

# Community-Based Initiatives for HIV Program Management among Most-at-Risk Populations



Sarathi Trust

Seeking an Inclusive Community:  
Voices for Change.

For years, 24-year-old Sandeep (pseudonym) hid his identity as a man who has sex with other men from his family and friends. Briefly, he found solace in a relationship with a bisexual coworker, but the man's marriage ended the relationship. Sandeep began cruising. Unaware of Sandeep's sexual orientation, his family insisted on his marriage. Sandeep watched, mute, as his family began to plan his wedding. However, his visits to cruising sites continued, and a chance encounter with a Sarathi outreach worker changed his life. After a one-on-one session with the outreach worker, Sandeep went for testing at an integrated counseling and testing center. He tested positive for HIV. Sarathi helped him to talk with his family and explain his true orientation, and the wedding plans were dropped. Today, Sandeep continues to work, relieved that he did not have to marry.

Sarathi is a community-based organization (CBO) created by and for men who have sex with men (MSM) that links members of most-at-risk populations (MARPs) with their community. This case study explores the significant role of community-based initiatives (CBIs) and the process of collaborating with CBOs to address HIV within communities of MARPs. The study focuses on two CBOs, both trained by the Avert Society<sup>1</sup> in

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<sup>1</sup> The Avert Society was a 10-year project established in 2001 as part of a bilateral partnership between the Government of India and the U.S. Agency for International Development (funded by the U.S. President's Emergency Plan for AIDS Relief) to provide technical expertise in managing HIV programs in Maharashtra State. The Avert Society worked with State AIDS Control Society, communities, and NGOs, including people living with HIV, to improve availability and access to prevention and care services for vulnerable groups in both rural and urban areas. Further detail on the Avert Society is available in other AIDSTAR-One case studies at [www.aidstar-one.com](http://www.aidstar-one.com).

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the high-prevalence state of Maharashtra—Sarathi, located in the city of Nagpur, and Prerana Samajik Sanstha (Inspire Community Organization, or PSS), an organization comprised of and for female sex workers (FSWs) in Aurangabad. The case study examines the conceptual frameworks for establishing the organizations and strategies that the CBOs used to address HIV among these high-risk populations.

Primary qualitative data for this case study were derived from interviews with members of PSS and Sarathi, staff at the Avert Society and Marathwada Gramin Vikas Sanstha (MGVS),<sup>2</sup> health care professionals, and government officials working on diverse aspects of social welfare. In addition, the Avert Society, PSS, and Sarathi provided reporting and quantitative data.

### HIV in India

Management of HIV programs remains a major concern for India, where an estimated two million people are HIV-positive. Encouragingly, prevalence in the general adult population has declined, from 0.44 percent in 2000 to 0.31 percent in 2009. However, overall prevalence across MARPs continues to be significant. As of 2010, HIV prevalence was 7.14 percent among people who inject drugs, 4.43 percent among MSM, 2.67 percent among FSWs (National AIDS Control Organisation [NACO] 2012), and as of 2009, 2.46 percent among clients of sexually transmitted infection clinics (NACO 2011b).

Phases II and III of India's National AIDS Control Programme (NACP) emphasized the need to focus on comprehensive and integrated HIV services among MARPs (NACO 2006). Under NACP III (2006-11), nongovernmental organizations (NGOs) or CBOs

led the management of HIV programs for MARPs through targeted interventions; CBOs eventually became the primary leaders for management of HIV programs among the MSM population and, in some instances, in FSW communities.

### Community-Based Initiatives for HIV Program Management among India's High-Risk Groups

The NACP focuses on mitigating HIV incidence among MARPs in India through targeted interventions led by NGOs and CBOs. However, experience indicated a need for greater engagement of MARPs. Involving members of MARPs as peers or outreach workers in NGO- or CBO-led interventions improves the program because the MARP members understand the context and their community's needs. Given the isolation and lack of resources that affect many MARPs, participation from within these groups is vital to ensure access by the community.

In India, a policy shift toward CBIs, intended to increase the engagement of MARPs in their own care, led to a steady increase in CBO-led targeted interventions among MARPs. Regulations require that CBOs employ members of the target MARPs. These interventions accounted for 5 percent of national HIV interventions in 2005, which increased to 13 percent in 2006–2007. According to NACO (2011a), there are 454 targeted interventions carried out among FSW groups in the country; 21 are managed by CBOs, and the rest are managed by NGOs. Among MSM, all 155 interventions carried out in the country are managed by CBOs.

Projects in a variety of settings have demonstrated the relevance of CBIs in managing HIV services among MARPs. Community-based initiatives facilitated HIV testing and counseling among MSM populations in Thailand (Spratt and Escobar 2011). In Caribbean countries, a peer-based intervention within community programs facilitated a sustained effort

<sup>2</sup> MGVS is an NGO supported by the Avert Society that implements targeted interventions with the FSW community in Aurangabad and is responsible for facilitating the formation and orientation of PSS.

to reduce HIV transmission and improved treatment outcomes among MSM (Avrett 2011). In India, CBIs have been developed to address the concerns of MARP groups in various regions, including MSM in Maharashtra (Robertson 2010) and FSWs in Kolkata, Karnataka, and Hyderabad (NACO 2006).

