TAI-VHS - Avahan

GOOD PRACTICE DOCUMENTATION

Community Ownership in STI/HIV/AIDS Prevention Program in Tamil Nadu

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Tamil Nadu AIDS Initiative (TAI) project was implemented by the Voluntary Health Services (VHS) with funding from the Avahan – India AIDS initiative of the Bill & Melinda Gates Foundation (BMGF). The project commenced its operation in April 2004, with the goal of scaling up and increasing the coverage of HIV/AIDS prevention among the sex workers of Tamil Nadu. The project has addressed Female Sex Workers (FSWs) and Male Sex Workers (MSWs) in the 13 high prevalence districts of Tamil Nadu. Initially project activities started with mapping data of 49,149 (34,353 FSWs and 14,796 MSWs). This HIV/AIDS prevention program was implemented by 24 NGOs experienced in HIV/AIDS field. The main objectives of the program were promoting behavior change among the FSWs and MSWs; reducing the burden of STIs,addressing issues related to vulnerability and promoting community collectivization & CBO formation.

PARADIGM SHIFT FROM SERVICE DELIVERY MODEL TO COMMUNITY OWNERSHIP

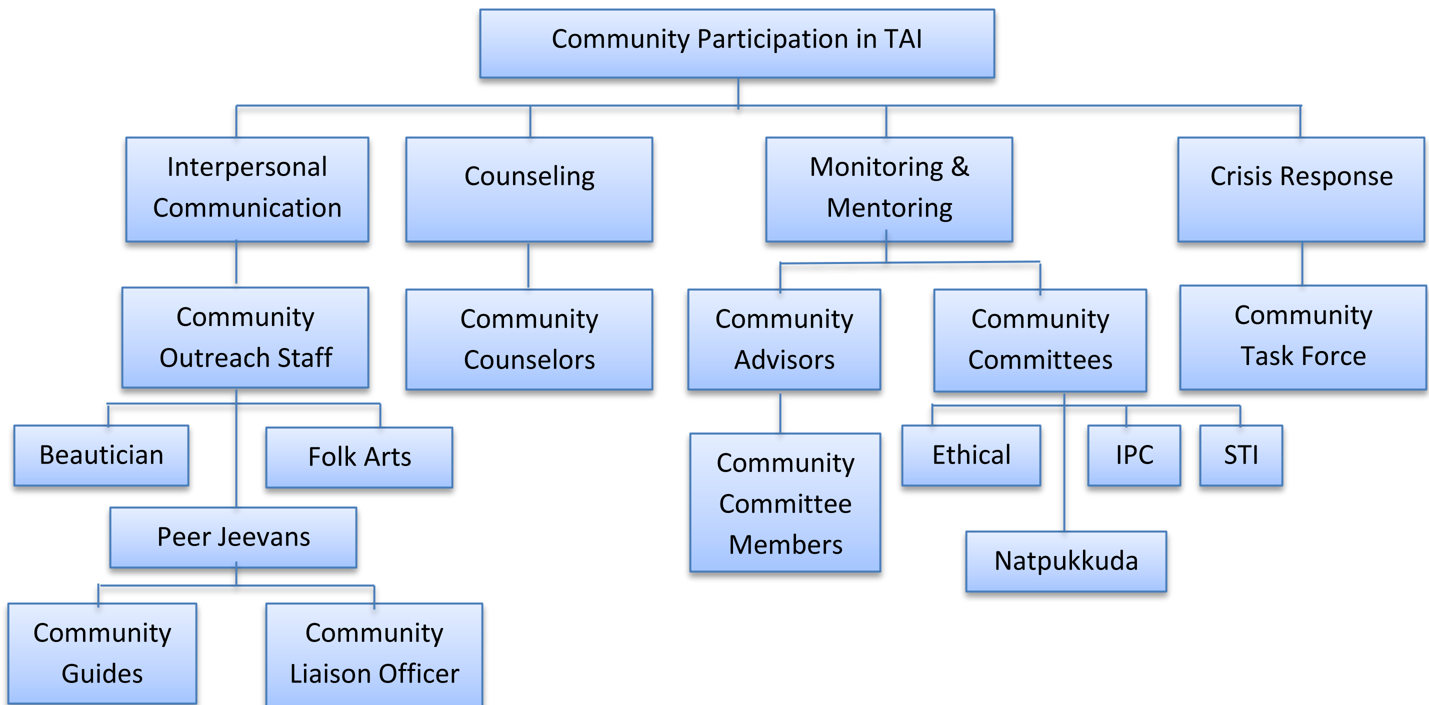
Usually, Targeted Intervention (TI) in HIV/AIDS prevention programs is focused on service delivery and community participation. The community participation is generally restricted to peer promotion. The planning, implementing and monitoring of the program are done by the staff of NGOs who are non-community. However, TAI felt that community involvement can be converted into community ownership by enabling them to lead the program. TAI provided space for the community to express their legitimate demands keeping in mind the principal core values such as respect to community, transparency, team work and result driven approach to the program. This earned the faith of the community and helped the shift from targeted intervention (TI) to Community Driven Prevention Program (CDPP). The community who had come across their peers suffering from STIs and seen deaths due to HIV took responsibility for prevention efforts. The CDPP became the foundation of TAI's intervention with sex workers and fostered sex workers ownership of the program and empowered them to take control over their lives and gain the right to better health. TAI engaged in community consultations, created a space for them, in decision making and built their capacity to manage the program. The community was now at the center stage in TAI program and all the activities were preceded by extensive discussions with them. The community members began to play important role in planning, implementing and monitoring the program.

