

Building People's Institutions in the Context of a HIV-AIDS Programme The MYRADA Experience

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Background

MYRADA has been implementing the AVAHAN sponsored HIV AIDS prevention programme in four districts of Karnataka (Gulbarga, Chitradurga, Bellary and Kolar) in partnership with Karnataka Health Promotion Trust (KHPT) since February 2004. This project (called the MYRADA Soukhya project) is a 5 year focused prevention project aimed at reducing the risk of HIV transmission in urban sex workers (SWs) in the selected districts.

MYRADA pioneered a large scale rural focused HIV AIDS Awareness and Control Programme in Belgaum District as early as 1994 which covered over 1 million adult population; the programme was supported by CHILD REACH and USAID. The programme ended in 1998. However, there was a gap of 6 years before any further work was taken up in this sector. Meanwhile, MYRADA had lost its trained staff and institutional experience in managing HIV AIDS Prevention Programmes. Hence, when the KHPT Project started in 2004, it could be said that the HIV AIDS Prevention Programme and working with SWs specifically was a new field for MYRADA.

*This paper traces the emergence of people's institutions in the HIV-AIDS Programme sponsored by **KHPT, CHARCA and CDC**. These emerging institutions have still to be tested. No one is claiming that they are appropriate to manage and sustain the functions that the SWs and others expect of them. A great deal of institutional capacity building is required; some may grow others may not; but there is evidence that some at least have the potential to promote and sustain the programme and to take the lead in setting an agenda. MYRADA is searching; feedback from the field is large; we need help to analyse experiences and to gain insights; **please therefore react to this paper.***

FIRST YEAR OF THE AVAHAN PROJECT: February 2004-March 2005

The first six months of the project were devoted to recruiting and training the new staff, and breaking into the sexual networks to make contact with SWs and network operators involved in the sex work business. In the first three months, there was an extensive mapping exercise conducted by an organization, Swasti, where the Soukhya staff also

participated. This gave them an insight into the sexual networks of their area, which facilitated outreach later on. This involvement also helped them to identify peer educators. By February 2005, all Soukhya projects were able to contact over 90% of the estimated SWs in the Districts.

While specific HIV risk reduction strategies were spelt out by KHPT through direct provision of services such as condom promotion and health check ups, MYRADA kept its eyes and ears open to see if people's institutions, comprising members who self-select themselves on the basis of mutual trust and support (whether full-time/part-time SWs or others), could help to add value to the service delivery approach. This "openness" which allowed members to self-select themselves was based on MYRADA's experience in promoting people's institutions like Self-help Affinity Groups. These groups provided the space and the opportunities to promote self-help and mutual support in order to achieve social and economic empowerment and changes in gender relations in private and public life. This openness allowed MYRADA to set a framework for the emergence of groups in the HIV/AIDS programme; the framework had the following defining features:

- MYRADA would keep its eyes and ears open to see if the SWs with whom it had built a rapport decided to **meet regularly** among themselves to discuss their problems and to find solutions. MYRADA considers this to be an indicator that the group members are willing to commit themselves to the objectives of self-help and to take up responsibilities on their own. However, feedback to MYRADA also highlighted the demonstration effect that existing self-help groups in the locality had on the SWs. If MYRADA found that a regular pattern emerged and that this was due to their own decision (not MYRADA's requirement) it would offer the group its services to build their institutional capacity so that they could function in a truly participative way, develop their own vision and mission as well as organisational systems as a basis for transparency and sustainability. Once this institutional basis was established, they could decide to promote federations and collaborative networks- which would establish their own agenda and pace of implementation for taking the lead in initiating and sustaining change in policies and attitudes which were biased against them. If the SWs did not meet regularly and did not show any desire to do so, MYRADA would continue to interact with them on a one to one basis.¹
- MYRADA would not project the message that these groups should be exclusively of SWs. Members would self-select themselves whether they are full-time/part time SWs or even others; the process adopted would be self-selection by members based on relations of mutual trust and support – or what could be called affinity or social capital.²

¹ By February 2005, MYRADA discovered that 60 Groups had emerged whose members had self selected themselves and who had decided to meet regularly. MYRADA called them Soukhya Groups to distinguish them from the Self-help Affinity Groups which it promoted in all its projects.

² In October 2006, MYRADA discovered that 363 groups had emerged. Out of this number 228 groups were exclusively of fulltime SWs and 135 had non-SWs as members. A caveat is required here. During the last one year there has been a tendency in MYRADA to project the message that the Soukhya Groups should be only of SWs. This has to be addressed.

