORWs) interact with the target group through one to one interaction and sometimes through group interaction at the parking zones. They also try to wipe out myths and misconceptions of the truckers about HIV/AIDS related issues. They also refer the individuals to these clinics for treatment. The PEs are selected from among the truck industry associated people (TIAP) like garage workers, local shopkeepers and local influential persons. They work purely on voluntary basis and do not take any honorarium like other projects of WBSAP&CS. Awareness programmes are organized in the field for dissemination of message on HIV/AIDS and STI. BPWT has been using various IEC materials like leaflets, calendars, flipcharts, talking doll

shows, etc in this programme. BPWT initially started with free distribution of condoms supplied by the Health and Family Welfare Department, Government of West Bengal. Later on keeping in mind with demand of target population, BPWT started social marketing of condoms through small non-traditional outlets (*Paan* shops, tea stalls, hotels, etc.). The outreach workers do the monitoring of the condom outlets on a weekly basis. The programme planning, progress, problems and other related issues are discussed at regular staff meeting. Accordingly every staff member carries out his/her responsibilities. The Project Coordinator is regularly supervising all staff members and their performances and is also maintaining contact with the Head Office of BPWT.

(d) People's Participation

The existing beneficiaries, volunteers, peer educators, local community and truck industry associated people mostly refer the beneficiaries (truck drivers and helpers) of this programme. The truck industry associated people (TIAP) include the Truck Owners' Associations, the Truckers' Associations, the Loaders' Associations, employees of different transport agencies, trade unions of the workers engaged in transport agencies and transport agency officials. The local community represents people attached with *Paan* Shops, Tea Stalls, hotels/*Dhabas*, etc. Truckers are not always available in any place because of the nature of their jobs. Naturally, they could not take part in programme planning. However, their feedback/opinions are obtained through the field level project staff members and considered at the time of programme planning. However, local community members and truck industry associated people actively participate in programme implementation. It is noticed that Rs. 30/- is taken as registration fees from the beneficiaries and they avail the medicine at free of cost from BPWT clinics. This registration fee was taken so that wastage of medicines can be prevented and also it helps to generate some fund for general health care. Because, WBSAP&CS gives money for STI care only. They do not contribute any financial resources. Local truck industry associated people are extending all cooperation to the project staff members including physical labour at the time of organizing awareness camp, etc. They help in arranging chairs, controlling crowd, etc.

Thus, we find that beneficiaries participate in need identification, beneficiary's selection and partly in programme implementation. But they do not participate in programme planning, resource contribution, monitoring and evaluation. Therefore, the situation can be treated as partial involvement of beneficiaries. But this is mainly

due to the nature of the beneficiaries' job. However, BPWT duly recognizes people's participation by accepting their suggestion.

(e) Monitoring and Evaluation

BPWT has developed a systematic MIS through which regular monitoring is done at the NGO level. The programme is monitored every month as per the monitoring format of WBSAP&CS. At the project level, the Project Coordinator has the overall responsibility of monitoring the staff, programme activities and finance. This is done through regular monthly staff meeting. In this meeting, programme activities, progresses of the work, problems, future plan, etc. are discussed. The Project Coordinator also reviews the progress of monthly plan in weekly staff meetings. Financial monitoring is done as per the programme budget on monthly basis. The Project Coordinator also makes surprise visit to the field. Besides it, Director and Administrative Officer of BPWT sometime make surprise visits to monitor the project activities. The Centre-In-Charge meets with all Project Coordinators to review the programme activities. Similarly, the Director and other senior officials of BPWT meet quarterly with all Project Coordinators and Centre-In-Charge for the same purpose.

Apart from the internal monitoring, the evaluation teams from WBSAP&CS and NACO also visit the project for monitoring and evaluating the programme and performances of BPWT. Thus, it is found that regular monitoring is done at this truckers' intervention project of BPWT.

(f) Sources of Funding

BPWT has been running this HIV/AIDS intervention project for truckers in KPT area since 1994. The Project is funded by WBSAP&CS annually since 2001 and previously the project was funded DFID. Every year WBSAP&CS asks project proposal and grants the fund after the project proposal is accepted and approved. But this fund is given for certain fixed components like Behaviour Change Communication (BCC), Cost of Service, Programme Management, etc. BPWT and other such NGOs are accordingly implementing the programme as per the guidelines of WBSAP&CS. But the project staff members felt that the fund is not adequate. There is no provision of providing medicines for the general health care, except STI care and management under this project. In KPT Project area, there is no near by health centre or hospital or nursing home. Naturally, in case of any health emergency, the truckers as well as truck industry associated people first approach the BPWT clinics for treatment. Lack of timely release of fund from WBSAP&CS is another

problem. Especially, the delay in release of fund is occurred in the beginning of every new financial year. BPWT is fully dependent on WBSAP&CS and it has no alternative source of funding this project now. However, since 1994 BPWT is running the Truckers' project in KPT as well as in Petrapole area successfully.

(g) Innovative component

In this project, few innovative components are found that helped to execute the programme in a better way. These components are: (1) Adoption of syndromic approach in the treatment of STI that gives quick relief is found very much useful. Because due to their migratory nature of job, the truckers have low treatment compliance rate; (2) Involvement of truck industries associated people and local shopkeepers, etc.; (3) Linking up with Bhoruka Blood Bank for blood test is an extra advantage for this project; (4) Annual sports is organized mainly with a view to recognise the contribution of local truck industry associated people and local community to ensure their participation in future too; and (5) Peer Educators work voluntarily and BPWT don't pay any honorarium to them like other TI projects of WBSAP&CS.

The basic approach adopted in this KPT project to empower the truckers against HIV/AIDS with satisfactory level are designed and implemented in accordance with the ultimate objective of the project i.e. to reduce the incidence of STI, HIV/AIDS among the truckers and their family members.

(h) Local Cooperation

BPWT gets active cooperation from the Kolkata Port Trust Authority without which it would have been difficult to run this programme within the port area. Besides it, BPWT also receives support from Health, Police, Social Welfare and other departments of government. This truckers' intervention project is operating in the parking zones/halting points of trucks within the KPT area. Therefore, it is not like other projects where local residents can participate in the programme activities. At the local level, there is one Advisory Board consist of representatives from BPWT, Truck Owners' Association, Transport Companies, CISF, local Police Station, local MLA and local Councillor of Kolkata Municipal Corporation. The Advisory Board meets quarterly and discusses the progress, problems of the programmes, etc. Sometimes this Board also took initiative and arrange awareness programme with the help of BPWT staff. In short, BPWT is successful in getting support from all truck industry associated people. The Transport Companies, workers of different transport agencies,

and trade unions of these workers, local shopkeepers — all extend necessary cooperation to the project staff.

It is evident from the above discussion that the Truckers' Project of BPWT suffers from few bottlenecks. For instance, it lacks full-fledged people's participation. delay in receiving fund, no provision for the general health care by WBSAP&CS, etc. On the other hand, the programme under the study has got some advantages like BPWT is having its own blood testing laboratory, active support from truck industries associated people, etc. But, the truckers' project of BPWT is fully dependent on WBSAP&CS for funding support. Hence, the programme is less sustainable.

[D] MANAS Bangla (MB)

It has been already discussed in Part-I of this Chapter that MB is the only organization, which is running Sexual Health Promotion and HIV Control Programme for MSM in West Bengal. Currently, MB is running this project through its eight DICs. These DICs are located at DumDum, Kadapara and Kasba (Kolkata district); Baruipur (South 24-Parganas); Bangaon (North 24-Parganas); Srirampore (Hoogly); Siliguri (Darjeeling) and Burdwan. Out of these eight DICs, DumDum DIC and Kasba DIC were purposively selected for this study as both of them are functioning since the inception of the project i.e. 2004.

(a) Objectives of the Programme

The broad objective of the programme is to reduce the incidence of STIs and HIV infections among the MSM and their partners. The specific objectives of the programme are: (i) to bring about behaviour change for safer sex practices amongst MSM population; (ii) to reduce STI and HIV infection among the MSM people; (iii) to prevent the transmission of STIs and HIV from MSM people to their partners and vice-versa; (iv) to provide STIs care and treatment services to MSM; (v) to create awareness about STI, HIV/AIDS, etc. among MSM people and their partners; (vi) to empower and enable the MSM community to assert their rights; (vii) to provide advocacy services; (viii) to prevent violence against MSM community members; (ix) to meet the health needs of MSM people; and (x) to reduce the stigma around gender or sexual identities of MSM among the common people.

(b) Programme components

Major components of the programme are: (i) pre-test and post-test counselling for blood tests at VCTC; (ii) counselling for PLWHA; (iii) condom and lube distribution; (iv) advocacy for protecting human rights of HIV/AIDS victim; (v) assistance for getting ARTs; (vi) referral of clients to other such organizations; (vii) home visits and counseling for family members; (viii) awareness campaign to remove stigma and to prevent social boycott; (ix) mass media campaign; (x) imparting training to internal staff members, volunteers as well as for the staff of other organizations; (xi) organizing health check-up camp; (xii) regular permanent clinics for STIs care and treatment at DICs; and (xiii) developing and distributing IEC materials.

(c) Programme execution

The programme is executed through a systematic process by involving different categories of staff members. MB has divided eight DICs into five Zones. There are five Zonal Project Coordinators (ZPC) to look after these DICs. For example, DumDum DIC and Bangaon DIC placed under one ZPC; Baruipur DIC and Kasba DIC under another ZPC; Srirampore DIC and Burdwan DIC look after by another ZPC; and remaining two ZPCs look after Siliguri DIC and Kadapara DIC respectively. It is executed through a chain work i.e. Zonal Project Coordinator (ZPC) → DIC in-charge (Counsellor) → MIS cum Accounts Officer →Field Supervisor →Outreach Workers (ORW) → Peer Counsellor →Peer Educators. In addition to these staff, there are one Doctor and one DIC Assistant in each DIC. The Project Director is the over all in-charge of the whole project. These DIC level staff are assisted by a Technical Team consists of HR Officer, Documentation Officer, Finance Officer, BCC Officer, STI Management Officer, Medicinal Officer, MIS Officer, Accountant and Project Office Assistant. The Project Director of MB heads this technical team. As per WBSAP&CS, there are no posts of Field Supervisor and MIS officer; but MB has appointed some ORWs in these posts for effective implementation of the project. The clinics offer counselling services for: (i) motivating the target group to comply with treatment (i.e. to complete the full course of medicine); (ii) abstaining from sex until recovery and proper condom and lube usage; (iii) treatment of their partners to prevent further infections; and (iv) exploring individual problems and helping them to develop safe health seeking behaviour. At the field level, peer educators and ORWs visit different Closing/Meeting Points (for example, Railway Stations, Parks, etc.) where MSM people are assembled and make

them aware about STIs, HIV/AIDS; refer STI cases to the clinic; distribute condoms. lubes and IEC materials as per pre-planned schedule. They also make efforts to build rapport with the local Police Stations. GRP. Clubs, etc. The Supervisors and other staff help peer educators in their activities. Peer educators are in regular touch with the target group people and take their feedback time to time about the services provided by MB. Regular staff meetings are held to discuss about the programme planning. progress. problems. and other related issues. During such meetings. individual tasks are assigned to each staff member. At the clinic level. Doctor provides treatment for STIs and other health problems. which is supplemented by the advice and counseling from the Counsellor. The Counsellor has been playing a very important role in the areas where contradictions regarding sex. gender. sexuality. sexual behaviour. sexual health. social norms and beliefs are confused with mental health issues. The timing of the clinics is 12'O clock to 8 pm and clinics are held 4 days in a week. In Baruipur DIC. the clinic is open for 5 days in a week. because every Sunday special clinic is held for *Hijras*. MB organizes number of community-based events to renew and enrich its old contracts as well as for possibilities in reaching out to other areas too. It also helps to form 'Support Group' where there is no such organization like MB. In practice. the Project focuses on building a relationship of mutual trust and rapport between the MSM community and the staff members of the project.

(d) Peoples' Participation

Beneficiaries. who regularly visit the DICs. directly participate in the meeting and involve in need identification. Most of the beneficiaries (MSM and their partners) are selected through referral services. The existing beneficiaries. community members. peer educators and other staff members of MB refer them. Sometimes regular visitors of DICs bring beneficiaries along with them. In MB. planning is done at the NGO level. but before finalizing the plan beneficiaries' feedbacks were considered after thorough discussion. Regular beneficiaries of DIC directly participate in GD/FGD and express their opinions. In case of outreach beneficiaries. their needs and problems are discussed and reported by the Peer Educators to the respective DIC and ultimately it reaches to Project Director of MB. Each beneficiary contributes Rs. 2/- as registration fee and avail the treatment and medicines at free of cost. They pay separately for condoms and lubes. which are sold by peer educators through social marketing. They do not contribute any financial resources. but physically participate in different

activities of DICs as and when required or asked for. Outreach beneficiaries also volunteer themselves in different outreach activities at the field level. Beneficiaries also participate in different activities of MB (for example community-based events, exhibition stall at fairs, etc.) as volunteers. Beneficiaries do not participate directly in monitoring and evaluation, but the project staff members consider their views and feedbacks. Beneficiaries extend full cooperation whenever any external research team or evaluation team comes to MB. Without beneficiaries' participation, it is impossible to implement this programme. Thus, beneficiaries' active participation is found in need identification, beneficiaries' selection, programme planning and its implementation; and to some extent in monitoring and evaluation. Therefore, except financial resource contribution the situation can be treated as full participation of the people in MB and it is truly a network of community-based organizations (CBO).

MB duly recognizes people's participation. The project staff members do it on the spot by appreciating or praising their contributions. It is also done through open appreciation in different meetings, giving them more responsibilities and accepting their suggestions. Above all, except doctors and few such other technical staff, majority of staff members (about 80 to 85 percent) are selected from among MSM community at all level.

(e) Monitoring and Evaluation

Within the DIC, Clinic level activities are regularly monitored and evaluated by the Counsellor (DIC in-charge) and MIS Officer of the concern DIC. The over all responsibility of monitoring the staff, programme activities and finance is rested with the Zonal Project Coordinators for the respective DICs placed under them. It is done through regular staff meetings. In these meetings, various reports and documents of field-level staff (like field diaries, etc.) are checked and discussed thoroughly. Besides it, the Project Coordinator sometime makes surprise field visit. At the top level, Project Director and the technical team members also time to time make visit to the DICs for the same purpose. The HR Officer, Finance Officer, MIS Officer, Documentation Officer, STI Management Officer regularly monitors and evaluates the activities of different DICs in their respective areas. The Governing Body members also time to time visit the Project Office and DICs. Besides this, the programme activities of MSM Project are monitored every month as per WBSAP&CS's monitoring format.

Apart from the internal monitoring and evaluation. WBSAP&CS and NACO. Delhi sends their teams for monitoring and evaluating the programme activities and performances of MB. Thus, it is understood that regular monitoring and evaluation are done in the MSM Project of MB.

(f) Sources of Funding

The Sexual Health Promotion and HIV Control Programme for MSM in MB is running from July 2004.The Project is funded by West Bengal State AIDS Prevention and Control Society (WBSAP&CS) annually and renewed every year after the submission of project proposal. MB bears 10 percent of the project cost and remaining 90 percent borne by WBSAP&CS. But the fund is provided for some fixed components like Behaviour Change Communication, Programme Management, Enabling Environment, Treatment Support, Desirable Support, Monitoring and Evaluation. Naturally, it is not adequate fund to run the different activities of the project. For example, WBSAP&CS has no provision for meeting the expenditure incurred for general health care and treatment; for meeting the expenditure of traveling allowances of Peer Educators, etc. the allotted fund is also inadequate to purchase requires clinical equipments. Lack of timely disbursement of fund from WBSAP&CS is another problem faced by MB. It has no alternative sources of funding the MSM project and is fully dependent on WBSAP&CS.

(g) Innovative Components

In MSM Project of MB, few innovative components are found that help in executing the programme in better way. For instance, (1) purchasing medicines directly from CDMU, Kolkata at low price to reduce the cost and thereby serving more beneficiaries; (2) collecting medicines from Physician's sample for the same purpose; (3) people with MSM behaviour are by and large creative and MB has trained a batch of such people in stitching and embroidery who are now successfully earn their livelihood from it; (4) a team of competent, committed and dedicated staff most of whom are selected from the MSM community. They are rendering services more as a community member than as salaried employees; and (5) strong networking with different government, NGOs and CBOs is instrumental in its successful advocacy programmes.

(h) Local cooperation

At the DIC level, MB gets cooperation from all concerned starting from the local Ward Councillors of Kolkata Municipal Corporation and other municipalities, Police,

Health. Social Welfare and other government and non-government agencies. But still the cooperation received from the government agencies is not upto the desired level. The project did not face so far any threat from political parties or any group with vested interests. But there were some incidences where project staff were harassed and humiliated by the local people because of prevailing social attitude towards the MSM and their sexual behaviour. There are incidences where police refused to register FIR in case of such harassments of the project staff of MB. Orthodox and puritan nature of our social norms and beliefs regarding sex and sexual behaviour is one of the common problems faced by MSM community everywhere. The situation has improved through MB's long and sustained efforts. Thus, cooperation of the local people is not satisfactory to the desired extent. But being a network of CBOs, MB always receives more than required support from the member organizations and MSM community in its different activities.

It is found from the above analysis that the basic approach of the project is based on giving due respect to the MSM population, recognizing their sexual behaviours and relying on their understandings. All activities of the programme are designed and implemented accordingly with an ultimate objective of enabling and empowering the MSM community to assert their rights. Except the resource contribution, there is full- fledged people's participation. At the same time, the programme suffers from few problems like delay in receiving fund, no financial provision for the general health care and traveling allowances of PEs by WBSAP&CS, etc. On the other hand, the programme under the study has got certain advantages like committed and dedicated staff most of whom are from MSM community, strong referral networking, central technical team, etc. But, this MSM programme of MB is less sustainable as it is fully dependent on WBSAP&CS for funding support.

[E] Human Development Research Institute (HDRI)

HDRI has been running HIV/AIDS Targeted Intervention Project for migrated labourers (ML) since 1997. Initially, the programme was started with the help of DFID (UK) and it was handed over to WBSAP&CS in 2001. Presently, the project is covering 25000 migrated labourers of Burrabazar (8000), Posta (7000), Jorabagan (4000), Mechua (3000), Ahiritola (1500) and Sovabazar (1500). Out of these migrated

laborers. 60% are Porters, 15% are Handcart pullers, 15% are Labourers, 5% are Sardars and 5% are engaged in other occupations. These people had to stay away from their family for a long time. Consequently, they wanted to fulfill their sexual desires by going to sex workers and thus become vulnerable for STD/HIV infections. This project is purposively selected for this study, as it is one of the oldest projects for MLs in West Bengal.

(a) Objectives of the Programme

The broad objective of the programme is to promote better sexual health among migrant labourers; and to reduce the incidence of STD/HIV infection among the ML, their family members and sex partners. The specific objectives of the programme are: (i) to provide sexual health education among ML; (ii) to bring about behaviour change for safer sex practice among ML; (iii) to reduce STD/HIV infection among ML; (iv) to prevent transmission of STD/HIV from ML to their family members and sex partners: (v) to provide STD treatment through syndromic approach along with general health care; (vi) to promote and distribute condoms through clinics and outreach activities; (vii) to provide networking and advocacy services at different level: (viii) to promote sustainability at different components of existing intervention programmes; and (ix) to empower and enable ML to assert their rights.