OUTREACH PROGRAM

TAI evolved outreach strategies such as: behavior change communication; condom promotion, referrals to HIV/STI testing and STI care services, positive prevention among the HIV infected, structural advocacy measures and community collectivization for prevention and care.

Across these strategies, community members played a key role in interpersonal communication, counseling, monitoring and advocacy. They served as the link between TAI, implementing NGOs and the community, retaining the focus of programming to the needs and sensitivities of KPs (Key population).

COMMUNITY STRUCTURE



BEHAVIOR CHANGE COMMUNICATION

The BCC strategy of TAI was evolved after community consultations which stressed the need for focus on issues relating to their lives, rather than focusing only on HIV prevention. Based on the issues raised by the community, BCC messages were formulated with the themes such as health and hygiene, need for friendship, spirituality, alternate occupation and saving plans, providing a safe environment for their children, legal rights, addressing violence & trafficking, substance abuse and leaning on spirituality for strength. While preparing the material, care was taken to ensure that community friendly language was used to describe situations taken directly from their lives so that the community could relate with the IPC material. The materials were pre-tested with the community before using them in the field. The community members who showed interest in the IPC materials and an aptitude for training were trained by TAI to become master trainers. This approach helped in disseminating the prevention and awareness messages to the maximum number of community by the trainer. The BCC components thus aimed to improve quality of life of the KPs; empower them to say "NO" to unsafe sex; increase health seeking behavior; reduce stigma and discrimination towards them.