- MYRADA very consciously took the decision not to start with savings in the Soukhya groups as it does in the SAGs. Instead the message projected was that they should meet to discuss the issues that affected them the most. (However, by October 2006, 337 groups (out of 363) had started savings, some of these groups had also started lending. When asked why they decided to save and lend, the reasons they gave were the following: (i) Children's' education, (ii) urgent health and household needs for which they had hitherto depended on loans from those who had some degree of control over them; this in turn increased their dependency and pushed them further into high risk sex work, (iii) finance to invest in alternate income generating activities so that they can reduce their dependence on sex work. (iv) Savings for their old age or when they could no longer earn through sex work. Many of these groups have also been able to get finance from Banks under the SHG-Bank linkage programme).

MYRADA also realised that there were several part time SWs in the self help affinity groups with which MYRADA had been working for several years; it was a humbling experience for the MYRADA staff to learn that they had not realised that there were part time SWs in the well functioning SAGs. This also provides a lesson to those intervenors who insist on SWs identifying themselves in public as a sign of empowerment; it should be left to each one to decide whether and when to do so. At the Kolar District meeting in 2005, one of the leaders of the DMSC, Sonagachi, Kolkata stressed that while sex work is not an occupation to be ashamed of, disclosure is not an indicator of empowerment and self esteem.

In the first year itself, it emerged that several of the SWs wanted to meet regularly to enable them to have a platform to discuss their burning issues. They were called Soukhya groups to distinguish them from Self help Affinity Groups (SAGs) and to identify them as part of the MYRADA Soukhya project. Savings and credit (a primary activity of SAGs) was not promoted by MYRADA. However, there were several cases where the Soukhya Groups interacted with the SAGs functioning in the area and soon followed their example. The following box gives one example.

In the Months of May & June 2004, the MYRADA staff had already built up a good rapport with Female SWs in Ambedkar Nagar in Challakere town. Most of the residents are living in huts without proper drainage and other basic amenities. Many women take up sex worker to supplement their incomes. MYRADA Soukhya staff began by inter-acting with SWs, referring them to STI Referral Clinics for treatments and promoting condom distribution and proper use. Mrs.Ratnamma, one of the SWs was selected as a Peer Health Educator for Ambedkar Nagar. The SWs did not show any interest in meeting regularly. During one of the interactions with the staff it emerged that the SWs were facing a lot of harassment from rowdies; they collected extortion money and threw stones on their houses at night. There were a few SAG groups in the area. The SWs met with them and discussed this problem. Together they decided to take action.

One night they caught hold of rowdies and handed them to the police. This incident taught the SWs a lesson, viz. "Unity is Strength". They decided to meet regularly and approached MYRADA staff to help them. A Soukhya Group was formed on July 18, 2004. At present the group has 15 members of whom 11 are SWs and the rest are others. They decided to follow the example of SAGs and introduced regular savings. They opened an account with Chitradurga Gramin Bank in Challakere. Most of the members have taken loans for income generating enterprises.

Institutional Developments and Learnings from The First Year

By the end of the first year, 60 Soukhya groups had emerged and project staff began to build their institutional capacity, using some of the modules that were used to build the organisational capacity of the self-help groups. The following features emerged as common to these groups:

1. All Soukhya Groups comprised only Female SWs and other women with whom they had an affinity. No MSMs (Male Sex Worker) met regularly; they had periodic gatherings which were of a different nature and will be discussed separately in another paper.
2. Majority of the members, if not all, were SWs. Any non-sex worker in the group was there at the invitation of the SWs and with the acceptance that these groups would focus mainly on sex worker related issues. MYRADA analysed the agenda of each meeting. From this analysis it was clear that the main issues on the agenda were largely related to socio-economic vulnerabilities such as poor/rented housing, inability to get a ration card, strong desire to send their children to school and to have access to alternate livelihoods.
3. Specific issues related to sex work that emerged in some areas included legal issues, police and *goonda* harassment and stigma and discrimination.
4. Most groups (contrary to MYRADA's expectations) unanimously decided to include savings as part of their activities. When asked for the reasons, they listed children's education, house hold needs, needs to invest in alternative incomes and need to save for their old age.

Building on this analysis and feedback, the groups were exposed to the SAGs to learn how vulnerable and poor women, when organized, can emerge as a successful force to contend various issues that confronted them. The SWs in the Soukhya groups realised that the SAG members –who were also poor and exploited when they started their groups - were able to address harassment and socio-economic issues only because these issues were handled collectively as a group.

Two major issues emerged from the feedback which required attention. MYRADA highlighted both.

