

FIELD VISIT REPORT

SAKSHAM MAHILA SAMITI

Community-led HIV prevention, service linkage and programme monitoring

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Submitted By

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Executive summary

- The organisation's community-led structure appears central to finding and maintaining contact with a dispersed and sometimes hidden FSW population.
- Outreach is adapted to work setting and availability; fixed office hours would create predictable access gaps.
- Community-based screening reduces distance and timing barriers, but confirmatory testing and ART linkage still depend on coordinated public-sector services.
- The reported M&E system is detailed and multi-layered, yet the available evidence emphasises output and compliance more than service quality, participant experience or longer-term outcomes

Case profile

Field	Description
Organisation	Saksham Mahila Samiti
Primary population	Female sex workers (FSWs)
Interview format	Joint semi-structured key-informant discussion with programme managers

Purpose and analytical question

The report examines how the organisation described its community-based HIV prevention model, outreach and service pathway, human-resource structure, monitoring and evaluation system, financing arrangements and implementation barriers. The central analytical question was: how does the organisation translate a government-supported targeted intervention into accessible services for its population, and where does the reported implementation model remain vulnerable?

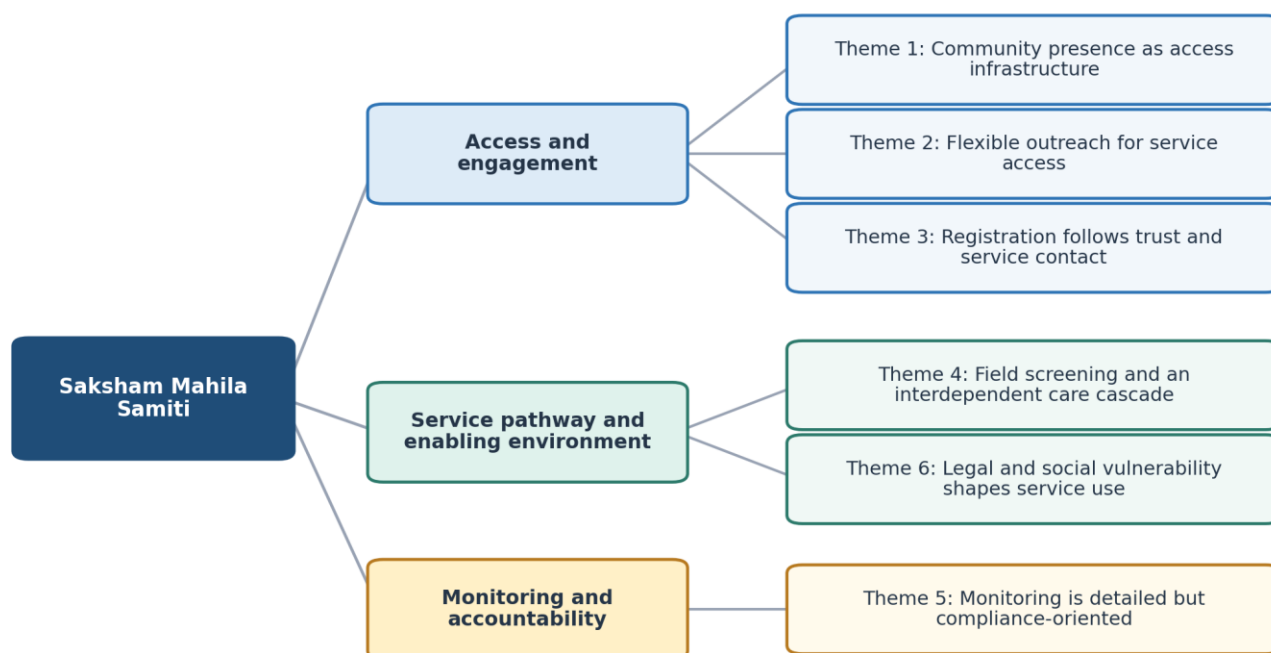
Methodology

- Design: This is an exploratory qualitative organisational case report based on one joint key-informant discussion. It documents how programme representatives described implementation; it is not an independent performance evaluation.
- Data preparation: The transcript was reviewed alongside nine field-note pages.
- Coding: A hybrid codebook was developed from programme-evaluation domains and issues emerging from the interview. Each evidence unit could receive more than one code. Code counts in the appendix refer to evidence units, not participants or importance.
- Theme development: Codes were clustered into candidate themes, checked against the original timestamps and field notes, and revised so that each theme had a clear organising idea, supporting evidence and practical M&E implication.

