

Alliance Myanmar Study Tour to India (Andhra Pradesh) September 2007

Experiences and Approaches on Community Mobilisation for Sex Workers



India HIV/AIDS Alliance

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Abbreviations

AIAP: Alliance India Andhra Pradesh
AIDS: Acquired Immuno-Deficiency Syndrome
AI-SEC: Alliance India Secretariat
ANC: Antenatal Clinic
AP: Andhra Pradesh
APSACS: Andhra Pradesh State AIDS Control Society
BCC: Behaviour Change Communication
CAG: Core Advocacy Group
CBO: Community-Based Organisation
CERA: Centre for Rural Action
CMIS: Community Management Information System
DIC: Drop-in Centre
FPP: Focussed Prevention Project
FSW: Female Sex Worker
HIV: Human Immuno-deficiency Virus
HRG: High Risk Group
IDU: Injecting Drug User
INGO: Implementing Non-Governmental Organisation
INR: Indian National Rupee
KP: Key Population
KPC: Key Population Consultant
M&E: Monitoring and Evaluation
MSM: Men who have Sex with Men
NACO: National AIDS Control Organisation
NACP: National AIDS Control Programme
NGO: Non-Governmental Organisation
ORW: Outreach Worker
PCA: Participatory Community Assessment
PE: Peer Educator
PHC: Primary Health Care
PLHIV: People Living with HIV
PSA: Participatory Site Assessment
SHG: Self-Help Group
SRH: Sexual and Reproductive Health
STD: Sexually Transmitted Disease
STI: Sexually Transmitted Infection
STO: Senior Technical Officer
TB: Tuberculosis
TG: Transgender
TV: Television
VCTC: Voluntary Counselling and Testing Centre

Executive Summary

Andhra Pradesh (AP) is one of the six high prevalence states in India. Out of the estimated 2.5 million HIV cases in India, about 10% is in AP (NACP-III, 2007). The last seven years' sentinel surveillance data of AP shows that the prevalence in Antenatal Clinics (ANC) has consistently remained greater than 1%. According to the Sentinel Site Surveillance (2006) conducted by Andhra Pradesh State AIDS Control Society (APSACS) in various districts, 20 out of 23 districts have HIV prevalence of more than 1% suggesting that the epidemic has moved from high-risk groups (HRG) to general communities. The sentinel surveillance (2006) shows a sero-prevalence of 1.4% among ANC and 22.26% among Sexually Transmitted Disease (STD) clinic attendees. The average sero-prevalence among sex workers and MSMs is 7.32% and 11.07% respectively (2006).

The India HIV/AIDS Alliance (or, Alliance India), Andhra Pradesh (AIAP) has been undertaking the Frontiers Prevention Project (FPP) and AVAHAN Focussed Prevention programmes with the funding support of Bill and Melinda Gates Foundation (India AIDS Initiative) since the year 2003. AIAP implements the programmes through 36 implementing NGOs (iNGOs) at various intervention sites across the Rayalseema and Telangana regions in AP. The target population for the programmes, called the Key Population (KP), includes the female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU) and people living with HIV (PLHIV). The key objectives of the programmes are to reduce the prevalence of sexually transmitted infection (STI) among KP; empower and mobilise individuals, groups and communities; and support the creation of enabling environment through individual and organisational capacity building. Currently, with a total coverage of over 60,000 KP in 143 sites, the programme intervenes by reaching out to them through peer educators (PE) and outreach workers (ORW), providing them with STI treatment through KP-friendly clinical services, developing community-managed and community-based organisations (CBOs), undertaking advocacy at different levels, and promoting safer practices such as condom-usage. All this is supplemented by developing and enhancing managerial and technical capacities of these organisations for effective implementation of the programme.

With the purpose of promoting cross-country exposure of the Alliance teams in various countries, to successful community-based initiatives, the International HIV/AIDS Alliance in Myanmar planned a Study Tour for a team of Alliance Myanmar staff (including NGO/peer educator staff) in September 2007. They visited intervention sites of the Alliance in Thailand and India. In India, the study team, a combination of 11 participants and a mix of Programme Manager, Project Officer, PEs, ORWs and Doctors, besides a Consultant for facilitation of the tour, visited the FPP-Avahan sites in AP. The objectives of the study team were to:

- Gather learnings from AIAP's programme implementation and their approaches/strategies for mobilising the community (especially the sex workers' community)
- Understand and learn about some of the relevant best practices that could be replicated at intervention sites in Myanmar.

This report is based on the documentation of this learning exchange and is aimed to support the Alliance's Strategic Direction 4 in 'Building an Alliance of Linking Organisations working effectively together' and to 'ensure knowledge generated from one programme informs what happens in another' both within a country and across country programmes. The Alliance's knowledge-sharing focus is on producing documents which allow its partner organisations to learn from each other on programmatic experiences, approaches and models.

The key topics/areas elaborated in the report are covered in the following sections:

- **Introduction**, which describes the AP state scenario in regard to HIV/AIDS, overview of FPP-Avahan programme undertaken by AIAP at various intervention sites, the target population

(i.e. KP), background and purpose of the study tour, and composition of the study team besides few staff from Alliance India team. This part of the report, in a nutshell, also describes the tour plan in AP that included sites of Hyderabad and Ananthapur.

- **Study tour** section elaborates on the plan and agenda of the entire tour in AP. The tour was spread over four days; the first and the fourth (last) day was spent in Hyderabad intervention site as well as AIAP office, and the second and third day were devoted to field visits in Ananthapur sites. On the first day, the study team was introduced to AIAP team and discussed briefly about the programme components, followed by a visit to Hayathnagar intervention site at Hyderabad. Here they went to the Mythri Clinic and drop-in centre (DIC) under the AIAP-LEPRA Society partnership. They interacted with the clinical staff about strategies for linking the KP with the clinic, including the quality of services provided. In the DIC, they interacted with the ORWs and PEs and got acquainted with their approach of identifying the KP, communicating and mobilising them to visit the Mythri clinic to avail the KP-friendly and confidential services. On second and third days, the team visited sites in Ananthapur town in AP, where the programme is being implemented by Centre for Rural Action (CERA), an INGO of AIAP. The study team interacted extensively with the CERA staff that included the Project Director, Project Coordinator, ORWs, and PEs. Intensive discussions were held with various community members, members of CBOs, PLHIV network, Core Advocacy Group, and other committees. They also got a first hand experience of the programme through field-visits made to communities, hotspots of FSWs and MSMs, DIC and Mythri clinic at the Tadipatri site. On the fourth day, the team discussed with the Senior Technical Officer (STO): Monitoring and Evaluation (M&E) about Clinic Management Information System (CMIS) and how information is managed and used for decision making in AIAP. In another session, STO: Clinical Services provided insights on the technical aspects of the clinical component in the programme. Finally, during debriefing, the study team put forth their observations and reflections.
- **Community mobilisation for sex workers: Methodologies, approaches and models.** It elaborates on how AIAP and its INGOs have been undertaking the programme and applying various strategies for mobilising and involving the community. However, this section of the report mainly focusses on community mobilisation for FSWs, as was relevant for the study team. The methods used by AIAP in regard to the same are: Participatory Community Assessment, outreach through ORWs and PEs, community-based clinical services and DIC for KP, formation of committees, collectivisation of sex workers through formation of CBOs, advocacy by sex workers, and mobilisation through events and theatre. This section also includes the various challenges faced by the CBOs, PEs, ORWs and other staff of NGOs during the course of the programme, and how they addressed the same.
- **Reflections** – as the title suggests, puts forth the study team's reflection on the key lessons they learnt in AIAP's intervention sites, how they could replicate some of the approaches in Myanmar in accordance with the country's context and situation, challenges they may face regarding the same and the kind of support they would require from Alliance India.