## Community-Based Initiatives for High-Risk Groups in Maharashtra

The nearly 419,442 people living with HIV (PLHIV) in Maharashtra state in India account for approximately 17 percent of all PLHIV in India (NACO 2011b). The state has a prevalence rate of 0.55 percent for its adult population, with greater vulnerability among high-risk groups—17.9 percent among FSWs and 11.8 percent among MSM populations (Avert Society 2009). Industrialization and tourism in Aurangabad and Nagpur districts create vulnerability to HIV through unsafe commercial sex practices (NACO 2006). The Government of Maharashtra developed CBIs to strengthen the HIV program for MARPs.

According to NACO (2007), the role of CBOs in HIV program management among MARPs is crucial for several reasons:

- When a community incorporates HIV programs, the uptake of services and commodities increases.
- Community-led interventions enhance the bonds among community members, motivating individuals at high risk of HIV to support their colleagues in accessing information and services.
- Community-based organizations have often been found to be most effective in scaling up HIV prevention.
- Community-led initiatives enable MARPs, as service consumers, to apply pressure to maintain

the quality of services, leading to a sustained demand for high-quality services.

- Program sustainability depends, among other factors, on the level of ownership by the community.

In accordance with NACP II and III, the Avert Society developed a number of interventions, led by NGOs or CBOs, for HIV program management among MARPs. The Avert Society focused on strengthening the role of members of MARPs, introducing them to their role through initial work as peer or outreach staff. The Avert Society then helped establish and strengthen PSS and Sarathi for their work with FSWs and MSM communities in Aurangabad and Nagpur, respectively.

The following sections describe the conceptual framework for developing CBIs for the Indian context, and the development and accomplishments of PSS and Sarathi.

## Setting the Ground for Community-Based Initiatives

Both NGO- and CBO-based approaches are relevant to HIV program management. The local context determines the potential for CBOs to play an active role. Community-based organizations can be the best choice for marginalized communities because they allow members of MARPs to converge and take collective, participatory action to advocate for change, which ultimately strengthens the community's commitment to controlling HIV. For instance, the flexible organizational structure of CBIs allows FSWs who are economically and socially disadvantaged to participate, while the assurance of anonymity widens the scope for participation.

NACO has emphasized the relevance of CBI in that they are high-context organizations, focusing on the local community and its needs, as opposed

to low-context organizations that focus more closely on goals and outcomes (NACO 2007). To ensure attention to the immediate needs and local conditions of the marginalized communities of Aurangabad and Nagpur, the Avert Society decided to give CBIs a leading role.

The operational principles of high-context organizations such as CBOs are essentially different from those that guide many low-context interventions (such as those conducted by NGOs), which reflect regional or national strategies, but may not align with local needs or community priorities. CBOs tend to give greater value to community interrelationships, viewing time and events in terms of cycles (rather than steps to be completed) and emphasizing community views and consensus. This gives CBOs certain advantages in terms of knowing their community and establishing trust but also confers distinct weaknesses, especially in terms of documentation and strategic planning.

The next section gives a brief overview of common measures taken by CBIs in addressing HIV in their communities.

### Understanding and Addressing the Needs of the Target Group

It is important to understand the target group prior to initiating a CBI. Sarathi, which started as an informal CBO and developed into a formal organization with support and input from the Avert Society, other agencies, and the government, began its work by seeking to understand the dynamics of being an MSM in Nagpur. To that end, Sarathi worked through a process that included: a) visiting different cruising sites to understand the profile of MSM; b) identifying local self-identified MSM or individuals who were sympathetic to MSM; c) creating informal communication systems with individuals from different walks of life who were part of the MSM community (whether willing to disclose this or

not); and d) helping this informal group to act as a sounding board, giving feedback on the relevance and feasibility of planned activities.

PSS developed differently; FSW members were brought together by MGVS and the Avert Society based on interest expressed by individuals. Most of the FSW members who came forward to set up or be part of PSS were already familiar with NGO-based HIV outreach programs. Organizational development for PSS included: a) creating a support structure to carry out administrative tasks and developing strategies that link community needs to national policies; b) providing sustained technical support; and c) mobilizing a large pool of FSWs to do field work because members could not afford to take on field work as a full-time task.

### Creating an Enabling Environment

Structural, functional, and individual factors often create barriers for HIV interventions (Chillag et al. 2002). Since the staff of both CBOs were members of the communities they worked with, they were able to identify and address many of the structural, functional, and individual factors that affect these communities.

**Structural factors:** These are system-wide factors that include policies toward a given community, the legal status of specific activities among community members, and the availability of resources for managing HIV programs. Institutional or structural arrangements can increase discrimination against PLHIV and marginalized groups; for instance, when health workers are biased against these groups. Biases can be institutionalized, resulting in nonallocation of the funding needed for work with MARPs or selective provision of services.

