#15YearsOfImpact
WE CARE.  INNOVATE.  TRANSFORM.
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FOREWORD

Dear Colleagues,

Welcome to #15YearsOfImpact, a compendium of some of our favourite impact stories, as narrated by independent evaluators, our partners and others who have worked with us shoulder to shoulder.

The idea of Swasti was incubated 16 years ago by Catalyst Management Services Private Limited, with a mission to improve the health and well-being of vulnerable and marginalised communities; through action research and implementation, technical support, knowledge management and policy advocacy.

The lived realities and life stories of every individual and community we work with and for, have inspired us to push for perspective change, paradigm shift and for impact at scale; often exploring out-of-the-box solutions for complex public health challenges. Inviting innovations from different sectors have allowed us to bring it to those who need it the most. ‘We Care. Innovate. Transform.’ This is our mantra and we use it to push our boundaries to affect communities positively, despite the insurmountable challenges that they face.

Over the years, we have nudged ministries and governments across the world to lean towards policies that work for the poorest and most marginalised, translating some of these policies into solutions at scale. Our investment in building community institutions have resulted in substantial dividends, which have evolved into self-reliant, resilient organisations. We have walked with women in factories through simple, uncomplicated lifeskills modules that have seen them transform into change agents and formidable leaders in their communities. We have experienced the determination of a 13-member organisation of women in sex work, which has now expanded to a community of 15,000 members.

In this publication, we illustrate glimpses of impact over the 15 years since our inception. Our body of work is presented on our website: www.swasti.org
As we celebrate our 15th anniversary, we are incredibly grateful to our committed team, alumni, volunteers, interns, fellows, advisors, board members, collaborators, consultants and partners. Today's world continues to be filled with people without access to food, water and safety. The environment has become more transient and dangerous and newer health challenges emerge. We arise from this with stronger resolve and a renewed sense of purpose.

I want to acknowledge our sibling organisations within the Catalyst Group — Vrutti, Fuzhio, Catalyst Foundation and mothership Catalyst Management Services — for being with us every step of the way.

To our founder, Shiv Kumar, who continues to inspire and guide the teams and who gracefully stepped aside for new leadership. In his words, “Impact means people realising their full potential and thriving” and that’s what Swasti’s mission is all about.

To our partner community organisations, you inspire us. To our technical partners, we are grateful for your trust and for helping us to be a stronger version of ourselves.

Here’s to our joint vision: A world of healthy people.

Dr. Angela Chaudhuri
Partner

@Angela_Swasti
Every single rupee you invest in a social development programme has the potential to break the intergenerational cycle of ill health, poverty and violence.

Social Return on Investment (SROI) is a framework for measuring and accounting for this very value returned on investment. It incorporates the entire gamut of social, environmental and economic benefits, guiding programmes and investments alike. Behind this number is the story of how the Avahan programme has ensured greater safety for communities, health-seeking behaviour, financial health and a reduction of new HIV infections.

SROI is a telling indicator of how well a programme can serve a community. Picture this scenario. The year is 2016. The sector has been jolted into accepting that healthcare does not work for the poor in most parts of Asia. The system is unfriendly, costly or both. On the demand side, health is not a priority for the poor either, unless it affects their daily lives and then too only symptomatic relief is sought. This results in repeat episodes of preventable illnesses and drug resistance to treatment. While promotive health delivers significant returns to the communities, it offers little incentive for private and government sectors alike.

The SROI’s results for Avahan India AIDS Initiative Phase III supported by Bill & Melinda Gates Foundation, tells us that for every USD 1 invested in Avahan, the community receives USD 29.78 in hand. This is a stunning statistic, given that the programme was delivered at the cost of only USD 19 against the sectoral benchmark of USD 100 per person every year.
Every one rupee invested in i4We gives a social return of Rs 3.32 in the hands of the community members. This programme shows an economic return on investment of a whopping 352 per-cent (under the process of certification by Social Value International).

The SROI findings for i4We guide us on how to break this cycle.

Invest for Wellness programme (2017) is a nurse led primary and promotive wellness model sustained through a blended financing model. It currently functions in four settings: urban slum, rural village clusters, garment factory cluster and collectives of marginalised women and sexual minorities.

Avahan India AIDS initiative Phase III (2014-2017) was implemented with 84 community organisations reaching 130,000 women sex workers, men who have sex with men (MSM) and transpersons.