The study team was very appreciative of the entire tour and found the field visits very fruitful. They saw the significance of community involvement for the programme, besides the fact that empowerment and mobilisation of the sex workers is crucial for their own benefit. Intensive discussions with the KP, CBO members, Committee members and AIAP and INGO staff gave them the opportunity to get first hand knowledge of how activities are being undertaken and community is being mobilised. However, they also viewed that taking such initiatives forward in Myanmar is quite challenging for factors such as the political situation in Myanmar, high stigma attached to sex workers and difficulty for sex workers to unite or even gather as a group. Finally, the team decided to continue

with their current strategy of one-to-one peer education, on one hand, and think of possible ways of replicating strategies in Myanmar for involving sex workers, on the other hand.

Introduction

Andhra Pradesh (AP), the fifth largest State in India with a population of around 75 million and a sex ratio of 978 females per 1000 males, shares its borders with Maharashtra, Chattisgarh and Orissa states in the north, the Bay of Bengal in the east, Tamil Nadu state in the south and Karnataka state in the west. AP can be broadly divided into three geographic regions – Coastal, Telangana and Rayalaseema.

With regard to HIV/AIDS, AP is one of India's six high prevalence states. Out of the estimated 2.5 million HIV cases in India, about 10% is in AP (NACP III, 2007). The last seven years' sentinel surveillance data of AP shows that the prevalence in Antenatal Clinics (ANC) has consistently remained greater than 1%. According to the Sentinel Site Surveillance (2006) conducted by Andhra Pradesh State AIDS Control Society (APSACS) in various districts, 20 out of 23 districts have HIV prevalence of more than 1% suggesting that the epidemic has moved from the high-risk groups (HRG) to the general community. The sentinel surveillance (2006) shows a sero-prevalence of 1.4% among ANC and 22.26% among Sexually Transmitted Disease (STD) clinic attendees. The average sero-prevalence in sex workers and MSMs is 7.32% and 11.07% respectively (2006). The Voluntary Counselling and Testing Centre (VCTC) data (April 2006-2007) indicates 12.31% HIV positive cases among the HRGs.

Alliance India, Andhra Pradesh (or, AIAP) has been undertaking the programme - Frontiers Prevention Project (FPP) and AVAHAN (India AIDS Initiative) at various intervention sites across the Rayalseema and Telangana regions of AP since the year 2003, with the funding support of the Bill and Melinda Gates Foundation. The programme is being implemented in 143 sites through 36 iNGOs, providing them with strategic, programmatic, technical and organisational development support.

The target population called the Key Populations (KP) includes the female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU) and people living with HIV (PLHIV). The key objectives of the programme are to reduce STI prevalence among KP; empower and mobilise individuals, groups and communities; and support the creation of enabling environment through individual and organisational capacity building. The services are delivered with the help of peer educators (PE) and outreach workers (ORW) along with various technical support staff, who have been mobilised from the community and trained. In addition, various doctors and paramedics have been recruited and trained for providing quality, friendly and confidential clinical services including counselling to the KP.

With the objective of deriving learnings from the implementation of the prevention programme for the KP especially sex workers and replication of relevant approaches/methods in their respective intervention sites, a study tour was planned for the Alliance team in Myanmar in September 2007. The visiting team was a combination of 11 participants, a mix of Programme Manager, Project Officers, PEs, ORWs and doctors, besides a consultant for facilitation of the study tour. Before visiting AP, the team had already completed its visit to the intervention sites of the Alliance in Thailand. In AP, the team was accompanied by Programme Officer (AIAP) and Programme Officer: Documentation (AI-SEC, Delhi) for providing them with facilitation and documentation support respectively. The names of the participants from Myanmar are *ab infra*:-

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S.No.	Name of the Participants	Designation	Name of the organisation
1.	Nyeint Nyeint Nway	Project Manager	Karuna, Pyay
2.	Phyu Phyu Aye	Peer Educator	Karuna, Pyay
3.	Dr. Khin Phyu Latt	Project Manager	Yaung Gyi Oo
4.	Than Than Win	Peer Educator	Yaung Gyi Oo
5.	Mar Mar Thein	Project Manager	Sakawar Myay
6.	Moe Thu	Peer Educator	Sakawar Myay
7.	Htike Htike San	Peer Educator	Sakawar Myay
8.	Aye Aye Lwin	Project Manager	Mahaythi Myittashin
9.	Mi Mi Soe	Peer Educator	Mahaythi Myittashin
10.	Tin Tin Htwe	Peer Educator	Mahaythi Myittashin
11.	Nyo Yamonn	Program Officer	Alliance

Apart from meeting the programme and technical staff from AIAP, the team made field visits to intervention sites of Hyderabad and Ananthapur, where the programme is being implemented by INGOs, the LEPRASociety and Centre for Rural Action (CERA), respectively.

Ananthapur falls in the semi-arid tropic and rain shadow zone, due to which it receives the second lowest rainfall in India and is thus prone to perpetual drought. As most of the population depends on agriculture for a living, the drought condition leading to frequent failure of crops is the reason behind low levels of income, added with high rate of migration in search of better livelihood options. Women, adolescent girls as well as children are easy subject to human trafficking and sexual abuse, and sex work, especially on highway, is a common phenomenon. Low awareness level on STIs, HIV/AIDS and related issues with practice of unsafe sex, are reasons enough for HIV prevalence. CERA, with the support of AIAP, has been implementing the FPP and Avahan programmes at the intervention sites of Ananthapur for curtailing the spread of HIV through community-driven approach and empowering the KP community.

