



ETHNOGRAPHIC DISSEMINATION IN STUDY COMMUNITIES IN MUMBAI, INDIA.

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Dissemination has meant to researchers:

- 📄 Publication in peer-reviewed journals and other scientific publications
- 📄 Reports to funders
- 📄 Position papers to policymakers
- 📄 Going to scale to interventionists in other sites

Less focus is given to the needs for the data of the study population from which the information is derived

Benefits of dissemination to the study population

- 📄 Making good on the “promissory note” we make to study participants and the community of which they are apart
- 📄 Validation of research results (“member-checking” in qualitative terms)
- 📄 Creating an opportunity for sustainability of the intervention
- 📄 Utilization of project results for population-based advocacy to external policymakers

The Problem: HIV in India

- 📄 HIV prevalence has been increasing in India although the specific rate is in dispute, ranging from 2.5 (.4%)-5.2 (.9%) million people
- 📄 The gender ratio has shifted over the last decade from 5 males to 1 female to 1.7 to 1
- 📄 Women's greatest risk for HIV/STI is transmission from their husbands
- 📄 Men are significant underutilizers of the public health care system for HIV/STI care

Male Sexual Concerns and Prevention of HIV/STD in India (2001-2007)

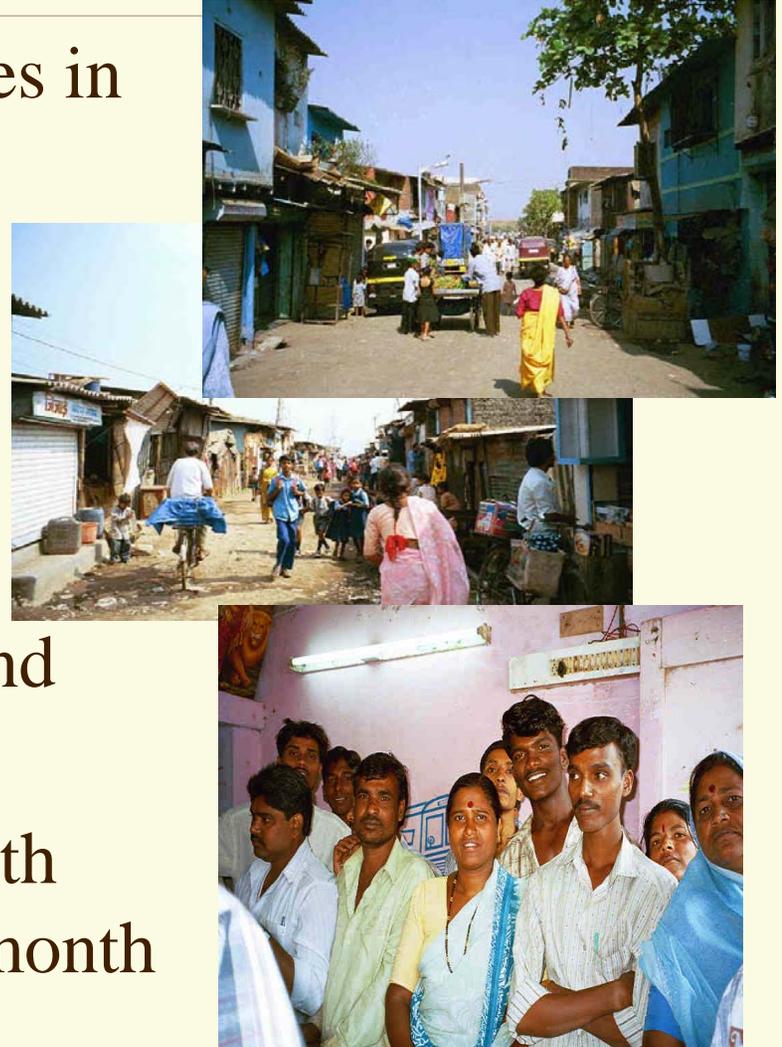
- 📄 Funded by NIMH
- 📄 Conducted in three urban poor (“slum”) communities in the northeastern part of Mumbai
- 📄 **RISHTA: Research and Intervention in Sexual Health: Theory to Action** (“relationship” in Hindu/Urdu)
- 📄 Collaboration of International Institute for Population Sciences (IIPS) in Mumbai, the University of Connecticut School of Medicine, and the Institute for Community Research, Hartford, Ct

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(MANKHURD)



The Study Communities

- ☞ Three “slum” communities in the northeast quadrant of Mumbai
- ☞ 700,000 people
- ☞ 66% migrants, primarily from northern Indian
- ☞ Mix of Muslims (54%) and Hindus (46%)
- ☞ Primarily day laborers with mean income of US\$75/month



Dissemination opportunity

The no-cost extension year (2006-2007) provided an opportunity to focus on disseminating the results of the project to the three study communities

📄 Seek sustainability for the interventions

📄 Learn how results can be communicated to a population with a wide range of literacy

📄 Build the research results into the fabric of the community

Key Concepts: Gupt Rog

Men's major concerns in terms of their sexuality focus on performance issues (*kamjori*), the nature of semen adequacy (*dhat*), and STI-like symptoms (*garmi*)

Etiology focuses on semen loss through nocturnal emission and masturbation

Consequences are described in terms of inability to satisfy wife and other women, threat to masculinity

Treatment by non-allopathic providers with little access to public allopathic services

