

# MYRADA

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No.2, Service Road

Domlur Layout

BANGALORE 560 071. INDIA.

Telephone : 25352028, 25353166, 25354457

Fax : ++91-80-25350982

E-mail : myrada@myrada.org

Website : <http://www.myrada.org>

*Dr. Maya Mascarenhas & Mr. Aloysius P. Fernandez*

## **HIV AIDS AND HIGH RISK GROUPS –**

### **Strategies for Sustainable Interventions**

#### **THE MYRADA SOUKHYA/SANKALP<sup>1</sup> EXPERIENCE**

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### **1. Introduction and Framework**

In early 2004, Myrada was selected as a partner by KHPT/Avahan to implement the 5 year Sankalp project in three districts – Gulbarga, Chitradurga and Kolar. At that time, it was understood that the program would aim to reduce the prevalence of HIV in these districts. This required a reduction of “risk” in the short term as well as “sustainability of impact” after the project period was over. This in turn required a strategy to reduce vulnerabilities, which the female sex workers found appropriate and in which they took the lead. It was decided to start with urban female sex workers and then to move into the rural pockets. In 2005, Bellary district was also added to this program. Subsequently, the rural component was dropped by Avahan *in all four Districts*; it became an urban/small town focused program entirely.

Certain components of the program were mandated by Avahan/KHPT like community outreach through peer educators, STI treatment, condom promotion, community mobilisation and creating an enabling environment. However the strategy to implement these components was not strictly defined in the beginning. Towards the end of the first year (2005), Avahan came out with

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<sup>1</sup> KHPT calls the project Sankalp (meaning decision) while Myrada calls it Soukhya (meaning well being)

the Common Minimum Program Guidelines. On its part, Myrada had several rounds of discussions internally, with KHPT and with the sex workers during 2004 with the objective of identifying the broad framework from which a strategy could emerge which was appropriate to implement the project effectively and to sustain the impact.

It is well known that the **risk** of HIV transmission is a multiple function of the **number** of sexual contacts and the **number** of unprotected sexual acts.

Myrada soon realised that any HIV prevention program that aimed at changing effective high risk behaviour ( increased sexual contacts, increased number of unprotected sex acts) had to factor in both indicators that directly reduce risk (use of condoms, decreased number of clients) as well as those that reduce vulnerability of the person who practices high risk behaviour. The causes of vulnerabilities were identified through interactions with the sex workers.

It emerged that **vulnerability** resulted from several factors, the main ones being dominance by the male client who refused to use condoms, lack of alternate livelihood sources, inability to access entitlements and health care services and the absence of supporting institutions of sex workers which would provide a social safety net as well as a power base to tackle and overcome these factors which created vulnerability.

Myrada learned from its experience with the poor and marginalised who formed self help affinity groups (SAGs ) as well as from its experience with Devadasis (see box below) that any strategy for change which starts with a limited intervention needs to expand in response to clients demands as they gain confidence and start expressing themselves. It also learned that one of the key elements that builds the basis for sustaining the impact of the intervention is the building of appropriate institutions managed by the poor and marginalised. These institutions provide them with the space to grow in confidence and management skills and the opportunity to federate in order to change oppressive social and gender relations at home and in the society which marginalise them and limit their livelihood options. This motivated Myrada staff to influence the sex workers to evolve an organisational strategy that would help to reduce all the factors listed above which cause high risk and vulnerability. Myrada also learned that the objective of sustainability must be factored into the strategy right from the beginning and not at the end of the project period.

Based on several group discussions in 2004 with the female sex worker community and our previous experience, Myrada developed the ABC4D framework for this program; later E was added making it ABC4DE (refer to Pg. 4). These discussions were based on the hypothesis that HIV prevention is achieved through a combination of both risk reduction and vulnerability reduction. **They are in fact causally interdependent.**

'Devadasi' is an old tradition in some parts of India, where a young girl is dedicated to a local deity/goddess and is expected to lead a life in the service of the goddess. They usually enter into long term relationships with male partners. However, over the centuries these women have been prone to exploitation and discrimination by society and many are also forced into prostitution.

Though dedication of devadasis is banned by law since 1982 in Karnataka, the tradition has continued to remain alive because of poverty and a lack of enforcement of the law. During 1989-90, a special programme was launched by the Karnataka Government through Women and Child Development Department ( KSWDC) to train devadasis in livelihood skills and support them to take up income generating programmes. Myrada was requested by government to help implement this programme. MYRADA deputed one of its senior staff to KSWDC to manage this programme. With the involvement of Myrada the focus of the programme expanded to cover not just the economic aspect but also to include a concerted effort to prevent more girls from being dedicated, and to organise the women already dedicated into an institutional framework that could protect their interests, prevent new dedications and build their self esteem. In the beginning, self help groups seemed to be the appropriate institution. Over time, it was seen that while self help groups could serve as a base but a larger and more visible institution would be necessary. After many months of meetings and discussions with the devadasis in every village of the district, Mahile Abhivruddi Mattu Samrakshana Samsthe (MASS) was registered in 1997, not as a federation of devadasi womens' self help groups but as a membership organisation to which any woman of Belgaum district dedicated as a devadasi could join in her individual capacity. Current membership of MASS is 3386. Its primary constituency was and continues to be the devadasis of Belgaum district. There are requests from devadasis of other neighbouring districts that they should be allowed to enroll as members as well, but so far this has not been considered as it might make the organisation too big and unmanageable. Besides, in Belgaum the organisation was formed through a long and participatory process, and it is necessary for women in other districts to go through a similar process rather than join a readymade organisation, since the dynamics created by the process is what has been empowering to the women of Belgaum.

The ABC4DE framework emerged as a comprehensive approach to address both these objectives, namely, risk and vulnerability. The E which was added

after feedback from the sex worker community gave self reliance priority; it underscores the importance of factoring in the objective of **sustainability** from the beginning.

### **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 an impact on this disease is through sustained behavioral change; this requires intense efforts with small groups of people involved in high-risk behaviour so that group pressure & sanctions for breaking accepted norms are strong enough to ensure compliance.

**C4** = continence, condom promotion, community approaches, and continuity: These are the components of the processes and strategy that emerged to bring about sustained behavioral change.

**D** = drugs, care and support: No HIV intervention can be considered complete or ethical without responding to the existing situation of an increasing number of infected persons. Services should include affordable and regular access to drugs, nutrition, basic care and support for those infected and affected by the disease.

**E** = empowerment - socio economic empowerment to reduce risks related to vulnerability; includes the skills and confidence to decide and to lobby for change of oppressive power relations related to gender and social structure and for space to take up alternate livelihoods

**The major components of a strategy that emerged during the first year itself that Myrada gradually integrated into the original Soukhya design are described below.**

## **2. Outreach – Strategy, institutions and sustainability**

**Outreach strategy:** KHPT's strategy was a “peer led only” approach to provide outreach services to the community of female sex workers. The peers – who

were selected and trained from among the sex worker community - met individuals on a one to one basis over the 5 year period.