RISK REDUCTION THROUGH COMMUNITY OWNERSHIP

Peer Educators: Peer educators (PEs) formed the backbone of TAI's outreach interventions. Peer educators were selected based on their interest to engage in outreach activities, good communication skills and willingness to work on a voluntary basis. The PEs were given the responsibility to engage in the grass root level outreach by being role models in terms of accessing the services from TAI. This created a sense of ownership among them. They took responsibility of their peers' lives by helping them access the services of TAI, which included risk reduction counseling, condom promotion, referrals for HIV testing and STI care. PEs and Out Reach Workers (ORWs) conducted individual risk assessment. They developed service maps to identify Government institutions for social security, health care provider locations, police stations and power structures (pimps/brokers/auto drivers) in the intervention area. This exercise helped PEs prepare micro-plan with inputs from ORWs and prioritized their services (HIV testing, Syphilis screening, STI clinic visit etc.). PEs engaged with their peers as friends and confidants, addressed their needs and concerns and provided solutions. PEs provided personalized care such as, crisis counseling, disputes regarding inheritance issues, marital issues, and facilitated access to government services (ration cards, voter ID, social welfare schemes, bank account etc.). TAI called its PEs, Peer Jeevans (PJs) to signify community members who can give a new lease of life to their peers, by showing concern, care and involvement in their peer's lives.

***Community Committee Members* (CCMs):** CCMs were elected representatives of the community, who could address issues faced by the community and also influence their opinion on health, and social empowerment. The CCMs took responsibility for solving the problems of their peers and felt that they were answerable. They worked with NGOs in improving uptake of services and forming community collectives. They were also involved in monitoring activities, where they identified issues and reported them to Community Advisors (CA), which were discussed in review meetings conducted by TAI.

Community Advisors: Community consultants who were part of designing the program were later engaged in providing advice to the implementers regarding the community sensitiveness of the program and they were called Community Advisors. The role of CAs was to connect TAI, NGO and the community and ensure service delivery. The CAs were leaders from among the community, who resolved challenging issues of the community. Their extensive field visits ensured that issues from the ground level got highlighted and were later resolved with the NGOs and intervention of TAI team.

Emotional and prevention counseling services: To make outreach activity more effective, peers were provided with emotional as well as prevention counseling. Some sex workers were not receptive to prevention messages as they were burdened with issues such as poverty, abusive husbands/partners, dependent children, money lenders, and power structures. Therefore, PEs would first identify the problem and help KPs resolve issues by engaging the support of Program Manager, Counselors and ORW. Initially, IPC materials centered around themes that dealt with emotional issues such as guilt, low self-esteem, lack of assertiveness, self-pity, helplessness, hopelessness, and stress that were reported by sex workers. ORWs and PEs received training on 'barefoot' counseling which covered basic counseling skills. The messages were simple, targeting emotional issues of the KPs and providing solutions to overcome them.

Dialogue-based interpersonal communication (IPC): TAI chose dialogue based interpersonal communication over IEC material. Dialogue based interpersonal communication involved active listening, empathizing, and engaging in 'need based communication' with the community. This paved way to promoting health seeking behavior by addressing their emotional needs. The time spent with the community, using the IPC, was effective in achieving the outreach objective of behavior change.

The IPC material was developed with community participation, which helped in creating the communication tools. The engagement of the community in developing IPC materials helped in looking at issues from the community perspective and taking on the ownership of the program. During interactions, the community expressed message fatigue regarding messages on HIV and their dislike for material which contained obscene portrayal of the sex workers. They wanted materials to depict them as people from the general population with concerns regarding family and children. These ideas were used extensively in developing IPC materials, which were sensitive to the needs and sentiments of sex workers. The types of material included short films, thematic apperception cards, audio visual aids, flip books, posters and talking mascots. These materials were used both in 'one to one' as well as 'one to group' outreach sessions.

SPECIAL EFFORTS

TAI 'Natpukkoodam' (Drop-in-Centre)

Natpukoodam a space for the community was created keeping in mind their need to rest and relax. The space within the 41 full time static clinics of TAI functioned as Natpukkodam. It was also a space for behavioral interventions, which were conducted through IPC sessions and materials such as audio, video and poster. During 'Prayer time' at the Natpukoodams, KPs would pray for their peers who were in distress. 'Sharing time' was meant for sharing & discussing issues faced by individual KPs with their families and society at large. The Natpukkoodam housed a cloth bank, with clothes collected by KPs, which was used for KPs who were in need. The Natpukkoodam also had a food bank, where in KPs brought a fistful of rice which was set aside on a daily basis for KPs during times of need. The Natpukoodam was supervised by a three member 'Natpukoodam committee' consisting of community members. The committee members led the activities of Natpukkoodam during 'sharing time' and 'prayer time'. Another three member 'IPC committee' facilitated regular IPC sessions at the Natpukoodams.