Reported programme pathway

- Community and stakeholder mapping identifies groups, locations and appropriate outreach times.
- Peer educators and counsellors establish contact, provide information and build trust through repeated engagement.
- Prevention commodities, counselling and community-based screening are delivered according to subgroup needs.
- Reactive screening results are referred for confirmatory testing, clinical assessment and ART linkage.
- Contacts, services, commodities, referrals and expenditure are documented for routine monitoring.
- Internal supervision, state review and periodic third-party evaluation provide successive accountability layers.

Thematic findings



Theme 1: Community presence is the programme's main access infrastructure

Community representation was not presented only as participation; it was described as the practical mechanism through which the organisation learns where women are working, when they can be contacted and who can introduce the team safely. Peer educators, community board members and trusted intermediaries connect formal programme requirements with a population that is dispersed and may avoid public identification.

Theme 2: Flexible outreach is necessary for service access

A fixed office schedule would miss many FSWs. The interview described different availability across home-based, street, spa, hotel and other work settings. Outreach timing was adjusted to avoid peak earning periods and to create enough privacy for counselling and screening.

M&E implication: Micro-plans should record setting-specific outreach windows and monitor whether services are delivered during those windows.

Theme 3: Registration follows trust and service contact

Registration was described as occurring after at least two services or contacts. This suggests that enrolment is not a single administrative event; it is the outcome of repeated engagement, counselling and demonstrated usefulness of the programme.

M&E implication: Monitoring should distinguish first contact, repeated contact, service uptake and formal registration rather than treating registration alone as the outreach result.

Theme 4: Field screening improves reach, but the care cascade remains interdependent

Community-based screening was described as reducing distance and timing barriers. However, reactive screening still depended on ICTC confirmation, clinical assessment and ART linkage. The organisation can initiate the pathway but cannot complete it without coordinated public services.

M&E implication. A complete cascade indicator should track screening, confirmation, ART registration and early retention, with documented responsibility at each hand-off.

Theme 5: Monitoring is detailed but strongly compliance-oriented

The reported system records contacts, counselling, tests, referrals, commodities and expenditure, and combines internal review with six-month state monitoring and two-year external assessment. At the same time, the interview repeatedly framed performance through targets and the risk of programme closure. The available evidence does not show how service quality or participant experience is measured.

M&E implication. Retain output accountability but add quality, linkage, retention and participant-experience measures so target achievement does not become the only definition of performance.

Theme 6: Legal and social vulnerability shapes whether services can be used

Stigma, policing, identity issues, partner reactions and GBV were described as part of the operating environment rather than separate from HIV prevention. Complementary legal, identity and SRHR support may help sustain engagement, although outcomes were not documented in the source material.

M&E implication. Referral protocols should connect HIV services with legal aid, GBV response, identity documentation and confidential psychosocial support, and should record completed referrals.

Recommendations

- Maintain quarterly micro-mapping of FSW settings and record the outreach window, access contact and service package for each site.
- Track the sequence from first contact to second service, registration, screening, confirmation, ART linkage and early retention.
- Disaggregate service delivery by sex-work setting without recording information that could expose identities or locations unnecessarily.
- Add participant-experience and service-quality checks to complement target and expenditure monitoring.
- Establish a documented referral pathway for GBV, legal aid, identity documentation, SRHR and psychosocial support, with completed-referral indicators.
- Triangulate self-reported performance with peer-educator records, MIS extracts, ICTC/ART linkage lists, commodity registers and external evaluation reports.
- Verify all programme targets, staffing ratios and reported monitoring frequencies before using them in a formal evaluation or budget.

