International HIV/AIDS Alliance in India
Supporting community action on AIDS in India

Programme Brief
April 2007

# Spotlight on Women, Sexual and Reproductive Health & HIV/AIDS

*"At the end of the day, after so much of physical work and providing sexual services to employers, we are too exhausted to have sex with husbands; sex for pleasure is a luxury of the rich and nourished…"*

(says a stone quarry worker in Tamil Nadu)

*Drudgery, exploitation and marginalisation, together, have many times depicted and defined the life and times of most women. There are millions of them, like the stone quarry worker quoted above, who continue to face violence including sexual abuse, and are relegated to silent oppression. Little has changed for most of them even at the turn of the millennium, as social perception of them continues to be extrapolated. Today, as one reflects upon the prominent vulnerability among women in the country, one is concerned to find a vast majority of them under the direct spectre of HIV/AIDS.*

## Alarming Impact of HIV/AIDS on Women

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The transmission and speedy proliferation of HIV in India seems to have added a lot more misery to the falling numbers of women, already suffering from malnourishment, illiteracy, domestic and sex-based violence, and poor health. HIV/AIDS has isolated and stigmatised those affected by it, though its social effects on HIV positive women are usually far more pronounced than their male counterparts. Stories of discrimination and ostracism have often been revealed from the field sites. Their partners' objection to testing for HIV on the one hand, and their inability to access treatment, care, prevention and related services due to paucity of resources on the other, has added to their despair. Women are often held responsible for bringing in HIV, and are usually castigated for their family's sickness. Above all, they have limited accurate and adequate information, as well as, confront discrimination even from the healthcare providers. All these, thus, deter them from addressing their own risks, taking preventive measures and seeking early diagnosis and treatment for sexual and reproductive health (SRH) and HIV. Such factors make them reluctant and hesitant in seeking the much needed information and services for SRH, HIV/AIDS and related legal remedies, and entitlements provided within social welfare schemes.

## Facts

There is dramatic increase from 3.5 million adults (15-49 years) living with HIV in 1998 to over 5.206 million in 2005 in India.

The overall adult HIV prevalence is 0.91%. Of the total estimated adult population, 38.4% are women living with HIV.

An upward trend in the female-male ratio of people living with HIV/AIDS from 55 per 100 males in 2001 to 60 in 2005 further indicates towards increasing feminisation of the epidemic. (*National Sentinel Surveillance, 2005*)

The average HIV prevalence among women attending antenatal clinics in India is 0.88%. Much higher rates are found among people attending sexually transmitted infection (STI) clinics (5.66%) and female sex workers (8.44%). *(HIV/AIDS Epidemiological Surveillance & Estimation Report for the year 2005, NACO, April 2006)*

## INSIDE

## Commonalities of Sexual and Reproductive Health (SRH) & HIV/AIDS

SRH is an important gateway for HIV/AIDS issues, as the majority of HIV infections are sexually transmitted or associated with pregnancy, child birth and breastfeeding. Often, women are unable to talk openly about matters related to HIV/AIDS due to the stigma attached. Since every woman has some SRH needs, a discussion on these issues gives an easy inroad into HIV/AIDS issues. The integration of the two programmes is likely to lead to important public health benefits as they require access to the same target group – the sexually active. Service providers for both require similar skills for addressing the needs of women and men. Modification of sexual behaviour is the prerequisite for disentangling SRH as well as HIV/AIDS problems. Condom usage is the key focus of both the programmes. Using condoms, also for prevention of HIV transmission, is thus considered as a method for dual protection. Furthermore, prevention of mother to child transmission and treatment of STIs also come under the umbrella of family planning.

## Significance of SRH & HIV/AIDS Convergence

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The fact that issues pertaining to SRH are correlated with those of HIV/AIDS cannot be ignored. The HIV/AIDS epidemic has accentuated the vital need to converge SRH and HIV/AIDS programmes to enhance the coordination of efforts to prevent sexual transmission of HIV, and to provide SRH services to HIV positive couples and other marginalised groups like injecting drug users, sex workers and men who have sex with men. The convergence would also improve access of HIV related information to the vulnerable population.

The integration of programmes related to both, would generate synergistic impact by leveraging the strengths of both fields in policy and service provision. Although programmes related to SRH and HIV/AIDS have been led vertically by the Indian Government through the Ministry of Health and Family Welfare – the Reproductive and Child Health (RCH) programme for the former and the National AIDS Control Programme (NACP) for the latter, yet government efforts in establishing necessary linkages due to rapid growth of the epidemic, were quite visible in the recent planning process for NACP-III. The National Rural Health Mission (NRHM) envisages the convergence of NACP, with over a decade of experience and technical competence in HIV/AIDS prevention and care, and the Health and Family Welfare programmes with its infrastructure, human resources and capacity to reach out to every village and community. This convergence is indispensable for ensuring effective service delivery, improving the lives of women and reducing stigma and discrimination.