TAI Azhagu Nilayam (Beauty Center):

Community members with a right aptitude were trained as beauticians to provide beauty treatment to peers. While they provided the beauty services, they also counseled KPs on risk reduction behavior and encouraged them to access clinic services. The beauty parlor concept was a part of skill building exercise for KPs to provide additional income. The Azhagu Nilayams were located within the Natpukoodams.

TAI KAAVIYA

TAI Kaaviya was an ensemble of transgender community, who were trained in traditional folk arts to deliver messages against stigma and discrimination towards marginalized. They conducted street plays in public places at intervention locations and performed at major social events such as World AIDS Day, Women's Day, Koovagam festival etc. They identified places which reported cases of harassment against transgender community from the general public and performed in such locations.

CONDOM PROGRAMME

The condom program of TAI ensured availability of condoms and promoted correct and consistent use of condoms among KPs. Between 2004 and 2006, TAI purchased condoms from the social marketing agency HLFPPT. Eventually in 2006, TANSACS started supplying condoms to the KPs. Condoms were also made available at the clinic and Natpukoodams.

The PEs and outreach team were involved in promotion and distribution of condoms. They were also involved in condom 'demo, re-demo' exercises. They addressed various myths and misconception regarding condoms and their use among KPs. The team also trained KPs in negotiating condom use, with clients who refused condoms. They used role play method and IPC materials to help KPs develop condom negotiation skills. IPC materials specifically targeted sex workers who might compromise condom use for extra money, by stressing on the disease prevention aspect of condoms.

Condom gap analysis was done every quarter for individual KPs, by calculating average number of sex acts per day and number of working days in a month. Based on this assessment, condoms were distributed on a weekly basis.

STI PROGRAM

The goal of the STI program of TAI was to reduce the burden of sexually transmitted infections among the high risk groups (HRGs). Specifically the program aimed at increasing the accessibility of the community to STI services, rendering quality STI care and, early case detection, diagnosis and treatment of STIs. The components and activities of this strategy included setting up of program owned clinics including full-time clinics and satellite clinics, besides providing referrals to government hospitals. While

selecting the location of the clinic, efforts were taken to identify the places which were easy for community's access by conducting Focus Group Discussions (FGDs) with community members. The doctors and clinic staff were sensitized to handle the target community with empathy. The outreach activities included providing referral services to the KPs to proximal full-time or satellite STI clinics. The clinic provided STI treatment to the KPs as well as their partners and children (general ailments). Counseling was provided in the field by the outreach team to the KPs on importance of STI care and early treatment. They were encouraged for lab test and to practice safe sex by ensuring consistent condom use. Community members, assisted in daily medical and administrative activities of the clinics and DICs, engaged in peer education and outreach activities, and built a supportive environment for those seeking services. In each clinic, an 'STI committee' was created with three community members who introduced services available at the clinic, provided clarifications and dispelled myths. They used various IPC materials for the specific purpose for dispelling common fears among HRGs regarding internal examination and drawing of blood. A community liaison officer was appointed at each clinic ensured HRGs returned for follow-up visits. They were trained and mentored by the nurse, and served as replacements for clinic assistants when required.

POSITIVE PREVENTION

The main focus of this strategy is prevention of HIV transmission to clients and partners; reduce the possibility of HIV re-infection, ensure adherence to ART and to improve their physical and mental health. TAI worked with the Clinton Foundation to initiate HIV screening of KPs in intervention districts. This exercise helped TAI estimate HIV prevalence among KPs and ensure appropriate referrals. This campaign also ran CD4 tests for HIV positive KPs & children and referrals to ART centers were provided as and when necessary.