- The first issue related to the strategy. If MYRADA adopted a strategy to work with groups as the basis of extension, what about those SWs who could not or did not want to form groups? Initially, MYRADA approached these SWs on a one-to-one basis and backed it up by organising awareness programmes for focus groups in the villages or during seasonal events which attracted SWs like the Mango Mandi in Srinivaspur, Kolar District. However, a survey was made to get a clear picture of the SWs who did not form Soukhya Groups in the project areas. It was discovered that some were full time SWs who came from far away places and gravitated towards events like Jathras/Festivals or Seasonal events like the Mango Mandi. These SWs returned to their base periodically. The project had no way of keeping in touch with these SWs. The programme strategy needs to take this into consideration and to include initiatives

that identify NGO/Government staff or others working to prevent HIV-AIDS in the villages to which they return. Others were part time and did not want to identify themselves publicly as SWs by joining Soukhya Groups. Many of these part time workers were already members of SAGs and had to resort to sex work during periods when cash was scarce or during droughts. They did not want to be identified publicly as SWs in the SAGs they belonged to. The project staff had to interact with these SAGs to ascertain what role they would be willing to play to help the members who were part-time SWs. It was felt that it would take at least six months to evolve a strategy together with the SAGs in order to cope with this issue. This issue was taken up in 2006 when the SHGs felt more confident.

- The second issue related to the increasing evidence that HIV-AIDS had gone beyond the high-risk group which was the focus of the AVAHAN project and had penetrated into the general community. On February 16, 2005 the Executive Director of MYRADA wrote to Mr. James Blanchard the then Project Director of KHPT. *“Four out of the five districts that we work in are classified as high prevalence districts with large numbers of HIV positive persons already identified. Any effort towards HIV prevention would need to include this population.”* However, since AVAHAN continued to focus on the high-risk group MYRADA began to consider whether it should leverage other resources to work in the general community. As a first step MYRADA decided to include some modules on HIV-AIDS prevention in its training programmes in all its project areas.

By early 2005, MYRADA put together its own approach to address HIV-AIDS. It could be summarised as the ABC4D approach which is briefly described below:

- A** = Awareness: an ongoing activity that is required to generate correct information about this disease to all populations.
- B** = Behaviour change which should be a consequence of effective awareness.
- C4** = Continnence (of changed behaviour; Condom use (proven scientific method of prevention); Community involvement and Continuity.
- D** = Drugs: for the HIV+ persons (ART and opportunistic infections) and STI treatment.

SECOND YEAR – (AVAHAN & CHARCA³) March 2005 to February 2006

By this time, MYRADA staff had succeeded in making contact with almost all the identified SWs and had built a rapport with this community. A participatory analysis of the progress of Soukhya groups conducted by selected staff and members of the Soukhya groups showed that: (a) these Soukhya groups of Female SWs (and others in some cases) based on affinity among the members showed evidence that they had the potential to become the basis for decision-making and management of the programme; they were already beginning to participate in planning and decision-making⁴. ***Note: The MSMs did not and still do not show (till mid October 2006) any inclination to meet regularly or to form groups. There are however a few exceptions. As on October 2006 there are 11 MSM Soukhya groups out of a total of 363. They do have periodical gatherings but they will be discussed in a separate paper.*** (b) Many of the groups had started to save money. (c) Many groups began to interact amongst themselves and to set the basis for a common platform. (d) They also began interacting with existing SAGs of non-SWs which were functioning in the area; this brought the Soukhya Groups into contact with the SAGs. (e) Group pressure began to emerge as an important factor in triggering behavioural change. The analysis concluded that MYRADA should invest in the institutional capacity building of the Soukhya Groups to achieve the following objectives:

1. To introduce and support behavioural change to safer sex practices within the group in order to achieve sustainable and consistent behavioural change.
2. To provide a platform for SWs to express their feelings, and to identify and prioritise their problems and needs, and get support to address the same.
3. To create an institution that could interact with a broader community through the Gram Sabhas and Panchayats in matters related to HIV-AIDS prevention and home-based care.
4. To enable SWs to get linked to various organisations, including financial institutions, which will provide them alternate livelihood options of their choice.
5. To develop an institutional network to support and lobby for the sex worker community.

³ CHARCA – is the acronym for Coordinated HIV-AIDS Response through Capacity building and Awareness (supported by UNDP). It was approved in September 2004 and covers 4 taluks of Bellary District.