## The India HIV/AIDS Alliance Efforts to Address the Feminisation of HIV/AIDS

Alliance India's in-depth experience, while providing support to children affected and living with HIV/AIDS, and people living with HIV/AIDS, through its Home and Community-Based Care and Support programme, drew it closer to the need for designing a programme for women, including those living with HIV/AIDS and at high risk. It has been seen that women, despite being positive, have been taking up the responsibilities of their families including the economic needs, even in circumstances where they are blamed for bringing in the virus. Often, women tend to ignore their health in general; HIV all the more deteriorates their condition. They are unable to realise that they have certain SRH issues too that need to be addressed. As a result they give least importance to accessing related information and services. With this, Alliance India identified the vitality of discussing HIV/AIDS within the context of SRH. With such a realisation, Alliance India was urged to design a programme for strengthening and developing community-centred approaches to meet the SRH and HIV-related needs of women in low-income settings.

Alliance India's programme – Community-Driven Approaches for Addressing Feminisation of HIV/AIDS – supported by the Department for International Development (DFID), integrated the SRH and HIV/AIDS issues of women. It has reached out to women who are

at high risk of HIV, including women living with HIV/AIDS (WLHA), and their communities. The programme has focussed on high prevalence and high vulnerability as the corner stones for selecting its geographical areas of intervention. Amongst its six selected states, while Tamil Nadu, Andhra Pradesh and Manipur have high prevalence; Delhi, Punjab and Orissa have high vulnerability. Increasing drug use, high migration and increasing prevalence of HIV amongst women visiting the antenatal care (ANC) and STI clinics have been seen as crucial in making them highly vulnerable. As per government data[1], HIV prevalence amongst women visiting ANC clinics is a considerable 2%, 1.25%, 0.5%, 0.25%, 0.25% and 0.13% at Andhra Pradesh, Manipur, Tamil Nadu, Delhi, Orissa and Punjab respectively. Likewise, HIV prevalence as high as 22.8% in Andhra Pradesh, 12.20% in Manipur, 9.2% in Tamil Nadu, 9.15% in Delhi, 4% in Orissa and 1.07% in Punjab has been noted amongst women visiting STI clinics. Significantly, high HIV prevalence amongst STI population in low prevalence states like Delhi and Orissa is a perturbing state of affairs. This speaks sufficiently of the escalating incidence of HIV/AIDS amongst women.

Vulnerability is further enhanced, as, even if there is moderate to high level of awareness on dual protective role of condoms among women, there is little application of that information in personal lives. For example, awareness level on the preventive role of condoms is as high as 42.1% in Tamil Nadu, 34.1% in Andhra Pradesh, 80.7% in Manipur, 77% in Delhi, 53% in Punjab and 30.5% in Orissa; but its usage is as low as 2.3% in Tamil Nadu, 0.5% in Andhra Pradesh, 4.2% in Manipur, 23.3% in Delhi, 15.5% in Punjab and 3.2% in Orissa[2] . Such a scenario along with Alliance India's grassroot experience has all the more added to the reason for strengthening its response in these states. This is being done, in sync with its partners organisations, through increased awareness and prevention in the high prevalence states, and by reducing stigma and discrimination in the highly vulnerable states with prevention as the primary objective.

| Intervention State | HIV Prevalence (%)[3] |
|---|---|
| Andhra Pradesh | 2.00 |
| Delhi | 0.25 |
| Manipur | 1.25 |
| Orissa | 0.25 |
| Punjab | 0.13 |
| Tamil Nadu | 0.50 |

# Sexual and Reproductive Health & HIV/AIDS

## *Exploring Women's Knowledge, Attitudes and Practices*

Alliance India undertook a Knowledge, Attitudes and Practices (KAP) survey for a better understanding on women's vulnerability to various STIs and HIV/AIDS on one hand, and to ascertain baseline information for an effective programme design, on the other. The KAP is one of the first such surveys in India that establishes representative KAP data on SRH issues amongst WLHA. It was conducted at selected sites in Andhra Pradesh, Delhi, Manipur, Punjab and Tamil Nadu – five of the six intervention states of Alliance India's SRH and HIV/AIDS integration programme. It surveyed 2,284 women and 987 male partners of women. The KAP, in turn, helped them explore their own SRH needs and their attitude towards WLHA in their family and community. At the same time, they developed understanding on relevant rights related to SRH and HIV/AIDS including services for addressing them.