Myrada used this peer approach as an entry point to establish a rapport with the community and to initiate basic outreach services. From its experience in various programs over twenty five years Myrada learnt that direct contact between all its staff (including senior staff) and the clients, in this case the sex workers, is important if the staff are to empathise with the community and pick up their messages quickly and correctly. Hence all the Myrada staff members including the community facilitators and Taluk Co-ordinators and not only the peers, met the community members at least once in 2-3 months. These interactions took place directly through special meetings which were structured in advance, so that the female sex workers could interact with senior Myrada staff directly. What emerged was a common vision broadly shared by sex workers who aspired to reach a stage where they have the power to insist on “Safe sex” (often against client’s demands), without “oppression from pimps” (who take a large proportion of the sex workers earnings) and without “harassment/marginalisation” from society or from any individual in their official capacity”. It was clear that the major concern was related to “power relations” embedded in gender and society which oppressed them in one way or the other<sup>2</sup>.

Myrada’s previous experiences with SAGs and the Devadasis indicated that peoples “power” is generated through the dynamics of well functioning peoples institutions; by participating in these group dynamics, the members gain the confidence and skills (which empowerment implies) to change oppressive relations . Hence, it began discussing with the sex workers whether they wanted to get organised, and if so, what would be the structure and functions of the organisation. Myrada did not impose any pre-established organisational structure and functions on the sex workers. This approach which started by building institutions of sex workers provided them with the space to influence other components of the Outreach strategy as described below.

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<sup>2</sup> Myrada now promotes the belief that sex workers have a right to practice safe sex, without oppression or harassment, to be able to explore alternate livelihoods if they want and to be respected by all.

**Outreach Institutions:** The Drop in Centre. The KHPT Program Guidelines conceived the Drop In Centre as a safe space to provide services as well as to meet and relax. It was equipped with a clinic, lounge area with TV, beds, bathing rooms, beauty parlours etc. This was a high cost intervention. One of the centres in Bangalore cost Rs. 70,000/- per month to maintain.

While Myrada agreed with the concept of having a safe and friendly space for the sex workers to meet and discuss their issues, it also wanted to factor in sustainability of this service. The community was consulted on what they wanted. At that point, we learnt that the key need of the sex workers was to be accepted by the community around them; they felt extremely marginalised and expressed the fear that if a separate space was “marked” out for them – like a Drop in Centre- it would increase their marginalisation. While the idea of a space to relax, bathe and be entertained seemed attractive, they were more interested in being integrated with the general community. They suggested that an alternative space be provided, but not one like the Drop in Centre. They all liked the idea of having a place in the government hospital itself as they could openly walk in along with others from the general community without drawing attention to themselves and meet in an institution which was open to all. This gave them an opportunity to mainstream with the general community and to feel less marginalised than before. The government agreed to this proposal that these centres in hospitals would provide sex workers with a space to meet, relax, and access information and counselling and to interact with others on relevant issues. These spaces in government hospitals were called **Soukhya Service Centres**; no rent was levied. These centres did not have beds, TV or beauty parlours which would have added both to capital and maintenance costs. Housing the Soukhya Service Centres in government hospitals was also a step towards integration of HIV/AIDS care in the general Health Care system and towards sustainability of both the services and the centre.



**The objective of sustainability:** One major objective in the outreach strategy which emerged from the feedback provided by sex workers and which is also part of Myrada’s over-all strategy was the objective of sustainability.

After several interactions with KHPT, Myrada came to the conclusion that KHPT (and for that matter even Avahan) did not consider “sustainability” as one of the objectives of the program initially. Their approach was that it was more important to first demonstrate a reduction in the incidence of HIV AIDS during the first five year phase, and then determine issues related to sustainability and withdrawal.

Myrada’s experience on the other hand indicated that: i) sustainability had to be a major concern from day one; otherwise extension models could be constructed which the clients would not be able to sustain (the Drop in Centre is an example); ii) once the culture of dependency is created, it is very difficult to promote financial and organisational sustainability after 5 years; iii) since the strategy included the objective of coping with oppressive “power” relations arising from a gender and social bias, it was necessary to promote strong institutions of sex workers which, during the program, could acquire the experience of changing these relations and which could continue the impact after the staff and resources of the project were withdrawn. Well functioning peoples institutions were required to ensure that these power relations did not emerge once again. These institutions have to be formed and trained as well as federated; this process takes time and therefore needs to be started in the first year itself. Flowing from its experience, Myrada realised that it had to promote appropriate peoples’ institutions which took ownership of the program and could continue to provide support to carry forward the impact and to respond to new problems. Hence the need to adopt both a more holistic approach to build the basis of sustainability of impact as well as one rooted in institutions of the people from the very beginning rather than a minimalist one which was promoted in the project design.

This outreach strategy emerged from an analysis of the social situation; it revealed that the causes that resulted in HIV/AIDS were far more complex than the lack of awareness. Adequate awareness could result in behaviour change provided other more fundamental hurdles did not exist. But they did exist even after the project intervention began. We discovered that women became sex workers because of poverty, or because as young women they had fallen in love and run away with the boy who subsequently left them; they could not return to the village because of traditional taboos. They were more vulnerable to get infected with HIV because they could not insist on the use of a condom given

the male dominated patriarchal society and the pressures that such a society creates (oppression and harassment). Oppressive pressures forced them to part with their earnings; they were forced to pay pimps and even officials in order to carry on their sex work.

It was clear that creating awareness was not enough as it was an issue of “power”. The women required power to reduce risk and sustain the impact of the project intervention. This “power” they could acquire by a) uniting in small groups which provided each one with the social space required to discuss their problems and decide on solutions and b) by federating the small groups at taluk and district levels. Together, it was expected, these institutions would lay the basis for sustainability of impact.

Myrada also learned from years of experience in development that for the impact of any intervention to be sustainable it required to be: a) low cost - in other words the cost of maintenance cannot be higher than the potential of the stakeholders/clients to maintain it in terms of income and time available; b) supported by an institution of the people which is appropriate to the resource to be managed or objective to be achieved; in other words the sex workers needed to craft an institution whose structure and functions they decided on in order to achieve their purpose. Myrada intervention strategy with high risk groups promoted these features namely i) low cost and ii) a strategy crafted by the sex workers.