The poor lose one to two months of productive time a year due to illness in the family. Nearly 50-60 per-cent live with some form of undiagnosed illness and die earlier than those who are economically better off. In India alone, about 50 to 60 million people in the last decade have been pushed to the brink of poverty because of health-related expenditures.

In scenarios such as these, that play out across the country everyday, programmes like Invest for Wellness (i4We) offer a lifeline for the poor. This 2 year old programme offers an encouraging glimpse of what could be possible if investments were made in primary preventive and promotive care.

Ten years ago, while working with farmers, Vrutti Livelihood Resource Centre noticed something odd about the people. Many of them looked aged beyond their years, seemingly malnourished. Farming couples were hunched over from pain, going to local clinics for analgesics to be able to work extra hours on the fields. Concerned, Vrutti invited Swasti, its sister outfit to come to Chikkaballapur and intervene.

Chikkaballapur, a district in Karnataka, India is a drought-prone region. Its only source of water is groundwater, contaminated with toxic levels of fluoride. The people it turned out, were suffering from fluorosis and in some places were even poisoned by trace arsenic.

A detailed needs assessment revealed that as much as people were aware about water causing these health problems, they did not know that it could be reversed. The study also revealed that men were willing to spend on alcohol but not on potable water. The study also showed that women wanted healthy water for their children and for their families if they were ill, but not for cooking because they believed that boiling water removed harmful toxins.

In addition, the study revealed that all previous health interventions that were grant-based (where communities accessed programmes, services and products for free) were popular but not sustained. The team understood that in order for people to use healthy water and avoid water from their wells, a well-thought out market model, with strong behaviour change interventions was needed. It also had to be owned and governed by the community. Thus emerged a market model where initial grant capital and technical support were...
catalysed externally (in this case through Swasti) and the community managed the operations and governance completely. A reasonable price point was set at 2 rupees per 20 litres.

Ten years later, the National Programme for Prevention and Control of Fluorosis (NPPCF) still did not address the provision of safe water, but politically it seemed like a good bet. Both political leaders and private companies used this opportunity to provide safe water.

An extensive study by two Water Fellows from Arghyam in 2018, revealed that most of the water plants established by political leaders or companies are non-functional or have been shut down, but the eleven community-led water plants, co-established by the community, continue to thrive. Thimammpalli, where the first community water plant was inaugurated back in 2013, still functions to full capacity.

Dr. Mahima from the local health center says, “Earlier, during summer, the clinic was overloaded with patients complaining of gastro-intestinal issues and water-related problems. Today, patients coming to the clinic have no water related diseases.”

Health interventions need a new kind of leadership: people from within the community who value both the business potential and social capital of the project. They are the ones who can keep it moving forward.

Swasti worked with Gram Panchayats in Chikka-ballapur to create a community-owned solution through investment in 10 water defluoridation plants and a tanker operating across two taluks of the district. Since 2017, Swasti only visits the water plants to meet old friends and enjoy a cold drink of water.

In Mamidikayalapalli, the medical costs have reduced by 100 per-cent, according to Vijay Kumar, the Gram Panchayat bill collector.

Find out more @nityajacob
Global development challenges are persistent. Evolving effective approaches to solving them requires robust evidence. Well designed research can have a wide influence on society, and the importance of good research in achieving positive impact on communities cannot be understated. Research methods should reach hidden and vulnerable populations, mitigate unconscious bias and elicit the most personal answers. To do this, they need to be nuanced, sensitive and distinct.

Traditional research methods sometimes have limitations in reaching the right participants in the right way, resulting in an inability to gather the most sensitive information and to hear voices that

The bias of social desirability to discuss matters related to sex and sexuality prevents collection of reliable grass-root level data.
matter. The bias of social desirability relating to sex and sexuality, for instance, prevents the collection of reliable grass-root level data on these issues as potential respondents fear the risk of inadvertent disclosure, uncertain of their place among social power structures. As a result, they stay away from the data collection process making it hard for conventional research methodologies to come up with reliable answers.

The deployment of multi-disciplinary teams of researchers, epidemiologists, government bodies and civil society representatives in a number of countries aimed at addressing this evidence gap has surfaced some effective methods.

Geographical mapping estimates were six to seven times higher and accurate than the conventional mapping estimates for the same territory.

Geographical mapping method: This is a method to estimate the number of hidden populations that work, live and frequent spots (used as a gold standard for estimating risk population like sex workers, for targeted HIV interventions).