The study tour

The study tour in AP was spread over four days from 18 to 21 September 2007. The proceedings were as follows:-

Date	Activity	Place/Organisation
18 Sept 07	• Introduction and interaction with the Alliance India teams	AIAP (Hyderabad)
	• Overview of AIAP & introduction to the programme	
	• Visit to Mythri Clinic/DIC	Hayathnagar (Hyderabad)/LEPRA
19 Sept 07	• Interaction with outreach workers and peer educators	CERA office cum Mythri
	• Introduction with iNGO team	

	<ul style="list-style-type: none"> Interaction with field workers at site Visit to Primary Healthcare Centre Interaction with sex workers Interaction with MSM 	clinic/DIC (Ananthapur) Tadipatri intervention site under CERA (Ananthapur)
20 Sept 07	<ul style="list-style-type: none"> Field visit – Interaction with PLHIV network 	Tadipatri intervention site under CERA (Ananthapur)
	<ul style="list-style-type: none"> Overview of CERA Interaction with members of District level CBO Interaction with members of local CBOs Interaction with members of Core Advocacy Group 	Office cum Mythri Clinic cum DIC under CERA (Ananthapur)
21 Sept 07	<ul style="list-style-type: none"> Presentation/discussion on CMIS Presentation/discussion on clinical component De-briefing/lessons learnt 	AIAP (Hyderabad)

Day One: 18 September 2007

Introduction:

The first day of the study-tour commenced at the AIAP office at Hyderabad, with a general introduction of the study team to Alliance India team that included members from both, AI-SEC (Delhi) and AIAP. Programme Officer from Alliance (Myanmar) was the interpreter for the rest of the team.

The study team put forth their expectations from the tour in AP. Some of these were: learning the main strategies, best practices, use of IEC/BCC materials, role of community in programme, community mobilisation for effective programming, role and leadership of CBOs, problems and challenges in AP, identifying the differences in situations and programmes in Myanmar and India, making programmes more sustainable and exploring possibility of replication of some relevant approaches/processes in Myanmar.

Subsequently, the agenda of the tour was discussed and relevant modifications were made based on participants' suggestions and expectations. Resource materials were disseminated to the team for their use, and were taken around the office and introduced to the rest of the staff.

Overview of AIAP and the programme:

In this session, the study team was given an overview of activities of AIAP with a brief on the programmes being undertaken. The purpose was to give them a background of the programmes, strategies and activities before they visited the intervention sites, for a better comprehension.

During this session, the team learnt about the four strategies of AIAP and its iNGOs for the programme – Outreach, Clinical services, Community mobilisation and Advocacy & Networking. The outreach strategy involves reaching out to the communities, identifying the KP, spreading awareness on safer practices and linking them with the clinics for healthcare facilities. Condom promotion, as part of the outreach strategy, includes undertaking condom demonstration, distribution and social marketing for the KP. In few intervention sites, use of female condoms has been promoted as a pilot test. Clinical services are provided to the KP through clinics being run under the programme, called 'Mythri', meaning 'friendship' in Telugu. Every Mythri clinic at various intervention sites comprises of a

Doctor, Clinic Administrator, Counsellor and PEs. There is also a drop-in centre (DIC) for the KP for relaxation, recreation, sharing their problems with peers and staff, and attending group meetings. Community mobilisation addresses the solidarity building as well as positioning them in decision making structures among the KP community through formation of CBOs, committees etc. Advocacy and Networking aims at creation of enabling environment for the KP to practice safe sexual health seeking behaviour.

Project management is another essential component of the prevention programme. This includes structuring of the team undertaking the initiative and building their capacities. The basic structure of teams in all project areas is – Project Coordinator (at some areas, there is also an Assistant Project Coordinator), Outreach Coordinator, Peer Educators, the Clinical Team and an Accountant.

Currently, the package of services provided for KP includes: STI services, BCC and condom programming; community mobilisation, enabling and structural interventions; social capital building, network and support group formation; leadership training and occupation skills building; empowerment and violence reduction; promotion of referrals to VCTC and care and support.

Subsequent discussions in the session entailed how community is involved in the intervention, decision making and management; capacity building focus areas, processes and tools; and strengths of the programme. Some of the strengths are: focus on community led processes, KP representation in decision-making bodies, community managed DIC, colour-coded STI kits, combination of static, outreach and mobile clinics, and sensitive positioning and branding of clinics.

Visit to Mythri Clinic and DIC:

The study team, then, proceeded to one of the intervention sites in Hyderabad, namely, Hayathnagar. It visited the Mythri clinic cum DIC being managed by the LEPRAS Society under the Avahan project. Out of the estimated population of 5000 (FSW and MSM), the programme at present works with a population of 2000 - 2250.

The study team met the Project Coordinator, clinical team and outreach workers. Interaction with the Project Coordinator gave them an insight into the overall functioning of the clinic and role of various staff. The team learnt how activities are undertaken through the four strategies of outreach, clinical services, community mobilisation and advocacy & networking.

The clinic's doctor informed the team about the specific roles of different clinical team members. When a particular member from the KP visits the clinic for the first time, the Clinic Administrator, who belongs to the community, interacts with the person and tries to understand the background. The person is sent to the counsellor and then to the doctor for tests and/or treatment, for which they strictly adhere to the NACO guidelines. The doctor undertakes an internal examination and provides treatment based on the identified symptoms. The doctor viewed that since the KPs are always exposed to risks, therefore they are encouraged to visit the clinic every month and also undergo internal examination (almost 80% of the KP undergo internal examination). The medicines, provided free of cost, are packed in different colours. For instance, grey and pink packs of medicines are for vaginal discharge and so on and so forth.

The most common symptoms observed by the doctor among FSWs are lower abdominal pain and vaginal discharge, and among MSMs it is urethral discharge. Condom promotion, counseling, nutritional knowledge, referrals to VCTC and other health services are some complimentary services provided to the KPs.

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Counselling, that includes psychosocial, pre and post HIV test, STI and partner counselling, is undertaken for all members of KP. Partner treatment is another important aspect of the clinical services.

Interaction with outreach workers and peer educators:

Meeting with the clinical staff followed with interaction with ORWs and PEs at the Hayathnagar intervention site. The interaction was mostly about their approach for identification of KP and communication. They described to the study team their strategy for mobilising the KP to visit the Mythri clinic to avail the services, various awareness spreading activities with the community, challenges and ways of addressing them.

Day Two: 19 September 2007

On the second day of the tour, the team reached the Ananthapur town in AP for visiting the intervention sites of the FPP-Avahan programme being implemented by CERA. This visit was for two days and entailed extensive interaction with the community and CERA staff. The team gained a first hand experience of the programme by making field-visits to hotspots, DIC and clinic.

Introduction with NGO team:

The study team was introduced to all the staff of CERA at their office cum Mythri clinic. After this, instead of continuing with the initial plan of interacting with staff for an overview of CERA and its implementation of the prevention programme, the team was taken to meet the communities first, in anticipation of the fact that they would be involved in the celebration of the ongoing Lord Ganesha's festival in the state.

Interaction with field workers at Tadipatri intervention site:

Tadipatri is a new intervention site (8 months) for the programme in Ananthapur. During the start up, the CERA staff identified the ORWs and PEs and provided them with basic training on HIV/AIDS and related issues. Although there is no static Mythri clinic at the site, yet there is a DIC for KPs, and the intervention is undertaken mostly through outreach work.

The study team visited the DIC and interacted with the ORWs, PEs and other community members. They gave the study team detailed information about various activities, such as, condom promotion, outreach camps, referrals, community mobilisation, formation of CBOs by the KP, advocacy and income generation activities undertaken by them, and lastly, the challenges and how they address them.

