

Creating Effective Structures for Community Led Targeted Interventions in HIV Prevention – The MYRADA Experience

Authors: M. Mascarenhas¹, A. P. Fernandez¹, et al

Background:

India has a “*concentrated HIV epidemic*” where the general prevalence is 0.36%, but prevalence in high risk groups is over 7%. (NACO, 2007). The National AIDS Control Programme (NACP-3) guidelines recognize the need to have community led interventions to ensure a sustainable response. Myrada has learnt that the most critical component is creating effective community structures along with aggressive capacity building that will enable sustained responses for high risk groups.

Myrada, an NGO in South India, has been implementing targeted interventions (Soukhya Project) with around 13000 sex workers (SW) for the past 4 years with the support of Bill and Melinda Gates Foundation. From the inception, the team has incorporated the idea of community led interventions through the formation and capacity building of small groups of 8-15 female sex workers. These groups have been formally trained through a twelve module program over 2 years to respond to both risk and vulnerability reduction issues of their members. They have also formed federations at local and district levels that would manage the outreach, community mobilization, linkages to services and enabling environment components of a targeted intervention program.

SOUKHYA PROJECT GOALS AND OBJECTIVES

Myrada has been implementing targeted interventions with the support of Bill and Melinda Gates Foundation (through the State Lead Partner – Karnataka Health Promotion Trust) since early 2004, and with Karnataka State AIDS Prevention Society in Chamrajnagar district. This intervention (called the Soukhya project by Myrada) is being implemented in 44 urban locations in the 4 districts of Gulbarga, Bellary, Chitradurga and Kolar in Karnataka. The teams work with around 17000 FSWs and MSMs.

Table 1 describes the details of the female sex worker high risk group population that has been identified and registered into the program.

Description	Chitradurga	Kolar	Bellary	Gulbarga	Chamrajnagar	TOTAL
Estimate during mapping (2004)	1707	3131	5021	3809	626	11294
Initial contact	2258	3481	4360	3837	739	14675
Registered	2200	3367	4376	3716	739	14398
Regular contact	1750 (78%)	3036 (90%)	4250 (97%)	2910 (72%)	500 (68%)	12446 (86%)
Had regular health check up	1491(85 % of contacted)	2480 (82%)	3832 (90%)	2160 (88%)	295 (59%)	10258 (82%)

¹ All from MYRADA, an NGO in South India: – www.myrada.org

Tested at ICTC	1497	2160 (90%)	3119 (76.5%)	935	67	7778
Linked to social entitlements	1567	2615	2638	2106	0	8926
Comm. Groups	84	164	177	84	25	534
Staff	20	27	24	23	6 + CBO trainer	101
Peers and CBO CRPs (ORWs)	20 + 10 CBO staff	16 + 28 CBO staff	33+ 11 CBO staff	41 + 13 CBO staff	9 + 2 CBO staff	119 + 64 CBO staff
Savings	1856110	3156703	3921162	1245275	4567820	10636030
Loan income	2188898	4656200	1642895	2251870		10739863

Table 1: as of November 2008

The stated goal of the targeted intervention is to reduce transmission of HIV/STIs in female sex workers, MSMs and their regular partners in 47 towns across 5 districts* of Karnataka. (* Myrada has recently taken up a new TI program in Bidar district, with support from KSAPS).

Total no. of sex workers registered into the programme: 17149; of which 14398 are FSWs.

Programme Components

Being a focussed targeted intervention prescribed by Avahan and NACO, the components are:

- **Outreach And Behaviour Change Communication** - through peer educators
- **Condom Promotion:** direct and through outlets
- Active promotion for **STI Management And Health Checkups:** through trained health care providers
- **Community Mobilization.**
- Providing an **Enabling Environment** – to reduce harassment, stigma and discrimination.