⁴ Accordingly, on March 29, 2005, the Executive Director of MYRADA wrote to Mr. Ashok Alexander the Executive Director of the Bill and Melinda Gates Foundation (copied to Mr. James Blanchard)

“Together with awareness creation, behaviour change can be initiated in this high-risk group through more inter-personal communication strategies; but this change needs some external pressure to be sustained. Our experience indicates that for behaviour change to be sustained, those in these focus groups (high risk women, men at risk, etc.) need to form their own institutions on the basis of affinity among members. We build on this affinity through institutional capacity building which includes pressure to conform to behaviour patterns accepted by the group and to accept sanctions for lack of conformity. The self-help affinity groups or SAGs have proved to be appropriate institutions to introduce and maintain behaviour change. The advantages include pressure from members of other groups as well as the community leaders that will enable the individuals to reinforce and adopt safer behaviours.”

6. To provide an institutional base to continue to promote activities beyond the project period.
7. To evolve a strategy that could provide an institutional base to relate with and support SWs who are not in groups including the MSMs.

Areas for Capacity Building for Year 2 based on the Objectives that emerged from an analysis of feedback from the Soukhya groups

1. Module 1

- a. About the Soukhya project and the NGO involved.
- b. Group concept (adapted from SAG capacity building manual)
- c. Unity- affinity in action (in context with SWs)
- d. Importance of self esteem- historical review of SWs.
- e. Common health problems of women

2. Module 2

- a. How to conduct a meeting (adapted from SAG manual)
- b. Group goals and objectives (adapted from SAG manual)
- c. Communication (adapted from SAG manual)
- d. Responsibilities of group members (adapted from SAG manual)
- e. Rules and regulations (adapted from SAG manual)
- f. Basics of gender and HIV

3. Module 3

- a. Leadership (adapted from SAG manual)
- b. Conflict resolution (adapted from SAG manual)
- c. Linkages with other institutions (adapted from SAG manual)
- d. Legal rights of Indian citizens and women in particular

4. Session 4: Topics

- a. Building vision (from SAG capacity building manual)
- b. PRIME (from SAG capacity building manual)
- c. Common fund management (from SAG capacity building manual)
- d. Savings and credit (from SAG capacity building manual)
- e. RCH and HIV Prevention services – available and how to access

EMERGING ISSUES

An analysis of the feedback from the Soukhya Groups, MSMs and SWs, threw up several other issues that need to be addressed. They are: (1) the growing trend for Soukhya Groups to come together to build a common platform and (2) the increasing demand from SWs for alternate livelihood support. (3) The increasing need to work with Male Clients. (4) Importance to include youth in the programme. (5) The spread of HIV-AIDS outside the high-risk groups into the general community. (6) Consequently, the need to work closely with Gram Sabhas and Panchayat Raj Institutions to promote and strengthen the ABC4D strategy. (7) The issue of sustainability. MYRADA made initial attempts to respond to these emerging issues. They are described below.

- 1. Common Platform:** The trend to build a common platform started in Chitradurga District early in 2005. This rapidly spread to the other three districts. In Chitradurga, 12 groups emerged during the first year (2004). There were many issues that were common to these groups as well as with other SWs. Therefore, the SWs asked if a common platform could be developed with representatives from different groups and areas. Thus, a district level committee was formed which had members from existing Soukhya groups and SWs who were not in groups. Several issues were discussed and decisions taken⁵ which gave them some confidence that coming together to build a common platform and network could help to protect and promote their interests.

Following Chitradurga's example, the other 3 districts decided to explore the possibility of setting up a common platform. The SWs and Soukhya groups discussed this and decided to form taluk level sex worker committees. It was decided that each committee would consist of 8-15 members, the majority being representatives of Soukhya groups; others who are not group members could also be elected to this committee. The roles and responsibilities of these committees would be developed during meetings. The Taluk committees also felt the need for a higher-level body at district level; hence they decided to form a Sex Worker Advisory Committee at the District level. This was replicated in all four districts by the end of 2005.

These Taluk level committees were renamed as Soukhya Okootas in July 2006. Currently, 32 towns have Soukhya Okootas. Only the new towns where work was

⁵ **Issues discussed were** ▪ Police Raids ▪ Harassment from public ▪ Inability to obtain Ration Card ▪ Desperate need for STI services and Legal Support Services ▪ The need for field exposure to visit groups ▪ Interest in formation of Soukhya group and request for support from MYRADA

Decisions taken were ▪ To set up advisory Committees at various levels ▪ Set up legal cells ▪ Lobby for one Sex worker on Government HIV-AIDS district committee ▪ Lobby for Ration cards by visiting DCs office ▪ Exposure visit to MASS (Devadasi Society) to be organised followed up by formation & capacity building of Soukhya Groups with MYRADA help ▪ Police sensitisation – advisory committee members to take the lead.

initiated during 2006 have not yet formed the Soukhya Okootas, as the Soukhya groups are just being formed and trained.