Visit to Primary Healthcare Centre:

The study team went to the government's Primary Healthcare Centre (PHC) at Tadipatri. Due to the absence of a Mythri Clinic at this site (as aforementioned), most of the KPs are referred to the PHC. The infrastructure of government's PHC is also being shared by CERA's clinical staff for its KP community. This is an outcome of the successful advocacy initiative of the CBO with the government at the Tadipatri intervention site.

Interaction with groups of FSW and MSM at hotspot:

The study team was divided into two groups, and each met the groups of FSWs and MSM, along with the respective PEs. Interaction with FSWs' group included topics such as: types of sex work (street, brothel, highway and secret sex work), FSWs' issues with their partners and rest of the community, stigma and discrimination and their ways of dealing with the same, health related issues including safe sex practices, their effectiveness as a group, and advocacy activities undertaken by them for

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their own rights and safety. Discussions led to many queries by the study team to the FSWs, who responded with ease and without inhibition.

The second group interacted with a group of MSM and discussed topics such as: how to identify MSM, categories of MSM based on their sexual preferences, how do PE's mobilise the MSM community members, advocacy issues dealt by the CBO of MSM, and the outcome of the advocacy initiatives by MSM. The key learnings that the study team gathered from this meeting were: formation of CBO for MSM helps in resolving issues pertaining to stigma and discrimination, MSM are at a greater risk as compared to other KP communities and promoting community-based outreach is more effective.

Day Three: 20 September 2007

Interaction with PLHIV network at Tadipatri:

The study team met the PLHIV network at the FPP site in Tadipatri. According to members of the network, being a part of it inculcated in them an attitude of 'positive' living and helped them gain strength to confront and address their problems. The study team was informed that the network started as a group of five members. The group later expanded and formed a network, which currently comprises of around 350 PLHIV. The network organises weekly and monthly meetings to discuss issues and identify solutions.

Further, the study team learnt about various social and legal issues faced by the PLHIV and their families, especially their spouses and children. Various activities undertaken by the network are: referrals to healthcare facilities, linkages with other NGOs, income generation initiatives for financial stability of the PLHIV and their spouses, linkages with various social welfare schemes and entitlements, and local resource mobilisation.

Overview of CERA, and interaction with members of District level CBO, local CBOs, and Core Advocacy Group (CAG):

At the office cum Mythri clinic of CERA, the study team interacted with the staff and members from KP, district level CBO, local CBOs, CAG and other committees. The Project Director briefly presented an overview of CERA and its HIV prevention programme with AIAP. Emphasising on the significance of undertaking the programme in Ananthapur due to low income levels resulting from the drought situation, causing factors for HIV prevalence like migration, human trafficking and sex work, added with low level of knowledge on HIV/AIDS and STI, lack of safer practices and access to healthcare facilities, he stated that Ananthapur, Galradinne, Kallur, Tadipatri, and Peddavaduguru are the five intervention sites of CERA.

This was followed by intensive discussions on best practices, community mobilisation by NGOs/KP, advocacy, community led structural initiatives, formation of local-level and district-level CBOs and activities undertaken by them, and formation and functioning of various committees especially the CAG.

Day Four: 21 September 2007

On the fourth day that was also the last day of the study tour, the team met the technical staff at AIAP in Hyderabad, who presented and discussed various technical areas of the programme. The day concluded with a debrief session amongst the study team, consultant and some Alliance India team members.

Presentation/discussion on CMIS:

The presentation and discussion on the Clinic Management Information System (CMIS) was conducted by Senior Technical Officer (STO): Monitoring and Evaluation (M&E), AIAP. The purpose was to provide them with an account of how information is managed in Alliance India and used for decision making. Putting forth that Management Information System (MIS) is a part of M & E, and a concept that puts different information together, STO: M & E told the team that CMIS is the software that helps generate information. The session also included how community is involved at various levels in the CMIS.

Presentation/discussion on clinical services (FPP and Avahan):

The session, facilitated by STO: Clinical Services, provided the study team with an insight into the technical aspects of the clinical component in the FPP-Avahan programme. Since the Avahan project deals with high risk population and FPP includes PLHIV, the clinical services provided through the Mythri clinics include sexual health counselling, STI diagnosis and treatment, and Opportunistic infection diagnosis and treatment. All clinics are equipped with examination equipment, diagnostic procedures and basic medical supplies, including treatment kits. During the session, the STO: Clinical Services enumerated the services provided by clinics, how clinical services are made KP friendly and how community is mobilised for accessing these services.

Debriefing session:

This was the last session of the day that marked not only the end of the Myanmar study-tour to India (AIAP) but also that of the entire tour including the Thailand visit. The participants in this session were the Myanmar study team, the Consultant and the Alliance team comprising of Director: Prevention, Programme Officers (AIAP) and Programme Officer: Documentation (AI-SEC, Delhi). Through a participatory and interactive method, the study team put forth their observations and reflected upon the approaches and processes for mobilising the community of sex workers, possible ways of replicating them in Myanmar, and support they anticipated from Alliance India.

Community Mobilisation for Sex Workers: Methodologies, Approaches, and Models

Involvement of the community and their inputs are a prerequisite to any intervention programme on HIV/AIDS for a greater impact. Empowerment of the KP (FSW, MSM, IDU and PLHIV) and creating a space for their voices is necessary to improve their access to various services for prevention of HIV. Participation of KP and other target groups with their varied experiences is crucial to the success of HIV/AIDS initiatives, whether care and support, awareness or prevention. The target groups, themselves affected, are rightfully equipped to understand the underlying issues of vulnerability and offer relevant ways of addressing them. Also, communities have the right to be involved in interventions and activities that concern them. Thus, it is true to say that community-involvement is necessary for both, ethical and practical reasons.

Viewing the aforesaid, Alliance India has always attached high significance to the engagement of the community in all its interventions. Training and capacity building of NGOs and CBOs, and participatory assessments of communities have been some of the means of mobilising the communities for them to voice their concerns. The same goes true for the FPP-Avahan programme being implemented by AIAP and its iNGOs. Thus, the programme aims at preventing STIs and/or HIV among KPs through the approach of community mobilisation and their involvement.

Key Approaches

With the strategy of community involvement in the programme intervention, AIAP and its iNGOs have been implementing the programme through five main components: outreach, clinical services, community-led intervention structural intervention, advocacy/networking/linkages, and project management including NGO/CBO capacity building. It is interesting to note that KPs are involved at every stage of the intervention, right from the designing to evaluation stage including implementation. Community's role has been crucial to the effective implementation of the prevention programme leading to greater response to HIV/AIDS. It would not be an exaggeration to say that a large group of KP members played a crucial role when the programme was initiated.

Participatory assessment of the communities:

Alliance India has been undertaking Participatory Community Assessments (PCA) for bringing communities together for sharing their experiences that helps them identify their own issues and needs. Such information when analysed plays a significant role in designing programme interventions. With similar purpose, AIAP conducted Participatory Site Assessment (PSA) (similar to PCA) across 26 sites, out of which 14 were FPP and 12 were Avahan sites. The PSA not only helped in the identification of hotspots of KPs and in reaching out to them and their issues, but also in taking the views and inputs of the communities, all of which were fed into the designing of the FPP-Avahan intervention.