(b) Programme Components

Major components of the programme are: (i) counselling for changing high risk behaviour and blood testing at VCTC/ICTC; (ii) counselling for PLWHA: (iii) awareness for migrated labourers and other vulnerable groups like slum dwellers: (iv) condom distribution and social marketing of condoms: (v) advocacy for protecting human rights of AIDS victims; (vi) assistance for arrangement of Antiretroviral Therapy (ART) through School of Tropical Medicine; (vii) referral to other such organizations for treatment, pathological tests; (viii) awareness campaign to remove stigma and to prevent social boycott; (ix) mass media campaign to improve the awareness among all concern; (x) imparting training to internal staff members and volunteers; (xi) organizing Health Check-up camp; (xii) regular permanent clinics for STD care and treatment; and (xiii) development and distribution of IEC materials.

(c) Programme Execution Process

HDRI has been running this project through five clinics. These clinics are: (1) Posta clinic, Burrabazar clinic, Ahiritola clinic, Mechua clinic and Sovabazar clinic. Posta and Burrabazar clinics open six days in a week; Ahiritola and Mechua clinics open

3days alternatively in a week and Sovabazar clinic opens twice in a week. The timing of the clinics is 8.30 am to 11 am. In each clinic there are doctor, nurse, counsellor and clinic attendant. The patients' names are recorded in the registers and case histories are maintained in the health cards of each individual patient. The clinics offer counselling services for: (i) motivating the target group to comply with treatment (i.e. to complete the full course of medicine); (ii) abstaining from sex until recovery and proper condom usage; (iii) treatment of their partners to prevent further infections; and (iv) exploring individual problems and helping them to develop safe health seeking behaviour. The programme is executed through a systematic process by involving different categories of staff members. It is executed through a chain work i.e. Project Coordinator →Clinic In-Charge (Doctors) → Counsellor →Outreach Workers (ORWs) → Peer Educators (PEs) → Volunteers. In addition to these staff, there are nurses, clinic attendants and accountant. There are 36 PEs are working in this project and all of whom are selected from the migrated labourers' community. Most of these migrated labourers are available in *Gaddi* (place of work) and in *Thek* (place of group residence). Migrated labourers reside in group and work under one 'Sardar' (leader). At the field level, ORWs and PEs time to time visit these migrated labourers at their 'Gaddi' and 'Thek' as per the planned schedule. These field level staff members interact with the target population one to one or in group and make them aware about STD/HIV/AIDS, refer the STD cases to the clinics, distribute condoms and IEC materials, etc. They also issue health cards to the beneficiaries. Other staff members like Counsellor, Project Coordinator, etc. also help these ORWs and PEs. As per pre-planned monthly schedule, meeting with Sardars, Community Influencers, Trade unions, Merchant Associations, etc. are held to discuss about different aspects related to the programme activities. Regular staff meetings are another platform to discuss about the progress of the project, problems, programme planning and other related issues. At the clinic level, weekly staff meetings are held to plan clinic and field level activities. Monthly staff meeting for all project staff members is held at the Project Office of HDRI. For the smooth functioning, there are no formal clinic level committees to look after the function of each clinic. But usually the concern staff members of HDRI with the help of representatives from local target population and other associated organizations do it. In practice, the project is functioning through building a relationship of mutual trust and rapport between the migrated labourers and the staff members of HDRI.

(d) People's Participation

The project is implemented through Outreach workers and Peer educators at the field level. Beneficiaries' needs and problems were discussed in the group meetings with them and reported to the NGO. Here, Outreach workers and Peer educators act as a via between HDRI and beneficiaries. Most of the beneficiaries are selected through referral services. The existing beneficiaries, community members, peer educators and other field level staff members of HDRI refer them. Here planning is done at the NGO level and approved by the Governing Body of HDRI. There are three community members who are selected as member in the Governing Body. It is noticed that beneficiaries pay Rs. 10/- as registration fee to avail the treatment at free of cost from the clinics run by HDRI. Beneficiaries do not contribute any financial resources, but provide infrastructural support (arrangement of venue, electricity, chairs, etc.) during Annual Gathering, Sardar's meet, awareness camp, etc. They also physically participate and contribute in different activities of HDRI in terms of controlling crowds, arranging tea, etc. So far monitoring is concerned, beneficiaries do not actively involve in it. Beneficiaries do not have any role in evaluation of the project, but they extend full cooperation to the external evaluation team by participating in FGD. Thus, beneficiaries' active participation is found in need identification, beneficiary's selection, programme planning and implementation. But they have limited scope for participation in monitoring and evaluation. Therefore, the situation can be treated as partial participation of the people.

But people's participation is duly recognized by HDRI. Every year, HDRI organizes Annual Gathering programme for migrant labourers through organizing sports, games, audio-visual show and awareness generation programme. The whole programme is actually organized with the active support and participation of beneficiaries. Besides this, HDRI has recruited 36 Peer Educators from the migrant labourers' community. This indicates that HDRI recognized their contributions in the implementation of the project.

(e) Monitoring and Evaluation

All the programme activities are monitored on weekly, monthly, quarterly, half-yearly and annual basis by different staff as per the monitoring and evaluation plan and strategy. The overall responsibility of monitoring the staff members, programme activities and finance is rested with the project coordinator. It is done through regular staff meeting. In such meetings review of progress, problems faced, plans, etc. are

thoroughly discussed and suitable decisions are taken for the future. At the top level, Governing Body is continuously monitoring and evaluating the project. Sometimes GB members, Project Coordinators make surprise visit to the field for this purpose. In HDRI, there is 'exchange monitoring system' i.e. monitoring is done by the Project Coordinator of other project. Sometime the Project Coordinator of Truckers' Project make surprise visit to the Migrated Labourers' Project or vice-versa to ensure effective monitoring and implementation of the project.

Apart from the internal monitoring and evaluation, WBSAP&CS send its team for monitoring and evaluation. Sometimes such teams come from NACO, Delhi also. Thus, it is found that regular internal as well as external monitoring and evaluation are done in the HIV/AIDS Targeted Intervention Project of Migrated Labourers in HDRI.

(f) Sources of Funding

DFID (UK) funded the HIV/AIDS Targeted Intervention Project for ML from 1997 to 2001(March). Since April 2001, HDRI is receiving fund from WBSAP&CS. Every year the project is renewed after the submission of project proposal. Out of the project expenditure, WBSAP&CS bears 90 percent and HDRI bears remaining 10 percent of fund in the project. Lack of timely disbursement of fund from WBSAP&CS is a problem faced by HDRI. It has no alternative sources of funding for the project and fully dependent on WBSAP&CS. If funding is stopped, the programme could not be run in future. However, HDRI will try to strengthen its fund raising programme in near future. So it is evident from the above discussion that project cannot be continued for long time without the support of funding agencies. Anyway HDRI is running this project successfully since 1997.

(g) Innovative component

Few innovative components are found in the Migrated Labourers' project of HDRI, which help to implement the programme in a better way. For instance, (1) linking up the ML project with the Truckers' project implemented by HDRI in the same area. Most of the migrated labourers are engaged in loading and unloading goods from these trucks. As a result, both the projects are running effectively; (2) similarly linking up the ML project with the Project for drug dependents also help in the effective implementation of each other, as many of the ML are drug dependents and they are getting help from the same NGO i.e. HDRI; (3) Annual Gathering programme for migrated labourers is a unique method for maintaining rapport with the community as well as for giving recognition to their contribution in the project;

(4) strong networking with pathological Laboratories helping the beneficiaries to do the pathological tests at subsidized price; (5) strong networking with the different government and non-government agencies is playing an important role in its successful advocacy programmes; (6) Sardars are selected by HDRI as referral agents in their respective communities.

(h) Local Cooperation

HDRI gets active cooperation from all concerned. Initially, there was some resistance from the Merchant's Association. But with the continuous effort and persuasion by HDRI, now the same Merchants' Association is extending all cooperation towards the smooth implementation of the project. Similarly the trade unions of migrated labourers are also extending all possible cooperation. Cooperation is also received from local Ward Councillor of Kolkata Municipal Cooperation, MLA, Police, Health, Social Welfare and other government departments. Thus, cooperation of the local people is satisfactory in implementing this HIV/AIDS intervention project of HDRI for migrated labourers.

From the above discussion, it is found that HIV/AIDS Intervention Programme for Migrated Labourers (ML Project) of HDRI is having few bottlenecks. For instance, partial participation of people, delay in receiving fund and staff mobility are the major problems. The programme under the study has got some positive aspects like representatives from MLs in the governing body of HDRI, strong referral networking, linking up with other projects of HDRI, etc. But, the programme is fully dependent on WBSAP&CS for funding support. Hence, the ML project is less sustainable.

[F] Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA)

At present SPARSHA is running the STD/HIV/AIDS Care and Support programme through three DICs and one CCC located in four districts of West Bengal. Kestopur DIC, Uluberia CCC and Sonakhali DIC are purposively selected for the study and Nandakumar DIC is excluded for its recent origin.

(a) Objectives of the Programme

The broad objective of the programme is to provide care and support to the people living with HIV/AIDS (PLWHA). The specific objectives of the programme are: (i) to

provide low-cost clinical care including ART through network; (ii) to provide counseling services with regards to stress management, ART, etc. for the PLWHA and their family members; (iii) to provide free anti-HIV medicines to reduce transmission of HIV from parents to child; (iv) to provide subsidized ART to a few HIV infected children belonging to poor family; (v) to reach out to PLWHA and train them and their family members on home-based care; (vi) to provide vocational training to the HIV infected/affected women for income generation activities; (vii) to facilitate HIV voluntary and confidential testing and counseling; (viii) to create support network for PLWHA; (ix) to document best practices on HIV/AIDS care and support for PLWHA: (x) to create awareness among the common people to reduce stigma and discrimination against PLWHA; (xi) to empower and enable PLWHA to assert their rights; and (xii) to provide advocacy services.

(b) Programme components

Major components of the programme are: (i) pre-test and post-test counselling at VCTC; (ii) counselling for PLWHA; (iii) condom distribution; (iv) advocacy for protecting human rights of AIDS victim; (v) assistance for getting ARTs; (vi) referral to other such organizations; (vii) home visits and counseling for family members; (viii) awareness campaign to reduce stigma and discrimination; (ix) mass media campaign; (x) imparting training to internal staff members as well as for the staff of other organizations; (xi) awareness for vulnerable groups like slum dwellers; (xii) regular permanent clinics for care and treatment of People living with HIV: (xiii) runs Short Stay Home for PLWHA; (xiv) awareness for school students; and (xv) vocational training for HIV infected/affected women.

(c) Programme execution

The programme is executed by involving different categories of staff through a systematic and logical process. It is executed through a chain work i.e. Project Coordinator (PC)→ DIC In-charge (Counsellor)→ Outreach Workers (ORWs)→ Community Based Peer Counsellor (CBPC). In addition to these staff, there are doctor, nurses, ward girls, accountant and office support staff. The doctor, nurses and ward girls are working in Uluberia CCC only. At the field level, ORWs and CBPCs as a regular activity visit and establish effective network with various government and private hospitals, health centers, nursing homes, DOT centers, etc. Physicians of these hospitals and health centres and local private doctors refer symptomatic clients to SPARSHA and it in turn assists them for blood testing, counseling, etc. at VCTC run

by the government. These field level staff members also contact specialist doctors for free medical help. Further more, they make visits to clients' home for getting family members involved in caring people with HIV. They also conduct community sensitization programme to foster community acceptance and participation. The ORWs and CBPCs are also involved in the inclusion of new People living with HIV into the network, expanding and strengthening the network.

Besides the above activities, condoms are distributed from the DICs to enable clients to practice safer sex. Counselling by well-trained counsellors is also done from DICs with regard to various issues including adherence to ART, stress management, *partner notification and legal rights for PLWHA. In addition, online information* dissemination on HIV/AIDS, issues related to sex and sexuality, and relationships as well as tele-counselling are also undertaken by the counsellors. In each DIC, staff meetings are held weekly to review, plan and discuss about programme related activities. Apart from it, a group meeting of DIC staff and HIV positive clients and their family members is held in every month. These meetings serve as a platform for sharing each other's experience and prepare future planning. Such meetings are known as 'light house' in SPARSHA as it shows direction in time of darkness and depression. At the end of each financial year, a meeting involving all staff members is held at the head office, Kolkata. SPARSHA also provides subsidized ART to the poor children infected with HIV. The parents/guardians bear only 1/3rd of the cost of the medicines and remaining 2/3rd is contributed by SPARSHA from its core fund. The approach that SPARSHA adopted is to respect the PLWHA and recognize their rights like any other citizens of the country. In practice, the project focus on translating their approach through building a relationship of mutual trust and respect between PLWHA community and staff members of SPARSHA.

(d) Peoples' Participation

Beneficiaries participate in need identification through monthly group meetings of DIC, through FGD and sometimes through one to one individual discussion with the project staff members. Most of the beneficiaries are selected through referral services by the existing beneficiaries. It is like snow ball effect. Besides this, different government and private health centers/hospitals, staff members of SPARSHA, etc refers beneficiaries. In SPARSHA, planning is done at the NGO level, but before finalizing the plan, beneficiaries' feedbacks are obtained through group meetings and FGDs held at DICs and considered seriously by the Governing Body. Beneficiaries do

not contribute financially, but participate in the different programme activities of DICs run by SPARSHA. Beneficiaries ensure their involvement by attending the programmes, by providing physical infrastructure like sitting arrangements, providing tea for staff and resource persons during awareness camps, etc. Without their participation, it is impossible to implement the care and support programme of SPARSHA. Beneficiaries also take part in monitoring activities through interactions with DIC level staff as well as with the Programme Management Unit (PMU) of SPARSHA. They do not take part directly in evaluation, but extend support and take part in KABP and other study of WBSAP&CS.

Thus, beneficiaries' active participation is found in need identification, beneficiaries' selection, programme planning and its implementation, monitoring and evaluation. Therefore, except financial resource contribution, the situation can be treated as full participation of the people and SPARSHA is truly a Community Based Organization.

Peoples' participation is duly recognized by SPARSHA through giving them opportunity to express their needs, problems, etc. Fees are paid to them when they act as resource persons in different programmes of SPARSHA and other organizations. Above all, except few technical staff, majority of staff members (70% - 80%) are selected from among the PLWHA at all level including the Project Coordinator.

(c) Monitoring and Evaluation

SPARSHA is having Programme management Unit (PMU) and Finance Management Unit (FMU) for monitoring and evaluation of care and support programme of WBSAP&CS. FMU is monitoring the financial aspects of each DIC. The secretary, PC and Accountant are the members of FMU. Similarly, the PMU is monitoring the programme activities of each DIC and CCC and it consists of Secretary, PC and other HIV positive persons. The Project Coordinator visits all DICs and CCC twice in a month to monitor the activities. The secretary visits each DIC once in a month, some times accompanied by the Vice-President, PC and Accountant. During their visit, they check the registers, bills, etc. maintained by the DICs. They also interact with clients in group meetings and also with different stakeholders to assess the need of the community to extend care components to the HIV infected/affected people. Besides this, FMU is also functioning in every DIC to monitor its financial activities of the concern DIC.

Apart from the internal monitoring and evaluation. WBSAP&CS time to time send its team to SPARSHA for the same purpose. Sometimes. such team from NACO. Delhi also visits to monitor and evaluate the project activities. Thus, it is found that regular monitoring and evaluation are done in HIV/AIDS Care and Support programme of SPARSHA.

(f) Sources of Funding

The STD/HIV/AIDS Targeted Intervention for Care and Support programme is running by SPARSHA since January 2004. The project is funded by WBSAP&CS annually and renewed every year. WBSAP&CS bears 90% of the project cost and *remaining 10% by SPARSHA. But the fund is inadequate to run the different* activities of SPARSHA. For example, there is no provision in the project for bearing the infrastructural and developmental cost. Besides this. the fund is too meagre to meet the demands of ART needed by the PLWHA. Though the Government is giving 1st line ART at free of cost. but there is nothing about 2nd line ART. The fund is also not sufficient for providing medicines for opportunistic infections (OIs). WBSAP&CS has no provision for funding the traveling expenses of the poor HIV positive people. who used to come from distant places to collect ART at the Government run ART centers. All these factors are preventing SPARSHA to expand its services to more number of PLWHA. Delay in releasing fund is another problem faced by SPARSHA. It has no alternative source for funding this project and SPARSHA is fully dependent on WBSAP&CS.

(g) Innovative Components

In the HIV/AIDS Care and Support programme of SPARSHA. few innovative components are found. These components are helpful in executing the project in a better way. Some of these components are: (1) a team of competent committed and dedicated staff and most of are selected from the people living with HIV. They are working more as missionaries than as salaried employees; (2) vocational training and formation of SHGs for helping the HIV infected/affected women in order to make them economically independent; (3) linking of these SHGs with AASHA – its sister organization for marketing their products; (4) strong networking with different government and NGOs is instrumental for its successful advocacy programmes; (5) networking with pharmaceutical companies helps in providing ART at subsidized rate to the HIV infected children; (6) treatment preparedness initiatives to help the clients

to cope up with the new ARV medicines; and (7) special emphasis on HIV infected/affected women and children.

(h) Local cooperation

SPARSHA is getting active cooperation from all concerned starting from the local pathological laboratories. PHCs. Sub-Centres, Sub-Divisional Hospitals. Medical Colleges. Block Development Offices. Panchayats. etc. The Gram Panchayats exempt road taxes for the vehicles of SPARSHA. It has organized advocacy meetings at different Block Development Offices successfully with the support from the concern authorities. The project staff are getting necessary cooperation in executing the programme from all above mentioned agencies. Being a CBO. SPARSHA always receives more than required support from the PLWHA community. their family members and relatives. Thus. cooperation from local people is satisfactory.

It can be summarized from the above analysis that it is an integrated programme. not just merely a HIV/AIDS care and support programme. The basic approach of the programme is based on giving due respect to the people infected with or affected by HIV/AIDS; recognizing their basic human rights by reducing stigma and discrimination against them. Accordingly. activities are designed and implemented by SPARSHA with an ultimate objective of enabling and empowering PLWHA. It has touched the hearts of PLWHA through its empathetic approach and efforts. Except the financial resource contribution, people's participation is full-fledged in the programme under the study. It has got competent. committed and dedicated staff most of whom are HIV positive. However, the programme suffers from few bottlenecks like delay in receiving fund, inadequate funding provision for the treatment of opportunistic infections and no funding provision for traveling allowances to the poor people living with HIV who come from distant places to collect medicines from ART Centres of WBSAP&CS and so on. This programme of SPARSHA is fully dependent on WBSAP&CS for financial support. Hence. the programme is less sustainable.

Thus. this section (Part-II) attempts to discuss about the programme activities of six selected NGOs under the study. It is found that the programmes studied suffer from one or more problems. Some of the problems are common in all the programmes under the study. These problems are lack of timely disbursement of fund by WBSAP&CS. except STIs. no funding provision for the treatment of general health problems of target groups, no provision for meeting traveling expenditure of Peer

Educators and People living with HIV, etc. In DMSC, MB and SPARSHA, people's participation is better than other three NGOs. One of the reasons for full people's participation is all the three above NGOs are CBOs or network of CBOs. Each programme has got some positive aspects and innovative components too. But, all the programmes are fully dependent on the funding agency i.e. WBSAP&CS. Therefore, all the programmes under the study are less sustainable and doubtful for their contribution in the someway in future.