Both Sarathi and PSS had to deal with the criminalization of their members' sexual activities,

which restricted field-level intervention. Sarathi worked toward policy change along with network partners and sought to address local perceptions in an assertive but nonconfrontational manner. PSS took a different approach, focusing on FSWs' rights to seek health care and emphasizing safe sex practices as a preventive measure. Both CBOs needed technical support to identify and address inhibiting or facilitating structural factors.

**Sociocultural factors:** To be effective, CBIs need to take into account local sociocultural views about their community. Negative attitudes about sexual orientation or behavior, whether overt or unexpressed, can impede the work of CBOs and slow down the development of social networks among MARPs and in the wider community.

Both Sarathi and PSS used the following approaches to address the sociocultural context:

- Holding informal discussions with small groups to explore difficulties faced within wider communities and cruising sites
- Documenting individual experiences of violation of rights at work, in the community, and during interactions with police or health care professionals
- Building informal support structures to address violations and ensuring support for rights through advocacy, networking, and legal action.

For example, despite laws that prohibit harassment of MSM, Sarathi found it necessary to sensitize local police officials, who were often reluctant to register a complaint about harassment because of personal prejudices. In instances like these, CBOs may need input from other agencies on establishing informal contacts within the police force to create a more receptive attitude and ensure protection for CBO members.

**Organizational factors:** Community-based organizations need to understand factors within the organization that enhance or reduce their efficiency. For many CBOs, the local context (rather than a specific organizational mission) determines the organization's focus, human resources, finances, and infrastructure; thus a CBO may evolve to take on activities beyond those specific to the vulnerable community or beyond addressing HIV. This overextension can lead to fatigue and reduced performance.

**Individual factors:** Individual factors, including the degree of marginalization experienced, caste affiliation, and residence in resource-poor areas, can affect the performance of CBOs or individual members. In addition, developmental realities of target groups can hinder HIV intervention (e.g., the difficulty of persuading those concerned about daily survival to focus on sexual risk taking), may also be beyond the scope of CBOs, and would require networking and collaboration with other agencies. Community-based organizations may require technical support or guidance to overcome these barriers.

Although close cultural or ethnic ties with MARPs can facilitate CBI, there is a risk of over-identification with these groups (Chillag et al. 2002), which can be counterproductive. To safeguard against this, both Sarathi and PSS required their outreach members to be assessed and trained in professional conduct. Given the turnover of outreach staff within both NGO- and CBO-led interventions, the need for training is frequent.

## Institution Building

Developing a CBO is a long-term process that begins either with an NGO initially acting as leader or with the CBO taking the lead with direct technical support. Both options involve:

- Building human resources
- Developing an organizational framework for planning and action
- Incorporating monitoring and assessment mechanisms
- Strengthening the scope for collective decision making and action
- Networking with agencies within and outside the project area
- Establishing linkages for collaborative action with the Maharashtra State AIDS Control Society, the District AIDS Prevention and Control Unit, and the Technical Support Unit.

Building human resources is critical given that many FSWs are socially and economically marginalized groups and MSM may lack expertise in implementing a health or development program.

Community-based organization member training is a staggered process, beginning with the selection of peer educators and outreach workers. Behavior change communication and efforts to increase access to services help to build trust and empower community members to examine and address their own risk and vulnerability. Local committees can be formed to address human rights, health, social entitlement, or economic concerns. These committees, established across various localities, are aware of the micro-context and can identify ways to address the dynamics of HIV across neighborhoods in a comprehensive manner.

## Achieving Change in a High-Context Intervention

The issue of high-context (cyclical) versus low-context (linear) approaches merits further

exploration. According to Chechetto-Salles and Geyer (2006), different styles of thinking or world views—high- and low-context perspectives—affect the management of development programs in different ways. The high-context approach, often taken by CBOs, is reflected in a focus on community consensus and cyclical events, in contrast to the low-context, linear approach often used in managing Western-style interventions.

As high-context CBOs seeking to effect social change, Sarathi and PSS had to consider specific issues:

- **Concept of self:** *The high-context approach tends to value communities first, followed by organizations and individuals, whereas agencies following a low-context or linear approach take the opposite view, prioritizing first the individual, followed by the organization and the community. Variations in the importance given to individuals can affect efforts to achieve social change.*
- **For example:** Sarathi had to consider the relative importance of the family, the local community, and the MSM group as the community. The central role played by family or the wider community differed based on the level of openness to belonging to the MSM community. These diverse needs shaped Sarathi's efforts to create networks within the district, reduce stigma, and strengthen initiatives for HIV management. Both Sarathi and PSS focused on the human angle, rather than individual rights, within the context of local developmental reality.

- **Implementation:** A CBO's priority in implementation would consider the effects on relationships or interrelationships, either within the wider community or the marginalized group. For example, the implementation of outreach activities, such as selecting individuals to lead particular activities, would be based on consensus. By contrast, an NGO would select individuals based on the role assigned to them within the organization and not necessarily based on consensus.
- **Sustainability:** The long-term effects of CBIs derive partly from their focus on relational aspects, which creates support networks to which individuals or groups are willing to contribute.
- **Communication:** Both Sarathi and PSS preferred oral communication over written forms, partly because of the cultural context and the educational background of the target groups. Thus outreach workers and counselors were trained to use pictorial educational aids and hone their powers of observation and perception, while also developing skills in communicating accurate information. To facilitate the retention of orally communicated messages on behavior change, the program ensured that members of the target communities received the messages repeatedly through a variety of program activities.