In Chitradurga, the Okootas have taken over the responsibility of recruiting and managing the peer payments. This has made the peers more accountable.

In keeping with the priorities established by the Soukhya Groups, and based on their requests, the focus during 2005-06 was not only to form new groups but also to strengthen formed groups through intensive institutional capacity building programmes. After a series of discussions, and building on past experiences with training of SAGs, the capacity building programme was defined into 8 modules. Four modules would be completed in the second year, and the remaining in the 3rd year.

- 2. Alternate Livelihood Support:** The demand for alternate livelihoods came up repeatedly during Soukhya Group meetings. MYRADA's approach has always been to promote self-help and empowerment. Consequently, the message given to the Soukhya groups was that MYRADA would be willing to help them provided they took the first step. Within a few months, in early 2005, we discovered that most of the Soukhya groups had followed the example of the SAGs and had started savings. Increasingly, they also started giving loans. MYRADA is trying to collect data, simple formats are being filled by staff, but much more has to be invested in streamlining the collection and analysis of data. Unless this is done we will not be able to provide the support in terms of linkages, skills and marketing that will add scale or value to the income generating activities that each Soukhya member has selected. However, a brief analysis of the data reveals the following picture as on September 2006.

District	Soukhya Groups				Savings	Soukhya Loans		Credit Linkage							
	FSW	Mem- bers	MSM	Mem- bers		No.	Amount	CMRC		Sanghamithra		Bank		Other*	
								No.	Amount	No.	Amount	No.	Amount	No.	Amount
Chitradurga	69	956	2	28	424,999	58	409,962	1	10,000	5	145,000	1	20,000	19	265,190
Gulbarga	56	837	3	34	269,245	65	112,900	0	0	0	0	0	0	0	0
Kolar	100	981	4	55	541,767	55	353,500	0	0	2	25,000	0	0	3	80,200
Bellary	124	2691	2	26	461,400	99	203,900	0	0	0	0	7	82,000	0	0
Total	349	5465	11	143	1,697,411	277	1,080,262	1	10,000	7	170,000	8	102,000	22	345,390

* Others – MYRADA and Rotary Clubs

Loans have been taken for education, health, trading, vehicles, domestic animals, cottage industries, etc.

- 3. Working with Male Clients:** Through our initial work with the focussed prevention programmes with female SWs, we found that we were able to convince the women about the importance of using condoms regularly as an effective prevention measure. However, they had a problem. The constant demand from the women was, "You have told us, we understand. Now go tell the men." We documented this demand regularly in our reports and presentations to KHPT and AVAHAN, and requested for more support to address clients, but were told repeatedly to approach the clients only through the SWs.

We have been conducting regular sensitisation programmes for probable male clients such as truck drivers, hamali's, auto drivers, construction workers, migrant labour, etc., but this has to be expanded and developed into a concrete targeted programme on a larger scale. We decided to raise resources from elsewhere. We received a response in 2005 from the Centre for Disease Control (CDC) that enabled us to work with these probable clients.

Through the CDC programme, we have been able to address men through workplace interventions. We find that men are consistently available in these locations, and the managements are very supportive in promoting a healthy lifestyle intervention for their employees. There has been an increased demand for testing, health camps and condom outlets in all these industries where we started the programme.

- 4. *Inclusion of Youth in Programme:*** The importance of including youth came up repeatedly. Through the CHARCA project and the CDC programme, MYRADA has been able to directly address the youth.

A major component of the strategy adopted by the CHARCA Project is to work with young girls and boys (13-25 years). From each village 2 girls and a boy were selected as peers and trained on how to understand and respond to issues related to youth and sexuality, adolescent health problems, age of marriage, child and sex abuse, etc. These peers in turn spread the message to 10 other girls and boys at a time. These peers are also members of the Village Level Committees formed in collaboration with the PRIs in all villages covered by the CHARCA project. Early trends show that these youth are very interested and committed to spreading awareness; they are willing to talk about sexuality and to put pressure on adults, their parents and community members to follow safe behaviour practices.

In the CDC project, the strategy to work with youth included the formation of "Red Ribbon Clubs" (pioneered by Tamil Nadu) in colleges. These clubs or institutions have a voluntary membership of around 30 members, and have to develop a vision and charter. Their focus is on internal programmes within their colleges and external programmes in their communities. So far, we have formed 88 Red Ribbon Clubs. Each club has selected 2 persons as peer leaders or volunteers for their group. These volunteers visited Bangalore and were exposed to care and support centres, where they had extensive interaction with the inmates of these centres and conducted debates on issues such as: Premarital sex is a good learning experience, sex work should be legalised, HIV positive persons should not be allowed to marry or have children; All HIV + persons should be isolated. The discussions that ensued revealed that the youth have deep insights and interest in promoting a late age of marriage, discouraging premarital sex, and promoting zero tolerance towards discrimination against HIV + persons.