### **3. Health Services:**

**Program Linked Clinics:** KHPT/Avahan advocated the starting of “program linked’ clinics where the NGO partners recruited a team of doctors, nurses and counsellors and set up a clinic for the SW community **only** – preferably within the Drop In Centre. It was a “**dedicated clinic**” **only for sex workers**. KHPT/AVAHAN agreed to Myrada’s proposal that “**referral clinics**” – namely general purpose clinics which already existed in the area and which were not dedicated only to sex workers - could also be used, but as secondary sources for the community to access services when the Drop In Centre was not available.

Myrada, in the first year, did not agree to start any “dedicated program linked clinics” as advocated by Avahan/KHPT as it would add costs to an already high cost Drop-In Centre. Further Myrada took the position that the referral clinics would be just as effective in implementing the program and achieving its objective as the dedicated clinics, provided certain inputs (listed below) were given to the referral clinic model. Therefore Myrada decided to promote the “referral clinic” model as the primary health service provider. Private medical practitioners, who were willing to work with and follow guidelines proposed by Myrada, were identified and selected by the community and the Myrada team. A MOU was signed between Myrada and the private clinic. All the doctors were trained in STI syndromic management. A set of guidelines and formats was drawn up to be maintained by the clinic, and regular monitoring of the clinics was done by the Soukhya team outreach workers. The outreach workers were trained in basic counselling skills; they provided counselling for all the clients at the clinic or in their sites. Quality checks were done periodically by the staff in each town, and later on by the members of the town level Okoota (Federation of Soukhya Groups; refer to Community Mobilisation – page 14 of this paper).

***KHPT/AVAHAN’s response:*** At the end of the first year, however, Avahan did not agree to this model of making the referral clinics the primary health service providers and insisted that Myrada follow its guidelines and set up high cost program linked clinics preferably in Drop In Centres. Myrada complied (reluctantly) in 3 of the 4 districts with Chitradurga being the exception.

***Outcomes at the end of the second year:*** At the end of the second year, it was found that the best performing health service district (measured by the number of FSWs accessing health services) was Chitradurga which had continued only with the “referral clinic” model and did not adopt the dedicated program linked clinic model. This proved Myrada’s position that the “referral clinics” could be just as effective as the “dedicated clinics”. In response to the request from sex workers in the other three districts, where they too preferred referral clinics, Myrada reverted back to the “referral clinics” model in the third year in the

other 3 districts and dropped the program linked dedicated model of Avahan in all Districts.

**Sustainability of the Referral Clinics:** From year 3 onwards (2008), with the objective of achieving financial sustainability, Myrada encouraged the FSWs visiting the referral clinics to contribute towards the fee of private medical practitioners (till then fully subsidized by the project). This amount was put into a health fund which was part of the common fund of the Soukhya groups. From an initial contribution of Rs 5/- per visit (in 2008), the FSWs (since April 2009) contribute Rs15/- per visit. This amount is collected by the Okoota members at town level and payment is made to the doctors on a monthly basis. In year 4 (2009) all districts took a further step towards laying the basis for financial sustainability. They identified a government doctor in each town as a referral doctor. This enabled the program to address sustainability in two ways – it linked the community to a permanent health service centre staffed by a the government doctor and it reduced costs since (unlike the private medical practitioners) there was no additional fee given to the government doctor. Other measures such as getting the women to use the government health book as a health record have been introduced in all districts.

#### **4. Condom Promotion:**

While awareness and empowerment of the FSWs through group dynamics and support were the major factors which helped to ensure that the clients used condoms, Myrada also factored in the objective of sustainability. KHPT guidelines promoted direct and free distribution of condoms to all FSWs. In the middle of the first year, Myrada learned from feedback that the FSWs were ready to levy a small amount from clients towards the condom since it would help clients to understand the value of condoms in the prevention of HIV. The FSWs also decided to set up a fund which they thought would offset any “zero condom stock situations” at a later date. This was initiated in Kolar as a pilot, but was shot down immediately by KHPT; Myrada then reverted to the practice of free distribution.

Interestingly, in July 2006, NACO (National AIDS Control Organisation) was actively promoting “social marketing” of condoms and mobilising the community to pay for condoms. When clearly told by the Director General of

NACO to “go ahead” with the idea of promoting condoms for a price, Myrada linked up the Soukhya groups to Population Services International, an organisation promoting a social marketing brand of condoms called Masthi for a price. This was a step towards sustainability.

## 5. Creating an Enabling Environment

KHPT/ Avahan guidelines gave a great deal of importance to this component.



Several sets of activities were initiated such as police sensitization programs, re-activating the District HIV AIDS committees etc. KHPT also focused on crisis management. KHPT actively engaged the police department at all levels, developed special programs for police sensitization and followed them closely. Myrada followed this lead; it took

up police sensitization in all 4 districts and followed up all relevant cases that came up.

At the time of starting the program, there was a high level of stigma within the community and the general population. Myrada initiated meetings with the District Health Officer and District Commissioner, as well as sensitization programs with the network operators (such as pimps, brokers, madams, auto drivers etc.). Myrada also partnered with the Dist. HIV AIDS Committee (which was already constituted by the state government but remained inactive) to formulate the joint action plan for the district.

Creating an enabling environment for Myrada however went further. Myrada listened to the sex workers who after a year in the program also wanted to adopt life styles which would make them more acceptable to the general community. This emerged especially among the older sex workers who realised that sex work could not continue beyond a certain age. They also began to express a desire to be accepted by the community after being marginalised for so long. Many of them decided to expand the portfolio of activities which earned them income; in other words, to look for other sources of income together with sex work. They approached Myrada with requests for training in

several skills. One expression of this desire to be mainstreamed was their response to the query often made by outsiders: “Are you sex workers?”. Many decided to say “NO”, especially if they were questioned in public since to respond “yes” would serve to marginalise them further.

Following several community meetings, **two needs emerged** very strongly from the community – **they wanted to be mainstreamed** socially and they wanted their **livelihood issues** to be addressed as priority. As far as their livelihoods were concerned, their priority was to attain a degree of self reliance and to access their entitlements (not only rights). Myrada supported both concerns on a priority basis; it encouraged linkages between Soukhya groups and various line departments, approached senior officials and conducted gatherings to which Soukhya members and officials were invited so that the sex workers could access their entitlements. Obtaining ration cards, voter IDs, housing schemes, accommodation of students in hostels and education support for the children of the FSWs etc. were activities that were taken up long before KHPT and Avahan decided to incorporate it into their program. This led to an enhancement of the trust level between the staff and the community and the reiteration of Myrada’s belief that the *“approach to female sex workers must be holistic and that they should not be reduced to one dimension –namely sex work”*<sup>3</sup>. In fact the sex workers themselves stressed this holistic approach after a few years in the program; they no longer wanted to be referred in public as “sex workers”; they had other needs as well which had to be addressed.