Outreach - Involvement of outreach workers and peer educators:

For undertaking the PSA, around 150 key population consultants (KPC) were identified from the community and trained on PSA tools, as a result of which, the entire mapping exercise was undertaken by the KPCs themselves. This helped in exploring the vulnerability factors and risk behaviours, and the availability of existing healthcare services including condoms availability and STI services. The PSAs also helped in understanding the other social and welfare issues of KP like violence (both physical and psychological), safe places for them, lack of resources and awareness leading to inaccessibility to healthcare and social welfare facilities, and harassment from general community as well as families. Such issues were also incorporated in the programme design for a comprehensive approach. Not only this, through the PSAs, the communities shared their ideas about safe sex as well as how the prevention intervention could be best implemented at the sites. Thus, community's information, views and ideas through the PSA were quite significant in identifying area of intervention, target population, services to be provided, location of DIC and clinic for KP and the process of intervention.

The PSA was not only an important means for designing the intervention, but was also an end in itself. As the assessment process involved wide scale discussions, self-introspection and reflection on the part of the communities, it led to a desire for action. This was the result of the development of a sense of self-worth by the marginalised KP as they experienced for the first time a feeling of dignity for being treated as equals and with respect, and their views being acknowledged. All these factored into the increase of confidence in the KPs, thus leading to community mobilisation as a significant approach for prevention of HIV/STI among the KPs.

After the PSAs were conducted and programme was designed, the implementation was initiated with the support of AIAP staff and the trained KPCs. During the FPP initiative, the KPCs were developed into outreach staff. Later, with the Avahan project, partnerships were established with various iNGOs with some of the PEs becoming ORWs. With this, outreach work for the FPP-Avahan programme was initiated.

The outreach strategy that means reaching out to the KPs with messages of behaviour change to prevent risk, violence and harm; STI and HIV prevention; positive living in case of PLHIV; and community participation, is an important component within the prevention programme as it helps in establishing contacts with other KPs in the community, and in linking them with various services like healthcare and condoms both within and/or outside Alliance's project. The ORWs and PEs are the key personnel in undertaking outreach work as they belong to the KP and thus their role is crucial to reaching out to other KPs especially those who are hard to reach such as FSWs and MSM including transgender (TG).

For conducting outreach work, the ORWs and PEs visit the communities especially the particular hotspots of FSWs, and make home-visits. Through various interactions, a particular ORW/PE identifies the FSWs and introduces herself to them, telling them about her own background as a FSW and how she developed into a low-risk from a high-risk KP. Gradually, after developing rapport with the sex workers, she talks to them about their sexual practices, trying to explore any risk behaviour. She talks to them about STIs and HIV/AIDS and various methods of prevention. This is accompanied with imparting knowledge on condoms including demonstration of its use. An important aspect of the outreach work is instilling in the FSWs the importance of health seeking behaviour and mobilising them to visit the Mythri clinic in their community, where they would receive quality clinical services free of cost, an enabling environment free of stigma and discrimination, and above all, confidential services. By ensuring KP-friendly services at the clinic, the ORWs and PEs motivate the FSWs and link them to the clinic.

An ORW for sex workers informed during discussions with the study team at Tadipatri (Ananthapur) that she makes regular home visits and encourages the FSWs to avail the services of the government clinic since Tadipatri site does not have a Mythri clinic. Apart from this, she also promotes condoms through demonstration and awareness on the advantages of condom use.

Special identity cards allotted to the ORWs and PEs by the INGOs, signifying them as sex workers who are working for social cause, protects them from any harassment by the general community, local police and/or other trouble-makers at the intervention site.

Community-based clinical services and DIC for KP:

One of the key requirements identified through the PSAs was the setting up of a clinic for sex workers (and other KPs) on account of the stigma and discrimination faced by them in other STI clinics. Therefore, STI clinics were set up by AIAP at various intervention sites and named as *Mythri* clinics, meaning 'friend' in Telugu language. Mythri clinics have been named so to provide an enabling and friendly environment to the sex workers to encourage them to visit the clinic without hesitation and regularly so that their health issues could be addressed to prevent them from STIs and/or HIV.

Friendly service for KPs (including sex workers) through Mythri clinics is also ensured by the doctors and other staff at the clinic by strictly adhering to the policy of confidentiality. For instance, audio-visual privacy is maintained for sex worker, i.e. a sex worker can talk to counsellor and doctor without being heard or seen. Also the fact that the clinic administrator is someone who belongs to the community makes the sex workers feel comfortable while sharing their background and problems. Therefore, responsive services to sex workers (and other KPs) are ensured in Mythri clinics.

With the purpose of continuously involving the communities and KPs in decisions relating to the Mythri clinic and its services, constant inputs are sought from them through various means. This approach not only helps to keep improving the quality of clinical services provided to them, but also to address their demands with regard to the same. For instance, opinion of the KP members has been taken

while deciding the clinic's brand name, identity, and locations. Periodic feedback on their satisfaction with the services, attitude and knowledge level of the doctor, timings of the clinic, and respect for their confidentiality at the clinic, is taken from KPs. Even while the recruitment of a particular staff at the clinic, their views are acknowledged. Formation of a Clinical Services Review Committee (to be elaborated in a later section) with maximum community representation is a significant attempt towards monitoring of the quality of clinical services.

DICs have been usually attached with the Mythri clinic at most of the intervention sites with the view that along with medical support, the sex workers (and other KPs) also require certain recreational activities for a sound psychological health. The DICs allow the sex workers to relax, play games, watch TV, meet friends and share their problems with peers facing similar issues. The DICs are also venues for them to conduct support group, CBO and other group meetings. In addition to this, some of the sex workers also undertake various vocational activities at the DIC such as henna-making (a traditional Indian art), beautician course, and educational and cultural activities and events.

Collectivisation of sex workers – Community-Based Organisations (CBOs) of sex workers:

While on one hand, CBOs have been formed by the sex workers themselves as a result of their realisation of the significance of collectivisation for addressing their issues more emphatically, on the other hand, these have been formed with the purpose of involving and mobilising the community and particularly the sex workers' community to voice their concerns.

During the interaction of the study team with the sex workers' CBO members at CERA office in Ananthapur, the sex workers reflected upon the formation of CBOs in the beginning. They said: *"When the project started, the Alliance (AIAP) staff explained about the concept of community involvement. But we never believed that it could ever happen as it was very difficult to visualise at that time. When they asked us and other KPs to form CBOs, we told them that it was not required and that we would work only for salary."*

We started our outreach work in the community, but some people started stigmatising and harassing us. They said that we were encouraging sexual activities and HIV/AIDS by promoting condoms. When we contacted district officials, they did not listen to us. We felt humiliated and dejected. Then we realised that we need to mobilise and involve the communities in our work for better results. We also realised that we need to form our groups as one of us alone would not be able to make a difference.