## Documenting Change

Both Sarathi and PSS had to move toward a low-context approach to document their activities in a standardized way that could be transferred to management of information systems and subsequently to develop public health policies. Documentation was challenging for both groups. Within high-context organizations, the focus is not on moving from one stage to another, measuring success in terms of steps taken or completed, but rather on developments within the local context that

involve relationships and agreements among various actors within the community.

To illustrate the difference, a CBO with a relational<sup>3</sup> world view will look at large-scale community events as part of a cycle, as events are repeated at regular intervals, and will develop a process for implementing activities in terms of links established within the community for planning, presentation style, and the human resources involved. A rational, low-context perspective may focus on time, day, location, participants, and the number of events undertaken, but it may not capture how the events actually affect the community and its relationships. Documentation strategies thus need to include the cultural factors that affect the lives of the local community, such as how caste, class, or even a local criminal element can affect the way project activities are implemented.

For example, a high-context intervention would take a particular approach in addressing safe sex—a low priority for communities where people are focused on their daily survival. In such a community, a cartoon on condom use might evoke a relational perspective; for example, showing cartoons on the difficulty in using condoms due to lack of privacy or the difficulty of ensuring access to condoms because of people's reluctance to carry them. Such an illustration could facilitate discussions and elicit high-context data that enrich the intervention.

There is a need to explore the implication of these different world views when considering community initiatives and their sustainability for HIV program management. It is critical to consider these differences when documenting the effects of CBIs.

<sup>3</sup> Relational thinking entails viewing public policy and personal issues through a relational lens, so that the organizational goals and values and the analytical framework focus on relationships. In this view, the health of relationships is most important, rather than material or individual goals. Relational thinking demands reconsideration of national and organizational priorities; a relational view, for example, would change the way a business is run or the way the criminal justice system functions (Relationships Global n.d.).

## Prerana Samajik Sanstha: A Community-Based Organization for Female Sex Workers

Aurangabad has a significant number of non-brothel-based FSWs, whom the Avert Society started working with in 2003. To plan an appropriate intervention program for FSWs in Aurangabad, the Avert Society carried out behavioral sentinel surveillance over five years (2004-09) among MARPs from seven districts of Maharashtra. Data from the non-brothel-based FSW community indicated several factors that increased vulnerability to HIV, including illiteracy (30.3 percent); having an average of approximately nine commercial clients and one nonpaying client in a week; being unaware of ways to prevent HIV (47.1 percent); the presence of genital discharge or genital ulcers (24.2 percent); and the presence of discrimination against PLHIV (58 percent of participating FSWs said that they would mind shaking hands with an HIV-positive person) (Avert Society n.d.).

Initially, NGOs took the lead in the targeted intervention, creating an environment that enabled FSWs to play an active role in the HIV intervention. From 2003 to 2008, interventions carried out by different NGOs, including MGVS, focused on identifying cruising or sex work sites; developing steps to increase rapport; undertaking prevention measures that focused on behavior change communication along with reducing vulnerability through treating sexually transmitted infections; and strengthening safe sex practices. In addition, vulnerable and HIV-positive individuals were linked to relevant testing, treatment, and social services.

Some FSWs involved in one of the interventions showed interest in carrying out an intervention as a community initiative. Providing managerial support, this led MGVS to form PSS as a community

organization comprised of and working for FSWs. Because the majority of PSS members had participated in previous interventions, they had acquired experience and insight that helped launch and strengthen their work.

MGVS and the Avert Society took several steps to create and strengthen PSS, including:

- Improving identification of FSWs and high-risk individuals through outreach, and using peer educators to target MARPs with information, education, and communication on safer sex behavior.
- Decreasing vulnerability to HIV through better understanding of the conditions that lead to unsafe sex practices. This entailed assessing risks and prioritizing MARPs who are at greatest risk.
- Developing public-private partnership services for sexual health concerns of FSWs and ensuring that preferred health care providers are involved in service delivery.
- Improving FSWs' access to HIV services at clinics and government-run integrated counseling and testing centers.
- Creating community committees to address FSWs' concerns, which increased the relevance of PSS services and facilitated the wider participation of the FSW community.

PSS was formally registered in 2008 as a separate entity and began to actively implement the HIV program in 2009 with initial guidance and support from MGVS. The organization has 21 staff members including a project director, a project coordinator, a monitoring and evaluation officer, an accountant, outreach and community mobilization workers, and peer educators who conduct outreach in

four areas (blocks) of Aurangabad district. The organizational objective is to create an enabling environment by increasing awareness of the issues that concern FSWs, working within and beyond the FSW community and with various stakeholders in institutional settings and in society at large. Addressing concerns of those within the FSW community who are affected by HIV empowers women to seek their rights and identify ways of advocating for change.