The sex workers in Kolar asked to be trained in several skills so that they could broaden their livelihood strategies. Myrada provided some funds for this training. When some of them decided to invest in income generating activities, Myrada linked them with Sanghamithra, a Not-For-Profit Micro Finance Institution which it had promoted. Sanghamithra has lent 167 Soukhya groups a total amount of Rs 126 lakhs upto August 2010 for investment in income generating programmes including education of their children which they identified as a priority. This was a further step towards financial sustainability, self confidence and empowerment.

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<sup>3</sup> Extract from page 5 of Myrada’s Agency profile.

## **6. Community Mobilisation – leading to Institution Building**

As this is the major domain in which Myrada was involved and in which it was expected to take the lead, it will be discussed in more detail. KHPT guidelines promoted mobilisation by organising events and gatherings or meetings at the Drop In Centre.

Myrada's experience over the years proved that mobilisation through events is only a first step. It has to move towards promoting institutions of sex workers, if empowerment is to be generated and sustained. Further since we also discovered that every institution needs to be appropriate to the resource to be managed or the objective to be achieved, a common or standardised institutional structure for all programs is not appropriate<sup>4</sup>

Accordingly, Myrada initiated weekly sex worker meetings at site level in an attempt to understand the possibility of forming small groups to discuss their problems. Our experience showed that female sex workers who come together in small groups are far more open and willing to discuss problems in depth; they also gain confidence to decide on solutions and to implement them. However, the members of these groups must be free to self select themselves. There are no external criteria for membership on the basis of which groups are formed. After the FSWs self selected the members of the group, Myrada provided institutional capacity building (ICB) which helped the groups to adopt and interiorise the basic features of an institution.

By the end of year 1, (March 2005) we found that 60 groups had emerged – most of them in Chitradurga. By year 5 (March 2009), we had 485 groups across 4 districts (Kolar and Chikballapur Districts had not been divided at that time). Each Soukhya Group had 8-15 members. The groups were meeting on a weekly basis. To ensure that these groups of FSW were free to decide on the roles and functions of the group, Myrada called them Soukhya groups (SG). This distinguished them from the Self Help Affinity Groups (SAGs) which had clear roles and functions.

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<sup>4</sup> Myrada also learned that the type of institution required will emerge from people's wisdom and it will be based on their strengths, not on their weaknesses. Myrada's role is to spot this emergence and support it. For example, affinity,(relations of trust and mutual support) the basis of the SAGs, existed before Myrada entered; this was the people's strength; we stumbled on it and fortunately decided to build on it. This approach cannot be dictated from on top. It requires that our staff have the ability to listen, feel and interact closely with people. Trust, transparency and good feedback are therefore essential features for it to function.

The following table gives the number of FSWs in Soukhya groups (SGs) as on March 2010.

District	Home based			Street based			Brothel based			Total			No. of groups
	Total SWs	SWs In group	%	Total SWs	SWs In group	%	Total SWs	SWs In group	%	Total SWs	SWs In group	%	
Chitradurga	1071	710	66.29	1116	306	27.42	94	22	23.40	2281	1038	45.51%	78
Gulbarga	82	4	4.88	3096	1036	33.46	34	0	0.00	3212	1040	32.38%	86
Kolar	211	87	41.23	1757	897	51.05		0		1968	984	50.00%	78
Bellary	2546	1541	60.53	1755	1010	57.55	162	17	10.49	4463	2568	57.54%	168
Chikballapur	238	136	57.14	1305	749	57.39		0		1543	885	57.36%	75
TOTAL	4148	2478	59.74	9029	3998	44.28	290	39	13.45	13467	6515	48.38%	485

Two Districts namely Chitradurga, and Bellary have a large number of Home based Sex Workers. In Gulbarga, Kolar and Chikballapur the largest number are street based. Gulbarga, Kolar and Chikballapur have no brothel based sex workers.

In Chitradurga, 66.29% of the home based sex workers are in Soukhya groups. In contrast, only 27% of the street based sex workers are in SGs. In Bellary, there is more or less an equal proportion between home based (60%) and street based (58%) sex workers in SGs. In Kolar, 41% of home based and 51% of street based sex workers are members of Soukhya groups. In Chikballapur, 57% of both home based and street based sex workers have formed SGs.

In both Chitradurga and Bellary, where there are brothel and dhaba based sex workers, very few of them (23% in Chitradurga and 10% in Bellary) have formed Soukhya groups. This is an interesting feature considering the fact that these sex workers are in one site only. It also shows that home based sex workers are more inclined to form groups perhaps because they are from the locality. The same would hold true of street based sex workers. The brothel based and dhaba based SW are probably from other areas and though they are in one site, they probably prefer to base their security and identity on the brothel or dhaba which also serves as their “home” rather than in the group. However these are assumptions which we need to look into further. What emerged however was that all the FSWs did not feel the need to form small groups.

By the end of the 2nd year (2006), several issues that emerged were documented in Myrada's RMS paper 45 - Building People's Institutions in the Context of a HIV-AIDS Programme -The MYRADA Experience.<sup>5</sup>

## 7. Learnings (October 2006)

Some of the learnings related to community mobilisation and group formation documented in October 2006 were the following :

1. A large number of the FSWs were keen to organise themselves into Soukhya groups. The mission of the Soukhya groups was to promote safer sex, without oppression or harassment. They assumed that the best way to achieve their mission was through organised groups; they had observed the SAGs which had had an impact on members' livelihoods and on their relations with society. Myrada provided training which focused on their mission and consciously avoided promoting savings as an activity for these groups as it does in SAGs, yet there was a unanimous decision by them to start savings and later to give credit. They had seen the SAGs and realised that forming such SAGs was a first step towards self reliance; they were aware that sex work could not go on beyond a certain age and hence they needed other sources of income. At the end of March 2006, 337 of the 363 Soukhya groups were saving, and were borrowing from Sanghamithra (The Not For profit MFI set up by Myrada which took the lead) and later from local Banks.
2. Another key learning documented was that the MSMs (**men who have sex with men**) did not spontaneously form and sustain similar groups; even though Myrada exposed them to the Soukhya Groups and SAGs, they preferred to have an "event" periodically which consisted of singing, dancing and a lunch rather than to build genuine groups which requires regular meetings, trainings and other organisational features. *"The MSMs did not and still do not show (till mid October 2006) any inclination to meet regularly or to form groups."* (Quote from the Myrada RMS 45 paper - 2006). This was the same time that KHPT and Avahan had decided to scale up the MSM program and to use the group approach. Myrada shared its experience with KHPT but it went ahead.