We were then sent for an exposure visit, like all of you have come here, to Kolkata (Capital city of West Bengal State in India) to interact with the sex workers there and gain knowledge on the strategies and processes of the programmes being undertaken for them. We were quite surprised as well as elated to see the unity amongst the sex workers there, the activities on HIV/AIDS, and their concern for their own children. All this transformed our minds completely.

After coming back to Ananthapur (AP State), we explained to the rest of the sex workers' community here all that we had learnt in Kolkata, the situation and involvement of communities there. However, their response was weak. Then we took this up as a challenge and tried to mobilise the other sex workers relentlessly. Gradually we started resolving some of the smaller issues in the community. As a result, other sex workers started gaining confidence in us and started joining the group. Thus, we saw the light of the day.

Subsequently, we, as a group, elected some members and formed a body. We are glad to tell you that we have become a legal entity now and we can use formal letter heads to write applications/letter

for required services. Gradually our scope of work started expanding – we started mobilising more sex workers and the general community, started addressing and solving each others' problems related to our personal and professional areas including legal, started sensitising the local police to our issues and those related to our harassment in the village, and started advocating and negotiating with the government for services. Now we have tremendous confidence in our CBO and are sure that we can solve our issues at our own levels. Today, we can say that our group has started living a life of dignity, getting respect from the community, police and government officials."

Thus, from the above-mentioned reflection of the sex workers, it can be summed that with the self-realisation of the sex workers that more impact can be made if they act as a group, they started forming CBOs. Various incidents pertaining to their harassment from the general community inspired them to seek confidence and support from law enforcing bodies and therefore they started sensitising the local police about their circumstances and issues, and advocating to them for the support they needed from them. The fact that the older sex workers were gradually losing out their work or being paid lesser by their partners, they realised the importance of becoming financially empowered. They started undertaking various income generation activities and maintaining savings for sustaining their livelihood and safeguarding their own and their children's rights. Thus, the sex workers soon realised that being a part of CBOs increases their confidence and helps them advocate and undertake various activities even better. More and more of them became members of the CBO by paying INR 5 each.

Achievements of the sex workers' CBOs

- Sex workers have understood the significance of collectivisation
- The sex workers directly contact the CBO to solve their problems
- CBO members directly approach representatives like Zila Parishad Chairman, Mayor and/or senior officials and doctors from the Government to address their issues and also involve them in their CBO meetings
- Initially the NGOs planned activities for the communities, but now CBOs have improved their skills in planning, implementation and evaluation of the project with NGOs doing only the facilitation role
- Have successfully advocated with – police and lawyers, gatekeepers (madams and pimps), media, positive networks, government departments and hospitals, and District Magistrate, to solve their issues
- Local communities' harassment was on the rise; CBOs have developed understanding of such problems and strategies to solve the same
- Attendance of sex workers has increased in the DIC because of CBO activities
- Mutual solidarity amongst different gender groups has increased and inclusion of MSM is not a problem any more

With discussions with the District level CBO members at CERA office, the study team came to know that out of the total 143 sites in AP where the FPP-Avahan programme is being implemented, 22 are in Ananthapur, and each site has a local level CBO for sex workers. After the local level CBOs were formed, their immediate objective was to increase the number of members to make their advocacy efforts easier and stronger. "United we stand, divided we fall" – was the concept they followed.

All local level CBOs together have formed one District level CBO for sex workers. Two members from each local level CBO are nominated for membership in the district level CBO. The district level CBO for sex workers is a legal entity consisting of a Board of eight members. The Board includes the President, Vice President, Secretary, Joint Secretary and Treasurer, who are elected by the CBO members.

The Board meets every month to discuss various issues. Local level issues (by local CBOs) are reported to District level CBO who have network and linkage with the senior officers in Police,

government and other institutions. As they advocate to resource persons at the district level, addressing local level issues becomes easier, faster and more effective.

Some of the issues faced by sex workers have been – children of sex workers are stigmatised and hence most of them are fearful of sending their children to school. Also, most of the sex workers do not have basic essential documents like ration card, identity card, voters' identity card, etc. There is a need for income generation activities for the older sex workers for a secure future. The sex workers face problems of police and general communities' harassment. All such issues among others are being addressed by the CBOs by various ways and means. For instance, by advocating to some senior officials in the Education department they have been able to facilitate admission of children of some sex workers into schools; they have collected money, a part of the membership fee, as contributions from the members of local level CBOs, for facilitating savings to start some income generation activities for the sex workers; if a sex worker is beaten up by police, the other members would get an FIR filed against the concerned official; uniform services are ensured for sex workers at every site due to their persistent mobility; and the practice of counselling the sex workers who are arrested during police raids has been initiated.

The sex workers from the district level CBOs have been using this platform to share experiences with each other. The members from the local level CBOs gain from this experience-sharing and try to replicate the strategies in their respective areas. Also common events and functions are conducted by the CBOs, such as *Pongal* festival, sex workers' day, women's day, candle light memorial, etc. that contributes in developing solidarity amongst the sex workers. Thus, CBOs gain strength, develop confidence in each other and make concerted efforts to address their issues.

Committees as a means to mobilise community:

The formation of committees within the various services/components in the FPP-Avahan project has been one of the strategies instrumental in mobilising the communities for sex workers. Some of these committees are: Clinic Services Committee, Project Administration Committee, Core Advocacy Group and DIC Committee. Some NGOs have also formed Staff Recruitment Committee involving KPs. The committees on an average have 8 – 10 members comprising of members from KPs and general community, led by the Head of the iNGO, usually the Project Director. Project Coordinators are also part of such committees. The purpose of forming these committees is to involve the communities at every level of the project – start, design, implementation and evaluation. The committees meet once in every three months to review the programme.

The iNGOs are free to establish any other committee as per their requirements. For instance, the sex workers' CBO in Ananthapur have formed core committees for different activities/ components of the programme. These are: Clinical Services Review Committee, Project Advisory Committee, Core Advocacy Group, Emergency Action Team, Monitoring Team, and Women's Cell.

Clinical Services Committee, which usually comprises of 6 to 8 members with a sex worker, a brothel madam, ORW, PE, and is convened by Clinic Administrator who is also from KP community, discusses and reviews the services of the clinic including quality, timing, and behaviour and attitude of doctors and other paramedic staff. This is accompanied by periodic visits of the committee members to the community for taking their feedback on the clinical services. The result of such review has been the change in the timings of the clinic according to sex workers' demand, increase in the internal examination for the sex workers, regularity in follow up with sex workers on STI problems, and increased inclusion of new sex workers for the clinical services.

Other committees formed by NGOs/CBOs at different intervention sites work on similar lines for mobilising the communities for addressing their issues for their betterment. This reflects on how community is itself involved in an organised manner in placing its demands and needs before the different stakeholders.