Network mapping method: The most vulnerable populations are often hidden and geographical mapping communities have moved out of geographies. This is where network mapping comes in.

Polling booth: In a polling booth, focus groups individually answer sensitive questions in a confidential manner. Much like an election, this methodology has a booth with a ballot box for each respondent. Around 12 to 15 simple 'yes' or 'no' questions are asked. This is followed by an open discussion with the group of the compiled responses. The method is used for national studies related to sexual health, nutrition and sanitation.

Ethical research methods with children: UNICEF published a toolkit titled Ethical Research Involving Children. A case study was developed using methods that allowed for the most sensitive information to be shared by children.

We would love to explore more methods with you.


Swasti Health Catalyst in partnership with Catalyst Management Services has developed path breaking tools and methodologies for gathering information. Several of these tools became national guidelines recognized by governments and international agencies alike.
In India, it is estimated that there are seven female health workers per 10,000 people.

This means that women comprise one third of the total health workforce in the country.
**WITHOUT GENDER EQUITY, UNIVERSAL HEALTH COVERAGE IS A PIPE DREAM**

Women shape healthcare but are kept out of the executive suite.

Gender equality in Human Resources for Health (HRH) is defined very specifically. ‘Women and men have an equal chance of choosing a health occupation, developing the requisite skills and knowledge, being fairly paid, enjoying equal treatment and advancing in a career.’ Yet, gender inequities are rampant among the health workforce and this issue is even more pronounced when it comes to policy development, planning and research.

In India, it is estimated that there are seven female health workers per 10,000 people. This means that women comprise one third of the total health workforce in the country. Conversely, the health system sees men dominate high-status health occupations. They are made doctors and managers and are trusted with policymaking roles. Women on the other hand, tend to be over-represented in nursing, midwifery and other ‘caring’ cadres.

In fact, gender analysis conducted in a few select countries has revealed many such disparities. Women were sidelined to associate professional roles, typically for nursing and midwifery positions. They also tend to average fewer working hours than men and earned significantly less than their male counterparts. Issues like stereotyping, marital status, sexual harassment and family responsibilities deter women from entering healthcare occupations. These disparities contribute to attrition and low morale among health workers.

In many parts of India, for example, women users express a wish or need for female practitioners,
particularly for maternal and child health care services, but there is continued shortage of women doctors, supervisors and specialists.

Inequity preys on men too. Male doctors may want to serve in rural areas but are demotivated by the absence of appreciation and support from colleagues as well as from the community.

Certain female-dominated occupations, notably nursing and midwifery, are often not given market value commensurate with their skill level, as the work is seen simply as “women’s work.” For instance, gender considerations exclude men from involvement in reproductive health services. Gender stereotypes or feminisation of caregiving work may reduce men’s participation in such occupations.

In developing countries, women are routinely passed over when it comes to senior positions at the central and the state levels, even if they are as qualified as or more qualified than their male colleagues. Instead, they are boxed into roles that give them no autonomy or decision-making authority.

Frontline health workers are mostly women and their supervisors are mostly men. These health workers not only meet targets of the programme, they also build reach within the community, for which they receive lower wages and are least acknowledged. They compensate for the shortcomings of health systems through individual adjustments, at times to the detriment of their own health and livelihoods.

Women comprise about one third of the health workforce, yet their salary is not on par with men in the same job. Women often leave the paid workforce when they get married or to care for their families. This means that they don’t save or plan for retirement. There are no special policies to address their parallel needs as mothers and wives, whether it is childcare or protection from violence.

Sometimes sexual favours are conditions for career progression or continuation in service.

In a study in Karnataka, India, female community health workers have reported that they are sexually harassed on their way to work or during work, making them reluctant to attend to obstetric needs of patients at night. Another study in Rajasthan has revealed that although supervisors informally acknowledge such problems, they do not assist female health workers in dealing with them because it is not part of their supervisory remit. The health workers also reported strained relationships between themselves and male supervisors who often ignored complaints of harassment and violence expecting the health workers’ presence on the job against all odds.

Unless we address gender disparities among the health workforce in India, we cannot tackle the shortage and maldistribution of health workers or improve access to quality services.

This is one of the series of fifteen studies published by the People for Health project. This project was a four-year initiative that focused on strengthening health workforce related policies and practices across state and non-state actors. ‘People for Health’ was jointly implemented with Public Health Foundation of India and supported by the European Union.