5 & 6. Spread of HIV-AIDS outside High-risk Groups to General Community (Namma Halli Programme) and The Growing Involvement of PRIs: Realising that HIV-AIDS was no longer restricted to the high-risk groups efforts were made to gain the support and build a rapport with the communities. The CHARCA team developed the Namma Halli programme as an entry point programme in all selected villages. The purpose was also to get rapid information on the resources in the village, the number of young girls, the major health and social problems faced by them, and to introduce the main messages of CHARCA to the village.

Process: This programme was spread over 2-3 days in each village, with the team residing in the village during this period. After entering the village, the team met all important formal and informal leaders, existing self help groups and informal groups of young men and women. They had one to one and one to group discussions on the CHARCA issue of HIV AIDS and young women, and invited the community to participate in several awareness sessions. The team focused more on working with smaller groups of women and young men through self help groups and informal groups of young men and women.

Awareness regarding HIV AIDS, the importance of gender issues in HIV AIDS was spread using various methods including street plays, focus group discussions, quizzes, video shows etc.

During this programme, the team also discussed the importance of community involvement right from the beginning and the idea of setting up a Local Village Committee to assist in the CHARCA project activities emerged.

Results: Some of the issues raised by women during the discussions on young women's health and sexuality included problems such as:

- a. Lack of support from husband and in-laws when the woman was sick.
- b. No hospital facility in the villages/ hospitals too far away
- c. Women friendly Doctors service are not available
- d. Doctors prescribing costly medicines
- e. Fear of husband/Drunkard husband
- f. Forcible sex by partner
- g. Less knowledge about family planning methods
- h. Extra marital affairs by husband

It was decided that all selected villages would have a Namma Halli programme, followed by specific training to SHGs and young women and men's groups. Then the community will select and form the village level committee and set up a Resource outlet.

Village Level Committees (Arogya Samithis): As a strategy to sustain services and programmes implemented in the villages through SHG trainings, Namma Halli programmes and youth training, the community felt the need for a group to continue the prevention efforts in their area. They decided to form a village level health

committee, consisting of representatives from SHGs, village leaders, ANM, anganwadi teacher, peer girl and boy members and EWR (elected women representatives). These committees were given training to understand the importance of this institution, the roles and responsibilities and how to develop an action plan for their village. Every group has set up a resource outlet, with supplies such as iron tablets, condoms, sanitary pads, information brochures etc.

These groups were also linked through meetings and visits to the gram panchayats, PHCs, legal services, and taluk hospital VCTC, care and support centres, positive networks etc. Hence the need for the programme to interact at all levels with Panchayat Raj Institutions – District, Gram Panchayat and Gram Sabha.

We have found that this institution has the potential to be viable, and have replicated it in the CDC programme. There has been a very good response to this from both the community and the staff.

7. The Issue of Sustainability

An issue which was discussed by the MYRADA staff related to the sustainability of programme interventions, particularly where condoms were distributed free of charge and major drop-in centres which were being set up under the KHPT programme which required very high maintenance costs and did not show any evidence that they could be sustainable after the project was over. This concern to set up institutions that had the potential to sustain themselves organisationally and financially is a core thrust of MYRADA's programmes, and therefore it was felt that it should also extend to the HIV-AIDS programme. A brief note describes this concern to promote sustainability in greater detail.

Issues Related to Sustainability:

1. *Pricing of Condoms:* MYRADA introduced the concept of payment of a token fee of Rs. 1/- for condoms from February 2004 itself. The intention was twofold: to build a common fund to address and crisis situation when there was no supply of condoms, and to use as an indicator of how many people were actually using the condoms (the assumption is that if they paid for it, there is a greater chance that it would be used). However, KHPT asked us to stop this process.

In July 2006, when this issue was brought up to NACO Executive Director Ms.Sujatha Rao at a state level meeting with HIV AID partners, she emphasised that paid condoms would be a worthwhile indicator of use. She also stated that NACO would measure success by the number of sold condoms and not free condoms distributed. (*In October 2006 KSAPS called for a meeting and proposed a training on Social Marketing of Condoms.*)

2. *Setting Up a Drop in Centre:* It became apparent early in the programme that there was a need to provide a safe and friendly space for the SWs to meet so that they could discuss various issues without any threats or discrimination. Therefore, MYRADA agreed to set up Soukhya centres, and were successful in getting adequate

free spaces in many government hospitals in collaboration with the health administration. However, KHPT was very keen that we follow the “Drop-in Centre” Model set up by them in Mysore. After visiting the centre, we found that this was not a cost effective or sustainable model as the running costs were around Rs.75,000/- per month. How would these be sustained over a period of time?