PART- III: STAFF MEMBERS' VIEWS

This Part has attempted to discuss about the views of staff members. In order to understand the staff's views, an interview schedule (Part-C) was used. The methodology chapter has given the details regarding the types of required data, sources of data, tools used for the collection of data and so on. In this regard, ten staff members from each selected NGO have been taken into consideration and views obtained from total sixty staff. A brief description of the profile of staff members and the views expressed by them are as follows:

PROFILE OF STAFF MEMBERS

(a) Sex of Staff Members

Table 6.1 gives an account for number of male and female staff members under six NGOs. Out of the purposively selected staff members, the numbers of males are found more as compared to females respectively in SCIR (80%), BPWT (70%) and MB (90%). On the other hand, numbers of female staff are more in DMSC (70%), HDRI (80%) and SPARSHA (60%). Similar trend is also found, if we consider the total staff strength of six NGOs under the study.

Table-6.1: Number of Male and Female Staff members

Sl. No.	*Organization*	*Male*	*Female*	*Total*
1.	SCIR	8 (80%)	2 (20%)	10 (100%)
2.	DMSC	3 (30%)	7 (70%)	10 (100%)
3.	BPWT	7 (70%)	3 (30%)	10 (100%)
4.	MB	9 (90%)	1 (10%)	10 (100%)
5.	HDRI	2 (20%)	8 (80%)	10 (100%)
6.	SPARSHA	4 (40%)	6 (60%)	10 (100%)
	Total	33 (55%)	27 (45%)	60 (100%)

(b) Age of Staff Members

Table 6.2 shows that none of the NGOs is having staff, who are below 21 years. The age of maximum staff members is above 40 years in DMSC (70%) and SCIR (50%). While most of the staff members in BPWT (70%), MB (80%), HDRI (50%) and

SPARSHA (50%) are aged between 21 years and 30 years. On the whole, out of 60 selected staff members, maximum (45%) belong to 21 years to 30 years category.

Table-6.2: Age of Staff Members

Sl.No	*Organisation*	*21years to 30years*	*31years to 40years*	*41years & above*	*Total*
1.	SCIR	1 (10%)	4 (40%)	5 (50%)	10 (100%)
2.	DMSC	1 (10%)	2 (20%)	7 (70%)	10 (100%)
3.	BPWT	7 (70%)	2 (20%)	1 (10%)	10 (100%)
4.	MB	8 (80%)	1 (10%)	1 (10%)	10 (100%)
5.	HDRI	5 (50%)	5 (50%)	--	10 (100%)
6.	SPARSHA	5 (50%)	2 (20%)	3 (30%)	10 (100%)
	Total	27 (45%)	16 (26.7%)	17 (28.3%)	60 (100%)

(c) Qualification of Staff Members

Table 6.3 indicates that the staff members of DMSC (70%) and SPARSHA (50%) have less educational qualifications i.e. below SSC, while most of the staff members in MB (80%) and BPWT (70%) are graduates. In HDRI, maximum staff members (80%) are having post- graduate qualification. Out of the total 60 staff members under the study, more than fifty percent staff members are having graduate and above degree.

Table-6.3: Educational Qualification of Staff Members

Sl. No.	*Organisation*	*Literate*	*Below SSC*	*SSC*	*HS*	*Graduate*	*Post Graduate*	*Total*
1.	SCIR	--	--	4 (40%)	3 (30%)	2 (20%)	1 (10%)	10 (100%)
2.	DMSC	5 (50%)	2 (20%)	1 (10%)	1 (10%)	--	1 (10%)	10 (100%)
3.	BPWT	--	--	--	--	7 (70%)	3 (30%)	10 (100%)
4.	MB	--	1 (10%)	--	1 (10%)	8 (80%)	--	10 (100%)
5.	HDRI	--	--	--	--	2 (20%)	8 (80%)	10 (100%)
6.	SPARSHA	1 (10%)	4 (40%)	2 (20%)	1 (10%)	2 (20%)	--	10 (100%)
	Total	6 (10%)	7 (11.7%)	7 (11.7%)	6 (10%)	21 (35%)	13 (21.6%)	60 (100%)

(d) Designation of Staff Members

It is evident from the Table 6.4 that 65 percent of the total sixty staff members under the study are field level workers i.e. Outreach Workers (51.7%) and Peer Educators (13.3%). Similarly, in each NGO between forty to eighty percent staff are field level

workers and between twenty to sixty percent are middle level staff i.e. peer counselor, counselor, nurse and doctor.

Table-6.4: Designations of Staff Members

Sl. No	*Designation*	*SCIR*	*DMSC*	*BPWT*	*MB*	*HDRI*	*SPARSHA*	*Total*
1.	PC	1 (10%)	--	1 (10%)	1 (10%)	1 (10%)	--	4 (6.7%)
2.	Doctor	--	--	1 (10%)	--	--	--	1 (1.7%)
3.	Nurse	1 (10%)	--	--	--	--	--	1 (1.7%)
4.	Counselor	1 (10%)	1 (10%)	1 (10%)	1 (10%)	2 (20%)	2 (20%)	8 (13.3%)
5.	Peer Counselor	--	1 (10%)	--	1 (10%)	1 (10%)	4 (40%)	7 (11.6%)
6.	ORWs	5 (50%)	3 (30%)	7 (70%)	6 (60%)	6 (60%)	4 (40%)	31 (51.7%)
7.	PEs	2 (20%)	5 (50%)	--	1 (10%)	--	--	8 (13.3%)
	Total	10 (100%)	10 (100%)	10 (100%)	10 (100%)	10 (100%)	10 (100%)	60 (100%)

VIEWS OF THE STAFF MEMBERS

The staff members have expressed their views on different issues regarding (a) stigmatization, (b) ethical issues related to HIV/AIDS, (c) violation of human rights, (d) major barriers in implementing the programme, (e) major reason of spreading HIV/AIDS and (f) future AIDS scenario and role of NGOs. The views of staff members are being discussed NGO wise qualitatively.

[A] Society for Community Intervention and Research (SCIR)

Table-6.5 gives details of full-time paid staff of Kolkata IDU Project. Out of the total 30 staff members engaged in this Project of SCIR, 10 staff are purposively selected representing different levels of staff for the present study. Apart from the Project Coordinator (PC), five staff are selected from Park Circus DIC and four from Goabagan DIC. By designation, there are five Outreach workers (ORWs), two Peer Educators (PEs), one Counsellor, One Peer Counsellor and one Project Coordinator. Out of these ten staff members, except the nurse, remaining nine are ex-IDUs.

Table-6.5: Characteristics of Full Time Paid Staff of Kolkata IDUs' Project

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Coordinator	2	M (1), F (1)	SSC, Graduate
2.	MIS Officer	1	F	Graduate
3.	Counsellor	4	M (1), F (3)	PG, Graduate& HS (2)
4.	Peer Counsellor	4	M (3), F (1)	HS, SSC (2) & VIII
5.	Nurse	3	F	SSC
6.	Outreach Workers	10	M (9), F (1)	Graduate, HS (4), SSC (4) & VIII
7.	Accountant	1	M	Graduate
8.	Asst. Accountant	1	M	Graduate
9.	Finance Administrator	1	M	PG
10.	Doctors *	2	M	MBBS
11.	Consultant #	1	M	PG
	TOTAL	30		

* *Part-Time; # Honorary*

(a) Stigmatization

The entire staff members express that they are not affected by the HIV/AIDS related stigma. All of them are happy for working in this programme. They also inform that they would not change job or move to any non-HIV/AIDS projects, if they were given such offer with same salary. Because they are getting better job satisfaction by serving their own community members i.e. IDUs. The nurse is happy as she is serving these people who are neglected by the society. Their family members are aware about the nature of their jobs. They receive support and encouragement from their respective family members and friends. None of them have ever experienced that people are trying to avoid them after knowing their nature of job in the HIV/AIDS field; rather people want to know more about the disease. All of them have admitted that this job helped them to get recognition and improve their social status. Therefore, the staff themselves are not stigmatized for working in the HIV/AIDS field. At the same time, they agree with the fact that due to fear of stigmatization, sometime even clients or their family members in spite of their awareness don't want to visit VCTC or such other organizations. These people are hidden in the society and are not coming under the targeted intervention project. Hence, the risk of spreading the HIV infection is very high. Most of the staff members have suggested that only mass awareness could reduce this fear of exposure and becoming a victim of social apathy. It is possible only through continuous effort by involving each and everybody. Few of them have

also suggested that more counselling is required to motivate these people for blood testing.

(b) Ethical issues

All of them are aware about the ethical guidelines related HIV/AIDS. But it is found that except the PC and Counsellor. their awareness is at superficial level. They are not well aware about the detailed guidelines except the issue of maintaining confidentiality about the client's HIV positive status and no discrimination against the HIV positive person. In SCIR, the doctor and counselor of the concern clinic can only know the HIV positive status of the client. All the ten staff strictly follow and main confidentiality about case histories of their clients and never discuss it with their friends and family members. They are more careful because IDUs are doubly stigmatized for their drug-taking habits and for their vulnerability to HIV/AIDS.

(c) Violation of human rights

All staff members inform that they would protest and play the advocacy role if any incidence of human rights violation occurred or discriminatory practices done with PLWHA. Out of the ten staff, there is only one Project Coordinator (PC) who has narrated one such incidence. This is a case of depriving an HIV infected widow from her husband's property by her in-laws. Here, the PC played the advocacy role successfully. There are many incidences occurred where doctors and nurses refused to do the treatment of HIV positive people in the government run hospitals. On this issue, most of the staff felt that more training is required for the health personnel. While two of them feel that exemplary punishment should be given to such doctors/health personnel. Because one such incidence has far-reaching impact on the common people and all the awareness created earlier gone into wastage.

(d) Major barriers encountered

Regarding the major barriers encountered during the implementation of this project, most of the staff members agree with these three reasons namely, indifferent attitude of the people, fear of stigmatization and migratory nature of the IDUs. In addition to these, few of them feel that lack of shelter-home equipped with food, bathing facilities, etc. is another barrier. Because such shelter-home is very much essential for the environmental modification as well as for changing the behaviour of the recovering IDUs.

(e) Major reasons of spreading HIV/AIDS

Majority of the staff members have identified poverty, migration and ignorance as major causes responsible for spreading HIV/AIDS at a faster rate. Some of them have also pointed out that ignorance, modern life-style (free mixing, etc.), effects of media (films, etc.) are also responsible factors.

(f) Future AIDS scenario and role of NGOs.

Regarding the future scenario in relation to HIV/AIDS, four staff members feel that HIV/AIDS situation in our country will be out of control. While remaining staff members feel that it would be within control if Government continues its effort by involving all other stakeholders. All of them also feel that NGOs would play the key role in the fight against this killer disease. Some of them have also suggested that Government should increase its coverage to include general population along with the vulnerable groups. Because, now the HIV infection is not restricted to high-risk groups, it spreads among all.

It is evident from the above analysis that staff members of SCIR under the study are not affected by HIV/AIDS related stigma. Majority of them are aware about the ethical issues related to HIV/AIDS and practice it always. They would definitely protest against the violation of human rights of PLWHA and have recommended more training for health personnel of government run hospitals to avoid such incidences in near future. Majority of them feel that fear of stigmatization, indifferent attitude of people and migratory nature of IDUs are the major problems that affecting the implementation of the programme. To them, ignorance, poverty and migration are the major reasons for spreading HIV/AIDS at a faster rate. Majority of them think that in future HIV/AIDS situation of our country will be within control, if government continues its present effort. All the staff members under the study feel that NGOs would continue its key role in the battle against the killer disease.

[B] Durbar Mahila Samanwaya Committee (DMSC)

Table-6.6 shows the characteristics of full-time paid staff of Sonagachi Project for CSWs. Out of the total 121 staff members engaged in this Project of DMSC, 10 staff members representing different levels are purposively selected for the present study. Out of these 10 staff members, seven are selected from Avinash clinic and three from Rambagan clinic. By designation, there are two Outreach Workers (ORWs), five Peer

Educators (PEs), one Counsellor, one Clinic Attendant and one Peer Counsellor. Five PEs, one ORW and one Counsellor are selected from Avinash clinic. Similarly, one Peer Counsellor, one ORW and the Clinic Attendant are selected from Rambagan clinic. Except the Counsellor, Clinic Attendant and one ORW, remaining seven staff members belong to sex workers' community.

Table 6.6: Characteristics of Full-Time Paid Staff of Sonagachi Project for CSWs.

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Director #	1	F	Graduate
2.	HR Officer	1	M	PG
3.	M & E Officer	1	M	PG
4.	Legal Adviser	1	M	LLB
5.	Finance Officer	1	M	Graduate
6.	STI Magt. Officer	1	M	MBBS
7.	Media Advo. Officer	1	M	PG
8.	Training Officer	1	M	PG
9.	Accountant	3	M	Graduate
10.	Office Asst.	2	M	Graduate
11.	Project Coordinator	2	M	PG
12.	Counsellor	10	M (4), F (6)	PG
13.	Peer Counsellor	14	F	SSC (4), Literate (10)
14.	Clinic Attendant	10	M	Graduate (6), HS (4)
15.	Outreach Workers	45	F (44), M(1)	Graduate (5),HS(7),SSC(10), Literate (23)
16.	Nurse	12	F	Diploma in Nursing
17.	Doctors*	15	M (13), F (2)	MBBS
	Total	121		

*# Honorary; * Part-Time*

(a) Stigmatization

All the staff members express that they are happy in working with this HIV/AIDS intervention programme. All of them have said that they are not affected by the HIV/AIDS related stigma by nature of their jobs. But seven staff who are ex-CSWs, have said that they are affected by the social stigma related to sex workers. They also express that they would not like to change the present job or move to any non-HIV/AIDS projects. They would not even move to any HIV/AIDS project working for other target groups. Because they are getting better job satisfaction by serving their own community members i.e. sex workers' community. The Counsellor, Clinic attendant and one ORW (Who do not belong to sex workers' community) are happy

as they are serving these people who are neglected and marginalized in the society. All of them informed that they receive support and encouragement from their respective family members and friends. None of them have ever experienced that people are trying to avoid them after knowing their nature of job in the HIV/AIDS field; rather people want to know more about the disease. All of them have admitted that this job helped them to get recognition and improve their social status. Therefore, the staff themselves are not stigmatized for working in the HIV/AIDS field. They also inform that sex workers are doubly stigmatized because of their profession and vulnerability to HIV/AIDS. Some sex workers simply avoid the clinics because they fear that they may be stigmatized and it will affect their earnings. Most of the staff members have suggested that this fear of exposure and becoming a victim of social apathy could be reduced only through mass awareness and continuous efforts of all.

(b) Ethical issues

All of them are aware about the ethical guidelines related to HIV/AIDS. They are aware about the issue of maintaining confidentiality of the client's HIV positive status, informed consent of the person for blood testing and non-discriminatory practices against the HIV positive person. They have narrated one such incidence that took place in Sonagachi in 1994-95. One reputed NGO of Kolkata planned to conduct research on HIV prevalence among the sex workers without any consultation with the sex workers and utilized the services of local police. Sex workers protested and put a stop to this violation of ethics. In DMSC, the doctor and counselor of the concern clinic can only know the HIV positive status of the client. All the ten staff strictly follow and main confidentiality about case histories of their clients and never discuss it with other persons like their friends and family members. They are more careful because CSWs are doubly stigmatized for their profession and for their vulnerability to HIV/AIDS.

(c) Violation of human rights

All staff members would protest and take up the issue with appropriate authority if any incidence of human rights violation occurred or discriminatory practices done with PLWHA. They can go to any extent until justice is given to the victims. One of them narrates one such incidence that took place few years back in Sonagachi project. This is a case of a physician of dubious repute who claimed that he had invented a vaccine against HIV. This physician wanted to trial his vaccine among the sex workers of Sonagachi without any clearance from the Indian Council of Medical

Research (ICMR). DMSC protested and successfully able to stop this so called vaccine trial. There are many incidences, where doctors and nurses have refused to do the treatment of HIV positive people in the government run hospitals. On this issue, most of the staff members feel that exemplary punishment should be given to such guilty doctors or other health personnel. Because one such incidence has far-reaching impact on the common people and will negatively affect the ongoing efforts to combat HIV/AIDS. But two of them feel that Government can open a separate Cell with specialized health personnel in every medical college to over come such problems.

(d) Major barriers encountered

The Sonagachi Project of DMSC is the oldest project for CSWs and is still functioning since 1992. Initially, DMSC has encountered so many problems in implementing this intervention project. Things were never smooth sailing. There is a vicious circle in every red light area like Sonagachi, controlled by vested interests, police-criminal-politician nexus. Here no one can live without negotiating with these elements. It is learnt from the experience that no headway could be made without negotiating with hoodlums and pimps who actually controlled the entire trade. There were resistances also from the *Malkins, Bariwalis, Babus* and even from the sex workers. Most of the sex workers were illiterate, ignorant and unorganized beset with factional and personal quarrels. All of them thought that this project would affect their earnings. It took long time for the project staff to convince them that the spread of AIDS may destroy their entire business. Gradually, the situation had been improved over a period of time as a result of the continued efforts of the staff members. Now most of these people are extending cooperation in implementing the project. All staff members inform that in recent times still there are two major barriers which affecting the implementation of this project. These two barriers are namely fear of stigmatization and migratory nature of street based or flying sex workers. Still many sex workers prefer private clinics instead of availing the services from DMSC run clinics at free of cost. Many sex workers also don't want to go for blood testing. Because they have the fear of stigmatization, which would ultimately affect their earnings by way of loosing customers. It is very difficult to work with flying sex workers, as they are not available regularly for intervention. In addition to these, few staff members feel that indifferent attitude of the people is another major barrier. Still

social attitude towards sex workers and PLWHA are not positive. As a result of it, numbers of people are not approaching VCTC or such clinics.

(e) Major reasons of spreading HIV/AIDS

Majority of the staff feel that unsafe sex and contaminated blood are the major reasons of spreading HIV/AIDS at a faster rate. Still blood banks in West Bengal are not in a position to fulfill the demand and thereby compelling people to purchase blood, which may be contaminated. Besides these, two staff members are of the opinion that poverty, migration and ignorance are major causes responsible for spreading HIV/AIDS at a faster rate. One of them also points out the modern life-style (free mixing, lack of parental control, etc.); effects of mass media (TV, films, etc.) as responsible factors.

(f) Future AIDS scenario and role of NGOs.

Regarding the future scenario in relation to HIV/AIDS in our country, only two staff members feel that HIV/AIDS situation in our country will be out of control. While remaining staff members feel that it would be within control if Government continues its effort by involving all other stakeholders. They also feel that awareness about HIV/AIDS is increasing gradually among all section of people. There is no second opinion about the role of NGOs. All of them are of the opinion that NGOs would play a key role in the fight against this killer disease. Because NGOs are more effective than the government agencies and can reach out to any target group at any place. Some of them have also suggested that Government should increase the coverage to include general population under its intervention project. They are not agreeing with the fact that only high-risk groups are more vulnerable to HIV infection and to them everybody in the society is equally vulnerable.

It can be summarized from the above analysis that the staff members of DMSC under the study are not affected by the stigmatization because of their jobs, but seven staff (who are ex-CSWs) are affected by social stigma attached to sex workers. All of them are aware about the ethical issues related to HIV/AIDS and strictly follow them in practice. They would protest if any incidence of violation of human rights of PLWHA occurred and suggest exemplary punishment for the guilty health personnel to avoid the repetition of such incidences in future. Majority of them think that fear of stigmatization and migratory nature of street-based sex workers are the major barriers in implementing the project. Most of them are of the opinion that unsafe sex and contaminated blood are responsible for spreading HIV/AIDS at a

faster rate. Majority of them are optimistic about the future AIDS scenario in our country and think it will be under control. There is no doubt among them regarding the major and effective role of NGOs in combating HIV/AIDS.