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<sup>5</sup> Can be downloaded from [www.myrada.org](http://www.myrada.org)

## 8. The Transition Strategy – The CBOs take the lead.

From March 2004 itself, it was clear that the Sankalp Soukhya project was a five year project ending in March 2009. All strategies were built around that time line. Myrada's strategy was to support the emergence of an institutional framework designed and managed by the Female SWs, which would take over (and lead) the various programs and activities which had been promoted during the project period. However these organisations would be free to decide what activity or program to give priority to and which to drop; they would be free to decide to support new and emerging needs. A framework of community based and owned institutions emerged at three levels (Field, Taluk and District levels) and are described in the following pages:

**At the Community level – Soukhya groups** This was the first layer of the organisational structure; it was formed and managed by the FSWs.

Initially they identified their health problems as a priority. These groups were called Soukhya groups (health groups) as the focus was on health. But they also realised that in order to protect themselves they had to demand that their clients used condoms and to use group pressure to back up their demand. They also decided to protect themselves from oppression (from pimps and madams who took a large part of their earnings) and from harassment of officials and other powerful persons.

Each Soukhya group has around 8-15 members; 95% of them are sex workers. Since the members self select themselves, there are a few non sex workers in a few groups who were invited to join the group by their friends with the consent of all other members in the group.



Though these groups were formed with the mission to promote safe sex without oppression and harassment, within 6 months they started savings and lending and decided to function like SAGs which they had observed. They approached Myrada for training in Institutional Capacity Building (ICB). There are 24 modules in the regular ICB package for SAGs. A special package was

adapted for the Soukhya groups and consolidated into 10 modules<sup>6</sup>. Later they asked for training in livelihood activities of their choice.

All members in the Soukhya groups undergo a 10 module training conducted over 16-24 months. Together with savings and credit, these groups promote the mission of the SWs namely “safe sex, without oppression or harassment”. They ensure that all their members get condoms regularly; they have the confidence to insist that their clients use them; they go for health checkups and participate in all mobilization events and meetings with Government and Police. All Soukhya groups have opened bank accounts and manage their savings and credit activities. In addition, they have been able to link several of their members to financial institutions and to secure entitlements. Experience at a later stage showed that they do not require the help of a peer worker once they have completed all ICB trainings and are meeting regularly for about two years.

***The following features and priorities emerged as common to these Soukhya groups:***

- i. All Soukhya Groups comprised only of Female SWs ; a few also had other women with whom they had an affinity. Any non-sex worker in the group was there at the invitation of the SWs; however they accepted that these groups would focus mainly on sex worker related issues.
  
- ii. MYRADA analysed the agenda of each Soukhya group meeting. From this analysis it was clear that there were specific issues on the agenda which related to sex work; these issues included legal issues, police and *goonda* harassment and stigma and discrimination. The other issues on the agenda, which gradually emerged and in many cases were the majority, 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

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<sup>6</sup> **1<sup>st</sup> Module:** intro to program; group concept; aims and objectives of Group; Common Health problems of women ; **2<sup>nd</sup> Module :** How to conduct meeting; Unity and affinity In action; Rules and regulations; Responsibilities of Soukhya members; Gender and HIV ; **3<sup>rd</sup> Module:** Leadership, Self esteem, communication and conflict resolution ; **4<sup>th</sup> Module:** Book keeping, Savings and credits, Common fund and management, HIV and RCH services ; **5<sup>th</sup> Module:** Soukhya level vision building; **6<sup>th</sup> module:** Linkage Credit, book keeping Social entitlements, other departments ; IGP and EDP; **7<sup>th</sup> Module:** Legal issue and HIV crisis management; **8<sup>th</sup> Module:** HIV AIDS Prevention Care and Support HIV – for positive persons; **9<sup>th</sup> module:** Collective Decision making; Okkuta concept ; Stigma and discrimination; **10<sup>th</sup> Module:** Soukhya group family level approach and community level approach. Group Grading

to alternate livelihoods. **Myrada decided to support these priorities of the SWs.**

iii. All 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 requirements, the need to invest in alternative income sources and the need to save for their old age.

### ***Roles and responsibilities of the Soukhya Groups:***

Part of the Institution Capacity Building training was to help the Soukhya Group members identify the functions of the groups; this was done in a participative manner; they were fully involved and gradually took the lead in these discussions and decisions.

Those in Soukhya groups more than 1 year old who had undergone at least the first 6 modules of ICB training decided to:

- Encourage non group members from their sites to join Soukhya groups.
- Ensure that all members have access and regular supply of condoms – and continue this practice.
- Promote social marketing (contribution to cost) of condoms. As a first step this was tried out in some groups and found to be a successful option for those who preferred better quality condoms. Later, more groups decided that they would attempt social marketing of the Masthi condoms in direct collaboration with Population Services International.
- Motivate all members to join the District level federation – Soukhya Samudhaya Samasthe (SSS) through the group or directly through endorsement from the Soukhya group.
- Ensure that all members continue to go for regular health check up at least once in 3 months. In both Bellary and Kolar, the groups instituted a health fund; any group member who went for a check up paid a certain amount to the common fund of the group; it was decided by the Okoota members that the money would be used for health purposes later on. In 2010, the members have gone one step further. They have decided that any group member who went for check up would have one of two options:
  - Pay a fee of Rs. 2/- to the Group Fund of the respective SAG for each check up done at a Government hospital by a trained government Doctor; no doctor's fee is charged in Government Hospitals

- Pay Rs. 15/- as user fee for any private referral clinic visit; this is 50% of the doctor's fee (the full fee = Rs. 30/-; remaining part subsidized by project).
- All money collected goes into the health fund. From this amount, the group reimburses part of the doctors fee (Rs. 30/- per patient per visit) to the Taluk Okoota which pays this amount on a monthly basis to the private doctor.
- Follow some of the standard group norms like weekly meetings, maintenance of all books, savings and lending.
- Motivate its members to go for annual HIV and syphilis testing.
- Ensure that any HIV positive sex worker within their group is registered with the local ART centre and is getting regular care and support services.
- Motivate all members to attend the 10 modules of ICB training.
- Ensure that the group maintains the programme register (a community tracking tool for health related services of group members) for its members and update it regularly.
- Conduct regular discussions of relevant issues (harassment, legal issues, linkages for loans, access to entitlement etc.) and take follow up action.
- Respond to any crises through linkages with the taluk level crisis management subcommittee (this committee of a few members from the Okoota focuses on addressing crises related issues).
- Obtain financial and social entitlements through the Soukhya Samudhaya Samasthe or directly.
- Apply for alternate livelihood programmes for its members directly or through the SSS.

Every Soukhya group that had completed first 6 modules of training maintains the programme register for their SW members. This register is no longer maintained by the Community facilitator/ ORW.

Soukhya groups less than one year old would still be assisted by a peer if so required.