Advocacy by sex workers:

Sex workers confront social marginalisation due to the stigma attached with them at multiple levels. Not only this, they usually face the antipathy of the general community and society at large. Due to this, they undergo many problems especially at the place where they live as they are not considered a part of the mainstream society. Some of the problems may be harassment from general community members but also from the law enforcing bodies, inability to avail of the general facilities and services, discrimination from healthcare providers, and issues related to their profession itself, among others. Therefore, it becomes necessary to create an enabling and supportive environment for them and a sustained behaviour and attitudinal change by the rest of the communities. An important approach to bring about such changes is sensitising the different stakeholders in their surroundings and advocating to them about their issues and needs. When such advocacy is done by the sex workers themselves, it becomes even more effective.

Thus, as part of community mobilisation for sex workers, different advocacy initiatives are being undertaken at the local level by different sex workers' groups including the CBOs. As mentioned before, the sex workers themselves believe that their advocacy efforts can be more meaningful and impactful if undertaken as a group. The sex workers' CBOs have been sensitising and advocating to different stakeholders for support, such as, sex workers' gatekeepers (pimps/madams), police and other government officials, healthcare providers, local NGOs and media.

One of the most important strategies adopted by the CBOs is the formation of a committee called 'Core Advocacy Group' (CAG), exclusively for undertaking advocacy initiatives for sex workers. CAG is a combination of members from different KPs – FSWs, MSMs, PLHIV and few IDUs, who are quite active in the community. The CAG is a reactive group, works round the clock, and deals with the problems faced by the KPs by intervening and resolving the matters within 24 hours. One of the outreach responsibilities of the ORWs and PEs is also to inform the KPs about CAG and its functions.

Until now, many issues have been resolved through CAG's action. Sex workers arrested by police during raids have been rescued by CAG members within 24 hours by sensitising the police. In another incident, a sex worker was brutally beaten up by her husband. While he forced her for sex work, he would also take away her money. She approached CAG, which immediately intervened and lodged a complaint with the police. The husband then promised that he would never beat his wife again.

Apart from CAG, which is functional at the district level, there are Emergency Teams of sex workers at the local level. The team resolves issues like children's problems, neighbours' harassment, partners' issues, etc. at the local level. However, if the team is unable to resolve issues at local level, they are reported to CAG.

While interacting with the group of sex workers in Tadipatri intervention site (Ananthapur), the study team was told about many incidents in which the emergency team resolved their issues. In an incident, the wife of the partner of a sex worker lodged a complaint against her to the police, falsely implicating her with the charge of kidnapping children (a serious offence in AP due to increased trafficking of children). Not only this, she also sent some men to beat up the sex worker. Under such harassment, the sex worker started absconding. Then the emergency team approached the police officials and tried to explain them about the situation, which they understood and empathised with the

sex worker. The police then threatened the wife that she would be arrested if she troubles the sex worker further.

Other issues resolved by the emergency team include: general health and pregnancy related cases when they are refused admission into hospitals; problems of sex workers at highways; and sensitising the gatekeepers for sending the child sex workers back to their villages.

The CBO members including those of CAG are given capacity building trainings, exposure visits, with review meetings, and internal and external monitoring system. These are the additional support given to the CBO members by iNGO and AIAP for strengthening their advocacy initiatives.

Mobilisation through events and theatre:

As high stigma is attached with the sex workers' community, the CBOs involve the general communities and sensitise them about their issues through the means of common events and street theatre. The CBOs celebrate festivals such as *Holi*, *Pongal* and Christmas, national events such as Independence Day, and other events like World AIDS Day, New Year's Day and Valentine's Day. Such events are organised at the DIC where apart from the KPs, there is involvement and participation of the general community and secondary stakeholders like police officials and panchayat members. Organising health camps and campaigns on HIV/AIDS through cultural programmes are other ways of sensitising and mobilising the communities. Such initiatives contribute greatly to the development of a feeling of togetherness between the KPs and general community.

According to the sex workers' CBOs, theatre is an important tool for edu-tainment that has tremendous impact on rural folks and is useful for conveying messages of hope and empathy with information on HIV/AIDS and STIs. Therefore, theatre is widely used by the CBOs to convey information to sex workers, other members of KPs and general communities, like, harassment faced by sex workers, modes of transmission of HIV and other STIs, prevention methods like use of condoms, services offered at the Mythri clinic, importance of regularly visiting the clinic, usefulness of internal examination, among others. The participants in such theatre shows are usually the sex workers, PEs and ORWs, who are provided training on techniques used in conducting such shows.

Challenges met and addressed

During the study tour, the team from Myanmar, through various field-visits and interactions, came across the challenges confronted by the NGOs/CBOs and KPs mainly related to implementation, outreach and general issues faced by them in the community. Some of the primary challenges and their ways of addressing them are *ab infra*:-

- Initially, when the PEs and ORWs (Tadipatri site, Ananthapur, AP) started visiting the DIC and disclosing their status as sex workers, they had to face many confrontations in their families. This became a major hurdle in their outreach work and thus many of them hesitated to visit the DIC. Undertaking a programme for sex workers was also difficult due to high stigma attached with them. Thus, involvement of the general community was deemed significant.

The iNGO (here CERA) staff conducted various home-visits, interacted with and counselled their families. To involve the general population and gain confidence amongst them, the sex workers' group and iNGO undertook certain common programmes with them. For instance, at the Tadipatri intervention site in Ananthapur, they addressed the common issue of drinking water. Since Ananthapur district is a drought-prone area, the rainfall is erratic and irregular and there is fast depletion of ground water, therefore, people here face problem of drinking water especially in the

summers. The CBO members came forward to address this and provided a mechanism of storing drinking water for the community, by purchasing earthen pots and keeping them under a shelter. The general population in the locality appreciated this effort and they started empathising with their issues.

In addition to this, organising various cultural events, common festivals, national events and awareness campaigns helped in the development of a sense of harmony between the KPs and general communities.

- During the outreach work, PEs and ORWs have been facing problem in convincing the sex workers to visit the Mythri Clinic. The first and foremost apprehension of the sex workers is getting exposed as high stigma is attached with the profession. Secondly, they are doubtful about the quality of services considering the discrimination faced by them from other healthcare providers. To address this, PEs consistently interact with them, informing them about their own situation as sex workers and the non-discriminatory services they received from the clinic. They discuss with them about their sexual and reproductive health (SRH) issues, and inform them about HIV/STIs and the KP-friendly services available in the clinic.

To avoid branding of the clinic as STI clinics for sex workers, attempt has been made to encourage general communities to visit the clinic for treatment. Also, services other than for STIs and HIV, such as tuberculosis (TB), leprosy and other basic healthcare facilities, are provided. The PEs motivate sex workers to visit the clinic first for their general health issues. Gradually, when they start visiting the clinic frequently, through friendly and sensitive discussions with the doctor and other paramedical staff, they are encouraged for internal examination.