[C] Bhoruka Public Welfare Trust (BPWT)

Table-6.7 highlights the detailed staff structure BPWT's Truckers' Project. Out of the total 28 staff members engaged in this Project of BPWT, 10 staff representing different levels are purposively selected for the present study. It has already been mentioned in methodology chapter. Out of these 10 staff members, apart from the Project Coordinator (PC), six are selected from Bhutghat clinic and three from Dhobiatala clinic. By designation, there are seven Outreach workers (ORWs), one Counsellor, one Doctor and one PC. Out of the 7 ORWs, four are selected from Bhutghat clinic and three are from Dhobiatala clinic. Similarly, the Counsellor and Doctor are selected from Bhutghat clinic

Table 6.7: Characteristics of Full Time Paid Staff of Truckers' Project

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Coordinator	2	M	PG, Graduate
2.	Counsellor	3	M (1), F (2)	PG
3.	Outreach Workers	16	M (9), F (7)	PG (5), Graduate (11)
4.	Accountant	2	M	Graduate
5.	Office Support Staff	2	M	Graduate
6.	Doctor *	3	M	MBBS
	TOTAL	28		

* *Part-Time*

(a) Stigmatization

All the staff members inform that the HIV/AIDS related stigma does not affect them. All of them have said that they are happy in working with this HIV/AIDS intervention programme. But they differ in terms of their reasons of happiness. Seven of them are of view that they are happy because of doing something good for the society, while others express about the challenging nature of the very job makes them happy. Majority of them said that they would not move to any non-HIV/AIDS project only because of stigma factor, if they were given any such opportunity. But, they could change the present job if they would have got better learning opportunities. All of them are of the opinion that their jobs don't involve any risk of getting HIV infection.

The family members of all staff members are aware about their nature of job and always extend support to them. Therefore, majority of staff members themselves are not stigmatized.

At the same time, they agreed with the fact that in spite of all efforts made during last few years, still stigma is very much present in our society. Due to the fear of stigmatization, many well-informed people even do not want to visit the clinics or VCTC. Almost every staff member thinks that only mass awareness could reduce such fear. It is possible only through continuous effort from all. Few of them have also suggested that more counseling and sex education at school level could also play a vital role to reduce the social stigma attached with HIV/AIDS.

(b) Ethical issues

All the staff members are aware about the ethical issues related to HIV/AIDS. But it is found that the knowledge is superficial among some of the field level staff. However, all of them are aware about these ethical issues like maintaining confidentiality about the patient's HIV positive status, consent of the person before blood testing and no discrimination against the person on ground of his HIV positive status. The doctor and counselor of the concerned clinics can only know the information about the person's HIV positive status. All staff members inform that strictly follow and maintain confidentiality about their clients. They even do not discuss it with their friends and family members. ORWs inform that even they maintain confidentiality with every client who attends the clinic. The doctor refers one such incidence of one truck driver who attended the clinic for treatment of STD; requested the doctor again and again for not disclosing it to his helper. Similarly peer educators and out reach workers inform that they take extra care in the field especially with those truckers who are not having any risk behaviour. These truckers are very reactive and are required to be dealt properly.

(c) Violation of human rights

In spite of the continuous awareness campaign, there are number of incidences when human rights of the HIV positive people are violated. Even today, doctors, nurse and other health personnel refuse to admit and offer treatment to the HIV positive people. On this issue, majority of the staff members feel that it is most unfortunate when such incidences occurred in the government hospitals. Only four staff members feel that only exemplary punishment of guilty health personnel can reduce such incidences. They have also justified their opinion with far reaching negative impact of one such

incidence among the general people. While remaining staff members feel that more training is required for the health personnel. All the staff members inform that would always protest and play the advocacy role if such incidences occurred in front of them. The project coordinator informs that one such incidence of discrimination that occurred in KPT project when a truck driver lost his job because of his HIV status and it was successfully settled through advocacy. BPWT has a very good networking with different positive people's network in different districts of West Bengal being the Resource Centre for the network of PLWHA.

(d) Major barriers encountered

Majority of staff members admit that they have been encountering some problems in this truckers' intervention project. They mainly identify two problems namely migratory nature of the truckers and fear of stigmatization. Behaviour change is not possible through only one counseling session. It is very difficult to follow up the cases. Besides it, sometime truckers are not in a position to avail the counseling services for their preoccupations, fears, etc. Due to stigmatization, even they are reluctant to visit doctors and thereby delay in treating STDs making them more vulnerable to HIV infection. The staff members also feel that inadequate fund is another problem. The salaries of the project staff have not increased and remain same over the years. In addition to this, except STD care and treatment, there is no fund from WBSAP&CS to address the general health problems of the target group. Four staff members feel that indifferent attitude of the people also sometime affect the smooth implementation of the project. Some truckers especially those without having any risk behaviour express their unhappiness for targeting them for HIV/AIDS. It is not easy to convince such kind of people.

(e) Major reasons of spreading HIV/AIDS

Most of the staff members are of the opinion that poverty, ignorance, migration and drug addiction/alcoholism are the major reasons of spreading HIV/AIDS at a faster rate in our country. So far truck drivers and helpers are concerned, all these factors make them more vulnerable. Their job compels them to stay away from their family for a long time and to get rid of this agony; many of them adopt high-risk behaviour like taking drugs, alcohol and other intoxicants; and visiting sex workers. Sometimes in spite of their awareness, they indulge in unsafe sex under the influence of intoxicants. In addition to these, two staff member blame the modern life style and

consumerism that have destroyed the social and moral values. They feel that pre-marital sex, extra-marital affairs, sex with multiple partners, etc. are all bye-products of modern life style.

(f) Future AIDS scenario and role of NGOs.

Six field level staff members think that the HIV/AIDS situation in our country will be out of control, if government did not change its policy. They feel that actual numbers of HIV infected people are much higher than the official figure. They also feel that unless economic conditions of the people are improved, AIDS will create havoc and destroy the nation. But remaining staff members are of the opinion that due to the efforts of Government, NGOs and other stakeholders, the situation will be under control. All the staff members also feel that the coverage of the project must be extended to include general population. Regarding the role of NGOs, all staff members strongly feel that in future NGOs will play a key role in controlling AIDS. They are always more effective than government agencies in reaching out grass root level target groups.

Having made the above analysis, it is found that none of the staff members of BPWT under the study are affected by HIV/AIDS related stigma. Most of the field level staff members are not well aware about the ethical issues related to HIV/AIDS. With regard to violation of human rights of PLWHA, none of them would tolerate such incidences if occurred in front of them and they have suggested training and exemplary punishment for guilty health personnel to avoid such incidences especially in government hospitals in future. They have encountered two major problems namely fear of stigmatization and migratory nature of truckers in implementing the programme. Majority of them feel that ignorance, poverty, migration and drug addiction are responsible for spreading HIV/AIDS. So far the future AIDS scenario is concerned, majority of them think that it would be out of control if government did not change its present policy. However, all of them agree that NGOs would play a key role in combating AIDS.

[D] MANAS Bangla (MB)

Table-6.8 gives the characteristics of full-time paid staff of MSM Project. Out of the total 60 staff members engaged in this Project of MB, 10 staff members representing different levels are purposively selected for this study. Out of these 10 staff members,

five each are selected from DumDum DIC and Kasba DIC. By designation, there are one Zonal Project Coordinator, one Counsellor (DIC in-charge), three Supervisors (ORWs), three Outreach Workers (ORWs), one Peer Counsellor and one Peer Educator. All the staff members except the Counsellor belong to MSM community.

Table-6.8: Characteristics of Full Time Paid Staff of MSM Project.

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Director	1	M	Graduate
2.	HR Officer	1	M	PG
3.	Document. Officer	1	M	PG
4.	BCC Officer	1	F	PG
5.	Finance Officer	1	M	PG
6.	STI Magt. Officer*	1	M	MBBS
7.	Medicinal Officer	1	M	Graduate
8.	Accountant	1	M	PG
9.	Office Asst.	1	M	Graduate
10.	Zonal P C	4	M	SSC, Graduate
11.	MIS Officer	9	M (8), F(1)	Graduate(6),PG(2),HS (1)
12.	Counsellor	7	M	PG (4), Graduate (3)
13.	Peer Counsellor	8	M	HS
14.	Supervisor (ORW)	8	M	Graduate (4), HS (4)
15.	Outreach Workers	7	M	Graduate(3),HS(3),SSC(1)
16.	Doctors*	8	M	MBBS
	Total	60		

* *Part-Time*

(a) Stigmatization

All the selected staff members express that they are happy in working with this Sexual Health Promotion and HIV Control Programme for MSM. All of them inform that they are not affected by HIV/AIDS related stigma. But excepting the Counsellor, all of them are affected by MSM's sexual behaviour related stigma. Because, still it is neither socially approved nor legally accepted sexual behaviour in our country. Except the Counsellor, all of them express that even they would not like to work in any HIV/AIDS project meant for other target groups. Because, they are getting better job satisfaction by serving their own community members i.e. MSM population. The counselor informs that she feels more secure with these people and is happy with this project as she is serving these people who are marginalized group in the society. Their family members and friends are aware about their nature of jobs and receive full support and encouragement from them. But, at the same time, they reveal that initially family members were reluctant and discouraged them. Few staff inform that due to

MSM related stigma, still their family members are not supportive. However, all of them inform that they do not tell about their nature of job to their relatives and neighbours because of this stigma. It is found that except the Counsellor, remaining nine staff members who belong to MSM community are not married. Therefore, it is quite doubtful that they properly inform about their nature of job to their parents, brothers or sisters. Five of them have experienced that people are trying to avoid them after knowing the nature of their jobs. Initially they felt bad and angry, but it is not against any particular person but against the prevailing social system that disapproves MSM's sexual behaviour and identity. All the staff members are of the opinion that their jobs do not involve any risk of getting HIV infections, but the working environment is risky as there are numbers of incidences of threat, harassment, humiliation, etc. from the local people, youth clubs, etc. Presently, the situation has been improved to some extent by the advocacy efforts of MB. All of them feel free in dealing with their clients because of their professional knowledge, skills, and rapport along with the advantage of belonging to the MSM community. Majority of staff members admit that their jobs helped to improve their social prestige and recognition, while three staff feel that they yet to receive such experiences. They also inform that MSM populations are doubly stigmatized because of their sexual behaviour and their vulnerability to HIV/AIDS. All of them agree with the fact that due to stigmatization many well informed clients or their family members do not want to visit the clinics. It is very difficult task to identify these hidden MSM populations. Hence, the risk of spreading HIV/AIDS through these people is very high. Most of the staff members have suggested that this problem can be reduced through mass awareness, introduction of sex education at schools, counseling for the clients and their family members, sensitization programme, etc. One of them suggests that policy makers will have to think about some new strategy to overcome such types of problems. After all life is precious than the stigma.

(b) Ethical issues

Except two staff, all of them have said that they are aware about the ethical guidelines related to PLWHA. However, all of them are aware about the issue of maintaining confidentiality of the client's HIV positive status, informed consent of the person before blood testing and non-discriminatory practices against the PLWHA, etc. In MB, except the doctor and counselor of the concern DIC and ZPC, other staff members are not in a position to know about the HIV positive status of the client. All

of them strictly follow and main confidentiality about case histories of their clients and never discuss it with other persons like their friends and family members. Being a member of the MSM community, most of the staff members used to take extra precaution in this regard. They are more careful because MSM people are doubly stigmatized for their sexual behaviour and for their vulnerability to HIV/AIDS.

(c) Violation of human rights

All the staff members are of the opinion that they would protest and take up the issue with appropriate authority if any incidence of human rights violation occurred or discriminatory practices done with PLWHA. They can go to any extent until justice is given to the victims. One Outreach worker has narrated one such incidence that took place one year back. One doctor misbehaved with one of the patients in School of Tropical Medicine (ART distribution centre). Immediately, the concern ORW protested and lastly the doctor accepted his fault. In recent times, there are many incidences, where doctors and nurses had refused to admit or provide the treatment to HIV positive people in the government run hospitals and medical colleges. On this issue, most of the staff feel that exemplary punishment should be given to such guilty doctors or other health personnel. Because one such incidence has far reaching impact on the common people and will destroy all the ongoing efforts to prevent and control HIV/AIDS through awareness. At the same time, most of the staff prescribe more training for the medical and para-medical staff. One of the Supervisors feels that the Network of PLWHA will have to play more effective role to reduce and avoid such unfortunate incidences. Another Supervisor feels that government should open specialized AIDS Cell equipped with suitable infrastructure and manpower in every medical college of West Bengal. Thus, it is found that staff members of MB are too much sensitive about the human rights of PLWHA.

(d) Major barriers encountered

The MSM Project of MB has been functioning since July 2004. Initially, MB encountered so many problems in implementing this intervention project because of the prevailing social attitude towards MSM and their sexual behaviour. Things were never smooth sailing. Landlords were not willing to rent their houses for the office or DIC purpose. Sometimes, landlord agreed but neighbours protested. The present Project Office of MB has faced same problem, but it is settled with the landlord's active support. Besides these problems, field level working environments were risky

for the project staff. With the continuous efforts of MB. these problems have been reduced to some extent. In recent times too, project staff are facing different types of problems. All the staff members unanimously inform about three major problems that are affecting the implementation of the project. These are indifferent attitude of the people. fear of stigmatization and ignorance about sexual health. STD. HIV. AIDS. etc. In addition to these problems. few staff members are of the opinion that inadequate finance and delay in disbursement of funds; migratory nature of clients and previous bitter experience of harassment. discrimination. etc. are also affecting the implementation of the project. Four staff members feel that it is very difficult to locate and identify the MSM clients for whom this project is going on. According to Zonal Project Coordinator. political non-cooperation. threat and harassment by the local people. youth clubs etc. are still going on. He has narrated one such incidence where one of the project staff was beaten up and his belongings are snatched by some unidentified youth while he was working with a client in one of the parks in Kolkata.

Thus. it is understood that prevailing social attitude towards MSM is one of the major barriers encountered in the implementation of the project. However. in spite of all these difficulties, MB is running this project with the help of its committed staff and strong networking and advocacy services.

(e) Major reasons of spreading HIV/AIDS

Majority of the staff feel that ignorance. migration and drug addiction are major reasons responsible for spreading HIV/AIDS at a faster rate in our country. Few of the staff members feel that modern life style of the present generation youth without having any parental or social control is also responsible for spreading HIV/AIDS. as these youth are having multiple sex partners. Besides these. two staff members are of the opinion that media is not playing its role properly. For example. through the different soaps and serials broadcasted in TV channels. a tendency of having multiple sex partners is developing gradually among the people. Regarding HIV/AIDS also. media never say that HIV/AIDS can also be spread through anal sex. This is most unfortunate part that NACO also continuing with the same instead of giving correct information to the people.

(f) Future AIDS scenario and role of NGOs.

Regarding the future scenario in relation to HIV/AIDS in our country. all staff members are optimistic and feel that HIV/AIDS situation in our country will be within control and will become a manageable problem only. But it will be possible if

Government continues its effort by involving all other stakeholders in its fight against this killer disease. There is no second opinion about the role of NGOs. All of them are of the opinion that NGOs would play a vital role in future too because of their efficiency and capabilities. The staff members have suggested few effective measures for preventing and controlling HIV/AIDS in our country. Some of these are: (i) to include more vulnerable groups like *Hijras*, etc. under the targeted intervention project; (ii) to involve more NGOs to expand the coverage of the project; (iii) to improve and increase the care and support services like supply of second line ART; (iv) to make arrangement for updating staff' technical knowledge and increase their salary to boost up the morale of the field staff especially; (v) to introduce sex education at the school level; (vi) to increase the number of VCTC, ART Centres, etc ; (vii) to frame effective BCC strategies; and (ix) to include 'anal sex' as one of the sources of HIV transmission in all the media campaign of NACO, WBSAP&CS and other such organizations.

It can be summarized from the above analysis that staff members of MB under the study are not affected by HIV/AIDS related stigma, but affected by prevailing MSM related social stigma. Majority of them are aware about the ethical issues related to HIV/AIDS and practice them always. They would definitely protest against the violation of human rights of PLWHA and have recommended exemplary punishment for the guilty health personnel of government run hospitals to avoid such incidences in near future. Majority of them feel that ignorance, fear of stigmatization, indifferent attitude of people towards MSM community are the major problems that affecting the implementation of the programme. To them, ignorance, drug addiction and migration are the major reasons for spreading HIV/AIDS at a faster rate. Majority of them are optimistic and think that in future HIV/AIDS situation of our country will be within control, if government continues its present effort. All the staff members under the study feel that NGOs would play a more effective role in the battle against the killer disease.

[E] Human Development Research Institute (HDRI)

Table-6.9 shows the characteristics of Migrated Laborers Project. Out of the total 26 staff members engaged in this Project of HDRI, 10 staff members representing different levels are purposively selected for the present study. It has already been

mentioned in methodology chapter. Apart from the Project Coordinator (PC), five staff are selected from Posta clinic, three from Burrabazar clinic and one from Mechua clinic. By designation, there are seven Outreach workers (ORWs), two Counsellors and one PC. Out of the 7 ORWs, four are selected from Posta clinics and three are from Burrabazar clinic. Similarly, two Counsellors are selected from Posta clinic and Mechua clinic respectively.

Table-6.9: Characteristics of Full Time Paid Staff of Migrated Labourers' Project

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Coordinator	2	F	PG
2.	Counsellor	4	M (1), F (3)	PG
3.	Outreach Workers	14	M (9), F (5)	PG(5),Graduate(7),HS (2)
4.	Accountant	2	M	Graduate
5.	Doctors*	4	M	MBBS
	TOTAL	26		

* *Part-Time*

(a) Stigmatization

All the staff members express that they are not affected by the HIV/AIDS related stigma by virtue of their involvement in this project. Majority of them inform that if they got an opportunity with same salary, they would not like to move and join any non-HIV/AIDS project. Few of them express that they will definitely accept better and interesting job offer, but it is nothing to do with HIV/AIDS field. They also feel that they are happy in working with this project for migrated labour. Some of them inform that they are getting better job satisfaction, as the nature of job is very challenging. All of them feel free to deal with their clients because of the training they have received in this regard. Except one, all staff members inform that their family members are aware about their nature of job and always receive support from them. The only staff member who has not informed his family members about his job says that he can't tell them that condom promotion is also part of his job. None of them have ever experienced that people are trying to avoid them after knowing their nature of job in the HIV/AIDS field. All of them are of the opinion that their jobs helped them to get recognition and improve their self-image. Therefore, the staff themselves are not stigmatized for being associated with HIV/AIDS intervention project for migrated labour. But at the same time all of them agree that due to fear of exposure and stigmatization, many people don't want to visit clinics or VCTC. The Project

Coordinator feels that the risk of spreading HIV/AIDS through such people is very high. Some of them have suggested that through more awareness and counseling such people can be motivated to visit clinics for treatment and blood tests. But two of the staff members blame few health staff of VCTC for breaking the confidentiality of client's HIV positive status. However, all staff members feel that though the situation has improved, but still lots to be done to remove HIV/AIDS related stigma from the society.

(b) Ethical issues

Except one staff, all the staff members inform that they are aware about the ethical guidelines related to HIV/AIDS. All of them are aware about the issue of maintaining confidentiality about the client's HIV positive status, non-discriminatory practices against the HIV positive people, informed-consent of the person concern before blood testing, etc. The only staff member, who does not know about the ethical guidelines, has joined recently and so far not attended any training programme. Except one Outreach Worker, all other staff members don't share the case histories of their clients with their friends and family members. The concern Outreach worker says that he shares case histories without disclosing the client's identity with a view to make others aware about the issue for changing their attitudes towards HIV/AIDS related stigma. All of them always maintain confidentiality about the problems of their clients. The Project coordinator feels sometimes it is required to reveal the HIV positive status of the client for his betterment only. He has cited the example of arranging ART where the client's HIV positive status must be revealed to the doctor concerned. In HDRI, generally the HIV positive status of the client is restricted to the doctor, counselor and sometimes to the Project Coordinator.