Find out more @shaonlich
WHAT CAN WE LEARN FROM INDIA’S AIDS RESPONSE?

In a post-2015 development world, what really stands out is the early realisation of the stakeholders that HIV is not just a medical issue.

Having followed the evolution of HIV response globally for over a decade, what stands out is the early realisation of the stakeholders that HIV is not just a medical issue, but also involves behavioural, social and economic factors. This realisation has led countries to think differently in their responses to the epidemic and has necessitated a multi-sectoral approach.

In India and across the world, remarkable progress has been made towards combating HIV and AIDS over the past two decades. The number of people infected with HIV and cases of AIDS-related deaths have reduced and there is a significant increase in the number of people seeking and receiving treatment.

India identified its first HIV case in 1986. Since then, much has changed. The country has shown strong political will, commitment and urgency in addressing the problem, leading to the evolution of one of the most comprehensive AIDS control programmes in the world. The National AIDS Control Programme in India has gone beyond just generating an HIV response—it has paved the way for some of the most successful experiments in social sector response. As a result of strong leadership and the consistent support of Government of India, the annual incidence of HIV infection among adults has fallen by about 57 per-cent between 2000 and 2011.

There are many reasons for the programme’s success in India. Evidence-backed planning, robust systems and timely policy creation really pushed the envelope.

A significant investment in technical quality and programme design led to widespread community participation and ownership. India’s experience in HIV prevention and control, presents us with many important lessons for the next phase of the global AIDS response and for health and development as a whole.

The proposed Sustainable Development Goals (SDGs) embody bold aspirations of the international community to end the tyranny of poverty,
ensure a life of dignity for all and secure the planet for future generations. To deliver these ambitious, interconnected goals, we need to think and act differently.

For example, reducing gender inequality and gender-based violence can help women and girls to negotiate safe sex and to protect themselves from HIV. The inclusion of men who have sex with men (MSM), transgender people, sex workers and people who use drugs has accelerated the progress of HIV prevention and control. Addressing economic inequalities through social protection and economic empowerment can reduce poverty, vulnerability to HIV and help keep people living with HIV healthy and contributing to their communities.

The lessons are clear. Now it falls upon us to apply them if we want to realise the vision of the SDG — a more prosperous, fair and sustainable world, one free from the scourges of discrimination and AIDS.

Find out more @loygeorge

HIV and Development Lessons
Published in 2014, this report was developed with the support of the United Nations Development Programme India. The report showcases some of the achievements, failings and learnings from an innovative and powerful AIDS response that can be adapted as responses to TB, non-communicable diseases and other emerging complex health challenges. Downloadable at: http://swasti.org/wp-content/uploads/2018/05/HIV-and-Development-Lessons.pdf
Did you know that in the aftermath of a natural disaster, sexually transmitted infections are more likely to increase among vulnerable communities?

In December 2004, after the tsunami devastated coastal areas around the Indian Ocean, many humanitarian agencies, funding organisations, governments, NGOs and private individuals came forward to support relief and rehabilitation initiatives.

In India, the coastal areas of Southern India and the Andaman and Nicobar islands were the most affected. Eighteen months after the tsunami, a study was conducted to understand the vulnerability of communities to HIV in the tsunami-affected coastal regions of India.

Integrating sexual health, particularly HIV related interventions, into disaster response has emerged as one of the strategic ways to avert new infections after a natural disaster. The existing guidelines and policies (e.g. SPHERE) have clearly laid out the processes to be followed under humanitarian emergencies. However, none of them directly address the needs of communities with regard to sexually transmitted infections including HIV, in the form of guidelines or minimum standards that can be incorporated as part of relief and rehabilitation programmes.

Swasti developed a toolkit and guide in partnership with Oxfam India with the support of the National Disaster Management Agency. The purpose of this guide is to help respond to matters relating to sexual health and to mainstream this care in response to natural disasters.

In 20 out of the 30 communities studied, vulnerability to HIV increased in the aftermath of the tsunami. This can be attributed to the physical, social and psychological conditions of the people, which led to a significant increase in unprotected sex with non-regular sexual partners, especially among people living in temporary shelters.