The role of the outreach team was to work closely with the clinic team in identifying KPs who were due for CD4 tests and link them to referral centers. The team was supported by counselors at STI clinics in providing HIV positive KPs with emotional & psychosocial support. The PEs & ORWs were accompanied by counselors during home visits to follow up on positive KPs who needed emotional support.

For positive KPs who continued in sex trade, messages regarding correct and consistent condom usage, regular follow up visits to ART centers and adherence to drugs were provided. The outreach team organized emotional & psycho-social support programs every month for the positive KPs. Nutritional support & counseling services were provided during these meetings. They also used this opportunity to

demonstrate preparation of low cost & locally available nutritious food. They assisted the positive KPs to lean towards spirituality, yoga and meditation.

STRUCTURAL ADVOCACY MEASURES

Structural advocacy measures were focused on identifying secondary target groups who were brothel owners, madams, pimps, brokers, lodge owners, auto drivers and partners, who were mapped at the hotspot level. The PEs & ORWs established rapport with them, introducing them to HIV prevention messages and the importance of condom usage. To emphasize the critical role of power structures in preventing HIV among sex workers, TAI developed videos for promoting safer sex behavior and protecting sex workers from violence/abuse from clients and anti-social elements. The team also conducted informal group meetings with power structures to sensitize them on the hardships faced by sex workers. They used videos such as 'Pasa Paravaigal' and 'Mounam' for this purpose.

TAI conducted stakeholders advocacy meetings inviting police personnel, government officials and the doctors from TAI clinics, to discuss issues affecting KP, build rapport with key stakeholders in the district and seek their support. Posters such as "Kanneerukku Vaipom Mutrupulli (We put an end to tears) " were displayed at women's police stations to sensitize them about the problems in the lives of the sex workers.

In addition to these measures, TAI formed a lawyers' forum with like-minded lawyers with concern towards welfare of sex workers. In each district, two lawyers provided legal inputs and coached KPs on basic legal rights which helped them guard themselves against harassment from partners/public, false accusations and arrests. The forum also trained KPs who could educate other KPs about their legal rights and defend themselves in times of crisis.

CRISIS RESPONSE SYSTEM

TAI evolved a very sound Crisis Management System through a well informed and empowered community. The Task Force for crisis response consisted of KPs, PEs, CCMs and CAs who addressed any case of reported violence within 24 hours depending on the nature of the violence. The CCMs and CAs were provided training to advocate for such issues with police. They were able to walk in to the police stations and negotiate justice for the victim of violence. The TAI lawyers were also contacted for any case of serious nature that required additional legal support. TAI developed a booklet called 'Kaakka

Kaakka' containing the contact details of the lawyers to reach them in an emergency. Kaakka Kaakka was made available to all the KPs.

COLLECTIVIZATION EFFORTS

To facilitate sustainable community movement and create community ownership, collectivization efforts were initiated by TAI. Different collectives were formed such as Key population (KP) collective, Peer Jeevan (PJ) collective and CCM collective. Community members were collectivized at the hotspot, block, district and state level. Large community gatherings such as KP convention and PJ convention were held at the district and state levels for sharing experience and solidarity. These gatherings helped in disseminating messages regarding outreach services to a larger audience. This led to the formation of registered Community Based Organizations (CBO) and their Federation.