During the past two years, PSS members received training in the following areas:

- Use of female condoms, especially in terms identifying patterns of use of male condoms, gaps in condom use, and the potential for using female condoms instead of male condoms
- Use of various types of condoms and communication strategies for use with different target groups
- Use of information, education, and communication material for one-on-one and group sessions
- Preparation and implementation of an institutional outreach plan
- Management of information systems and the basics of data collection and maintenance
- Management and administration training for community organizations.

Of the total number of FSWs (1,551) that PSS reached, 99 percent (1,543) registered with the organization.

## Sarathi: HIV Management among Men Who Have Sex with Men

Negative cultural and political views on deviations from “normal” sexuality and sexual expression continue in India. Thus, despite progress made in policy and legislation, preventing HIV among MSM is difficult. Within India, MSM consist of various subgroups, based on their sexual orientation and identification,<sup>4</sup> all of whom face stigma and discrimination. Except for very visible transgender or Hijra groups, and those who are openly part of the MSM population, most MSM remain hidden, especially in rural areas and smaller towns.

To further understand the MSM community and its vulnerability to HIV, the Avert Society carried out behavioral sentinel surveillance in seven districts of Maharashtra from 2004 to 2009. A sample of MSM (1,957) suggests the following characteristics: MSM are literate, are employed or self-employed, and have multiple partners (paying and nonpaying). The mean age at first sex was 17 years, and the sex was anal in 65 percent of cases. Whereas 80 percent participated willingly in their first sexual act, 14 percent reported forced sex. Nonuse of condoms occurs in 10 percent of cases and is linked to perceptions of safety and priorities; for example, assumptions that a college-going partner presents a low risk, or risk taking because of financial need. Sarathi, registered in 2007, operates in several districts, although the majority of its activities are in Nagpur (which this case study focuses on). Sarathi takes a holistic and sustainable approach to HIV program management, featuring

<sup>4</sup> Kothis refers to those who show varying degrees of femininity and are receptive partners for both anal and oral sex. Panthis is the term for the partner who takes on the male role (insertion or penetration) in anal or oral sex. Men who both receive and insert during penetrative sex are termed “double deckers.” Hijras are transgender persons.

**TABLE 1. MSM POPULATION COVERED BY SARATHI TRUST.**

TYPE OF MEN WHO HAVE SEX WITH MEN	REGISTERED MEMBERS	ACTIVE POPULATION	DROPPED OUT
Kothi	1,015	675	340
Panthi	701	515	186
Double decker	375	284	91
Hijras	58	45	13

active MSM participation and a sense of ownership among members. During the initial phase of this CBO initiative, active support was provided by the Humsafar Trust,<sup>5</sup> Lakshya Trust,<sup>6</sup> and friends of PLHIV. The Avert Society collaborated with Sarathi to launch a program to address HIV concerns of MSM in Nagpur district (a population estimated initially at 670, but subsequently revised upward as acceptance of the program grew).

Sarathi initially conducted awareness building before taking responsibility for the Avert Society’s comprehensive community initiative in 2010. Establishing a good rapport throughout the MSM population helped Sarathi achieve wide participation and address the different needs of the subgroups (Table 1). At present, the CBO covers 30 hot spots in the district through 21 staff members, including field workers, four community mobilizers, four outreach workers, three shadow leaders (trainees from the MARP community who learn and take on certain tasks), and a committee coordinator.

Sarathi’s strengths include the following:

- The ability to explore sensitive information regarding unsafe sexual practices and to increase the participation of MSM members
- Development of an enabling environment through advocacy with different stakeholders and sensitization of the local community
- Strategies to reduce the practice of unsafe sex including risk assessment, increased accessibility and utilization of condoms, and easier access to health care services
- Creation of linkages with various agencies to increase support for health care and social entitlement among PLHIV.

## Results: PSS and Sarathi

As CBOs, PSS and Sarathi identified and met the diverse needs of their communities in a number of ways, as documented below.

**Increasing reach and utilization of services:** Participatory mapping exercises facilitated by sex workers and MSM populations steadily increased reach and utilization of services. Data showed that both coverage and service provision for FSWs increased after PSS received organizational strengthening (Table 2).

<sup>5</sup> Humsafar Trust was established in 1994 in Mumbai and works with MSM groups. Through the years, Humsafar has sensitized health care staff, media, and the government to the concerns of the MSM population. Humsafar has begun working in other areas of India, including Maharashtra, focusing on training MSM agencies to initiate work in local areas.

<sup>6</sup> Lakshya Trust is a CBO registered as a public trust in Gujarat and works for sexual minorities addressing their social, economic, legal, psychological, health, and spiritual concerns.

**TABLE 2. REACH AND SERVICE PROVISION TO FSWs BY PSS, AURANGABAD**

	2008–09	2009–10	2010–11	APRIL–JUNE 2011
Population reached with services	272	954	1,027	1,174
Number of condom outlets	7	54	58	58
Sexually transmitted infection referral/clinic attendance	202	1,658	3,130	546
Sexually transmitted infections treated	188	1,217	634	30
Integrated counseling and testing center referrals	270	1,520	2,447	410
HIV tests taken at integrated counseling and testing centers	85	1,153	1,443	272
Sexually transmitted infection–positive results	93.1%	73.1%	20.3%	5.5%

Sarathi's coverage of MSM reached also increased from 2007 to 2011, especially post-2010 after undertaking the comprehensive community intervention on HIV prevention, treatment, care, and support (Table 3).