Myrada had developed its own strategic approach to tackling HIV AIDS and called it the ABC4DE approach

MYRADA'S ABC4DE APPROACH TO HIV AIDS

- A = awareness:** a basic and key element of any HIV intervention that needs to target the total adult population to bring about a better understanding of the disease and also to reduce stigma and discrimination.
- B = behavior change:** the only way to make and impact on this disease is through sustained behavior change; this requires intense efforts for smaller groups of people who are involved in high risk behavior
- C4 = Continnence, condom promotion, community involvement , continuity :** are the processes identified to bring about sustained behavior change.
- D = drugs, care and support:** no HIV intervention can be considered complete or ethical without responding to the existing situation of increasing number of infected persons.
- E= Empowerment of Social & Economic aspects.**
Services should include providing access to drugs, nutrition, basic care and support of those infected and affected by the disease we are trying to prevent.

Key elements for sustainable intervention in the Soukhya project.

When Myrada took up this project, it looked at sustainability and cost effectiveness from year one itself, and identified specific areas for sustainability.

1. Exploring the formation of a local community institution at ground level based on the strengths and needs of the community members.
2. Changing roles of staff from implementers to facilitators over 3 years.
3. All health services to be provided by existing govt. and private providers through collaborative linkages (contrary to the Avahan suggested model of a program linked clinic)

Therefore, in contrast to several other organisations and programs, Myrada only set up referral clinics in its districts and started forming Soukhya groups from the first year.

This paper focuses on one of the strategies: - formation of a local community institution of female sex workers with systematic and aggressive capacity building.

COMMUNITY BASED ORGANISATION STRUCTURE

How it began:

Taking into account Myrada's successful experience with small groups², the team decided to experiment with forming small groups of sex workers to give them a platform to discuss issues of their interest. Right from the beginning, the team recognised them as different from other women's self help groups (SHGs) and called them Soukhya groups. Credit and savings were not introduced to them in the beginning. However, after a few modules of capacity building and interaction with other active SHGs, the women decided to save too. Within a year, there were 60 + groups across the working area, and 4 years later, we now have around 500 Soukhya groups.

Components of the Community Institution

1. Soukhya group

The smallest unit of the CBO, called the Soukhya Group (SG), is the foundation of the community structure. It is made up of small group (8-15 persons) of sex workers from the same site who meets weekly on a fixed day fixed time basis. This group was formed to discuss relevant issues and initiate risk reduction and vulnerability reduction programmes. However, within 6 months, they also started savings, credit and asked Myrada to provide additional livelihood trainings and linkages.

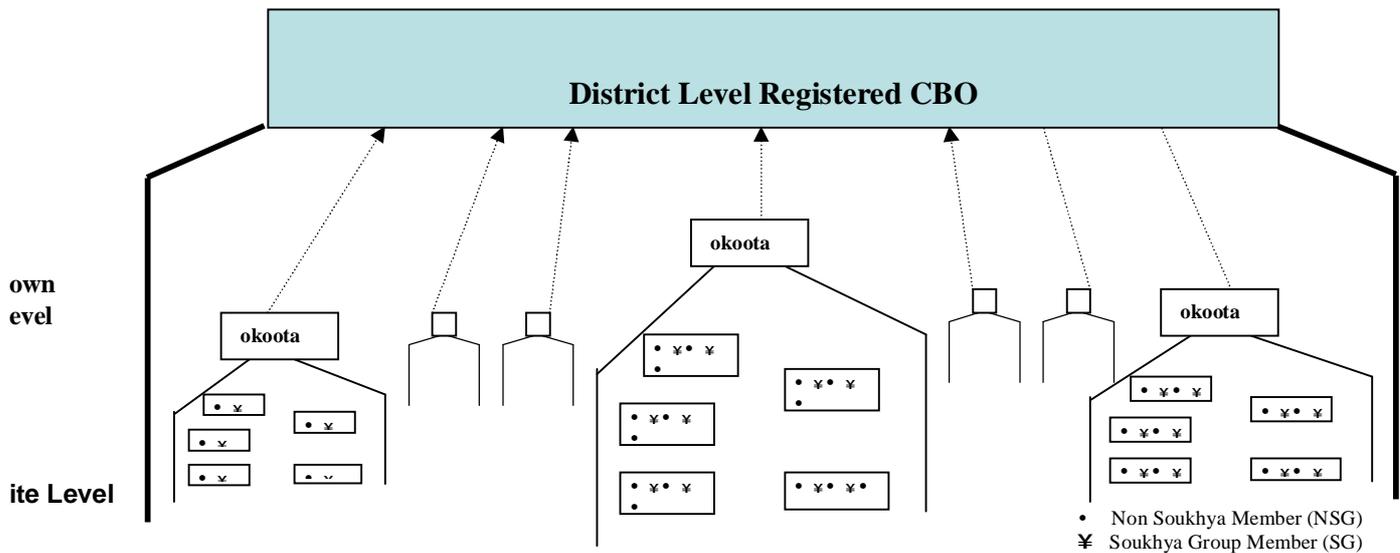
Every group functions independently, and is today linked separately to financial institutions and other linkages.