The study also found that despite mainstreaming and capacity building efforts, HIV prevention during emergencies has not been very successful. Most relief agencies ignore sexual health issues when it comes to their public health initiatives.
IMPACT IN NUMBERS

# OF LIVES ENRICHED DIRECTLY

500,000 +

FUNDS RAISED FOR COUNTRIES AND COMMUNITY ORGANISATIONS

USD 854 MILLION

SOCIAL PROTECTION UNLOCKED FOR INDIVIDUALS FROM VULNERABLE COMMUNITIES

USD 417 MILLION

GENDER PROPORTION IN WHOLE OF SWASTI

55.4 %

of Women + Transperson staff
(Industry standard is 53 per-cent)

# OF CORE EMPLOYEES
and project staff since inception
497

# OF VOLUNTEERS AND INTERNS
171 from 15 COUNTRIES
Volunteers and Global Health Fellows

GENDER PROPORTION IN LEADERSHIP OF SWASTI
58% of leadership/supervisory positions are held by women.

# OF CSO PARTNERS
> 800 Capacities built at community organisations and Government departments.
When women in factories undergo lifeskills training related to communication, health and hygiene, it has shown significant positive outcomes in their daily lives, in the workplace as well as in their communities.

The Tufts University Labor Lab conducted an impact evaluation using randomised controlled trials, of the Women In Factories training programme in El Salvador, Honduras, Bangladesh and India since 2014. In India, this study was conducted on the Women In Factories programme (WIF), an initiative of the Walmart Foundation’s Women’s Economic Empowerment Initiative (WEEI) programme.

WIF has trained more than 60,000 women worldwide in critical lifeskills related to communication, hygiene, reproductive health, occupational health and safety and gender norms. Select women received additional advanced leadership training for their work and on lifeskills for personal and career development.

“When women want to take charge and build something, they cause a ripple effect. Give them the right tools and they will contribute back to the business and their communities”, says Shankar, who leads the WIF programme at Swasti.

By early 2019, Swasti reached more than 200,000 women in 300 to 250+ factories, across 20 brands through programmes like Walmart’s Women in Factories, Levi’s Worker Well-Being, GAP’s PACE, Debenham’s Life, BSR’s HER programme, Primark’s My Life, Inditex’s Sakhi and Swasti’s own Invest4Wellness (i4We) programme.

Find out more @ShankarAG15
Results from the Tufts study

The Tufts study attributes tangible business outcomes to the health and socio-emotional well-being of women working in the factories.

PRODUCTIVITY INCREASED BY

39%

The number of women arriving late to work reduced from 45 per 100 women to 17.

Download the Foundational Training report:

Download the Advanced Training report:
In 2003, a group of 13 women in sex work in Bangalore formed their own community organisation, Swathi Mahila Sangha (SMS) and threw open its doors to marginalised women in the city. They had visited Bangladesh and Kolkata and were impressed with how women in sex work were running community institutions there. These institutions provided significant empowerment for its members. Drawing support from various partner organisations and following stringent protocols of elected community leadership, SMS drove innovations that were designed to meet the needs of the community.

In 2005, the Bill and Melinda Gates Foundation partnered with SMS on a project called Pragati, Avahan I. The project started with a needs assessment among women in sex work that produced some important discoveries.

While sex work in India is not a crime, running brothels and soliciting clients is illegal under the Immoral Traffic Prevention Act (1956). The purpose of the Act is to curb human trafficking and combat sexual exploitation for commercial purposes. However, systems and individuals often interpret sex work in ways that lead to harassment, detention and arrest of sex workers, endangering them further.

“Women in sex work were nervous about carrying condoms as they often faced police harassment.”

On the night of 5th December 2005, Helen, a peer educator with the Pragati project, went to mobilise support for an event concerning access to HIV/AIDS services for the community. She was mercilessly abused and beaten by the police. This incident led to the formation of a Crisis Response System.

In collaboration with SMS, the women formed their own crisis team, which they named the Rapid Response Team. They conducted sensitisation meetings with 1,800+ police personnel on HIV and explained how women and girls are lured into sex work or are forced to take up sex work due to poverty, violence and destitution.

The outcome of SMS’s Crisis Response System was that by early 2019, nearly 8,000 cases of violence had been addressed. Perpetrators included clients, partners, husbands and even the police.
HIV prevention programmes rarely ask vulnerable communities what they really need. As it turns out, their priorities are very different. Women in sex work were preoccupied with the safety of their children and were focused on making just enough money to survive. Their health came last on their list of priorities.
Social support is important for women in sex work to “challenge power relationships and structural barriers that contribute to their vulnerability.”