Limitations

- The evidence comes from a single joint interview and cannot establish thematic saturation.
- The two organisations were discussed together; some governance, financing and monitoring evidence is therefore shared rather than independently elicited for each organisation.
- The machine transcript contains major Hindi speech-to-text errors and inconsistent speaker diarisation. The audio file was available but could not be decoded in this environment.
- Programme manager accounts were not triangulated with peer educators, service users, ICTC/ART staff, programme contracts, MIS extracts, financial records or evaluation reports.
- Reported targets, staffing ratios, service frequencies and perceived effects are self-reported and require documentary verification.
- The findings describe implementation processes and perceived barriers; they cannot estimate HIV prevalence, programme effectiveness or causal impact.

Conclusion

Saksham Mahila Samiti was described as a community-embedded bridge between FSWs and formal HIV services, using peer access, flexible outreach and staged trust-building. The principal evidence gap concerns independently verified service quality, completed care cascades, participant experience and outcomes. Further assessment should preserve the community-led model while verifying records and adding quality- and outcome-focused measures.

Next evidence priorities

- Verify sanctioned targets, staffing arrangements, monitoring schedules and evaluation claims against current programme documents.
- Triangulate the management account with peer educators, service users and ICTC/ART or other referral partners.
- Reconstruct a de-identified service cascade from first contact through confirmatory testing, ART linkage and early retention, with safe subgroup or site disaggregation.

Appendix A. Organisation-specific analytic codebook

The codebook uses a hierarchical framework suitable for manual entry or plain-text import into QualCoder. Frequency shows how many segmented evidence units received each code; they do not measure importance or prevalence.

No.	Code	Operational definition	Evidence units
1	Target population	Statements identifying the population group(s) served and distinctions between subgroups.	2
2	Community-led governance	Community representation in the governing board, organisational decisions or programme oversight.	2
3	Community staffing	Recruitment or participation of community members in programme roles.	1
4	Peer educator role	Field identification, outreach, counselling support, follow-up or reporting undertaken by peer educators.	3
5	Outreach timing	Adjustment of outreach schedules to the availability and work patterns of community members.	2
6	Site and network mapping	Use of locations, social networks, gatekeepers or micro-mapping to identify and reach participants.	2
7	Trust-building before registration	Repeated contact or initial service provision before formal programme registration.	1
8	Counselling and prevention information	Individual or group counselling and HIV/STI prevention information.	2
9	Commodity distribution	Provision and tracking of condoms, lubricant, needles/syringes or other prevention commodities.	1
10	Community-based screening	HIV screening undertaken in field or community settings.	2
11	Confirmatory testing and ART linkage	Referral from screening to ICTC confirmation, registration and antiretroviral treatment.	2
12	Clinical and referral network	Coordination with doctors, ICTCs, ART centres, STI services or other health facilities.	2
13	Routine reporting	Recording and reporting contacts, counselling, screening, referrals, commodities or other programme outputs.	3
14	Target and indicator management	Use of programme targets, registration expectations and performance indicators.	4
15	Dynamic cohort and attrition	Changes in active programme populations due to mobility, ageing, lower risk, death or loss to follow-up.	1
16	Internal monitoring	Weekly meetings, field supervision or internal review of implementation.	1
17	Six-month state review	Periodic state-level performance review and follow-up visits described as occurring every six months.	1
18	Third-party evaluation	External organisational, programme, finance, document and field assessment described as occurring every two years.	1
19	Funding and PFMS	Government funding flow, electronic payment or Public Financial Management System processes.	1
20	Procurement and stock accountability	Purchasing rules, quotations, stock issue/return, breakage or consumption records.	1
21	Project leadership	Project director, programme manager, counsellor and related role arrangements.	2

No.	Code	Operational definition	Evidence units
22	TI-system escalation	Communication and escalation through the state Targeted Intervention division or designated representatives.	1
23	Legal and identity support	Legal awareness, advocacy, identity documentation or interaction with police/lawyers.	2
24	Gender-based violence and partner concerns	GBV, spouse/partner response, disclosure or safety concerns.	2
25	Stigma and social exclusion	Stigma, discrimination, family rejection or negative social labelling.	2
26	Surveillance and research participation	Participation in sentinel surveillance, STI research or related programme studies.	1
27	Access barrier	Distance, timing, mobility, hidden settings, service availability or other factors restricting access.	3
28	Adaptive implementation	A programme adjustment introduced to overcome an identified access or delivery barrier.	5