(c) Violation of human rights

All staff members inform that they have not witnessed personally any incidence of human rights violation of PLWHA during their service life. But in reply of their reactions towards such incidences, five of the staff members told that they would protest and play the advocacy role in this regard. The remaining five staff members are of the opinion that they will take up the issue with appropriate authority, if any incidence of human rights violation occurred or discriminatory practices done with PLWHA. There are many incidences, where doctors or other health personnel had refused to admit or provide treatment to the HIV positive people in the government run hospitals or medical colleges. On this issue, surprisingly most of the staff do not

express their views or opinions. Only two staff express their views in this regard. One of them feels that the guilty doctors will be punished severely by canceling their registration, while the other staff talks about the need for more training for the health personnel.

(d) Major barriers encountered

This HIV/AIDS intervention project for ML has been running by HDRI since 1997. Initially, things were not smooth sailing. The resistance was faced from the Merchants' Association and the migrated labourers mostly work under the different merchants of this Association. The Association at the beginning wrongly perceived that through this project, migrated labourers will be more right conscious and may create troubles for them through organized movements. Besides this, HDRI encountered many problems even from among the migrated labourers' community and their trade unions. It took long time and through continuous efforts of the project staff, HDRI able to convince them that the spread of HIV/AIDS may affect all and destroy the entire business. Gradually, the situation has been improved over a period a time. Now most of these people are extending cooperation in implementing the project.

Presently, most of the staff members inform that there are three major barriers which affecting the implementation of the project. These barriers are: (1) indifferent attitude of the people; (2) fear of stigmatization; and (3) ignorance of the people. Most of these migrated labourers are coming from rural and backward areas in search of earning their livelihood. Most of them are illiterate and totally ignorant about the HIV/AIDS. At the same time after becoming aware about the HIV/AIDS, they become too much worried. Besides this, the prevailing social attitude towards these migrated labourers and their occupations are not also good. These indifferent attitudes of the people thus become another barrier in implementing this project. As a result of these, many of them are not willing to visit the clinics for treatment or health check up. In addition to these three barriers, three staff members feel that migratory nature of the clients is another problem affecting the project. Many migrated labourers used to visit their native places during cultivation and crop harvesting seasons and not available for few months. Therefore, it is not possible to follow up these people and thereby affecting the smooth implementation of the project.

(e) Major reasons of spreading HIV/AIDS

Most of the staff members feel ignorance, migration and drug addiction are the major reasons for spreading HIV/AIDS at a faster rate. In addition to these reasons, few staff members are of the opinion that modern life style, poverty, effects of media especially about the free mixing, extra-marital relations, etc are also responsible for spreading HIV/AIDS. Interestingly, one staff points out that rape or forced sex is also responsible for spreading HIV/AIDS. However, the Project Coordinator feels that migration is the only reason responsible for spreading HIV/AIDS quickly in our society.

(f) Future AIDS scenario and role of NGOs.

In relation to future HIV/AIDS scenario in our country, only two staff members feel that HIV/AIDS situation in our country will within control if Government and all other stakeholders continue their efforts in this regard. They also feel that gradually social attitude towards the PLWHA will be changed and stigma will be reduced. Surprisingly, the remaining eight staff members including the Counsellors don't express their views on this issue. However, all of them are of the opinion that NGOs would play a key role in the prevention and control of this killer disease. Because all of them feel that NGOs can reach to the grass root level and can work with any target group, which is not possible for any government agency. Besides this, services provided by the NGOs are better than government organizations in terms of quality and cost.

In brief, it is found that the staff members of HDRI under the study are not stigmatized and would not change their jobs for HIV/AIDS related stigma, but for better opportunities only. Majority of them are aware about the ethical issues related to HIV/AIDS and practice them always. With regard to the violation of human rights of PLWHA, they inform that they would protest against such incidences. But surprisingly, most of them do not express their views on the incidences of human rights violation and denial of treatment of HIV positive people in the hospitals and medical colleges run by the Government. They have encountered ignorance, fear of stigmatization and indifferent attitude of people as the major barriers in implementing the project. To them, ignorance, migration and drug addiction are the major reasons for spreading HIV/AIDS at a faster rate. Surprisingly, majority of them do not comment on the future HIV/AIDS scenario in our country. However, they all are

agreed with the fact that NGOs would continue to be the key player in controlling HIV/AIDS in future too.

[F] Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA)

Table-6.10 highlights the characteristics of full-time paid staff of HIV/AIDS care and support programme. Out of the total 30 staff members engaged in this Project of SPARAHA, 10 staff members are purposively selected representing different levels for the present study. Out of these 10 staff members, four staff are selected from Kestopur DIC and three each from Uluberia DIC and Sonakhali DIC. By designation, there are two Counsellors (DIC in-charge), four Outreach Workers (ORWs) and four Community Based Peer Counsellor (CBPC). All the staff members except one are HIV positive and five of them are 'AIDS widow'.

Table 6.10: Characteristics of Full Time Paid Staff of HIV/AIDS Care Programme

Sl.No.	*Designation*	*Nos.*	*Sex (M/F)*	*Qualification*
1.	Project Coordinator	1	M	Graduate
2.	Counsellor	4	M (1), F (3)	PG, Graduate (2), School level(1)
3.	CBPC	9	M (2), F (7)	Graduate (1), School level (8)
4.	Outreach Workers	8	M (3), F (5)	PG (5), Graduate (7), HS (2)
5.	Accountant	1	M	PG
6.	Nurse	2	F	Graduate
7.	Ward Girl	2	F	School level
8.	Office Staff	1	M	Graduate
9.	Doctor *	1	M	MD
10.	Consultant #	1	M	MD
	Total	30		

** Part-Time; # Honorary.*

(a) Stigmatization

All the selected staff members express that they are happy in working with this HIV/AIDS Care and Support Programme. Because they have got an opportunity to serve some other unfortunate people like them and don't want to see them suffer like themselves. All of them inform that they are not affected by HIV/AIDS related stigma

by nature of their job, but nine of them affected because of their own HIV positive status. Because, HIV positive people still are the victims of discrimination and stigmatization in the society. However, none of them would like to change the present job or move to any non – HIV/AIDS projects as they are getting better job satisfaction by serving their own community members i.e. PLWHA. The only HIV negative staff is happy with this project as he is serving these people who are marginalized group in the society and victim of social apathy. Majority of staff members' family members and friends are aware about the nature of their jobs, and receive full support and encouragement from them. But, at the same time, they reveal that initially family members were reluctant and discouraged them. Two staff inform that due to HIV/AIDS related stigma, their family members are not aware about their nature of job as well as their HIV positive status, as they don't want to put them in an embarrassing situation. However, all of them inform that they have not told about their nature of job to their relatives and neighbours because of this stigma. Out of the ten staff, there are three males and seven female staff. Out of the female staff, five are 'AIDS widow' and remaining two are unmarried because of their HIV positive status. It is found that all the three male staff are married including the HIV negative staff. Two male HIV positive staff members inform that their wives are also aware about their HIV positive status. Two of them have experienced that people are trying to avoid them after knowing the nature of their jobs. Initially they felt bad and angry, but it is not against any particular person but against the prevailing social system and because of their ignorance. But majority of them admit that the working environment is risky as there are numbers of incidences of threat, harassment, humiliation, etc. from the local people, neighbours, health personnel, etc. Presently, the situation has been improved to some extent by the advocacy efforts of SPARSHA, but not too much. All of them feel free in dealing with their clients because of their professional knowledge, skills, and rapport along with the advantage of their own personal experiences. Majority of staff members admit that their job has helped to improve their social prestige and recognition to some extent. Therefore, staff members themselves are not stigmatized for working in the HIV/AIDS project. All of them agree with the fact that due to fears of exposure and stigmatization, many well informed clients or their family members do not want to visit the clinics, DICs or such other organizations. Hence, the risk of spreading HIV/AIDS through these people is very high. Most of the staff members suggested that this problem can be reduced

through mass awareness, community sensitization programme, introduction of sex education at schools, counseling for the clients and their family members, etc. One of them suggests that policy makers will have to think about some new strategy to overcome such types of problems.

(b) Ethical issues

All the staff members are aware about the ethical guidelines related to PLWHA. It is found that all of them are aware about the issue of maintaining confidentiality of the client's HIV positive status, informed consent of the person before blood testing and non-discriminatory practices against the PLWHA, partner notification, etc. In SPARSHA, except the doctor and counselor of the concern DIC and PC, other staff members are not in a position to know about the HIV positive status of the clients. All them strictly follow and main confidentiality about case histories of their clients and never discuss it with other persons like their friends and family members. Being the HIV positive person, most of the staff members used to take extra precaution in this regard. They are more careful because HIV infected and /or affected people are more vulnerable to stigma and discriminations. The Counsellor of Sonakhali DIC recalls one such incidence. The DIC invited the Block Development Officer (BDO) of the concern Block in one of its community awareness programme, where the BDO openly refused to take tea offered by one of the DIC staff. The BDO also urged the community people to identify HIV positive people and isolate them from the locality for saving other people from infection. Later on, SPARSHA head office has made advocacy and able to settle the matter.

(c) Violation of human rights

All the staff members are of the opinion that they would protest and take up the issue with appropriate authority if any incidence of human rights violation occurred or discriminatory practices done with PLWHA. They can go to any extent until justice is given to the victims. One Outreach worker has narrated one such incidence that took place one year back. One doctor of a Sub-Divisional hospital in Howrah district marked HIV status of the patient in red ink and refused to admit him on the ground of other patients' safety. The staff members of SPARSHA protested and took up the matter with the concern Chief Medical Officer of Health (CMOH). Lastly the doctor accepted his fault, but no action was taken against him. The Counsellor of Sonakhali DIC informs that still the VCTC of Midnapore Medical College and Hospital is operating from only one room. There is no separate room for counseling and naturally

it is not possible always to maintain the confidentiality of HIV positive persons. It is most unfortunate. because this is happening in a Medical College. In recent times. there are many incidences, where doctors and nurses refused to admit or provide the treatment to HIV positive people in the hospitals and medical colleges run by the government. On this issue, most of the staff members feel that exemplary punishment should be given to such guilty doctors or other health personnel. Because one such incidence has far reaching impact on the common people. At the same time. such incidences increase the sufferings of the concern HIV infected persons and their family members. Most of the staff also prescribe more training for the medical and para-medical staff; special AIDS Cell/Ward for PLWHA and recruit HIV positive persons as a staff in such Special Cell/Ward. At the same time, majority of them feel that the Network of PLWHA will have to play more effective role to reduce and avoid such unfortunate incidences. Thus. it is found that staff members of SPARSHA are too much sensitive about the human rights of PLWHA.

(d) Major barriers encountered

The HIV/AIDS Care and Support Programme of SPARSHA has been functioning since January 2004. Initially, SPARSHA encountered so many problems in implementing this intervention project because of the prevailing social attitude and stigma towards PLWHA and their family members. Things were never smooth sailing. Landlords were not willing to rent their houses for the office or DIC purpose. Sometimes. landlord agreed but neighbours protested. The present Project Office of SPARSHA has been facing some problem and will be shifting its office very soon. Besides these problems. field level working environments are risky for the project staff. With the continuous efforts of SPARSHA. these problems have been reduced to some extent. In recent times too, project staff are facing different types of problems. All the staff unanimously inform that five major problems that are affecting the implementation of the project. These are indifferent attitude of the people. fear of stigmatization, inadequate fund. migration and ignorance about sexual health. STD. HIV. AIDS, etc. In the Sonakhali DIC areas of Paschim Medinipur district. many people are working as goldsmith and migrated to Mumbai. Surat. Ahmedabad and other big cities for better income. Many of them has contracted HIV from these cities and subsequently infected their spouses in their respective native places. Thus. HIV spreads from cities to villages. Similarly. many people migrated to UP. Gujrat.

Rajasthan, and other states from the areas under Uluberia DIC of Howrah district. These people are working as *zari* workers (silver and golden coloured thread work on *sarees* and some of them infected with HIV and later on infected their spouses residing in their respective native villages. Majority staff members complain about the discriminatory and non-cooperative attitude of the health personnel of government run hospitals. In addition to these problems, few staff members are of the opinion that inadequate finance especially for care and support with ART medicines and nutritious foods clubbed with delay in disbursement of funds has been affecting severely the implementation of the project. Previous bitter experiences of harassment, discrimination, etc. are also affecting the implementation of the project. Most staff members feel that it is very difficult to locate and identify the HIV clients for whom this project is going on. Because of the fear of stigmatization and social boycott, these people are not coming out for testing and treatment. HIV infected women are the worst sufferer as they are thrown out from their in-law's house as well as from parent's house. In most of the cases, they are blamed for the infection of their husbands. According to the Counsellor of Sonakhali DIC, political non-cooperation, threat and harassment by the local people, youth clubs etc. are still going on in different parts of the state.

Thus, it is understood that prevailing social attitude towards PLWHA is one of the major barriers encountered in the implementation of the project. However, in spite of all these difficulties, SPARSHA is running this project with the help of its committed staff and strong networking and advocacy services.

(e) Major reasons of spreading HIV/AIDS

Majority of the staff feel that ignorance, poverty, migration and drug addiction are the major reasons for spreading HIV/AIDS at a faster rate in our country. Few of the staff members feel that modern life style of the present generation youth without having any parental or social control is also responsible for spreading HIV/AIDS. Two ORWs also feel that poor health infrastructure of the government hospitals and poor work culture among the staff sometimes causes infection of HIV. There are many such incidences where hemophilia patients infected with the HIV simply because of the negligence of health staff. Besides these, few staff members are also of the opinion that media is not playing its role properly. For example, through films, different soaps and serials of TV channels, a tendency of having extra marital affairs, multiple sex partners, etc are developing gradually among the people. Regarding

HIV/AIDS also, media mainly highlights unsafe sex as if the only source of HIV infection/transmission. But infection through contaminated blood could not be ignored. as Government and licensed private blood banks are still not capable of meeting the blood requirements in our country. Therefore, people are forced to use contaminated blood.

(f) Future AIDS scenario and role of NGOs.

Regarding the future scenario in relation to HIV/AIDS in our country, majority staff members are pessimistic and feel that HIV/AIDS situation in our country will be out of control unless NACO changes its existing National AIDS Control Policy. The situation will be worst if vaccines are not invented in near future. But it will be possible if Government continues its effort by involving all other stakeholders in its fight against this killer disease. They also feel that awareness about HIV/AIDS is increasing gradually among all section of people. There is no second opinion about the importance of NGOs. All of them are of the opinion that NGOs would play a key role in future too because of their efficiency and networking capabilities. The staff members have suggested few effective measures for preventing and controlling HIV/AIDS in our country. Some of these are: (i) to include more vulnerable groups like TB patients, hemophilia and thalassemia patients etc. under the targeted intervention project; (ii) to improve and increase the care and support services like supply of second line ART; (iii) to increase the number of VCTC, ART Centres, etc.; (iv) to involve more NGOs to expand the coverage of the project; (v) to introduce sex education at the school level; (vi) to make arrangement for updating staff technical knowledge and increase their salary to boost up the morale of the field staff especially; (vii) to provide more fund for purchasing medicines for Opportunistic Infections; (viii) to provide financial assistance for paying conveyance to PLWHA for reaching the treatment centers, so that they can avail ART regularly; (ix) to introduce HIV treatment facilities at the doorsteps like at PHCs, Sub-health Centres, etc.: and (x) to involve HIV positive people in the care and support programmes for PLWHA.

It is evident from the above discussion that the staff members of SPARSHA under the study are affected by the HIV/AIDS related stigma not because of the nature of their jobs, but because of their HIV positive status. All of them are aware about the ethical issues related to HIV/AIDS and strictly follow them always in practice. They would protest if any incidence of violation of human rights of PLWHA would have occurred and have suggested exemplary punishment for the guilty health personnel of

government hospitals to avoid the repetition of such incidences in future. Majority of them think that ignorance, migration, fear of exposure and stigmatization and inadequate fund are the major barriers in implementing the programme. Most of them are of the opinion that ignorance, poverty, migration and drug addiction are mainly responsible for spreading HIV/AIDS at a faster rate. Majority of them think that HIV/AIDS situation in our country will be out of control unless government changes its present policy. There is no doubt among them regarding the major and effective role of NGOs in combating HIV/AIDS in future too.

Thus, this section (Part-III) highlights the views of selected staff members of six NGOs under the study on different issues related to HIV/AIDS. It is found that no staff members of six NGOs are affected by HIV/AIDS related stigma because of the nature of their jobs. But staff members of DMSC, MB and SPARSHA are affected by prevailing social stigma related to CSWs, MSM and PLWHA respectively. It is to be noted that most of the staff members of these three organizations are selected from the respective target groups. But, SCIR is exception in this context because SCIR also selected most its staff from among the target group (IDUs). However, staff members of all the six NGOs have admitted the existence of HIV/AIDS related stigma in the society and have suggested mass awareness programmes, counseling, sex education at school, etc. to reduce it.

Majority of the selected staff members of six NGOs are aware about the ethical issues related to HIV/AIDS and always practice them. With regard to the violation of human rights of PLWHA, all staff members have said that they would protest against such incidences. On the issue of preventing such incidences occurred in government run hospitals, staff members of DMSC, MB, SPARSHA have suggested exemplary punishment for the guilty health personnel; staff of SCIR suggested more training and staff of BPWT suggested more training along with the punishment for the culprits. Surprisingly, majority of staff members of HDRI has not made any comments.

With regard to the major barriers encountered in implementing the project, selected staff members of all the NGOs have talked about ignorance, fear of exposure and stigmatization, indifferent attitude of the people towards AIDS, migration and drug addiction. Staff members of six NGOs differ in terms of their opinions on the major reasons for spreading HIV/AIDS at a faster rate. However, they have identified that ignorance, poverty, migration, drug addiction, unsafe sex are the major reasons

responsible for spreading HIV/AIDS. Most of the staff members of SCIR, DMSC and MB are optimistic about the future AIDS scenario in our country. They think that the situation would be under control, if government continues its effort by involving all stakeholders. But staff members of BPWT and SPARSHA think that situation will be out of control, if government did not change its policy. Surprisingly, majority of staff members of HDRI have not expressed their views in this regard. However, all staff members of the six NGOs are of the opinion that NGOs would play a key and more effective role in combating HIV/AIDS in future too.

PART-IV: PERCEPTIONS OF THE BENEFICIARIES

Perception refers to the way of seeing or awareness/understanding of beneficiaries towards the working of NGOs. Since the NGOs under study are engaged in HIV/AIDS care and their main thrust is to prevent and control the HIV infection and spread of AIDS. perception of beneficiaries is our centre of attention. The methodology chapter has given the details of beneficiary selection. In this context. two groups of beneficiaries from each selected NGO have been considered except SPARSHA. Only one group of beneficiaries (PLWHA) is formed with the permission of SPARSHA. Normally. it does not allow outsiders to interact directly with PLWHA. but they have considered the researcher for academic purpose only.

In order to understand the beneficiaries' perceptions. data collected from each group of beneficiaries are being discussed below NGO wise separately. For understanding the perceptions of beneficiaries better. the discussion covers (a) necessity of NGO's HIV/AIDS programme. (b) cost and quality of NGO's services. (c) staff cooperation and (d) scope of beneficiaries' participation. A brief conclusion regarding the perception has been drawn at the end of discussion under each group. Table-6.11 shows the profile of the beneficiaries.