Cultural opportunities

- 📄 A salient set of concepts about sexual health concerns and treatment seeking
- 📄 Preliminary data, which showed significant association between *gupt rog* and risky behavior
- 📄 A public allopathic system seeking ways of engaging men into treatment for STI-like symptoms, but little understanding of *gupt rog* syndromes
- 📄 Traditional practitioners who address *gupt rog* concerns, but had limited training in sexually transmitted infections



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Formative ethnographic research

-  Key informant interviewing with governmental, community and religious leaders
-  Mapping and observation of three communities
-  In-depth interviews with men and women
-  Baseline survey of a random sample of 2408 men
-  STD testing with a subset of 641 men
-  Survey of 245 private practice providers and the public health clinics

Outcomes of the formative research

- 📄 Involvement by community leaders
 - 📄 Venues provided for RISHTA activities
 - 📄 Imams and priests providing encouragement for involvement in RISHTA programs
 - 📄 Residents of the communities taking active roles in the project
 - 📄 Providers, both allopathic and non-allopathic, actively participating in the project
- Community participation in combination with an ethnographic understanding of the communities provided a base for future dissemination

Multi-level intervention

LEVEL	COMPONENTS
COMMUNITY	<ul style="list-style-type: none">Opinion leadersCommunity eventsStreet dramasMen's meetings
PROVIDER	<ul style="list-style-type: none">TrainingSupportReferral system
PATIENT	<ul style="list-style-type: none">Risk reduction educationSyndromic managementUnderstanding etiology and consequences

Community Education

Street
Play



Banner
Display



Men's
meeting



Video
Shows



Intervention: Provider Level

- ☞ Men's Health Clinic in the public allopathic urban health center established in 1st experimental community
- ☞ Organization of non-allopaths in the 2nd experimental community
- ☞ Training for both groups of providers in an ecological model of care and syndromic management





Evaluation Methods

- ☞ Baseline cross-sectional survey (2003) of 2408 married men and an Endline survey of 2730 married men (2006)
- ☞ STI testing for syphilis, HSV2, gonorrhea and Chlamydia at Baseline (641) and for gonorrhea and Chlamydia at Endline (903)
- ☞ Randomly selected patients (573) drawn from four groups: trained v. untrained and allopathic v. v. non-allopathic, followed from pre-treatment (T1)-to post-treatment (T2, 24-48 hours) and follow-up (T3, six months later)

Evaluation Results

- ☞ The communities showed an overall significant and precipitous drop in extramarital sex and STDs
- ☞ Communities, where education was combined with provider intervention had better outcomes than the one with education only
- ☞ Men who participated in community education had better outcomes than those who did not participate
- ☞ Men who utilized a trained provider had better outcomes than those who did not participate
- ☞ A synergistic response to both participation in community education and use of a trained provider

How to convey the results to residents of the three communities?

1. Interviews conducted with key informants
2. Individual communities and comparisons between 2003-2006 to assess progress
3. By outcome variables that mattered to residents including EMS, STD rates, violence, alcohol use and *gupt rog* problems

Field research staff reviewed these data, developed oral presentations, role play and street drama and through their community relationships and ethnographic knowledge organized meetings in the three communities from September 2006 to March 2007.

Dissemination outcomes

1. 21 community meetings were held from September 2006 to March 2007
2. Attendance at these events averaged approximately 30 residents
3. Discussion of comparisons over time demonstrated to residents that a number of outcomes had positively changed and some had not
4. Residents recognized that many of the positive changes could be attributed to RISHTA interventions but further work needed to be done
5. Residents generated the need to organize to sustain RISHTA interventions and to develop new interventions to further affect outcomes

Community action groups (CAGs)

- 📄 Residents who were active in their communities and in CBOs developed cross-cutting CAGs specifically to sustain RISHTA community activities
- 📄 The three communities each formed a male CAG.
- 📄 At the insistence of active women, two women's CAGs were formed as well that have established the base for the next RISHTA project focused on women

RISHTA supports

- 📄 A series of meetings were held with the CAGs in the period from March-September, 2007 to facilitate structure and organization
- 📄 A program was held at IIPS to train representative members of each of the CAGs and to form a network of CAGs
- 📄 RISHTA provided a small amount of materials and support for the CAGs to organize and conduct street dramas, community meetings and distribution of educational handbills
- 📄 A follow-up meeting was held after the end of the project in January 2008, with over 100 CAG members at IIPS to recognize their accomplishments.

Ethnographic dissemination

- 📄 Ethnographic methods were used to understand the culture and community
- 📄 Rapport and relationships with community members over the course of the project
- 📄 A culturally-defined approach to addressing HIV/STD prevention that drew on local concepts and resources
- 📄 An understanding the network of formal and informal relationships in the communities
- 📄 Formed the basis for understanding how to build the research results into the life of the communities

Current situation and limitations

- 📄 The CAGs continue to provide a regular schedule of community education activities
- 📄 Evaluation of CAG active members indicates a very positive responses to involvement but little data on community impact
- 📄 Greater sustainability could have been achieved with more involvement if NGOs and CBOs
- 📄 The need to build dissemination structures from the beginning of the project

New Project

- An RO1 (2008-2013) focused on prevention of HIV/STI transmission from husband to wife in the same communities (continuous projects for 15 years)
- Involving both the CAGs, the NGOs and the providers in the first year as collaborators in community level intervention
- Creating the expectation that the process of building the project and the results will also be owned by the communities.