SMS, through its work, eventually won the support of the police. The women were now finally able to talk about the violence and harassment they faced via the excesses of the police force and leveraged existing checks and balances to protect themselves. Between 2005 and 2010 alone, SMS reported 1500 instances of violence where the police were the main perpetrators. Due to the sustained fight for justice, in 2008, an Assistant Sub-Inspector who had sexually abused the sister of a sex worker and framed several false cases was suspended from duty. Another policeman was fined and ordered to apologise publicly for instances of abuse.

As soon as incidents of violence reduced, women started getting their friends and acquaintances to join the organisation. The services included helping them secure government social security entitlements, programmes on stigma reduction, nutrition drives and counselling sessions. The community-level awareness encouraged women to save money and to stop borrowing money from local moneylenders. They in effect, started to take control of their lives.

Says Shrirupa Sengupta, who leads Communication within Swasti, “Strong and vibrant community organisations are vehicles that serve the needs of hidden and vulnerable communities.”

Today, Swathi Mahila Sangha independently serves more than 13,000 people, with a full-time staff of 60 and part-time staff of 120. In 2018, it saw a

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75 women from different community organisations across 5 States of Karnataka, Maharashtra, Andhra Pradesh, Telengana and Tamil Nadu became paralegal volunteers for their area.

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turnover of 1.7 million dollars. It offers support in the form of skills training, loans, livelihoods, scholarships, education for children of sex workers and support to access social entitlements.

Bill and Melinda Gates Foundation provided start-up investment between 2013 and 2017 through Avahan Phase III that covered 50+ locations catering to 1,00,000+ individuals across 5 States.

Find out more @shrirupa
DO WE NEED TO CONFORM TO BE HAPPY?

India requires its youth to identify as either girls or boys and they are usually assumed to be heterosexual. Those who do not conform to their biological genders, are set off on a cycle of violence and trauma that saps their potential.

The first thing anyone ever asks when a child is born is whether the baby is a girl or a boy, while a more sensible question may be to enquire after its health. Instead, the newborn receives balloons in pink or blue. As the child grows up, it is surrounded by social signalling that it must want blue because he’s a boy. Is it wrong then for the child to want a Barbie in a pink dress?

Gender non-conforming (LGBTQI) youth face hostile school environments and this is often amplified in rural settings. In addition to facing stigma from their peers and wrestling with self-doubt, most do not find solace at home as parents find this situation confusing, often blaming exposure to media or “bad” friends. The extreme pressure and isolation that this causes makes way for perpetrators to step in and exploit these young people.

A series of studies conducted by Oregon State University and Swasti aimed to gain insights into decision-making paradigms of gender non-conforming youth and transpersons in relation to self-care and health seeking behaviour. It revealed some startling statistics.

About 80 per-cent of 4,000 transpersons felt coerced to surgically reassign their gender. Almost every one of them have seriously considered or attempted self-harm or suicide at least once in their lives. The study involved art projects and dreaming exercises involving memory regression. This revealed that most gender non-conforming and LGBTQI persons hit rock bottom between the ages of 10 and 15. Several reported being disowned
The discourse in India on gender non-conforming youth is largely around HIV prevention and Section 377, but it has never really sought to understand them. The self, the environment, everything provides fodder for discrimination, physical and mental trauma and ultimately, much reduced human potential.

It therefore became imperative to do more for this significant and hidden chunk of the population. Thus was born the GenY programme, that provided lifeskills to young people on grit, resilience, self-reliance, relationship management, conflict resolution, sexuality and gender identity formation. The programme also created curricula for counsellors, teachers and peers on counselling and emotional health.

Consider Shankar’s story. After completing the GenY programme, Shankar (not his real name), 22, sat down with his mother to discuss his gender identity. He had always believed that she hated him for being effeminate. The programme helped Shankar talk to his mother about his gender and sexuality.

“We need to continually strive to unravel how youth understand and express gender as it is critical to address health disparities in this important population,” says Angela, who has worked in this area since 2002. She hopes this study improves emotional health support services for teenagers and that teachers and parents begin to help transkids and gender non-conforming kids feel more comfortable about accessing the care they need.

The GenY initiative, with the support of the Canadian High Commission in India was launched in January 2017. The initiative reached close to 4,000 people. The Department of Social Welfare in Tamil Nadu scaled this programme across 10 colleges.