**Challenges:** Some of the challenges faced during group formation included:

- Sex workers initially did not want to disclose their identity even to other sex workers.
- Women (non sex workers) in the local areas wanted to know why they were excluded from the group since they were aware that all programs were group based.
- It was difficult to motivate high volume and high earning sex workers to join groups
- There was a fear of stigma of being branded as a sex workers group
- Street based sex workers had difficulty in attending weekly meetings
- Due to alcoholism some sex workers were disturbing the group meetings
- Interference of partners and clients during the group meetings

**Over the years, the groups have learnt to handle these situations effectively.**

### **At the Taluk level - Okoota**

The trend to build a common platform started in Chitradurga District early in 2005. In Chitradurga, there were many issues that were common to the Soukhya groups as well as with other FSWs. Therefore, the FSWs asked if a common platform could be developed with representatives from different groups and areas. As a result, a town level committee was formed which had members from existing Soukhya groups and FSWs who were not in groups. Several issues were discussed and decisions taken<sup>7</sup> 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 FSWs and Soukhya groups discussed this. They decided to form a common platform or a Federation at taluk level as a first step. It was decided that each Federation 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 Federations would be developed during meetings.

These Taluk level Federations were named as **Soukhya Okootas** in July 2006. The Okoota is the federation of all Soukhya groups in the taluk who opt to join. Every major sex worker site is represented by 2 members at the taluk level "Okoota". From every site, one member represents the Soukhya group members

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**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 forming 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 followed up by formation & capacity building of Soukhya Groups with MYRADA support ▪ Police sensitization – advisory committee members to take the lead.

and the other represents the non Soukhya group sex workers. These members are selected by the site following a site level community meeting.

All 44 towns in the programme have a Soukhya Okoota. In three towns, where there are many sites there are 2 Okootas. The Okootas are not registered bodies. Each Okoota has around 25 members. These members have elected a president, vice president, treasurer and secretary. All Okootas have opened bank accounts. They have formed 3 sub committees in each Okoota – the health sub-committee, crisis sub- committee and social entitlements sub-committee.

### **Roles and responsibilities of the Taluk Okoota**

These roles and responsibilities which emerged during Okoota meetings and training programs<sup>8</sup> for their members were reviewed over 2 years and finalised around 2008.

#### 1. Regular organisational functions:

- Selection and monitoring of peers
- Regular review meetings.
- Regular monitoring of Soukhya groups
- Accounting of all Soukhya groups and Audit
- Forwarding monthly reports to the District SSS..

#### 2. Outreach:

- Conducting fortnightly Sex workers meetings for non Soukhya group FSW
- Planning and conducting Sex workers conventions twice a year
- Registration of new female sex workers
- Monitoring especially of vulnerable sex workers such as young sex workers and HIV positive workers

#### 3. Health

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#### <sup>8</sup> Training modules for Soukhya Okootas

**Module 1** ; - Okkuta concept and collective decision, Goals and objectives of okkuta, Rules and responsibilities of Okkuta members ; **Module 2**: Leadership, Crisis management, Communication and public speaking;

**Module 3**: Financial management, Linkage, Documentation, Okkuta registration ; **Module 4** : Vision Building; **Module 5**: Planning, Implementation, Monitoring and Evaluation of programs

- Social marketing of flavoured condoms.
- Referring cases to ICTC/care and support centres/ TB
- Monitoring of Referral Clinics- this is in turn discussed with the Community Resource Person.
- Motivating for regular health check up

#### 4. Supporting an enabling Environment:

- Responding to any crisis situation through the crisis subcommittee.
- Assisting and organizing mass programmes including Celebration of days such as World AIDS day, International women's day, All health days
- Building Linkages with the line departments
- Recommending EDP and skills training for group members.

#### 5. Community mobilization and Livelihood Support:

- Forming and nurturing Soukhya groups.
- Building Institutional Capacity of Soukhya Groups (consultant to be hired such as the Taluk Coordinator, CMRC manager)
- Linking Soukhya groups to banks and accessing social entitlements etc

### **At the District level – Soukhya Samudhaya Samasthe (SSS)**

While the Taluk Okootas began to respond to collective needs of Soukhya groups and community members, the Okoota members in Chitradurga district also expressed a need to have a registered representative body at the district level. This was replicated in all other districts by the end of 2005. There were two major reasons for a district level body: i) most of the institutions with which linkages were required had their offices at district headquarters; ii) Government programs required a formally registered body that complied with all legal requirements to apply for and receive programs/projects. Since it would not be practical for each town to have a registered body and since most programs and projects were decided and managed at district level, the Okoota members decided to have a representative body at district level which was registered. This is how the District body emerged.



The District level organisation is called the **Soukhya Samudhaya Samasthe or the SSS**. Two persons from each Taluk Okoota are nominated as members of the SSS.

These members constitute the governing board which has a President, Vice President, Secretary and Treasurer. The secretary also plays an executive role. All four Soukhya Samudhaya Samasthe units (in 4 Districts) have been registered under the Karnataka Societies Act and follow all statutory requirements.

The SSS has recruited individual members through the Soukhya groups. All members of the group contribute an amount for the SSS to their respective Soukhya groups; the group pays an annual membership fee to the SSS. Those sex workers not in groups can also register as members provided they are endorsed by a local Soukhya group. Individual FSWs can therefore become members of SSS.

### **Roles and responsibilities of the Soukhya Samudhaya Samasthe (SSS)**

These roles and responsibilities were drawn up following several consultative meetings and specific trainings held for SSS members.

1. Regular Organisational functions:
  - Maintain the office and provide running costs etc.
  - Conduct Monthly Staff meeting and Board meetings
  - Conduct General Body meetings annually
  - Arrange for proper accounting and audit of all Taluk Okootas
  - Collect taluk monthly reports and consolidate them.
  - Manage the Corpus fund: Enrol new members, (they have to pay a membership fee which goes into the Corpus fund).
  - Conduct Six monthly Peer performance appraisals
  - Select and manage CRPs.
  - Conduct Staff appraisals together other community members.
  
2. Outreach and Health services
  - Market flavoured condoms
  - Monitor all clinics (by the Health subcommittee)
  - Establish linkages with Government hospitals
  - Refer to ICTC/care and support/ TB
  - Motivate regular health check up
  - Monitor young sex workers
  - Ensure that all HIV + sex workers are linked to ART centre and care and support services.

### 3. Enabling Environment:

- Respond to any crisis situation
- Assist and organize mass programmes including celebration of days such as World AIDS day, International women's day, All health days,
- Promote Linkages with the line departments
- Attend the District HIV/AIDS Advisory committee meeting
- Facilitate and document best practices.