6 தினகரன்

சென்னை 24 ஜனவரி 2011

திருநங்கைகள் தினம் அறிவிக்க கோரி

சென்னையில் திருநங்கைகள் இன்று மாபெரும் பேரணி

முதல்வரை சந்தித்து மனு கொடுக்க முடிவு

RESULTS

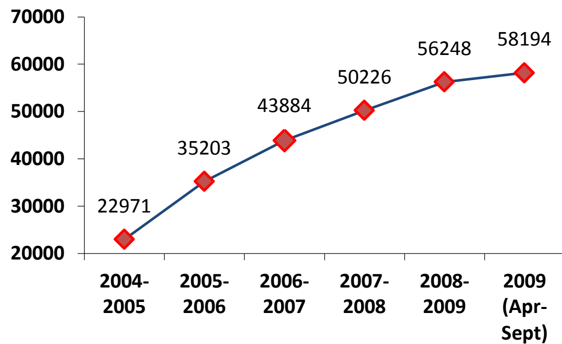


Fig1a: Coverage of sex workers between April 2004-September 2009 in TAI intervention districts (Source: TAI MIS data)

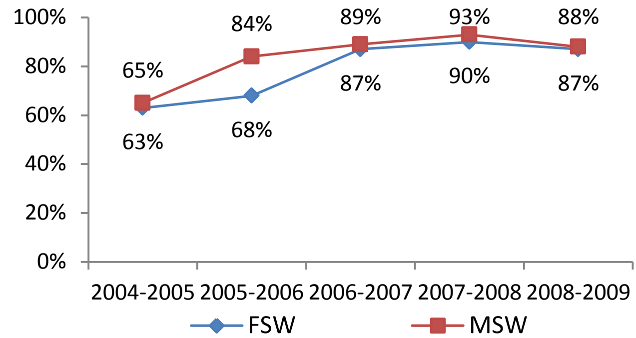


Fig1b: Proportion of sex workers who were individually reached by the outreach program between April 2004 - September 2009

The graphs (1a & 1b) show total coverage and outreach (FSW and MSW) respectively for the time period from April 2004 to September 2009. Coverage and reach of sex workers increased 1.5-2 times during this period. TAI programs were gradually transitioned to TANSACS from the year 2009.

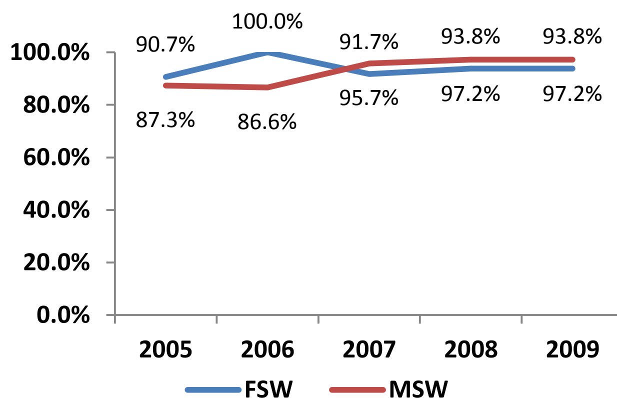


Fig 2: Condom usage during last sex with occasional client – FSW & MSW between 2005 - 2009

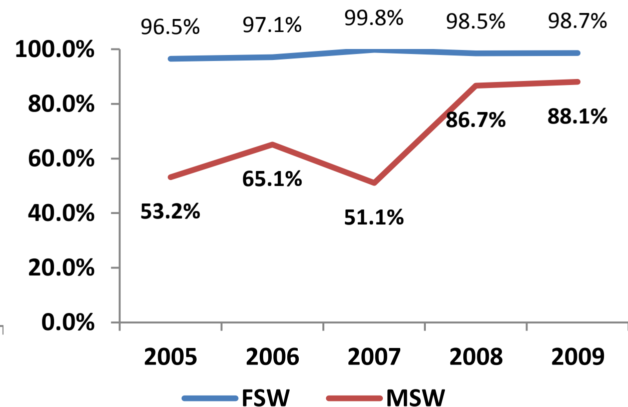


Fig 3: Voluntary HIV testing among FSWs and MSM between April 2004-September 2009 (Source: BSS/IBBA - 2009)