Find out more @Angela_Swasti
We need to continually strive to unravel how the youth understand and express gender, as it is critical to address health disparities in this crucial age.
SHAMA KARKAL TAKES OVER AS CEO

Following 16 years of leadership by Founding President Shiv Kumar, Shama Karkal took on the role of CEO in April 2017. Ever since her involvement with the Golden Gate Regional Centre in the US, where she worked with developmentally disabled children and adults, Shama has focused on channeling her passion for social good into a career. After returning to India in 2004 with a Masters in Social Work from the University of Maryland, Baltimore, she took up meaningful and deep work stints in maternal and child health, first with SAATHI and then in Kushal Foundation, both non-profits.

Shama joined the Swasti family in 2004 as a Monitoring, Evaluation and Learning (MEL) officer for project Pragati, the largest HIV prevention and empowerment initiative, working with 15,000+ sex workers in Bangalore, India. She is currently the elected chair for the Asia Pacific Alliance for Sexual and Reproductive Health and Rights and works globally on complex public health challenges.

Shiv Kumar, Founder President says, “I have full faith that Shama will take Swasti to the next level.”

Along with sectoral experience and leadership, Shama brings to the role a combination of empathy and expertise in human-centered design, project management at scale and resource mobilisation.

Follow @ShamaKarkal
For the poorest and most marginalised populations, it is difficult to access mainstream financial security and services or to strive for a life of safety. Facing poverty, violence and discrimination on a daily basis, individuals find themselves caught in a web of deprivation, making them vulnerable to exploitation and abuse.

In India, the state and central governments provide more than 200 social protection schemes that reduce levels of vulnerability, risk and deprivation among the most marginalised communities. Some examples of social protection schemes in the country include pension schemes, health insurance, education assistance and housing schemes.

These schemes protect vulnerable populations against political, economic, environmental or health catastrophes.

While several such schemes are available in the country, marginalised communities who need this the most, often do not know about the very existence of these schemes. Even if they are aware, accessing the schemes is a major challenge due to cumbersome procedures and somewhat insensitive government machineries. This is why the Single Window Model of social protection was introduced to educate vulnerable groups about social protection and assist them in accessing the schemes.

The model works with various stakeholders and systems to ensure that the most deserving communities have access to these schemes. This was first piloted by the United Nations Development Programme (UNDP) and National AIDS Control Organisation (NACO) in India. It was then scaled up for HIV/AIDS interventions through support by the Bill and Melinda Gates Foundation via the Avahan Phase III programme. It was later brought into the National AIDS Control Programme (NACP).

Over a period of 3 to 4 years, social protection schemes worth more than rupees 1,500 crores were made available to the communities through the Avahan programme. Apart from scholarship and monetary entitlements, people from these vulnerable communities have secured passports, BPL cards, insurance, voter IDs, Antyodaya Anna Yojana (AAY) and ration cards.

Today, the programme has helped to shape the approach of social protection for poor, marginalised and vulnerable communities in India and has been proven to work for communities in urban slums, rural poor, marginalised factory workers and other such groups.

UNDP and NACO commissioned Swasti and the Vrutti Livelihood Resource Centre to carry out a study of the existing livelihood programmes for PLHIV and other vulnerable communities. The study highlighted issues in the design and approach of livelihood programs and the limited impact on poverty reduction of those infected and affected by HIV for a variety of reasons.

The study identified, among other things, social protection as an effective strategy to reduce economic and health shocks related to HIV infection for marginalised communities. Increased risk of HIV infection for communities like sex workers, MSM and transgender communities is often a result of extreme poverty and exploitation. Subsequent to the study, Swasti developed and piloted the Single Window Model, which helped at-risk and those living with HIV to access social entitlements and social protection schemes.

Find out more @pbhoopathy76

Download the study at: http://www.in.undp.org/content/india/en/home/library/health/social-protection-that-works-for-plhiv---a-compendium-of-case-st.html
For the vulnerable, there is a darker side to a visit to the hospital - Hospital Acquired Infections (HAIs) and patients with weak immune systems are the most susceptible. Inadequate water, sanitation and hygiene (WaSH) account for about 10 per-cent of all infections.

Good WaSH infrastructure and hygiene practices, especially hand washing, are critical in health centres.

The most common HAIs are infections of the urinary tract, bloodstream, surgical site and pneumonia, all of which have strong links to WaSH, especially hand hygiene. Poor WaSH is linked to maternal mortality and morbidity, especially sepsis. A review in 2011 of HAIs showed that in some developing countries, up to one in every two patients (45.6 per-cent) left the hospital with an infection they did not have on arrival.5

Swasti undertook a study on the status of WaSH in health care facilities in Karnataka, Madhya Pradesh and Odisha. The study found that staff in these centres were indifferent to taking basic hygiene and sanitation related precautions to prevent infections. While nearly all facilities had toilets, 40 per-cent were dysfunctional or unusable.