3. *Health Services by Programme Clinics (KHPT) versus Referral Clinics*: MYRADA, in its projects, has worked successfully with existing medical services (both private and Government) to provide health care to communities. We proposed to try this same approach for the provision of health services to the SWs. The focus would be on selecting doctors with whom the SWs were comfortable, giving them adequate training and necessary equipment, and monitoring them on a close basis to ensure quality. We called these Referral Clinics. In the first year, all the four projects only used the Referral Clinic Model successfully.

However, AVAHAN staff, following a visit to Kolar in February 2005, insisted that MYRADA set up program clinics in compliance with the common minimum programme that they developed for the project. Therefore, MYRADA (reluctantly) set up a few program clinics in 3 of the districts, but did not set up any in Chitradurga where it continued to work with Referral Clinics as a Pilot. Incidentally, Chitradurga district topped all other districts in the performance in provision of health services for the year April 2005- March 2006; this was stated by KHPT during a partner’s meeting.

THIRD YEAR: April 2006

At the beginning of the third year (April 2006) there were 244 Soukhya groups across the four districts covered by the KHPT Programme.

Particulars	Soukhya Groups				
	Bellary	Chitradurga	Gulbarga	Kolar	Total
Total number of Soukhya Groups	56	67	46	75	244
Total membership	734	901	578	861	3,074
Total meetings held in the year	1,211	5,199	889	3,751	11,050
Savings	186,812	281,050	82,862	239,031	789,755
Condoms sold (in collaboration with PSI)	2,300	994			3,294
STI treated	210	172		139	521

An analysis showed that:

- 1/3 of all registered FSW were in Soukhya groups, a further 1/3 were already members of existing SHGs such as Stree Shakthi, Swa-Shakthi or other NGO groups; and the remaining 1/3 were not in any type of groups.
- Most Soukhya groups had undergone the capacity building programs as planned and had completed training upto the 3rd module. The 4th module could not be completed as funds were cut in the fourth quarter by KHPT.
- All groups were meeting regularly on a weekly basis and maintaining the necessary minutes and records.
- 80% of the groups had regular savings and had opened accounts in the banks.
- 15 groups had linked to financial institutions viz., Sanghamithra (7 groups, loan amount – Rs.170,000/-), and Banks (8 groups, loan amount Rs.102,000/-), a further 23 had received revolving funds from MYRADA, Rotary Clubs and CMRCs amounting to Rs.345,390/-.
- Further capacity building was required in Year 3.
- Several members had initiated alternative livelihood opportunities through loans (277 members had taken loans).
- Some groups had initiated internal management of the project activities and expressed an interest in taking over these responsibilities.

Since the analysis showed that 1/3 of all registered FSW were in Soukhya groups, and a further 1/3 were already members of existing SHGs such as Stree Shakthi, Swa-Shakthi or other NGO groups, while the remaining 1/3 were not in any type of groups, a strategy had to be evolved in a participatory manner with the peer members and Soukhya groups for each of these three categories.⁶

The strategy that emerged is briefly described below:

⁶ The 1/3 FSWs who were not in any group consisted of those who had recently been contacted those and have begun to show evidence of meeting regularly, migrating and seasonal SWs and finally those who did not show any inclination to form groups.)

1. For those in Soukhya groups (these were largely full time SWs)

- i. Responsibilities of the groups would include:
 - Condom supply and distribution to its members.
 - Regular health check up of its members; encouraging partner/client treatment.
 - Regular discussion of relevant issues (harassment, legal rights, linkages, etc.)
 - Updating the programme register
 - Motivating its members to go for HIV testing
 - Care and support for Persons Living with HIV-AIDS (PLHAs) in their area – either home or institution based.
 - Promoting alternate livelihoods and linkages to financial institutions
- ii. *Documentation:* Each Soukhya group would maintain the programme register for their SW members. This would be done in consultation with the community facilitator, who would continue to maintain the master programme register.
- iii. Specific peers would be assigned only to Soukhya groups. Their responsibilities would be discussed by the groups and assigned in consultation with the Soukhya team. This would be a transition stage to a phase where the peers would not be separately identified, but would be regular members of Soukhya groups.
- iv. Capacity building of the Soukhya groups would continue (described below)