### 4. Community mobilization:

- Assist in forming and nurturing SGs in taluks.
- Assist Capacity building of SG and Taluk Okootas
- Refer members for skills training (recommended)

Briefly, to summarise - the organisational structure that emerged by 2008 was as follows<sup>9</sup>:

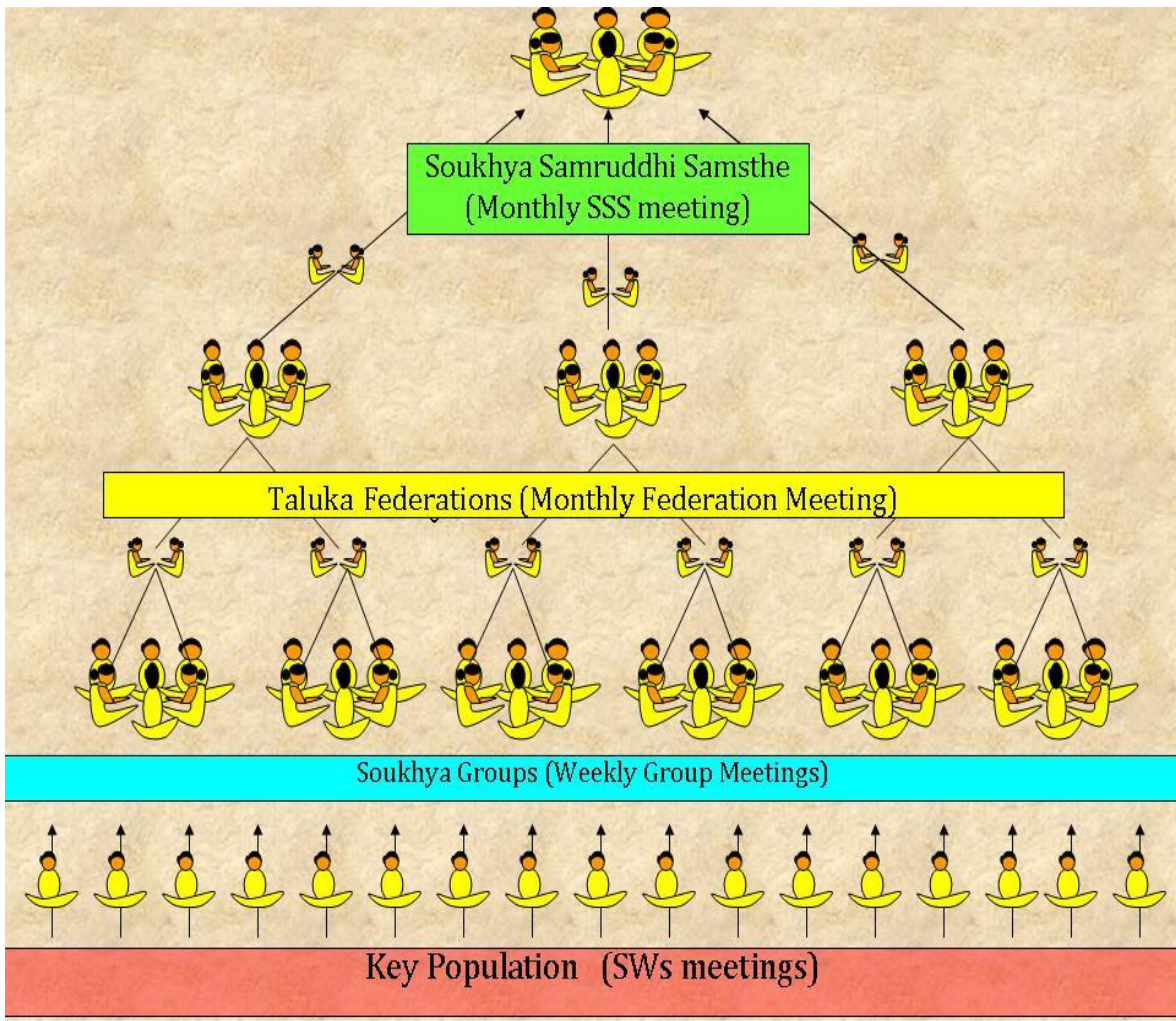
**Community level-** *Soukhya groups*. (covering around 52% of the FSW community). These groups are now able to take care of their immediate outreach needs like getting condoms and updating health information, organising health checkups and responding to other vulnerability needs.

**Taluk level** - at town level: These are the advocacy, monitoring and supporting institutions of the Soukhya groups. Since these federations are located at the town level, they are able to track the progress of the groups and the community members in the sites of those towns. They identify Community Resource Persons and peers to help them with monitoring

**District level** – *Soukhya Samudhaya Samasthe* – SSS - at district level: this apex institution of Okoota federations is the legal representative of the groups and community members affiliated to it. This institution focuses on larger issues such as fund raising, linkages, higher level advocacy, organizing mass media (TV and radio) programs etc.

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**Caution:** However while the Soukyha groups have emerged and largely stabilised, the Taluk level Okootas and District Level SSS still require some degree of support from Myrada. From April 2010 onwards, Myrada has taken on the role of institutional capacity building (ICB) following several meetings held with SSS. The SSS members in each district have drawn up specific training plans for their members at Taluk level and requested Myrada to facilitate these trainings. It is expected that this support will continue until March 2012. Myrada has received financial support from both KHPT and the CDC-GAP program to provide this training in institutional capacity building (ICB) .

**8.1 Comments on the transition strategy and process:** Myrada understood from year one (2004) that the Sankalp project would be a 5 year program and therefore it adopted a strategy which built up the SW's capacity to progressively take over responsibilities so that it would be able to hand over complete responsibility to the community before withdrawing in 2009.

Towards the end of year 2008, Myrada learnt that there was a phase 2 for another 3-5 years during which NACO (via KSAPS) would take over the funding of the KHPT/AVAHAN program. A meeting arranged by KHPT on transition from Avahan funding to NACO funding (via KSAPS) took place where it was agreed that Myrada would transition Kolar and Chitradurga Districts in 2009 April, and the other Districts after 2 years.

Myrada's proposal to KHPT for the year 2008-09 stated clearly that the district level community based organisation – Soukhya Samudhaya Samasthe (SSS) would take over all FSW related programs and that Myrada would only support a MSM and SSS capacity building program in Phase 2. Separate proposals were sent by the District SSS and Myrada; KHPT however wanted only one proposal from Myrada, which was given. All proposals made it clear that FSW components would be implemented through the SSS.

Chitradurga was dropped by NACO and only Kolar (including Chikballapur) was transitioned from Avahan to NACO funding in 2009 October. Chitradurga has been proposed by NACO for transition from Avahan funding to NACO in April 2011.

From our experience, the process of transition - **namely from a programme where the NGOs are in the lead to one where the CBOs take the lead**- takes about 3 years of extensive capacity building and mentoring; this

Institutional Capacity Building (I C B) is required for CBOs to manage their roles and responsibilities. The process of transition from private donor (Avahan) to NACO will also require at least an additional year (therefore a total of 4 years) of external financial support to mentor the CBOs formed (if they are already in place prior to transition date), to hire and re-orient new staff (since salaries are much lower in the NACO budget – previously experienced staff will not be willing to continue) and for other additional administrative costs.