2. Mid level (town/ taluk)

After a year, the community members realised that were capable of looking after their own health needs, condom usage and finances. However, they expressed a need to have a common platform at both town and district level with representatives who could take up certain issues and interact on their behalf. Initially started of as advisory committees, these turned into federations called "okoota". Another decision taken by the women was that, since only around 50% of their community members were in Soukhya groups, the okoota would have representation from the non Soukhya group community of sex workers too. Each okoota, located at the town level, was made of representatives from each site (One Soukhya group member and one non Soukhya group member). Each okoota has around 25 members. They meet fortnightly and have constituted sub committees that address three key areas identified by the women: health, legal and crises issues and linkages to socio-economic entitlements.

Fig. 1: Community Based Institutional Structure

² Myrada pioneered the self help group movement in India in the early eighties, after having failed with cooperatives and collectives.



Ground level: Sites with sex workers in Soukhya groups (SG) and not in groups (NSG)

Town level: Soukhya okoota (federation): 2 members from each site (1 SG and 1 NSG) – maximum 26 members.

District level: Soukhya Samudhaya Samasthe {Registered Community based organization (CBO)}.

- 2 members from each Soukhya okoota in the governing body
- membership from community members endorsed through Soukhya groups

Currently there are 485 FSW Soukhya groups comprising 6499 female sex worker members in Soukhya groups in the Myrada Soukhya program.

COMMON FEATURES at all levels (Soukhya groups, okootas and district CBO)

1. Separate institutions with bank account audited annually.
2. Regular meetings on a fixed day fixed time schedule.
3. Systematic programme MIS, finances & livelihood strategies.
4. Intensive capacity building for all members.



CAPACITY BUILDING

Separate modules are available for training the different CBOs. Each module is around 4 hours minimum, and contains one health topic compulsorily.

Soukhya group

12 modules over 2-3 years

Institutional concepts, book keeping, leadership, conflict resolution, self esteem, unity, linkages, vision building, roles and responsibilities, action plan, fund management, HIV and RCH issues, crisis management, group evaluations

Soukhya okoota (Federation)

5 modules over 6 months

Institutional concepts, leadership, crisis management, financial management, programme monitoring and supervision, vision building, roles and responsibilities, linkages, documentation

District CBO

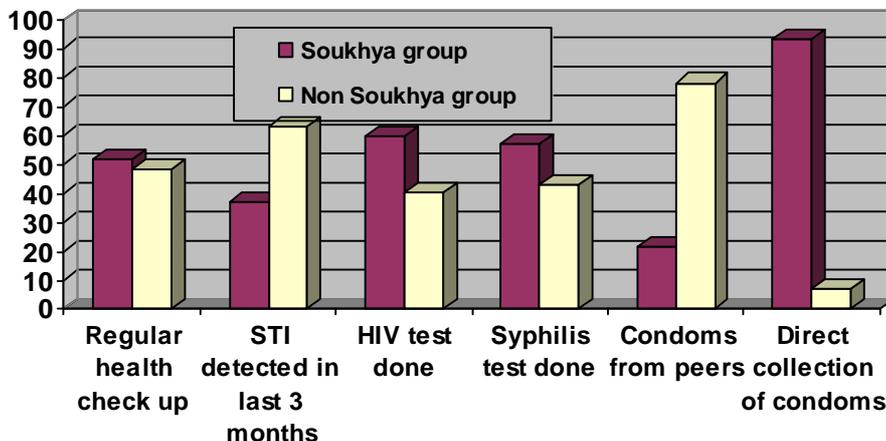
9 modules over 1 year

Federation concept, institutional concepts vision building, roles and responsibilities financial management, statutory requirements managerial training, mobilization & linkages training, crisis management

By the end of the third year, it was found that several Soukhya groups were managing the outreach services on their own. Therefore, they decided that they did not want a peer educator. The peers were reduced considerably from 200 to 101, and close to 400 Soukhya groups now manage their own outreach and health services.