The Ministry of Health and Family Welfare (MoHFW), Government of India, issued Kayakalp - Swachhata Guidelines for Public Health Facilities6 to improve the hygiene and cleanliness of health facilities and reduce hospital acquired infections. Incredibly, the study showed that these guidelines have not had much impact because the monitoring tool was paper-based.

The need of the hour was recognised to be a fast, low-cost and reliable way to report, assess and act - ideally a mobile app that provided real-time information not only to the administration of the hospital but to the higher-ups, to call for help, highlight challenges and ensure accountability.

In response, Swasti Health Catalyst, supported by its sister organisations in the Catalyst Group, created the WaSH app. The solution consists of an android app and web platform to help hospitals monitor and execute healthy WaSH practices.

The app is aimed towards providing healthcare facilities and real-time access to WaSH information. With regular real-time monitoring resulting in enhanced WaSH standards maintained in healthcare facilities, the quality of health services will eventually improve. This would prevent infection and thereby reduce preventable deaths among mothers and newborns.

Read about it here: https://www.socialapphub.com/interview/wash-assessment-system-hospitals

The frequency of peer outreach is associated with increased likelihood of and shortened duration to clinic utilisation among female sex workers.
Peer-led outreach is a critical element of HIV and Sexually Transmitted Infection (STI) - reduction interventions aimed at sex workers. Swasti studied the association between peer-led outreach to sex workers and the time to utilise health facilities for timely STI syndromic detection and treatment.

A study led by the University of Houston and co-authored by Swasti, used data from 2,705 women sex workers registered under Pragati, a women-in-sex-work outreach programme, from 2008 through 2012. The study used data on the timing of peer-outreach interventions and clinic visits, among sex workers. The team used an Extended Cox model, with the density of peer educator visits in a 30-day rolling window as the key predictor, while controlling for the sex workers’ age, client volume, location of sex work and education level.

The principal outcome of interest is the timing of the first voluntary clinic utilisation. Researchers wanted to see how soon after meeting the peer did the woman sex worker voluntarily go to a clinic for a check-up or treatment.

Researchers found that the more the peer visits, the earlier the women visited clinics for the first time. (HR: 1.83, 95% CI, 1.75–1.91, p < .001). 18 per-cent of all syndrome-based STIs detected come from clinic visits in which the sex worker reports no symptoms, underscoring the importance of inducing clinic visits in the detection of STI.

The researchers found that clinic utilisation results in the detection of STI-syndromes that the sex worker would have otherwise missed. This underscores both the importance of peer-led outreach and the role of clinic visits. By encouraging sex workers to come to the clinic, the outreach workers are helping detect STI that would have otherwise gone unnoticed.

In 2012, Swathi Jyoti received an award for the Best Urban Community Micro Enterprise from the Citi Foundation, which honours exemplary community micro enterprises and the significant role played by organisations in nurturing and promoting them.

Swathi Jyoti was selected from 130 other urban micro enterprises in the country for this award, based on its work towards economic empowerment of vulnerable women, in this case women in sex work.

This award was presented at the Citi Micro Enterprise Awards (CMEA) ceremony held in 2012 where four community micro enterprises and one innovative livelihoods enterprise promoter were felicitated for successfully building self-sustaining businesses, creating employment and for their meaningful contributions to their communities. The Honorable United States Ambassador to India, Nancy J. Powell, together with CEO of Citi India, Pramit Jhaveri and the Governing Council Members of the Awards programme presented the awards.

Most sex workers do not get the benefit of financial services, and even fewer receive respect when accessing them. They often resort to informal loans, which drives them to further debt or to survive by making risky choices. Swati Jyoti was set up to remove financial compulsions that drove women towards unsafe sex work.

Run by Swasti and Swathi Mahila Sangha (SMS), this micro enterprise offers financial services through drop in centres at their doorstep. Women can easily withdraw money, reducing pressure during lean days and thereby helping them negotiate safe sex.

This micro enterprise was set up by Swathi Mahila Sangha, a community organisation of women in sex work and incubated by Vrutti and Swasti. It offers life-saving financial services to more than 11,000 women in sex work.