**Building a supportive environment:** HIV programming for MARPs requires a comprehensive approach that goes beyond addressing the layered marginalization of being an MSM or FSW and HIV-positive. To create acceptance among society, the programs focused on sensitizing secondary and tertiary stakeholders.

For example, Sarathi helped to create an enabling environment by advocating for MSM with personnel from law enforcement, members of the media, and local leaders in an effort to address misinformation and biased perceptions about nonmainstream sexual choices. Between 2008 and 2010, the organization sensitized 69 media personnel, 215 police officers, and 25 local leaders. Sensitizing the police is especially important because they play a crucial role locally in terms of allowing or restricting harassment based on sexual deviation, and addressing harassment expands the ability of MSM to assert their rights. Advocating with the

media led to the publication of informed articles on MSM, which appeared in local papers during World AIDS Week from 2008 to 2010. Additionally, articles were also written that discussed the criminalization of homosexuality and the harassment MSM experience. These articles set the stage for greater understanding of MSM.

Sarathi held health camps in 2007 and 2009, which offered a safe space for MSM to openly discuss their sexuality and health concerns. The dialogue with health professionals allowed providers to understand MSMs' needs and overcome their biases. Also, in 2010, Sarathi launched an insurance scheme for PLHIV. The organization also launched an innovative approach to outreach by establishing online groups in 2009. The two online groups (Nagpur space on PlanetRomeo.com and the social networking site, SARATHI<sup>7</sup>) allowed MARP members to interact and provide information on counseling and treatment. There are around 194 members in these groups, and they participate in Sarathi's community events, including parties, seminars, movie screenings, and group discussions (Sarathi Trust 2012).

<sup>7</sup> [www.orkut.co.in/Main#Community?rl=cpn&cmm=100540243](http://www.orkut.co.in/Main#Community?rl=cpn&cmm=100540243)

**TABLE 3. REACH AND SERVICE PROVISION TO MSM BY SARATHI, NAGPUR**

	2007-08	2008-09	2009-10	2010-11	2011-12
Population reached with services	293	568	1,240	1,353	1,519
Sexually transmitted infection referral/clinic attendance	32	63	498	1,897	2,445
Sexually transmitted infection cases diagnosed and treated	14	59	306	264	71
Integrated counseling and testing center referrals	56	295	920	2,118	1,917
HIV tests taken at integrated counseling and testing centers	12	131	481	1,123	1,426
Sexually transmitted infection–positive results	43.8%	93.7%	61.4%	13.9%	2.9%

PSS initiated a number of self-help groups as a way of increasing the self-reliance of their community. Beginning in 2009, PSS set up savings schemes and microenterprises—initially 8 groups and subsequently 16 (of which 14 were described as functioning well). Although these ventures have varied levels of success, they overall convey a sense that marginalized groups have other options for economic independence.

**Care for PLHIV:** Comprehensive HIV program management enables organizations and communities to identify and address the needs of PLHIV and those who are affected by HIV, such as a partner or relative of an HIV-positive individual. Participatory approaches improved their reach to PLHIV in their respective communities.

Given that many FSWs who have not been sensitized are likely to fear interaction with PLHIV, a community initiative can play an important role in developing a support structure for those who live with or are affected by HIV. PSS identified and provided counseling for 31 HIV-positive FSWs, 10 of their partners, and 21 children who were affected by HIV (none of the children were HIV-positive). PSS registered and provided care for 19 FSWs and their

spouses, of whom 7 are on antiretroviral therapy (ART); 1 was treated for tuberculosis.

Before the CBO was launched, Sarathi reached only 3 PLHIV in 2007 and 27 in 2008, but this number increased considerably in subsequent years (Table 4).

The director of Sarathi is the convener for the pressure group Sangarsh in Nagpur, and this linkage has facilitated Sarathi’s advocacy activity and ensured that PLHIV have timely access to CD4 tests and other options. Provision of care for PLHIV includes registering for ART, ensuring that clients needing to be on ART have access, referring PLHIV to the drop-in center run by the Network of Positive People and to community care centers, and referring PLHIV to the YMCA for nutritional support.

By networking with over 29 NGOs and CBOs, Sarathi has strengthened the MSM initiative across the district and has become an active partner in advocacy activity at the state level. People living with HIV are made aware of available government social security schemes and receive help in getting access to these schemes.

**TABLE 4. CARE OF PLHIV IN THE MSM COMMUNITY**

YEAR	PEOPLE LIVING WITH HIV REGISTERED	PEOPLE LIVING WITH HIV LINKED TO ANTIRETROVIRAL THERAPY	PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL THERAPY
2009	120	116	9
2010	52	48	7
2011	19	13	1
2012	8	6	1
<b>Total</b>	199	183	18

**Addressing marginalization:** Reaching high-risk populations, who may converge in dark corners during late hours, is difficult. Both CBOs focused on reaching these populations and helping members receive necessary social support. For example, PSS helped 149 FSWs obtain ration cards and open bank accounts; 4 FSWs were helped to receive benefits from social schemes.