When Myrada looked at what impact this institution has had on achieving the objectives of the targeted intervention, the team realized that there was a significant difference in the outcome of those FSWs in Soukhya groups. The tables below depict this trend. It must be remembered that all the Soukhya groups below are independent, working without the help of a peer educator.

Table 2: Impact of effective community structure on HIV risk reduction



- 51.7% of the community who visited the clinic once every quarter were SG members. All of them went on their own, while the non Soukhya group members were escorted by peers.
- 36.72% of the STI cases were detected in SG members.
- SG members have voluntarily gone for a HIV test (59.7%) and a RPR test for syphilis (56.89%); compared to NSG members who were escorted for HIV test (40.3%) and syphilis test (43.11%)
- 92.83% of the SG members get their own condoms (bar 6), while 78.1% of NSG community get condoms from a peer educator (bar 5).

It is well recognised that HIV prevention is a factor of both risk reduction and vulnerability reduction. Our teams have focussed equally on both and have seen excellent results.

Vulnerability reduction outcomes

There has been a significant advantage for SG members across all vulnerability reduction services.

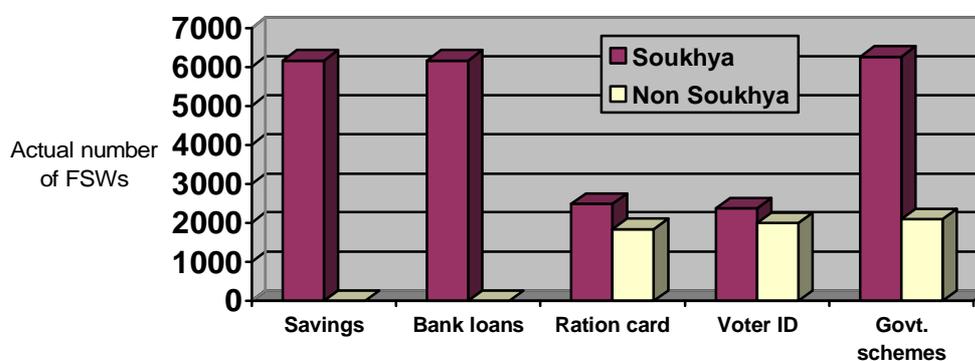


Table 3: Vulnerability reduction outcomes

Next Steps

1. All outreach services (access to HIV information, condom supply and regular health check ups) will be managed by the CBO.
2. CBO will explore linkages/ referrals of all its members, as well as attempt to recruit more members through formation of new Soukhya groups at the ground level.
3. Changing staff roles from implementation to technical assistance for CBO

- project.
4. Myrada to completely withdraw from 2 districts in next 6-8 months and phase out from remaining 2 over 12-18 months.

Conclusions³

It is quite evident that effective community organization has a significant impact on risk and vulnerability reduction in HIV targeted prevention indicators. In addition to the regular deliverables of behaviour change communication, condom promotion and treatment of STIs, a key component is building and enabling an effective community structure. In the Soukhya program, we have seen an impact in the program already.

This has been possible because of three factors:

1. Community organization has evolved in a bottom up participatory manner into an explicit structure engineered by the groups, made up of three levels. This progression is a function of the needs expressed by the community itself.
2. Each level has very clear roles and responsibilities, decided by the groups at lower level. All units of the CBO monitor the physical and financial progress of their members with specific MIS systems in place.
3. Intensive capacity building from the first year itself has enabled the community structure to now manage on its own with need based support from the project team.

³ For more details, contact: **Dr. Maya Mascarenhas, MYRADA** (mayahiv@yahoo.com)