Table-6.11: Profile of the Beneficiaries' groups

Sl. No.	*Name of the NGO*	*Types of Target Group*	*Name of DIC/Clinic*	*No. of Members*	
				Male	*Female*
1.	SCIR	IDUs	Park Circus DIC	11	-
			Goabagan DIC	12	3
2.	DMSC	CSWs	Avinash Clinic	-	12
			Rambagan Clinic	-	10
3.	BPWT	Truckers	Bhutghat Clinic	9	-
			Dhobiatola Clinic	8	-
4.	MANAS Bangla	MSM	DumDum DIC	10	-
			Kasba DIC	8	-
5.	HDRI	Migrated Labours	Posta Clinic	10	-
			Mechua Clinic	9	-
6.	SPARSHA	PLWHA	Kestopur DIC	10	6
			Total	**87**	**31**

[A] Society for Community Intervention and Research (SCIR)

Group-I

It is formed with 11 male members at Park Circus DIC. The members belong to different background. The age group varies from 20 years to 57 years. All of them attending Day Care Centre regularly. Five of them are attached with SCIR since inception (1999).

(a) Necessity of NGO's HIV/AIDS programme

Beneficiaries inform that before the starting of SCIR, there was nothing to look after the health conditions of IDUs in this region particularly. The present SCIR office is located in the slum and is near Gobra Railway station. Slum dwellers are residing both sides of the railway track. The present area was full of jungle and was a safe den for anti-socials and drug addicts especially after the evening. Now after the starting of SCIR's clinic, the IDUs and local people are getting the treatment and medicines from the qualified doctors at free of cost. SCIR is also distributing needles and syringes to reduce the use of contaminated needles, which also reduces the risk of HIV infections too. At the same time IDUs are getting Oral Substitution Therapy (OST) if they are willing to shift from injecting drug use under Harm Reduction Programme. SCIR is also providing necessary counseling to the IDUs and their family members. Besides these, recovering IDUs are getting vocational training at Printing Press and Leather units.

Beneficiaries also told that their Children are getting education in the primary school run by the SCIR at Park Circus DIC. Children of local poor people are also getting education in this school. During FGD, majority of them expressed that to them SCIR is every thing and there is no alternative of it. All members pronounced that SCIR has contributed a lot in terms of creating awareness about HIV/AIDS and providing health services.

(b) Cost and quality of NGO's services

For general health care, medicines are provided totally at free of cost by SCIR. Similarly IDUs are getting new needles and syringes at free of cost under the Needle and Syringe Exchange Programme (NSEP). Those who opted for OST are also getting Buprenorphine at free of cost. Condoms are also distributed among the IDUs without charging any price for safe sex. Beneficiaries also informed that they are paying one rupee only per day to avail the food at SCIR. But it is not compulsory: they can take

tea, etc outside SCIR also. They are very happy with these facilities. Beneficiaries are also happy with SCIR's networking with various polyclinics where they get concession for different pathological tests, x-ray, etc. SCIR has also good network with other organizations for referral services. One member complained about the quality of food. But immediately other members pointed out that the project has no provision of giving food. SCIR has arranged it from other organization for their betterment only. Few members expressed their dissatisfaction about the doctor who comes in the first half for few hours only. None of the beneficiaries have clear and correct idea about the source of funding. In brief all members are happy and satisfied *with the quality of services provided by SCIR.*

(c) Staff cooperation

Beneficiaries are of the opinion that doctors, nurse and other staff members are very cooperative. They can approach any staff without any hesitation and always receive good responses. Doctors attend their problems with patience and nurses also carefully clean and dress their wounds, abscess, etc. Few members also revealed their bitter experiences regarding apathetic attitude and rude behaviour that they received from the doctors and other health staff of Chittaranjan National Medical College. All members expressed that they never got such good behaviour and respect in any other place other than SCIR. Staff members are extending all cooperation in making alternative arrangement for those who are unable to pay for the medicines, pathological tests, etc. Outreach workers (ORWs) and Peer educators regularly visit the field and make people aware about AIDS, distribute needles and condoms. Members also told that even for solving other family problems, they consult and get advices from the staff.

(d) Scope of beneficiaries' participation

With regard to the scope of participation in SCIR's activities, beneficiaries have mixed views. They don't have any scope of participation in planning, monitoring and evaluation. However, they participate in beneficiary's selection by referring new IDUs. They don't contribute financially, but they offer physical labour when SCIR is organizing any awareness camp or putting up exhibition stall, etc. SCIR recognizes their contribution and selected ORWs, Peer Educators and other staff from among the recovering and ex-IDUs. The group members also cooperate the SCIR when Evaluation Teams come from the WBSAP&CS and other funding agencies. But beneficiaries don't take part in the selection process of the staff. All recovering IDUs

of Day Care centre participate daily in various activities like gardening, arranging chairs for meeting/discussion, etc.

In a nutshell, beneficiaries have a better perception towards the activities of SCIR. They feel that SCIR's intervention is required more because of the indifferent attitude of the health personnel in government hospitals. They feel more homely and comfortable in SCIR.

Group-2

This group is formed in Goabagan DIC of SCIR with 15 members. All of them are attending the Day Care Centre regularly. In this DIC, clinic is held three days in a week i.e. on Monday, Wednesday and Friday. The timing of the clinic is 9.30 am to 12.30 pm. Out of these 15 beneficiaries, there are 12 male and 3 female members. The age of the members varies from 18 years to 45 years. Most of them are either unemployed or self-employed. Three female members are CSWs and one of them is HIV positive.

(a) Necessity of NGO's HIV/AIDS programme

As like as the first group of Park Circus DIC, the members of this group informed that before the starting of this DIC by SCIR, they have faced lots of problem in government hospitals. The health personnel used to neglect them whenever they go for the treatment of abscess, injuries, etc. They don't have money to visit private doctors or hospitals and used to consult quack doctors. All of them have admitted they don't have any knowledge on HIV/AIDS and effects of needle/syringe exchange. Now after the starting of SCIR's clinic, the beneficiaries inform that IDUs are getting the treatment and medicines from the qualified doctors at free of cost. SCIR is also distributing needles and syringes to reduce the use of contaminated needles, which also reduces the risk of HIV infections too. At the same time IDUs are getting Oral Substitution Therapy (OST) if they are willing to shift from injecting drug use under Harm Reduction Programme. They also inform that in case of serious patients and detoxification, SCIR refers to other appropriate health care institutions. SCIR is also providing necessary counseling to the IDUs and their family members. The Goabagan DIC also runs a Day Care Centre for the recovering drug addicts. In reply of the researcher's question on where they would go if SCIR closed down this DIC, members inform that they could not imagine such situation. Majority of them expressed that to them SCIR is every thing and there is no alternative of it. All

members pronounced that SCIR has contributed a lot in terms of creating awareness about HIV/AIDS and providing health services.

(b) Cost and quality of NGO's services

With regard to cost of medicines and other facilities. members of the present group inform that SCIR provides medicines totally at free of cost for the treatment of abscess and other general health problems. As like as the first group, this group also informs that IDUs are getting new needles and syringes at free of cost under the Needle and Syringe Exchange Programme (NSEP). Those who opted for OST are also getting Buprenorphine at free of cost. Condoms are also distributed among the IDUs without charging any price. Beneficiaries will have to pay in case of pathological tests like x-ray etc. But members of the present group are happy with SCIR's networking with various polyclinics where they get concession for such pathological tests. SCIR has also good network with other organizations for referral services. Everyday SCIR provides lunch to the beneficiaries of Day Care Centre at free of cost. Beneficiaries also inform that they are paying one rupee only per day to avail the tea at SCIR. But it is not compulsory; they can take tea. etc outside SCIR also. None of the beneficiaries have clear and correct idea about the source of funding. Some of them inform that fund may be given by the government. In brief. all members are happy and satisfied with the cost and quality of services provided by SCIR.

(c) Staff cooperation

The members of this group are also satisfied with the doctor, nurse and other staff members of SCIR. All of them are very cooperative. kind and behave nicely with all beneficiaries. Doctors patiently hear their problems and nurses also carefully clean and dress their wounds, abscess. etc. All members expressed that they never got such good behaviour and respect in any government or private hospitals. According to the beneficiaries, staff members are extending all cooperation in making alternative arrangement for those who are unable to pay for the medicines, pathological tests. etc. They also inform that even they consult the staff members for their family problems and get advices from them. One of the female members appreciates the advocacy role of the staff members.

(d) Scope of beneficiaries' participation

With regard to the scope of participation in SCIR's activities. beneficiaries have almost similar views as like as the members of the first group. They don't have any

scope of participation in planning, monitoring and evaluation. However, they participate in beneficiary's selection by referring new IDUs. They don't contribute financially, but they offer physical labour when SCIR is organizing any awareness camp or putting up exhibition stall, etc. The group members also cooperate and participate when evaluation teams come from the WBSAP&CS and NACO. SCIR recognizes their contribution by selecting ORWs, Peer educators and other staff from the recovering and ex-IDUs. According to beneficiaries, majority of the staff members in SCIR are selected from the IDUs. But beneficiaries don't take part in the selection process of the staff. All recovering IDUs of Day Care Centre participate daily in various activities like arranging chairs for meeting, discussion, etc.

In a nutshell, beneficiaries have a better perception towards the activities of SCIR. They feel that SCIR's intervention has helped them to become aware about HIV, AIDS, safer injecting procedure, etc and has improved their self-esteems. They feel more homely and comfortable in SCIR.

[B] Durbar Mahila Samanwaya Committee (DMSC)

Group-1

The group is formed with 12 members at Sonagachi red light area under Avinash Clinic of Sonagachi Project. All members belong to sex workers community. Out of 12 members, there are two *malkins* (madam) and 10 sex workers. The age group of sex workers varies from 20 years to 40 years and *malkins* are quite aged. *Malkins* are not now engaged in sex work.

(a) Necessity of NGO's HIV/AIDS Programme

Beneficiaries informed that before the starting of clinics run by DMSC, the health conditions of sex workers was very poor. Because of the apathetic attitude of health personnel as well as of general people towards sex workers, they were not able to go to government hospitals. They had to depend on the quack doctors practicing in and around mainly for the treatment of STIs and related problems. Majority of sex workers were illiterate and ignorant about these diseases. Regarding treatment, they had to depend on the *malkins* and pimps for the advice. Only a few sex workers of high-income group used to avail treatment facilities at private nursing home. The economic conditions of the most sex workers were also bad. They had to give share from their earnings to *malkins*, *bariwalis* and pimps as per their demands. Similarly, sex workers were compelled to give 'tax' to the local dons and policemen. There was

no unity among the sex workers. During the economic crisis, they had to take loans from the moneylenders at higher rate of interest.

In the context of above situation, all beneficiaries acknowledge the contribution of DMSC. They also informed that initially they resisted the STD/HIV intervention project (SHIP) started by All India Institute of Hygiene and Public Health (AIIH&PH). But later on when sex workers were recruited as peer educators and especially after the formation of DMSC in 1995 – they started to believe and took interest in the programme activities. As per the beneficiaries, now DMSC has multi-dimensional activities in Sonagachi. It runs SHIP, health clinics, non-formal schools for CSWs and their children, residential homes for the school going children of CSWs, vocational training centre for the aged CSWs, VCTC, etc. When the researcher asked about the necessity of the HIV/AIDS programme of DMSC, beneficiaries did not deny its importance. According to them, DMSC has been working for last 12-13 years. As a result of working for long period, the CSWs are now more aware about STIs, HIV, AIDS and safer sexual practices. Now CSWs insist their customers for using condoms and the rate of condom use has increased significantly since 1992. They also inform that most of the sex workers have their own bank accounts in Usha Cooperative Bank (sister organization of DMSC) and get rid of moneylenders. They are more secure now and the exploitation of local dons, police, etc. has reduced remarkably. They are also happy with the functioning of Self Regulatory Board, which prevents trafficking, and entry of minor girls (below 18 years). All of them admitted that DMSC has enabled them to realize the strength of unity; increased their self-esteem and helped them to dream a better future of their children. All of them recognize the necessity of HIV/AIDS programme and other developmental programmes of DMSC in improving their overall status in general and health status in particular.

(b) Cost and Quality of NGO's HIV/AIDS care services

According to beneficiaries, DMSC provides medicines at free of cost for the treatment of STIs and other common health problems. It also provides treatment for TB under DOT programme. The clinic is not only open for CSWs but also for their customers. Timings of the clinic suits all concern i.e. morning clinic for sex workers and evening clinic for their customers. Beneficiaries pay only seven rupees as registration fee. This is done to reduce the wastage of medicines and to raise some funds for better functioning of the clinic. They don't have any grievance regarding registration fee,

rather they are satisfied with this arrangement and feel it is justified. In case of medicines that are not available in the clinic, they purchase themselves from outside medical stores. In case of pathological tests, etc., Mamata Care and Training Centre (VCTC) of DMSC is having HIV and VDRL testing facilities with pre-test and post-test counseling. Beneficiaries also inform that DMSC has a very good networking with different polyclinics where they get concessions for different pathological tests. The project staff also regularly visit the sex workers to distribute condoms and IEC materials; and discuss about their problems. Having remembered the past stories, all beneficiaries said that they are far better now because of DMSC and its multi-dimensional activities.

(c) Staff Cooperation

Beneficiaries are of the opinion that all staff members of DMSC are very cooperative. There is no doubt in it. They can approach the staff without any hesitation as most of them are from sex workers community. They feel free and homely at clinic also. The Doctor listen to them carefully and advice them meticulously. Peer educators visit and meet the sex workers in each building of the brothel regularly. Peer educators also organize group meetings for creating awareness; distributing condoms and IEC materials and motivate them to go to the clinic for any health problem. Beneficiaries and peer educators can understand each other well and feel comfortable, because all of them from the sex workers community. Beneficiaries narrated their experiences and compared the situation with government run hospitals where everybody hates them because of their profession. They are of the opinion that in spite of low salary, peer educators and other staff members of DMSC are very sincere, committed and do not neglect their duties. Beneficiaries are very happy with the staff members who treat them as their own family members.

(d) Scope of beneficiaries' Participation

Group members have informed that there is ample opportunity for beneficiaries to participate in different programme activities of DMSC. Because, it is an organization of the sex workers, by the sex workers and for the sex workers. DMSC accepts and considers beneficiaries' valuable opinion at the time of planning the programme activities. Beneficiaries took part in need identification and beneficiary's selection. They also participate in programme implementation. They do not contribute financially, but they offer physical labour and participate in different activities of DMSC like in organizing awareness camps, All India Entertainment Workers'

Conference, putting up exhibition stall, etc. Beneficiaries also participate in monitoring and evaluation through its local Branch Committee members. For smooth running of its each clinic, DMSC constituted the Clinic Management Committee and includes beneficiaries' representatives from local Branch committee of sex workers.

In brief, we understand that beneficiaries have better perception towards the working of DMSC. Successes of various programmes completed previously and existing at present have contributed to make this perception. They acknowledge its contribution for improving their health status and awareness level on different issues like STIs, HIV, AIDS, safer sexual practices, etc. They prefer DMSC for its multi-dimensional activities and integrated approach. They feel that services of DMSC are more relevant than that of the government hospitals.

Group-2

This group is formed with 10 members at Rambagan clinic of Sonagachi Project. All the members are CSWs. The age of the group members varies from 22 years to 35 years. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

As like as the first group, the members of the present group have also narrated the same story of sufferings of the sex workers' community before the starting of STD/HIV Intervention Programme initially by AIIH&PH and later on by DMSC. There was none to extend help and support to the sex workers. According to the beneficiaries, the health and economic condition of the CSWs were very bad at that time.

In the context of above situation, all beneficiaries acknowledge the contribution of DMSC. DMSC has recruited many sex workers as staff in this project. This has given them lots of confidence as they are respected and recognized at least by some people of the society. Beneficiaries have appreciated various multi-dimensional activities of DMSC in Sonagachi like health clinics, non-formal schools for CSWs and their children, residential homes for the school going children of CSWs, vocational training centre for the aged CSWs, VCTC, etc. They are more secure now and the exploitation of local dons, police, etc. has reduced remarkably. Members express their happiness with the functioning of Self Regulatory Board (SRB) of DMSC. SRB is trying to prevent trafficking, and entry of minor girls (below 18 years) in sex trade. During this FGD with the members, the peer educators came

with one such new CSW to the counsellor for knowing her case history and her opinion. She is not a minor. Members inform that if she is not willing, DMSC would help her to send to her home or rehabilitate in some other place. All of them have admitted that DMSC has enabled them to realize the strength of unity; increased their self-esteem and helped them to dream a better future of their children. The members reacted differently when researcher wanted to know where they would go if DMSC stopped the project in future. All members confidently informed that this would never happen as the whole sex workers community is involved with DMSC and they would extend all support to sustain the current project. In nutshell, all the members acknowledge the importance of DMSC.

(b) Cost and Quality of NGO's HIV/AIDS care services

The members of this group also inform that they get medicines at free of cost for the treatment of STIs and other common health problems from the clinic of DMSC. It also provides treatment for TB under DOT programme of the Government. They pay Rs. 7/- only as registration fees and are satisfied with this arrangement. This is done to reduce the wastage of medicines and to raise some funds for the treatment of general health problems as WBSAP&CS provides fund for STIs only. The clinic is open 3 days in a week for CSWs and their customers. Timings of the clinic suits all concern i.e. 11 am to 2 pm. Members express their happiness over the record keeping system of the clinic. Each patient's treatment record is maintained through individual card, which helps both doctor/counsellor and patients. In case of medicines that are not available in the clinic, they purchase themselves from outside medical stores. In case of pathological tests, Mamata Care and Training Centre (VCTC) of DMSC is having HIV and VDRL testing facilities with pre-test and post-test counseling. DMSC has a very good networking with different polyclinics where beneficiaries get concessions for different pathological tests. All the members inform that they are satisfied and feel far better now with DMSC and its multi-dimensional activities.

(c) Staff Cooperation

With regard to the staff cooperation like the first group, this group is also happy with the staff members of DMSC. The group members praise about the sincerity of the Outreach Workers and Peer Educators who regularly visit the field and doing their work as per the plan. The project staff members also regularly visit the sex workers to distribute condoms and IEC materials; and discuss about their problems. The peer educators bring patients on clinic days and organize meetings with different

stakeholders on other days. The group members are also happy with the cordial attitude and behaviour of doctor, counselor and other staff members who always advise them like their own family members. They also inform that they feel comfortable in the DMSC's clinic, because most of the staff members belong to sex workers' community. Staff members extend all cooperation in making arrangement for pathological tests, referral to other organizations, etc. They also offer advises in their personal matters. In brief, beneficiaries are happy with the staff members of Rambagan clinic of DMSC.

(d) Scope of beneficiaries' Participation

With regard to the scope of beneficiaries' participation in programme activities, members of this group also reply that there is ample opportunity. They participate in beneficiaries' selection, need identification, programme planning and implementation; monitoring and evaluation, but they do not make financial resource contribution. The project staff also consulted beneficiaries to know about their opinions about the programme activities. DMSC accepts and considers beneficiaries' valuable opinion at the time of planning the programme activities. They do not contribute financially, but physically participate in different activities of DMSC like in organizing awareness camps, putting up exhibition stall, etc.

In brief, we understand that beneficiaries have better perception towards the working of DMSC. They acknowledge its contribution for improving their health status and awareness level on different issues like STIs, HIV, AIDS, safer sexual practices, etc. Lastly, they feel proud to be a part of the DMSC's battle for the rights of sex workers.