Sarathi faced obstacles in its initial outreach attempts. The outreach activities occurred in public parks from 6:00 p.m. to 2:00 a.m. and at public toilets from 7:00 p.m. to 1:00 a.m. Staff were initially hard to find and were harassed by police when they tried to conduct outreach. In some cases, outreach workers were blackmailed. Frightened that their orientation would be exposed, some MSM members were silent about the violence that they experienced.

Over time, Sarathi overcame these challenges by educating MSM on their rights and continuing with advocacy, outreach, and care for PLHIV and those affected by HIV. Sarathi also became a member of the Integrated Network for Sexual Minorities, a forum that allows CBOs to advocate for MSM at the national level.

## What Worked Well

**Outreach and participation:** Initiating social interaction with members of marginalized groups requires building trust and acceptance. Both PSS and Sarathi were able to establish connections through members and members' activities, as in the example of committees that extended their reach beyond the immediate area.

**Addressing barriers to creating an enabling environment:** Sarathi and PSS carried out diverse field activities to identify and address barriers to developing an enabling environment. The crucial steps taken include the following.

**Creating an environment for change:** Both organizations created an environment for change by increasing opportunities for open interaction between MARPs and peer educators, outreach workers, health care professionals, police personnel, media, and members of the MARP community.

- **Building networks:** The CBIs in Aurangabad and Nagpur helped strengthen local human resources including peer educators, volunteers, community mobilizers, and committees for health, human rights, finance, and education. The participatory process led to the development of block-level

committees, consisting of six to seven members and many volunteers who captured and addressed the local (micro-level) concerns of MARPs in their communities.

Particular accomplishments included:

- Empowering the MARP by building knowledge about basic rights and encouraging MARPs to support their rights.
- Questioning rigid attitudes regarding sexuality and sexual identity. Efforts by the committees for health, education, and advocacy created a forum for examining existing prejudices and myths, which facilitated the interactions between MARPs and various stakeholders.
- Enabling MARP members to obtain loans during financial crises through self-help groups, and offering alternate sources of income through small business ventures, such as running a catering service, setting up a small grocery shop, or opening a fruit juice stall.

**Strengths of the cyclical approach:** The CBIs in Aurangabad and Nagpur demonstrated the relevance of high-context approaches in management of HIV. The cyclic approach characteristic of this type of intervention enhances all activities that recur periodically, such as mapping exercises, awareness programs, organization of health care services, and, to an extent, provision of services to PLHIV.

The cyclical approach, with its focus on the needs and networks among both marginalized groups and the wider community, is able to bring in a holistic perspective to HIV management and identify subtle nuances of the local context, including:

- Identifying ways in which discriminatory policy or legislation are reflected at the micro level
- Pointing out how the local context shapes overt and subtle expressions of discrimination and strengthens cues to maintain it
- Creating culturally relevant space for change while addressing discriminatory or risky behavior stemming from individual, sociocultural, institutional, and structural factors.
- Solidifying progress toward a rights-based approach without inducing conflict and facilitating strengthening of community support mechanisms at the macro level.

## Challenges

### **Getting beyond barriers to change:**

Community-based organizations have strong intercommunity ties that position them to identify local barriers to HIV programming, but addressing policy barriers at the government or institutional level is often beyond their scope. Policy change requires strategic advocacy and networking with agencies and stakeholders that have the necessary technical expertise. Making policy change a reality at the community level is a long-term process and can be a challenging task, especially when discrimination is institutionalized within the health care service delivery system and greater society.

### **Balancing the roles of cyclical and linear approaches:**

Many programs (such as Western-style interventions) approach projects in a linear way, expecting to meet goals and targets within a specified time line. Given the difference between the cyclical and linear viewpoints, there is risk of discord, and one approach may eliminate or reduce the impact of the other. Balancing the two approaches requires sensitivity to the relevance of the two views for different activities.

There is also a need to re-examine the documentation process. The linear approach of documenting outputs may be selective and can fail to capture successes achieved through cyclical activities. Cyclical activities may lead to a CBO's development of organizational skills that enhance the participatory process and the contributions provided by various community actors, but this is difficult to capture. Community-based organizations tend not to focus on documentation, yet ensuring good documentation requires sensitivity to both approaches.

**Difficulties of building community-based organizations:** Developing a robust CBO requires acquisition of skills that are linear in nature, including developing long-term strategies, managing budgets, and arranging for continuous staff training. In the case of PSS, most of the individuals who played an active role in the earlier intervention program were illiterate or had limited management skills. Yet the growth of PSS required individuals who could be trained to develop capacity in these areas, which was initially supported through MGVS and the Avert Society. Discussion on moving forward without support from NGOs has created discord and insecurity among long-time PSS members. A similar discomfort is seen among MSM in discussions about moving ahead; although Sarathi members have more education and training, not all are comfortable with the linear approach to managing HIV programs.