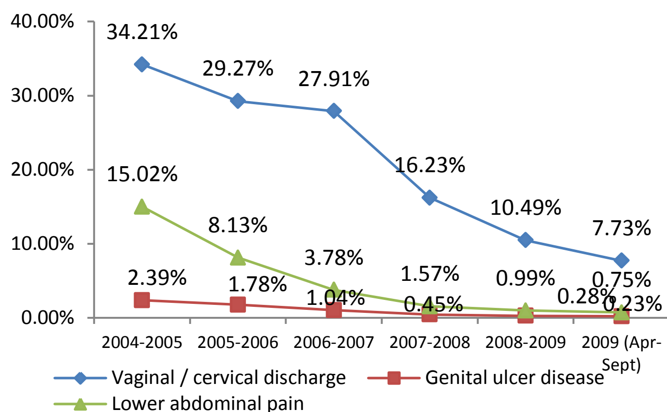


Fig 4a: Trends in symptomatic STI visits among FSWs between April 2004-September 2009

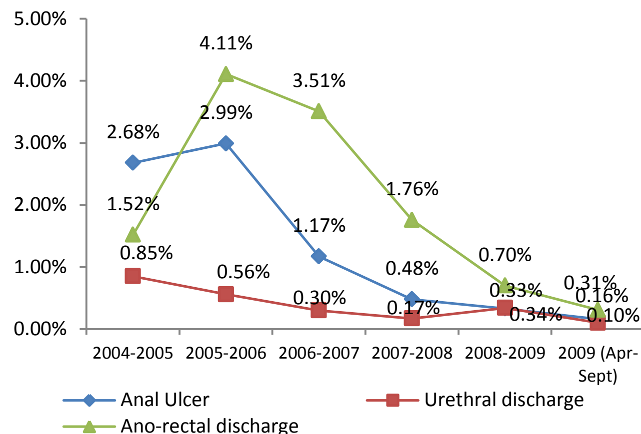


Fig 4b: Trends in symptomatic STI visits among MSM between April 2004-September 2009

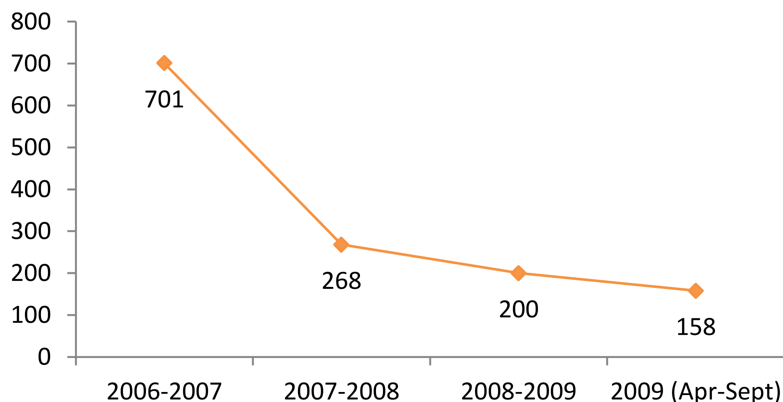


Fig 5: Reported instances of violence against sex workers between April 2004-September 2009

Condom use (Fig 2) among FSWs and MSM during last sex with occasional client showed a 2-5% increase during this time period. Voluntary testing (Fig 3) showed an exponential increase in uptake among MSM while FSWs continued their trend of higher uptake of HIV testing services. During this time, a steady decline in prevalence of STI syndromes among KPs was observed (Fig 4a & 4b). The reported number of violence instances against sex workers reduced from 701 in 2006-7 to 158 in 2009.

DISCUSSION

TAI program achieved 79% of the proposed target coverage of 80% of HRGs in the 13 high prevalence districts of Tamil Nadu. The HRGs (FSWs and MSMs) are a hidden and difficult to reach group, at high risk of STI/HIV/AIDS. TAI program with its in built strategy of keeping the community at the center stage and involving them from designing to monitoring the program was able to reach this group and to scale up the coverage in a short period of time.