[C] Bhoruka Public Welfare Trust (BPWT)

Group-I

The first group was formed in Bhutghat clinic. It was formed with 9 members. Out of these 9 members, six were truck drivers and remaining three were helpers. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

Kolkata Port Trust is situated in South-West Kolkata. Kolkata Port is an international transshipment point for cargo ships. The major halting points for trucks are Bhutghat, Babubazar and Dhobiatola. The truckers usually stay within the parking area until unloading and loading processes are over. Trucks are operating under different

transport companies. The waiting/halting period for truckers varies from 2-3 days to 15 days. There is no other health centre or clinics except BPWT's clinic in the parking zone or near by. Three members of this group informed that they knew about the clinic run by BPWT since last 5 years. Except two members, others informed that they never personally visited clinic for their own treatment. These two members visited the clinic for fever, but none of them visited BPWT's clinic for the treatment of STDs. Most of them have not much idea about Kolkata city and about different hospitals and medical colleges. Being the outsiders, they are naturally worried about the cost of treatment and quality of treatment. There are few 'quacks' practicing near by. All members are of the opinion that they feel secure in the presence of BPWT's clinic where at least one doctor is there to attend any emergency health problems. In case of referral also, they get all cooperation from the BPWT staff. All of them inform that now they are quite aware and alert about HIV/AIDS. Some of the group members revealed that many people from truckers' community have been availing treatment from the clinics run by BPWT. All of them recognize the necessity of BPWT's clinic and its HIV/AIDS programme. They feel more comfortable in this clinic as it is exclusively for truckers and truck industry associated people.

(b) Cost and Quality of NGO's HIV/AIDS care services

According to the beneficiaries, the BPWT run clinics provide them medicine at free of cost for the treatment of STD and other common diseases. The patients pay Rs. 30/- as registration fees. In case of medicines that are not available in the clinic, beneficiaries purchase themselves from outside medical stores. In case of blood test, the samples are collected in the clinic and sent to BPWT's modern laboratory. For other pathological tests, beneficiaries pay from their pocket, but the project staff members help them to avail these tests at a concession rate through its good networking with different polyclinics. The project staff regularly meet and discuss about AIDS etc. and distribute IEC materials to them. Their misconceptions regarding HIV/AIDS are now removed through such interactions with the project staff members. Two members expressed that earlier BPWT used to distribute condom at free of cost, but recently they have stopped the old system. Some of them are also of the opinion that all medicines for general health care are not available with the clinic. None of the members have clear idea about the source of funding for this project. In brief, members of this beneficiaries group are happy with the quality and cost of

HIV/AIDS and STD care services. But they are not fully satisfied with BPWT's clinic as it lacks proper infrastructure to meet all health care needs of truckers.

(c) Staff Cooperation

Beneficiaries are happy with the staff of BPWT. They are of the opinion that in spite of dusts and other hazardous conditions, field level staff members are regularly visiting the field and patiently doing their work. They behave nicely with the target group. Normally, truckers feel awkward when they visit any doctor's chamber because of existing social class system. But in BPWT clinic, doctor carefully listen the beneficiaries' problems and advice them properly. The beneficiaries also inform that they feel comfortable in the BPWT's clinic as other than truckers and truck industry associated people, other people don't visit the clinic. Staff members extend all cooperation in making arrangement for pathological tests, referral to other organizations, etc. In brief, beneficiaries are happy with the staff members of BPWT.

(d) Scope of beneficiaries' Participation

With regard to the scope of beneficiaries' participation in BPWT's activities, beneficiaries are of the opinion that, due to their nature of job, they could not stay there for long time. Hence, they could not participate in all activities of the HIV/AIDS project. However, they refer their colleagues (truck drivers and helpers) to BPWT for treatment, counseling, etc. Whenever BPWT organizes any awareness programme, etc. the project staff members invite the beneficiaries. The project staff also consulted beneficiaries to know about their opinions about the programme activities. Therefore, beneficiaries participate in beneficiary's selection, need identification, but they do not take part in resource contribution, programme planning, monitoring and evaluation. The situation can be called as partial participation of the beneficiaries.

In a nutshell, we find that beneficiaries have positive perception towards the working of BPWT. They acknowledge its contribution for improving awareness level on different issues like STD, HIV and AIDS, safer sex, etc. But they have certain grievances regarding the free medicines for general health care and social marketing of condoms. In general, they feel comfortable with BPWT's clinic and project staff.

Group-2

The second group was formed in Dhobiatola clinic. It was formed with 8 members. Out of these 8 members, four were truck drivers and remaining four were helpers. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

As per the information provided by these group members, there is no other health centre or clinics except BPWT's clinic in the parking zone. There are few 'quack doctors' practicing near by. Like the first group members, this group also has not much idea about Kolkata city and about different hospitals and medical colleges. Being the outsiders, they are naturally worried about the cost of treatment and quality of treatment. This group informed that they got different services from the clinic run by BPWT like treatment of STDs and medicines; free advice regarding safer sex, HIV/AIDS; condoms, etc. In case of referral for pathological tests, they get all cooperation from the BPWT staff members. All of them recognize the necessity of BPWT's clinic and its HIV/AIDS programme for the truckers in KPT parking zone.

(b) Cost and Quality of NGO's HIV/AIDS care services

As like as the first group of beneficiaries, this group replies that the clinic provides them medicine at free of cost for the treatment of STD and other common diseases and takes Rs. 30/- per patient as registration fee. When medicines those are not available in the clinic, beneficiaries purchase themselves from outside medical stores. Blood tests are done at free of cost in the BPWT's modern laboratory. For other pathological tests, beneficiaries pay from their pocket, but the project staff members help them to avail these tests at a concession rate through its good networking with different polyclinics. This group also acknowledges the efforts of project staff members in making the truckers aware about STD, HIV, AIDS, etc. Some of the group members are not satisfied, as all medicines for general health care are not available in the clinic. None of the members have clear idea about the source of funding for this project. In brief, members of this beneficiaries' group are happy with the quality and cost of HIV/AIDS and STD care services. But they are not fully satisfied with BPWT's clinic as sometime it fails to meet all health care needs of truckers.

(c) Staff Cooperation

With regard to the staff cooperation, this group is also happy with the staff members of BPWT. They praise about the sincerity of the field level staff members who regularly visit the field and doing their work as per plan. The group members are also happy with the behaviours of doctor and counselor who always advise them for the welfare of the beneficiaries. Staff members extend all cooperation in making

arrangement for pathological tests, referral to other organizations, etc. In brief, beneficiaries are happy with the staff members of BPWT.

(d) Scope of beneficiaries' Participation

With regard to the scope of beneficiaries' participation in BPWT's activities, this group replies the same. Due to their nature of job, they could not participate in all activities of the HIV/AIDS project. However, they refer their friends (truck drivers and helpers) to the clinic of BPWT. Therefore, beneficiaries participate in beneficiary's selection, need identification, but they do not take part in resource contribution, programme planning, monitoring and evaluation. The situation can be called as partial participation of the beneficiaries.

In a nutshell, we find that beneficiaries have positive perception towards the working of BPWT. They acknowledge its contribution for improving awareness level on different issues like STD, HIV and AIDS, safer sex, etc. Few of them are aggrieved, as they are not getting all medicines for general health problems. In general, they feel comfortable and happy with the project staff members of BPWT.

[D] MANAS Bangla (MB)

Group-1

The group was formed with 10 members at DumDum DIC. All members belong to MSM community. The age group of beneficiaries varies from 19 years to 36 years. Four of the group members associated with this DIC since inception of the project i.e. from 2004. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

Beneficiaries inform that the health condition of MSM population was very poor before the starting of the DIC/clinics run by MB. As already pointed out in Part-I of this chapter, there are few organizations working with MSM population with their limited funds and capacities. Beneficiaries have little or no knowledge regarding STIs, HIV, AIDS, etc. A good number of them are vulnerable to such communicable diseases. Because of the MSM related stigma, they were not able to go to government hospitals or private clinics. They are compelled to depend on the quack doctors mainly for the treatment of STIs and related problems that too in distant places. Because of the fear of exposure and stigmatization, even they were not able to consult any nearby doctors. At the same time they can't discuss their problems with their family members. As a result, they had to suffer from extreme psychological stress and

anxiety. No one was there to help them. There was no channel of communication among the MSM community members. There was no safe place to meet with their partners other than railway station, park etc. but many a time they had to face trouble from local people, club members, police, etc.

In the context of above situation, all beneficiaries acknowledge the contribution of MB. At least now they can meet their community members at the DIC without any fear of harassment and humiliation by others. Here, they feel comfortable and shares their joys and sorrows with their fellow MSM community members. At the same time, they are getting different types of services from the clinic run by MB at this DIC. They are getting free health check-up, treatment and medicines from the doctor; counseling and advices for their psychosocial and health related problems from the counselor; learning condom use procedure through demonstrations by the staff; attending different awareness meeting on HIV, STIs, AIDS, Safer sex, etc. along with IEC materials. Above all the environment of DIC is MSM friendly, where they can freely share their feelings, emotions and problems; and also get an opportunity to introduce with many new MSM community members. The native places of many beneficiaries are 20-30 k.m. away from the DumDum DIC. Two of them are residing near Bangaon DIC of MB, but attending this DIC due to fear of exposure in their locality and MSM related stigma. When the researcher asked about the necessity of the HIV/AIDS programme of MB, beneficiaries did not deny its importance. They all recognize the necessity of this programme in improving their over all status in general and health status in particular. All the beneficiaries are of the opinion that MB is everything for them and they cannot think of anything without MB. That is why in spite of financial problem, they are coming from long distances to attend the DIC and clinic of MB. All the group members admit that MB has enabled them to realize the strength of unity, increased their self-esteem and helped them to exercise their rights, instead of feeling guilty and marginalized in the society. All of them recognize the necessity of sexual health promotion and HIV/AIDS control programme run by MB.

(b) Cost and Quality of NGO's HIV/AIDS care services

According to beneficiaries, MB run clinic provides medicines at free of cost for the treatment of STIs and other common health problems. Ruptures, tearing etc. are very common in anal sex and doctor provides necessary advice and treatment for these problems too. Beneficiaries pay only Rs. 2/- as registration fee. This is done to raise

some funds for better functioning of the clinic. reduce the wastage of medicines and to make them realize about the importance of such services. Beneficiaries are satisfied with this arrangement and feel it is justified. In case of medicines that are not available in the clinic, they purchase themselves from outside medical stores. MB supplies most of the medicines. It collects medicines from physicians' sample and purchase medicines from directly from CDMU. Kolkata at low price to cater the needs of its beneficiaries. In case of pathological tests like blood test. X-ray. etc.. MB refers them to different polyclinics. Beneficiaries also inform that they get concessions for different pathological tests because of the MB's good networking with different polyclinics. Beneficiaries earlier used to get condoms and lubes at free of cost. But now due changes in the policy of WBSAP&CS. they have to pay for it. Few beneficiaries are not happy with this arrangement. but they have grievance against the government. not against the MB. For outreach beneficiaries. the ORWs and PEs regularly visit the field and interact with them to know about their problems. They also distribute condoms. lubes and IEC materials; refer them to clinic for treatment and invite them to visit DIC. Considering the past experiences. all beneficiaries feel that they are far better now because of MB and its different activities through DIC and clinics. But they also express that there is a need to open more DICs/Clinics to cover many MSM living in remote places for which it is difficult for them to access these few clinics located in the city. None of them have any detail idea about the source of funding for this project. but they guess that the government may sponsor it. In brief, they are satisfied with the cost and quality of services provided by MB

(c) Staff Cooperation

According to beneficiaries. all staff members of MB are very cooperative. There is no doubt in it. The Doctors listen to them carefully and advice them properly in simple languages like their elder brother. The Counsellor also offers guidance and advice regarding their health problems. psychosocial problems and even for family related matters. They can approach the staff without any hesitation as most of them belong to their own MSM community. They feel free and homely at DIC and clinic. Beneficiaries, who regularly visit DIC. feel that they almost become family members of MB. At the field level. PEs and ORWs regularly visit and meet the clients. Being the member of same MSM community, both project staff and beneficiaries can understand each other well and feel comfortable to share their feelings, problems. etc.

They are of the opinion that in spite of low salary, peer educators and other staff members of MB are very sincere, committed and do not neglect their duties. They work more as selfless social workers than merely as salaried employees. Some of the beneficiaries narrated their bitter experiences and compared the situation with any government or private run hospitals where everybody is indifferent and neglect them because of their sexual behaviour. In a nutshell, beneficiaries are very happy with the staff members of MB who treat them as their own family members.

(d) Scope of beneficiaries' Participation

Beneficiaries inform that there is ample opportunity for them to participate in different programme activities of MB. Because, it is an organization of the MSM, by the MSM and for the MSM community members. Beneficiaries, who regularly visit DIC, directly participate in need identification, beneficiaries' selection, programme planning and its implementation. In MB, planning is done at the NGO level, but it accepts and considers beneficiaries' opinion received through project staff. Outreach beneficiaries' feedbacks are obtained and considered through PEs and ORWs. Beneficiaries do not contribute financially, but they offer physical labour and participate in different activities of MB (for example, organizing awareness camps, putting up exhibition stall, street play, etc.) as volunteers. Beneficiaries do not directly participate in monitoring and evaluation, but their feedbacks are obtained through GD/FGD by the project staff. They extend cooperation to the external evaluation team of WBSAP&CS by participating in GD/FGD.

In brief, we understand that beneficiaries have better perception towards the working of MB. They acknowledge its contribution for improving their health status, self-esteem and awareness level on different issues like STIs, HIV, AIDS, safer sexual practices, etc. They prefer MB for its multi-dimensional activities and rights-based approach. They cannot imagine a situation if MB stops working for them for any reason in future.

Group-2

The group was formed with 8 members at Kasba DIC. All members belong to MSM community. The age group of beneficiaries varies from 18 years to 40 years. Two of the group members associated with this DIC since inception of the project i.e. from 2004. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

As like as the first group. this group also narrated the same story of sufferings of the MSM community before the starting of MB's sexual health promotion and HIV control project. There was none to support them. In the context of this situation. all the members acknowledge the contribution of MB. Now they can come and meet their fellow community members without any fear of harassment or humiliation. They feel very homely and comfortable in the DIC and in its clinic. The DIC offers numbers of services like health check-up and treatment for STIs and general health problems. counseling and advice for different problems. awareness on STD. HIV. AIDS. safer sex. etc. Above all. DIC provides a platform to meet with new community members. share their joys and sorrows together and develop a support base. Like the first group. this group members also admit that MB helps them to realize the strength of unity. increased their self-esteem and helped them to exercise their rights. All of them recognize the necessity of sexual health promotion and HIV/AIDS control programme run by MB.

(b) Cost and Quality of NGO's HIV/AIDS care services

This group of beneficiaries also informs that they get treatment and medicines at free of cost from the clinic. They pay Rs. 5/- as registration fee to avail the services of the clinic and are satisfied with the arrangement. In case of medicines not available in the clinic. they purchase it from the outside. But generally most of the medicines are available in the clinic run by MB. In case of pathological tests. etc. the project staff make necessary arrangement for referral services to other polyclinics. Beneficiaries inform that because of MB's good networking with other polyclinics. they get concessional rates for such tests. Considering the past experiences. all group members inform that they are better now because of the MB's efforts. But none of this group is aware about the source of funding for MB's project clearly. But they guess that it may be by government or any foreign funding agency.

(c) Staff Cooperation

With regard to the staff cooperation like the first group. this group is also happy with the staff members of MB. The group members praise about the sincerity of the Outreach Workers and Peer educators who regularly visit the field and doing their work as per plan. The group members are also happy with the cordial attitude and behaviour of doctor. counselor and other staff members who always advise them like their own family members. They also inform that they feel comfortable in the MB's

clinic, because most of the staff members belong to MSM community. As a result they understand each other nicely and there is hardly any misunderstanding takes place. Staff members extend all cooperation in making arrangement for pathological tests, referral to other organizations, etc. They also offer advises in their personal matters. In brief, beneficiaries are happy with the staff members of Kasba DIC of MB

(d) Scope of beneficiaries' Participation

With regard to the scope of beneficiaries' participation in programme activities, this group also replies that there is ample opportunity. They participate in need identification and beneficiaries' selection. The project staff also consulted beneficiaries to know about their opinions about the programme activities. In MB, programme planning is done at the NGO level, but after giving due consideration to the beneficiaries' feedback. The beneficiaries who visit DIC regularly directly participate in different meetings, GDs and FGDs and express their opinions and views. The feedbacks of outreach beneficiaries are obtained through PEs and ORWs. Thus, they also participate in the programme planning and its implementation. They do not contribute financially, but physically participate in different activities of MB. Therefore, beneficiaries participate in beneficiaries' selection, need identification, programme planning and implementation, but they do not take part in resource contribution, monitoring and evaluation. But they extend cooperation to the external evaluation teams of WBSAP&CS.

In brief, it is found that beneficiaries have better perception towards the working of MB. They acknowledge the necessity of MB and its contribution in improving their health status, self-esteem and awareness level on different issues like STIs, HIV, AIDS, safer sexual practices, etc. In general, they feel comfortable and happy with the project staff members of MB.

[E] Human Development Research Institute (HDRI)

Group-1

The first group was formed in 24/C, Jorabagan Street under Posta Clinic of HDRI. It was formed with 10 members. Out of these 10 members, six were Porters and remaining four were labourers. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

The geographical area covered under the HDRI's HIV/AIDS intervention project covers a large area, which includes Burrabazar, Posta, Jorabagan, Mechua, Sovabazar and Ahiritola. The total number of migrated labour working in this area is around one lakh. Most of them are rural poor people who are forced to leave their native place in search of livelihood. They are working as Porters, Handcart Pullers, Sardars, Labourers, hawkers and workers of different shops. They are hardly educated and having little or no knowledge and information about STD, HIV, AIDS, safer sex, etc. A good number of them are vulnerable to STD, HIV or other communicable disease and may endanger the life of their innocent family members in their respective native places. With this background information, the researcher tries to know about the beneficiaries' perception about the contribution of HDRI.

Beneficiaries inform that the health condition of migrated labourers was very poor before the starting of clinics run by HDRI. Because of the apathetic attitude of health personnel towards the migrated labour and poor infrastructure, they were not able to go to government hospitals. They had to depend on the quack doctors practicing in and around mainly for the treatment of general health problems and STD related problems. Majority of them are illiterate and ignorant about these diseases. Regarding treatment, they had to depend on the Sardars and local shopkeepers for the advice. Most of them belong to low-income group and can't afford to do treatment in private nursing home or under reputed doctors. There was no unity among the migrated labourers and divided region wise like *Biharis*, *Oryas*, etc. During the economic crisis, they had to take loans from the moneylenders at higher rate of interest.

In the context of above situation, all beneficiaries acknowledge the contribution of HDRI. They also informed that initially they resisted the HIV/AIDS intervention project. But later on when Peer Educators were recruited from among them, they started to believe and took interest in the programme activities of HDRI. As per the beneficiaries, now HDRI runs health clinics for the general health problems as well as for the treatment of STDs. When the researcher asked about the necessity of the HIV/AIDS programme of HDRI, beneficiaries do not deny its importance. According to them, HDRI has been working for last 10 years. As a result of working for long period, the migrated labourers are now more aware about STD, HIV, AIDS and safer sexual practices. Now the rate of condom use has increased

significantly. All of them admitted that HDRI has enabled them to realize the strength of unity; increased their self-esteem and helped them to dream a better future. All of them recognize the necessity of HIV/AIDS programme of HDRI in improving their overall status in general and health status in particular.