Linking CBIs with the linear style of management incurred many challenges, including:

During the initial period, the process of strengthening CBOs, with their cyclical management style, to attain programmatic goals was extremely slow and required frequent guidance and support; for example, to guide relational emphasis in cyclical approach toward program management in a participatory manner. This is an issue with which NGOs working with CBOs often struggle.

Setting in place a dynamic monitoring system requires human resources sensitive to the local reality so that they can accommodate the limitations of the linear documentation style.

The considerations for documentation in high-context organizations need to be explored to help interventions perceive and address informal norms that hamper programmatic intervention.

Achieving a balance between linear and cyclical approach calls for time and resources beyond the scope of specific projects. Guidelines on working with the two viewpoints need to be part of every program. The present case study testifies to this need.

## Recommendations

Community-based organizations have a clear role to play in HIV program management among MARPs because working with these populations requires a participatory, flexible approach and sociocultural sensitivity to their concerns and the social barriers experienced. To strengthen the role of CBOs within HIV program management as a long-term strategy, organizations should consider the following recommendations.

**Acknowledge the value of the high-context perspective:** HIV program management requires establishing overall goals and an understanding of the steps needed to achieve them—the linear approach—but also an extensive understanding of the local context, which is a natural strength of CBOs. There is a need to strengthen CBOs by developing an appropriate documentation mechanism through a participatory process, ideally a mechanism that could be adapted to various micro-contexts to maximize use by the diverse human resources available.

## Improve orientation on the linear

**approach:** Conversely, there is a need to introduce and increase acceptability of the linear approach to facilitate organizational growth and sustainability. This requires orienting CBO members on the linear approach and selecting interested individuals to learn skills for the linear style of management, especially those pertaining to administration, governance, and collaborating with other partnering agencies. Learning these skills does not imply a rejection of the cyclical approach, which may remain the preferred style of management.

Consider linking cyclical and linear management styles without destroying the essence of CBIs. The benefits of a combined strategy would reach beyond HIV programs; for instance, the strategies could be applied to youth groups, women's groups, self-help groups, and other organizations that would benefit from this approach, especially in rural areas.

Strengthen the "sense of self" in high-risk groups: Members of CBOs primarily perceive themselves in relation to their community, secondly as organization members, and finally as individuals. Priorities in the linear realm are opposite: the individual first, then the organization, and then the community. The order of prioritization affects how a CBO functions. In seeking behavior change that emphasizes "individual change," the CBO would work in a consensual manner with the community and use a relational approach to facilitate activities for change. The focus would not be on individuals in isolation, but on their relationship to their family and community.

However, when CBOs are made up of MARPs, the situation may differ because MARPs may have several concepts of the "self." For example, a Hijra would wear one type of attire in a "safe" setting but yet, when visiting family, would likely wear male attire so that the family and community would not feel threatened. Interventions that focus exclusively

on the individual (in the linear style) can take a confrontational attitude, which can result in opposition by the community and family. Alternatively, taking a cyclical approach entailing frequent revisits with minor changes occurring throughout the journey may ultimately enhance receptiveness in the community and family.

Other areas where the prioritization of self can be introduced include the following:

- **Unsafe sexual practices:** It may be difficult to address unsafe sex by focusing on individual benefits when an FSW's priorities are often her family's or children's needs. Female sex workers would need access to alternate means of meeting their family's or children's needs before changing their risk-taking behaviors, because avoiding a financial crisis for their family is an immediate need.
- **Addressing discrimination:** The human rights perspective prioritizes individuals over community, but PLHIV may see the community as the first priority. This may discourage disclosing their HIV status to others to protect not only themselves, but also family members from being marginalized by the community. Thus, programs that aim to change these perceived priorities can drive away PLHIV, even those who may be open about their status.

**Raise the importance of district-level initiatives:** Improving the linkages between CBIs and district-level initiatives can improve the local relevance of national and state programs and policies. In the case of India, this will require greater focus on creating networks linking government agencies and the activities of the Link Workers Scheme,<sup>8</sup> especially

<sup>8</sup> The Link Workers Scheme is a community-based project launched under NACP Phase III as a way of increasing the availability of HIV prevention, testing, treatment, and support services for MARPs based in rural areas where, according to surveillance, over half of India's PLHIV live.

in rural areas, which are often neglected in favor of urban settings.

Given the importance of the local context, it is possible to use the human resources of CBIs to seek solutions for a range of communicable diseases, which would also strengthen the scope for integrated HIV management. ■

## RESOURCES

AIDSTAR-One: [www.AIDSTAR-One.com](http://www.AIDSTAR-One.com)

Avert Society: [www.avertsociety.org](http://www.avertsociety.org)

Mumbai District AIDS Control Society:  
[www.mdacs.org](http://www.mdacs.org)

National AIDS Control Organisation:  
[www.nacoonline.org/NACO](http://www.nacoonline.org/NACO)

U.S. Agency for International Development/India:  
[www.usaid.gov/in](http://www.usaid.gov/in)

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