- Although emphasis has been made on public-private partnership for providing clinical services to sex workers for the purpose of sustainability, yet many sex workers have been reporting issues of stigma and discrimination at these institutions, unavailability of medicines most of the times, over-crowded nature of these centres, and inconvenient timings. The HIV positive sex workers face greater stigma at these centres. Such issues have been addressed by various NGOs/CBOs through advocacy initiatives, e.g. with hospitals for KP-friendly services, with the District Collector (senior official of Indian government) of Ananthapur, etc.
- Sex workers have been facing harassment from the local police, e.g. physical beating, arrests, false implications, etc. Many efforts have been made by the CBOs to bring about an attitudinal change in them. A number of sensitisation and advocacy meetings with the police department have been conducted, they have been involved in various events organised by CBOs, and PEs and ORWs have collectively explained them about the situation of sex workers and the programme being undertaken for them. Also, many legal awareness activities have been conducted for the sex workers that help them advocate to the police for their issues.

Reflections

Through various interactions with AIAP, NGO and CBO members and among themselves, the study team from Myanmar reflected upon the key lessons they learnt from their intensive tour across AIAP's intervention sites in Hyderabad and Ananthapur (AP). The reflection entailed the various strategies/approaches and processes for mobilising the community for not only the sex workers but also other KPs like the MSM and PLHIV, the replication of the same at intervention sites of Myanmar within the country's context, challenges that they could face in Myanmar, and the kind of support that they would expect from Alliance India.

Key learnings and observations from study team:

- To change the attitude of the general community towards the KP, advocacy is being undertaken by the KP themselves at various levels with various authorities and other stakeholders. Gaining confidence in general population leads to easy programming for KP and also helps in undertaking advocacy activities.
- There are many strategies to mobilise the general population; infact KP-led projects benefit the general community in many ways.
- Collectivisation as an important tool for community mobilisation is a success among KP as they are able to form various groups, networks and CBOs at local and district levels.
- The services at Mythri clinic are KP-friendly and importance is given to the community's view for decision-making at various levels.
- PEs who also belong to the KP, are empowered enough to empower others in the community. They are being looked up to by the community people as role models.
- Sex workers have been forming groups like self-help groups and undertaking various income generation activities for economic sustainability.
- KP are able to divulge their status as sex workers, MSMs and/or PLHIV.
- Some sex workers are also benefiting from the education support provided under the programme that includes certificates for advanced studies, i.e. accreditation.
- The PEs and ORWs still have problems in reaching out to secret sex workers.
- There is, more or less, acceptance of internal examination in the community, however it's not immediately accepted and requires consistent one-to-one interaction and counselling (In Myanmar, it is not accepted).
- The strategies are not very different in India and Myanmar, however since situations are different, some of the lessons from here can be taken there.
- There is lot of importance attached to KP's feedback and decisions and their needs are given utmost priority.
- There is emphasis on public – private partnership other than Mythri clinic; for instance, CERA is using the infrastructure available in government healthcare centre.
- Here, the government also has programmes for KP and works in coordination with NGOs.
- The aged sex workers, who are unable to continue with their work, are being supported with income generation activities and healthcare initiatives. Although there is no separate programme catering to this, yet, such support has been generated as a result of the self-realisation of the sex workers themselves. The CBOs have realised the importance of saving money and creating sustainability for older sex workers, as, comparatively, they do not have many clients and/or the money paid to them is quite less than what the younger sex workers are paid.
- AIAP's technical support and capacity building initiatives have made the NGO/CBO staff quite empowered and skillful.

Challenges in Myanmar:

It is known that with the abrogation of democracy in Myanmar since early 60s and the absolute control over all institutions by the ruling military junta, the ground for collectivisation, collective action, people's participation in decision making and people-centred advocacy is for all practical purposes non-existent. The political situation in Myanmar does not allow civil society formations to effectively carry out awareness and prevention related activities in the context of HIV/AIDS. There is no gain saying the fact that civil society action needs spaces and places that are severely constrained in authoritarian political environments.

Therefore, it is difficult to form groups, and for some CBOs that have been formed it a challenge to undertake advocacy, they need to take permission from higher authorities, and it is all the more difficult for KP to lead such initiatives. Similarly, running an STI Clinic, a DIC for sex workers, using it as a workplace and involving the general community are big challenges. Due to the above-mentioned political situation in Myanmar and high stigma attached to sex work and HIV/AIDS, the PLHIV as well as sex workers cannot divulge their status. Therefore, overall, it is a challenge undertaking a community-led initiative for them.

Most of the existent programmes are targeted interventions and are not able to involve the general community. Issues like difficulty in regularly following up and keeping a track for sex workers due to their high mobility and secretly undertaking sex work, inability to organise KP-led CBOs, inability to work in coordination with the Government, less acceptance of internal examination in the community and near to impossible situation of convincing them for the same, are some of the common issues faced in Myanmar.

Opportunities in Myanmar:

Although the above-mentioned challenges are faced by NGOs in regard to undertaking community-led programmes for sex workers as well as mobilising the community for the same, yet there are some opportunities and possibilities in Myanmar that could allow undertaking few initiatives that the study-team learnt from AIAP's programme for sex workers in AP¹. Some of the opportunities are as follows:-

- Although a static STI clinic especially for sex workers is not possible, yet starting a mobile clinic led by CBOs is a possibility
- There are some people who are actively involved in advocating for human rights in Myanmar, who could be involved for the cause of sex workers
- Support groups and SHGs could be formed; an attempt can be made for starting income generation activities for older sex workers. To begin with, the project staff could share some of their skills with the sex workers as part of vocational training helping them undertake small-scale income generation activities like beauty parlour, food stalls, etc.; and literacy classes for sex workers
- Efforts can be made towards building unity and self-reliance among sex workers
- Counselling of minor girls to prevent them from undertaking sex work
- They can reach local and freelance sex workers; reaching to secret sex workers is not possible
- As it is not possible to operate a DIC in Myanmar as permission needs to be sought from authorities for any kind of gathering/association/collectivisation, Preferred Provider is possible. Through resource-mapping exercise, the sex workers could give information about the service providers that they usually prefer and linkages could be established with them for regular services

¹ Although the study team from Myanmar was exposed to the overall prevention programme catering to members of all KPs – sex workers, MSM, PLHIV and IDU, being undertaken by AIAP and its partner NGO in AP, however initiatives for only sex workers are relevant for them.

Areas/topics recommended by study-team for TS from Alliance India:

- Empowerment of sex workers
- Enhancing KP's skills in counselling
- Registration of CBOs
- Management training including financial management for sex workers and project staff
- Management of SHGs for sex workers
- Communication skills

Thus, although the study team realises the importance of community involvement and sex workers' mobilisation for their own benefit, yet the opportunities in Myanmar for taking such initiative forward is difficult and challenging. The main apprehensions and worries, as expressed by the study team were: local authorities and political situation of Myanmar, sex workers' fear of getting exposed, and difficulty for sex workers to unite or even gather as a group. At the closing of the study tour, while the team decided to continue with their current strategy of one-to-one peer education, they also proposed to extrapolate the lessons learnt through the study tour and think of opportunities and strategies in Myanmar for the programme on sex workers.