The WHO defines Best Practice as, "knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and context". The discussions in this documentation are based on the criteria established by the WHO.

The Peer Educators (PEs) who formed the backbone of the program were able to take ownership of providing services and commodities to the sex workers who were allotted to them. The ratio of PE to KP was 1: 30 in order to ensure continuous reach and increase service delivery and sustain effectiveness of the program.

Effective use of IPC in one – to – one and one to group sessions helped in imparting knowledge regarding importance of risk reduction, RMC (Regular Medical Check-up) and treatment of STIs, which in turn helped in reducing the disease burden.

The present compilation of good practices of TAI throws light on containing HIV transmission through community empowerment and ownership. Community ownership resulted in the formation of 23 CBOs of whom 17 have been empowered to run TIs with a grant from the government; and the rest wait their opportunity to demonstrate similar capability. The process of CBO formation and empowering them to run TIs were completed within a short span of 3 years since the commencement of TAI program. The program is considered to be relevant since the ANC prevalence of HIV was brought down from 1.01% in 2003 to 0.25% in 2006. The program gave utmost importance to maintaining the confidentiality with regard to the sensitive information of individual KPs. This was adhered to in respect of personal, social, medical and other relevant information. TAI designed its program keeping in mind the sustainability of the program. It involved community at all levels of management. The community was actively engaged in planning, designing and monitoring the program in order to impart the skills to the community to run the CBOs and TIs by themselves. TAI also created linkages with partner agencies, which could provide

necessary skills for managing the CBOs and other programs. Linkages were also established with government institutions for social entitlement, police personnel for advocacy and health care providers for health care needs. TAI also spent considerable amount of time in helping the community members get trained in resource mobilization techniques. The political commitment of the community was established through their access to political leaders and government officials. This contact was made use to influence government decisions, in addressing stigma & discrimination faced by the community. The government also established a welfare board for Transgenders and announced 15th April as TG (Transgender) Day in Tamil Nadu, which is first of its kind in the country.

CONCLUSION

The TAI program evolved as a community empowerment model, resulting in disease prevention and reducing STIs/HIV/AIDS. The consistent effort of TAI during the last 9 years, with community at the centre stage, resulted not only in program ownership but also in bringing about a sustained community movement. The outcome of this effort was the formation of 23 CBOs of whom 17 implement TIs, with support from TANSACS. Two federations have been established, one each for FSWs and MSMs. The empowered community has come a long way in CBO governance, imbibing leadership skills, networking with HIV and Non-HIV organizations.

TAI continues to provide mentoring support and has initiated the social protection program to address the needs of the marginalized community beyond HIV/AIDS.

Abbreviations

AIDS	:	Acquired Immunodeficiency Syndrome
ANC	:	Ante Natal Care
ART	:	Antiretroviral Therapy
BCC	:	Behaviour Change Communication
BMGF	:	Bill & Melinda Gates Foundation
CA	:	Community Advisor
CBO	:	Community Based Organisation
CCM	:	Community Committee Member
CDPP	:	Community Driven Prevention Program
DIC	:	Drop in Center
FGD	:	Focus Group Discussion
FSW	:	Female Sex Worker
HIV	:	Human immunodeficiency virus
HLFPPT	:	Hindustan Latex Family Planning Promotion Trust
HRG	:	High Risk Group
IEC		Information Education Communication
IPC	:	Interpersonal Communication
KP	:	Key Population
MSM	:	Men having sex with men
MSW	:	Male Sex Worker
NGO	:	Non- Governmental Organisation
ORW	:	Outreach Worker
PE	:	Peer Educator
PJ	:	Peer Jeevan
STI	:	Sexually transmitted Infection
TAI	:	Tamilnadu AIDS Initiative
TANSACS	:	Tamilnadu State AIDS Control Society
TI	:	Targeted Intervention
VHS	:	Voluntary Health Services
WHO	:	World Health Organisation

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