(b) Cost and Quality of NGO's HIV/AIDS care services

According to beneficiaries, HDRI run clinics provide medicines at free of cost for the treatment of STD and other common health problems. Beneficiaries pay only Rs. 10/- as registration fee to avail the services from the clinic. The registration fees are taken to reduce the wastage of medicines and to raise some funds for better functioning of the clinic. Beneficiaries don't have any grievance regarding registration fee, rather they are satisfied with this arrangement and feel it is justified. In case of medicines that are not available in the clinic, they purchase themselves from outside medical stores. In case of pathological tests like X-ray etc. HDRI refers them to different polyclinics. Beneficiaries also inform that HDRI has a very good networking with different polyclinics where they get concessions for different pathological tests. For blood tests, blood samples are collected in the clinic of HDRI itself. The project staff also regularly visit them in their *Gaddi* (place of work) or *Theks* (place of group residence) to distribute condoms and IEC materials; and discuss about their problems. Having remembered the past incidences, all beneficiaries said that they are far better now because of HDRI and its different programme activities. None of the group member has any idea about the source of funding for this project. Few members guess that the fund may be coming from the government.

(c) Staff Cooperation

Beneficiaries inform that all staff members of HDRI are very cooperative. They can approach the staff without any hesitation. They feel free and homely at clinic also. The Doctor and nurse listen to them carefully and advice them properly in simple languages. The counselor explains and guides them like their own family members. Peer Educators and Outreach Workers visit and meet them regularly. These field level staff also organize group meetings for creating awareness; distributing condoms and IEC materials and motivate them to go to the clinic for any health problem. Beneficiaries and peer educators can understand each other well and feel comfortable, because all of them from the same community. Beneficiaries narrated their experiences and compared the situation with government run hospitals where everybody neglects them because of their occupations. They are of the opinion that in

spite of low salary, peer educators and other staff members of HDRI are very sincere, committed and do not neglect their duties. Some of them requested the researcher to do something to increase the salary of field level staff of HDRI. Beneficiaries are very happy with the staff members.

(d) Scope of beneficiaries' Participation

Group members have informed that there is opportunity for beneficiaries to participate in different programme activities of HDRI. It is working for their betterment. Beneficiaries took part in need identification and beneficiaries' selection. HDRI accepts and considers beneficiaries' valuable opinion through Outreach Workers and Peer Educators at the time of planning the programme activities. The Governing Body approves the programme Planning. Three members from the migrated labourers' community are representing in the Governing Body of HDRI. They also participate in programme implementation. They do not contribute financially, but they offer physical infrastructural support (like arrangement of venue, electricity, chairs, etc.) during Annual Gathering, Sardars' Meet, awareness camp, etc. They also physically participate and contribute in different activities of HDRI in terms of controlling crowds, arranging tea, etc. Beneficiaries do not participate in monitoring and evaluation. But they extend cooperation to the external evaluation teams of WBSAP&CS by participating in focused group discussion (FGD).

In brief, we understand that beneficiaries have better perception towards the working of HDRI. They acknowledge its contribution for improving their health status and awareness level on different issues like STD, HIV, AIDS, safer sexual practices, etc. They feel that services of HDRI are more relevant to them than that of the government hospitals.

Group-2

The second group was formed in 314/B, Rabindra Sarani (Kachauri Gally) under Mechua Clinic of HDRI. It was formed with 9 members. Out of these 9 members, there were three Handcart Pullers, three Porters, one Sardar and two Hawkers. The summary of the FGD is being discussed below.

(a) Necessity of NGO's HIV/AIDS Programme

As per the information provided by these group members, there is no other Government's health centre or clinics except HDRI's clinic in their area. The Sardar informs that there were few private nursing homes and 'quack doctors' practicing near by. But they can't afford the treatment facilities of nursing homes. This group has not

much idea about different hospitals and medical colleges in Kolkata. Being the outsiders. they are naturally worried about the cost of treatment and quality of treatment. The group members have informed that they get different services like treatment of STDs and general health problems; free advice regarding safer sex. HIV/AIDS; condoms. etc. from the clinic run by HDRI. In case of referral for pathological tests. they get all cooperation from the HDRI staff members. All of them recognize the necessity of the clinics run by HDRI and its HIV/AIDS programme for the migrated labourers.

(b) Cost and Quality of NGO's HIV/AIDS care services

As like as the first group of beneficiaries. this group replies that they receive medicines from the clinic of HDRI at free of cost for the treatment of STD and other common diseases. They pay Rs. 10/- only as registration fee. The medicines. which are not available in the clinic. beneficiaries purchase themselves from the outside medical stores. Blood tests are done at free of cost and samples are collected in the clinic itself. For other pathological tests. beneficiaries pay from their pocket. but the project staff members help them to avail these tests at a concession rate through HDRI's good networking with different polyclinics. This group also acknowledges the efforts of project staff members in making them aware about STD. HIV. AIDS. etc. Some of the group members are not satisfied, as all medicines for general health care sometimes are not available in the clinic. None of the members have clear idea about the source of funding for this project. In brief. members of this beneficiaries' group are happy with the quality and cost of HIV/AIDS and STD care services. But they are not fully satisfied with HDRI's clinic as sometime it fails to meet their all health care needs.

(c) Staff Cooperation

With regard to the staff cooperation like the first group, this group is also happy with the staff members of HDRI. The group members praise about the sincerity of the Outreach Workers and Peer educators who regularly visit the field and doing their work as per plan. The group members are also happy with the behaviours of doctor. nurse and counselor who always advise them as their own family members. They also inform that they feel comfortable in the HDRI's clinic. Staff members extend all cooperation in making arrangement for pathological tests. referral to other organizations. etc. They also offer advises in other personal matters. The Sardar informs that the project staff members of HDRI once helped them on the issue of poor

bonus payment made by their employers. In brief, beneficiaries are happy with the staff members of HDRI.

(d) Scope of beneficiaries' Participation

With regard to the scope of beneficiaries' participation in programme activities, this group also replies that there is ample opportunity. They participate in need identification and beneficiaries' selection. The project staff also consulted beneficiaries to know about their opinions about the programme activities. They also participate in the programme planning through their representatives in the Governing Body of HDRI. They do not contribute financially, but provide infrastructural support like venue, chairs, electricity, etc. at the time of various programmes of the project. They also physically participate in different activities of HDRI. Therefore, beneficiaries participate in beneficiaries' selection, need identification, programme planning and implementation, but they do not take part in resource contribution, monitoring and evaluation. But they extend cooperation to the external evaluation team of WBSAP&CS. The situation can be called as partial participation of the beneficiaries.

In a nutshell, we find that beneficiaries have positive perception towards the working of HDRI. They acknowledge its contribution for improving awareness level on different issues like STD, HIV and AIDS, safer sex, etc. In general, they feel comfortable and happy with the project staff members of HDRI. But some of them are not happy with the general health care services of its clinic.

[F] Society for Positive Atmosphere and Related Support to HIV/AIDS (SPARSHA)

The researcher is grateful to the Secretary of SPARSHA for allowing him to interact directly with the beneficiaries who came to attend the monthly group meeting of HIV positive people at Kestopur DIC. The group was formed with 16 members at Kestopur DIC. Out of the 16 beneficiaries, there are ten male and six female members. The age group of beneficiaries varies from 22 years to 47 years. Five of the group members associated with this DIC since inception of the project i.e. from 2004. Majority of them are unemployed, few of them are daily wage earners and self-employed.

(a) Necessity of NGO's HIV/AIDS Programme

Beneficiaries inform that before the starting of the DIC run by SPARSHA, the conditions of HIV positive people was very poor. As already pointed out in the profile of SPARSHA (Part-I of this chapter), there were no organizations working with the HIV positive people in West Bengal at that time. One of the old beneficiaries informs that they have little or no knowledge regarding HIV, AIDS, safer sex, etc. They felt quite helpless when they came to know about their HIV positive status. Because of the HIV/AIDS related stigma, they were refused and denied treatment in government hospitals. The behaviors of the health personnel towards the HIV positive persons were so terrible that they don't want to recall those bitter experiences. Because of the fear of exposure and stigmatization, even they were not able to consult any private doctors or go to private hospitals. They are compelled to depend on the quack doctors mainly for the treatment of STD and other related health problems that too in distant places. At the same time they can't discuss their problems with their family members. As a result, they had to suffer from extreme psychological stress and anxiety. No one was there to help them. There was no channel of communication among the HIV positive members. Therefore, when they came to know about SPARSHA, they consider it as a gift from the god only.

In the context of above situation, all beneficiaries acknowledge the contribution of SPARSHA. In DIC, they feel comfortable and shares their joys and sorrows with their fellow HIV positive community members. At least now they can meet their fellow community members at the DIC without any fear of harassment and humiliation by others. Besides it, they are getting different types of services from the SPARSHA through this DIC. They are getting free health check-up, medical advices, treatment and medicines for common health problems from the doctor; counselling and advices for their psychosocial and health related problems from the counsellor; attending different awareness meeting on HIV, STD, AIDS, safer sex, etc. along with IEC materials. Two female beneficiaries inform that they have received vocational training on making jute products with the help of SPARSHA. All of them inform that SPARSHA also helps to get ART from the School of Tropical Medicines and now five of them are taking ART regularly. One female beneficiary informs that her child is getting ART at the subsidized rate. Majority of them inform that they have received advocacy support from SPARSHA as and when they required it. Above all, the environment of DIC is PLWHA friendly, where they can freely share their feelings,

emotions and problems; and also get an opportunity to introduce with many new HIV infected members. The native places of many beneficiaries are 30-40 kilometers away from the Kestopur DIC. Even two of them are residing in Purba Medinipur district, but attending this DIC due to fear of exposure in their locality and stigma. When the researcher asked about the necessity of the HIV/AIDS programme of SPARSHA, they all recognize the necessity of this programme in improving their over all status in general and health status in particular. All the beneficiaries are of the opinion that SPARSHA is everything for them and they are alive because of it. That is why in spite of financial problem, they are coming from long distances to attend the DIC and group meetings of SPARSHA. All the group members admit that SPARSHA has enabled them to realize the strength of unity, increased their self-esteem and helped them to exercise their rights, instead of feeling guilty and marginalized in the society. All of them recognize the necessity of HIV/AIDS care and support programme run by SPARSHA.

(b) Cost and Quality of NGO's HIV/AIDS care services

According to beneficiaries, SPARSHA run clinic provides medicines at free of cost for the treatment of STD and other common health problems. The doctor at Uluberia DIC provides necessary advice for maintaining healthy life and how to take necessary precautions to prevent the spread the HIV infection. In case of other DICs, SPARSHA is having a very good networking with different local specialist doctors to help the beneficiaries as per their needs. Beneficiaries will have to fill up a Membership Form to avail the services from DICs. No membership fee or registration fee is charged from the beneficiaries. In case of pathological tests like blood test, X-ray, etc., SPARSHA refers them to different polyclinics. Beneficiaries also inform that they get concessions for different pathological tests because of the SPARSHA's good networking with different polyclinics. The Outreach Workers and Community Based Peer Councellors regularly visit and maintain effective network with various government and private hospitals, health centers, nursing homes, etc. They also regularly keep in touch with each PLWHA. The DICs also distribute condoms, and IEC materials; refer them to clinic for treatment and advice them to visit DIC regularly. Counselling is an important part of the care and support programme of PLWHA. Beneficiaries inform that they receive counseling with regard to various issues like adherence to antiretroviral medicines, stress management, partner notification, legal rights of PLWHA, etc. Considering the past experiences, all

beneficiaries feel that they are far better now because of SPARSHA and its different activities through DIC and clinics. But they also express that there is a need to open more DICs or clinics to cover many PLWHA living in remote places for whom it is difficult to access the services from these few DICs. Few of them inform the difficulty of bearing the cost of traveling for collecting ART or CD4 testing at free of cost from School of Tropical Medicine, Kolkata. Because it is far away from their native places. But they do not have any grievance against SPARSHA in this regard. They feel that government should consider this aspect of suffering by the PLWHA also. At the same time, two beneficiaries from Purba Medinipur inform that sometimes SPARSHA bears their traveling cost. None of them have any detail idea about the source of funding for this project, but they guess that it may be sponsored by the government and by public donations. In brief, they are satisfied with the cost and quality of services provided by SPARSHA.

(c) Staff Cooperation

Beneficiaries inform that all staff members of SPARSHA are very cooperative. The Doctor and the Counsellor listen to them carefully and also offer guidance and advice regarding their health problems, psychosocial problems and even for family related matters. They can approach the staff without any hesitation, as majority of them are HIV positive. They feel free and homely at the DIC of SPARSHA. Beneficiaries, who regularly visit DIC, feel that they belong to a single family of SPARSHA. At the field level, Community Based Peer Counsellor and Outreach Workers regularly keep contacts with their clients. In case of emergency, they also make home visit to help the beneficiaries. If required, they conduct community sensitization programmes and advocacy meetings to reduce stigma among the community people. Being the member of same PLWHA community, both project staff and beneficiaries have good understanding with each other and feel comfortable to share their feelings, problems, etc. They are of the opinion that in spite of low salary, peer counsellors and other staff members of SPARSHA are very sincere, committed and do not neglect their duties. The staff members work more as social workers than merely as salaried employees. Some of the beneficiaries narrated their bitter experiences and compared the situation with health personnel of any government or private run hospitals where everybody is indifferent and hate them because of their HIV positive status. In a nutshell, beneficiaries are very happy with the staff members of SPARSHA who treat them as their own family members.

(d) Scope of beneficiaries' Participation

According to beneficiaries, there is ample opportunity for them to participate in different programme activities of SPARSHA. Because, it is an organization of the PLWHA and for the PLWHA. Beneficiaries directly participate in need identification, beneficiaries' selection, programme planning and its implementation through the monthly group meetings of DICs. In SPARSHA, planning is done at the NGO level, but it accepts and considers beneficiaries' opinion received through project staff of DICs. Beneficiaries do not contribute financially, but they offer physical labour and participate in different activities of DICs run by SPARSHA. Beneficiaries ensure their involvement by attending the programmes, by providing physical infrastructure like sitting arrangements, providing tea for staff and resource persons during awareness camps, etc. Beneficiaries also take part in monitoring activities through interactions with DIC level staff as well as with the Programme Management Unit (PMU) of SPARSHA. Beneficiaries do not directly participate in evaluation, but they extend cooperation to the external evaluation team of WBSAP&CS by participating in GD/FGD. SPARSHA also recognizes beneficiaries' participation by recruiting them as project staff at different level including the Project Coordinator.

In brief, we understand that beneficiaries have better perception towards the working of SPARSHA. They acknowledge its contribution for improving their health status, self-esteem and awareness level on different issues like STD, HIV, AIDS, safer sexual practices, ART and its side effects, CD4, etc. They prefer SPARSHA than any other organizations for its multi-dimensional activities and rights-based approach. They cannot think of a situation if SPARSHA stops working for them for any reason in future.

In a nutshell, this section (Part-IV) has highlighted the beneficiaries' perceptions towards the working of six selected NGOs under the study. Out of eleven groups, eight groups have expressed positive perception and few members of remaining three groups have shown dissatisfaction. By and large, beneficiaries have better perception towards the working of respective NGOs. The HIV/AIDS programmes of the respective NGOs are satisfactory to the beneficiaries. These NGOs have helped them in improving their health status and awareness level on various HIV/AIDS related issues. These programmes include more preventive services and less curative services. Out of the six NGOs, SPARSHA only runs HIV/AIDS Care

and Support services for PLWHA. So far anti-retroviral medicines (ART) are concerned, it is distributed by the government through a very few ART distribution centers in West Bengal. Majority of the beneficiaries use these NGOs as a stepping-stone for better referral health services and to avoid the indifferent attitude and apathy of the health personnel in government run hospitals.

In brief, this chapter has discussed about the profiles, programme activities, staff's views and beneficiaries' perception of six selected NGOs in four parts separately. A brief summary was given at the end of each part. **Part-I** has discussed about the different aspects (such as past background, objectives, organizational structure, infrastructure, present activities, future plan, etc) of selected NGOs. It is found that DMSC, BPWT and HDRI are comparatively bigger organizations than SCIR, MB and SPARSHA in terms of financial turn over and volume of activities. The target groups for the HIV/AIDS programmes of SCIR, DMSC, BPWT, HDRI, MB and SPARSHA are IDUs, CSWs, truckers, migrated labourers, MSM and PLWHA respectively. All the selected NGOs have multi-dimensional programmes and HIV/AIDS is an important aspect under their wide spectrum of activities. Despite of having many difficulties, NGOs of the present study are eye opener and pathfinder for the neglected, marginalized and poor masses. All of them have unique approach and are reformative in operation.

The **Part-II** attempts to discuss about the programme activities of six selected NGOs under the study. It is found that the programmes studied suffer from one or more problems. Some of the problems are common – such as lack of timely disbursement of fund by WBSAP&CS, except STIs, no funding provision for the treatment of general health problems of target groups, no provision for meeting traveling expenditure of Peer Educators and People living with HIV, etc. Each programme has got some positive aspects and innovative components too. But all the programmes are fully dependent on the funding agency i.e. WBSAP&CS. Therefore, all the programmes under the study are less sustainable and doubtful for their contribution in the someway in future.

Part-III highlights the views of selected staff members of six NGOs under the study on different issues related to HIV/AIDS. It is found that no staff members of six NGOs are affected by HIV/AIDS related stigma because of the nature of their jobs. But staff members of DMSC, MB and SPARSHA are affected by prevailing social stigma related to CSWs, MSM and PLWHA respectively, as most of the staff

members of these three organizations are selected from among the respective target groups. However, staff members of all the six NGOs have admitted the existence of HIV/AIDS related stigma in the society and have suggested mass awareness programmes, counseling, sex education at school, etc to reduce it. Majority of the selected staff members of six NGOs are aware about the ethical issues related to HIV/AIDS and always practice them. With regard to the violation of human rights of PLWHA, all staff members have said that they would protest against such incidences. With regard to the major barriers encountered in implementing the project, selected staff members of all the NGOs have talked about ignorance, fear of exposure and stigmatization, indifferent attitude of the people towards AIDS, migration and drug addiction. Staff members of six NGOs differ in terms of their opinions on the major reasons for spreading HIV/AIDS at a faster rate. However, they have identified that ignorance, poverty, migration, drug addiction, unsafe sex are the major reasons responsible for spreading HIV/AIDS. Most of the staff members of SCIR, DMSC and MB are optimistic about the future AIDS scenario in our country and think that the situation would be under control, if government continues its effort by involving all stakeholders. But staff members of BPWT and SPARSHA think that situation will be out of control, if government did not change its policy. However, all staff members of the six NGOs are of the opinion that NGOs would play a key and more effective role in combating HIV/AIDS in future too.

Part-IV has highlighted the beneficiaries' perceptions towards the working of six selected NGOs under the study. Out of eleven groups, eight groups have expressed positive perception and few members of remaining three groups have shown dissatisfaction. By and large, beneficiaries have better perception towards the working of respective NGOs. Majority of the beneficiaries use these NGOs as a stepping-stone for better referral health services and to avoid the indifferent attitude and apathy of the health personnel in government run hospitals.

So, we can conclude from the case studies (discussed in Part-I, II, III and IV) that an NGO engaged in HIV/AIDS care in West Bengal can help in improving the health status and awareness on HIV/AIDS by providing more preventive and less curative services. These NGOs can also supplement the government run health care institutions in combating HIV/AIDS in the state. But, the programmes of these NGOs would be less sustainable after the project duration. Therefore, for the continuation of a full-fledged programme, that project has to be on with adequate funding support.