## **8.2 Problems encountered during transition from Avahan managed program to NACO:**

- In the NACO template, there is no line for community mobilisation at all. Whereas, at least 14% of the Avahan budget was directly related to community mobilisation costs, with a further additional 10% of shared budget from the outreach component.
- NACO does not allow any flexibility between budget lines. This hampers programs where expenditure in some lines cross the approved budget due to unexpected changes.
- The NACO budgets for salaries over the period of the project are fixed and do not allow for annual increments for staff; the rising costs of living are not accounted for. The NACO budget does not allow for annual staff increments based on the argument that contractual staff of the government are given a fixed package. However, the staff is not government staff – they are staff hired by the partner NGO. The NGO (Myrada in this case) has personnel policies which mandate it to give annual increments. Besides, even with contractual staff who are usually on a yearly contract, the government increases the rates yearly when a new contract is signed.
- There is no provision in the NACO budget for overhead administrative costs incurred for audit fees, overall monitoring by the NGO, communications and hosting review meetings, visits from KSAPS etc.
- There is no provision for the NGO to plan and conduct any internal capacity building. The NGO is dependent on the SACS and an external agency for this; this results in long delays in training new staff.

A key feature of the “NACP – 3” policy of NACO is to transition its Targeted Intervention programs to the community led organisations (CBOs). However,

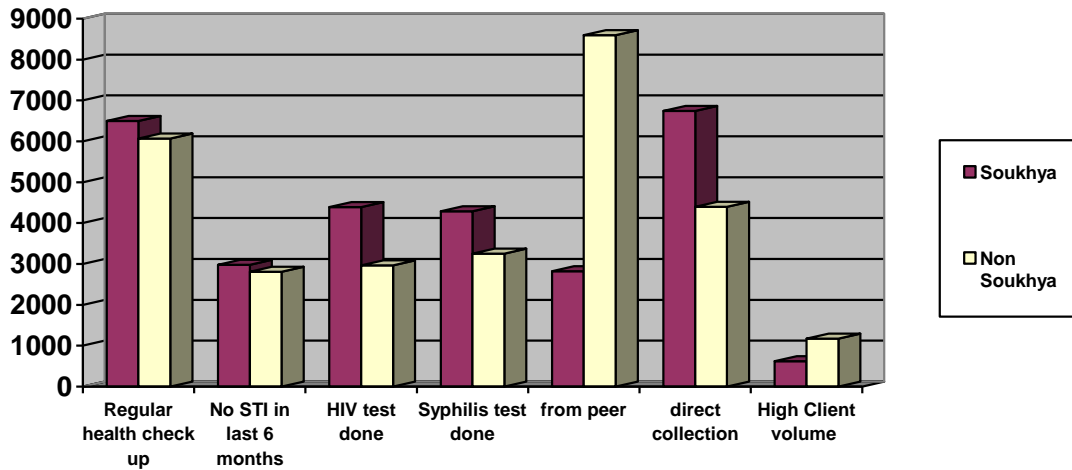
there is no provision in the budgets for administrative cost, staff costs etc for the CBOs to function during the period of transition. There is not enough money in the NGO budget that can be shared with the CBO during the period of transition

## **9. Impact: Risk reduction Indicators**

Myrada, with the support of Avahan/ KHPT had an opportunity to explore sustainable and cost effective strategies in order to assess the hypothesis that HIV prevention requires effective strategies for **both risk reduction and vulnerability reduction** for the impact to be effective and sustainable.

Feedback from the field shows that the strategy of community institution building has resulted in significant reduction in vulnerability, which in turn has lowered risk. The socially and financially secure female sex worker who has become less vulnerable now has the confidence and power to negotiate (exercise control over) both condom use as well as the number of partners to ensure safer sex behaviour.

A study done by Myrada in 2008 and presented as a poster at the World AIDS conference in Mexico shows a significant difference between the impact on those female sex workers in Soukhya groups versus those not in groups. Even though there were peer educators directly providing services to the non Soukhya group sex workers, the strategy of group formation has shown that women in groups are more likely to access services, take condoms directly from the drop in centres and reduce their client volume compared to those not in Soukhya groups. This difference is even more visible in the vulnerability indicators. This is because one of the key advantages of being in a group is easier access to social entitlements and financial services. The tables below show the comparative impact related to these two indicators in the two groups – those in Soukhya groups and those outside.

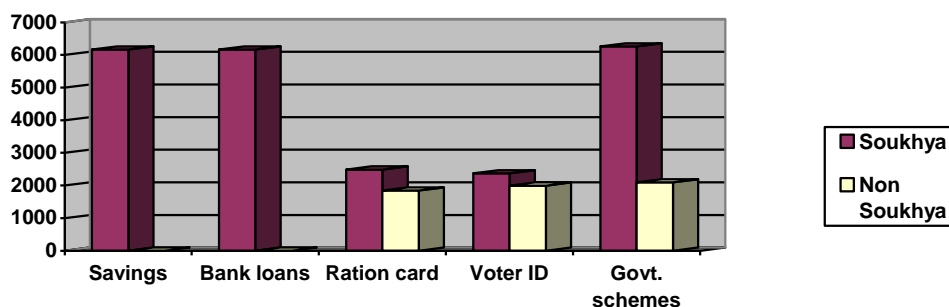


The figure above depicts the differences in HIV risk reduction services that are a part of a Targeted Intervention program. In all parameters studied, there is a significant difference between FSWs who are in Soukhya groups compared to those not in groups. There is a significant difference in the reduction in client volume amongst those FSWs in Soukhya groups.

In the figure below, the parameters include various socio economic benefits received by the sex workers, which in turn have reduced their vulnerability and therefore their risk to HIV infection.

The difference in the benefits received is significant between those in Soukhya groups and those not in groups.

**Access to social entitlements and financial services:**



## **Conclusion**

Myrada, with the support of Avahan/ KHPT had an opportunity to explore sustainable and cost effective strategies to prove the hypothesis that HIV prevention requires effective strategies for **both risk reduction and vulnerability reduction**.

Our strategy of community institution building has also shown significant reduction in vulnerability, which in turn has lowered risk. The female sex worker who is socially and financially secure can now negotiate both condom use and number of partners to ensure safer sex behaviour.

There is a significant difference in the risk reduction indicators of those in Soukhya groups versus those not in Soukhya groups which strengthens this learning.

Myrada as an organisation has always focussed on sustainability and community based strategies. The focus on providing space (and resources) for community organisations to emerge at several levels, using referral clinics and building the institutional capacity of the groups to take over responsibility progressively, has laid the basis for sustainability of impact achieved through the Soukhya programme.