2. For those in other SHGs (these were largely part-time SWs)

In view of the feedback received that these groups were not fully comfortable with promoting outreach services, it was decided to conduct a rapid assessment with these SWs to determine if they were comfortable with the idea that outreach services (HIV/STI awareness, condom promotion and health check ups) could be promoted through their existing SHG group. Care would be taken not to disclose the identity of the SW in these groups. Other issues related to sex work would be addressed during the regular SW meetings and at other platforms. Based on the results of the assessment, the following approach was suggested:

- i. Till the assessment is complete, peers would be the main stay of providing outreach services directly to these SW.
- ii. If the SW agreed to outreach through the group, then special meetings would be held with these groups to establish how these services could be initiated, and by whom.
- iii. If the SW does not agree to outreach through the group, then the peer would continue to provide the outreach services.

3. For those not in any group

The strategy of a peer led approach would carry on for this category of SWs. Attempts would continue to be made to encourage them to meet if they found it useful.

Agreements were also arrived at on two other issues:

1. Since it was clear that the SWs had given priority to alternate livelihoods, and had backed up this interest by regular savings, internal lending and even accessing loans from Banks in many cases, it was decided to add an 'E' for Economic Empowerment to ABC4D strategy. It was therefore agreed that MYRADA would make a special effort to improve the skills of SWs in order to add value and scale to the income generating activities for which they have borrowed.
2. It was also agreed that no investment would be made in major service centres which did not have the potential to achieve sustainability, both financial and organisational, by the end of the project.

4. Capacity Building of Soukhya Groups in Year 3:

Since the majority of groups did not complete module 4 in year 2, this critical area would be the first area of capacity building (vision building and action plan).

- **Module 1: Taluk Level Vision Building and Action Plan:** 2 representatives from each Soukhya group in the taluk, the Community Facilitator, 2 peers and the Taluk Coordinator will be supported to develop a common vision and action plan for their taluk level Soukhya groups. 2 members from the Taluk Advisory Committee would also participate. This will be a 3-day institutional capacity building programme conducted by experienced MYRADA staff.
- **Module 2:** This is for each Soukhya group. Each group will study the overall taluk plan, use it as an overall framework and make a plan for their own group. This will be a one or two-day session, repeated if necessary, and facilitated by the CMRC managers and taluk coordinator.
- **Module 3: Importance of Book Writing and Documentation:** ½ day session for every Soukhya group member to understand the importance of documentation.
- **Module 4: Home Based Care and Support for HIV:** The objective is to train all Soukhya group members how to look after positive persons in their group or area.

CONCLUSION:

MYRADA's approach to institution building in the HIV-AIDS programme has resulted in the following institutions at different levels. These institutions have been promoted under the KHPT, CDC and CHARCA programmes. All are not strong or functioning as required; much more institutional capacity building is required. We have still to ascertain whether all are appropriate institutions or whether they need to be changed.

- In Towns that come under the KHPT programme, Soukhya groups of SWs (and MSMs) have emerged; these are participatory institutions.

- In Villages covered by CDC and CHARCA, existing SHGs promoted by MYRADA and other NGOs and other programmes like Stree Shakti continue to function; many of them have part-time SWs as members.
- In Villages covered by CDC and CHARCA, Arogya Samithis have emerged at the Village level. These are representative institutions.
- At Town level, under the KHPT programme, Soukhya Okootas have been formed by the Soukhya Groups; these are representative institutions.
- At Taluk level, under the CDC and CHARCA programmes, no Taluk level institution has emerged, but there is strong collaboration with the Positive Network Group.
- At the District level, under the KHPT programme a District Soukhya Okoota has been formed. Under the CHARCA /CDC programmes no district institution has been formed but there is strong collaboration with the Positive Network Groups.

It is therefore clear that institution building started from the bottom with the Soukhya groups and SHGs (which are participatory institutions) and then moved upwards as and when required by the base groups. The responsibilities and functions of the representative institutions were not decided by MYRADA but by the groups at the base. This development is quite different from networks starting from on top at State Level.

<u>KHPT</u>	
District Level:	District Soukhya Okoota (Representative Institution)
Town Level:	Soukhya Okootas (Representative Institution)
Sub Town Level:	Soukhya Group (Participatory Institution)

<u>CHARCA & CDC</u>	
District Level:	No institution but strong collaboration with Positive Network Group
Taluk Level:	No institution but strong collaboration with Positive Network Group
Village Level:	Arogya Samithi
Sub Village Level:	SHGs (existing)