Amongst the respondents of the survey, more men (22%) were HIV positive than women (only 12%). Although 88% women were found at risk of HIV as against 78% men, yet the difference between the two was only 10%. Hence, apart from the PLHA amongst the respondents, almost all the others belonged to the vulnerable section. All this, including the fact that majority of the vulnerable women were married (95%) highlighted the relevance of SRH and HIV/AIDS interventions with the general population. Two out of five WLHA were either widowed or deserted, signified the need for specifically designed SRH services irrespective of the marital status of women.

Knowledge on areas of maternal health was found to be quite minimal. For e.g., only 30% of all women and 20% of those pregnant knew the importance of iron and folic acid tablets. Although 90% women had received advice on diet during pregnancy, 76% on breastfeeding and 70% on newborn care; yet only a little more than one-half claimed to have received information on family planning (including birth spacing), danger signs and/or costs of delivery.

[1] National AIDS Control Organisation, Ministry of Health & Family Welfare, Government of India: HIV/AIDS Epidemiological Surveillance & Estimation Report for the year 2005; April 2006

[2] National Sentinel Surveillance, 2005

[3] National AIDS Control Organisation, Ministry of Health & Family Welfare, Government of India: HIV/AIDS Epidemiological Surveillance & Estimation Report for the year 2005; April 2006

Only 33% women and 36% men were found to have an overall understanding of RTI; in fact most of them misunderstood the way RTI is transmitted. Only 29% women and 25% men felt that RTI may be cured. One-third of the men could not describe any STI-related symptom in women. This was a worrying baseline revelation especially because the respondents recruited for this KAP study were either those who were at risk (majority reported one or more symptoms of RTI/STI; 89% of women had problem of vaginal discharge) or those who were HIV positive. While majority of respondents, i.e. 95% said that they had heard about HIV/AIDS, yet awareness on the modes of transmission of HIV was much lower. This was despite the fact that the respondents were recruited from local HIV community organisations and that 12% women and 22% men were HIV positive.

Women were found to have higher awareness than men especially on issues such as heterosexual intercourse, mother to child transmission, transfusion of infected blood and needles/blades/skin puncture. Despite this, the present level of SRH indicators for women in India portrays another story. Serious power differences in man-woman relationship in society impede women in translating their knowledge of their sexual and other rights into practice. Some of the KAP findings that directly indicated limited say of women in matters related to their own sexual health were — 44% women said that they could not refuse to have sex with husband even if he has an STI; 50% found it difficult to discuss sex with husband, and; only 42% men had discussed with their wives the use of contraceptives once or twice in a year, whereas 13% women revealed that the decision for use of any contraceptive method was mostly taken by the husband. Such a situation signified the need for involving more men in SRH related programmes.

Contraceptives were being used by 42% of WLHA for avoiding pregnancy. 35% of women had undergone sterilisation. Sterilisation may lead to low usage of condoms, as they are usually perceived as only a contraceptive method, rather than also a technique for HIV prevention. Hence, sterilisation of three-fourth of women necessitated behaviour change communication towards dual protection. Also the fact that over half were unaware about how to use a condom, was a concern. Therefore, issues around unsafe sexual practices with regard to HIV and STI transmission need to be addressed when sterilisation services are sought.

The baseline survey unraveled the fact that a miniscule 6% of the women had sufficient awareness on relevant laws, policies, rights and entitlements for PLHA and other vulnerable groups. A negligible number were found to have ever received any legal advice and/or support. Thus, the need for a comprehensive package of health, social welfare and legal services, was reinforced for ensuring quality lives for women.

Unawareness on available support in the communities, and/or disinterest in seeking it, was seen amongst PLHA, both women and men. 68% women and 85% men were not members of any support group. Perhaps, because seeking active support could lead to the exposure of their HIV positive status in their community, and possibly distanced them due to the stigma attached to HIV/AIDS. Such a lack of interaction with other community members and those confronting similar issues lessened their opportunities for attaining greater information on SRH and HIV/AIDS. Hence community involvement has been highlighted as the key element for Alliance India's efforts on SRH and HIV/AIDS integration.

## A Community-Driven Approach

Constant inputs from the community are prerequisite for an effective response to HIV/AIDS. Alliance India has thus attached high significance to the involvement and active engagement of the community including PLHA and key population (sex workers, men who have sex with men, injecting drug users). Enhancing community action to provide care and support to PLHA and preventing the spread of HIV/AIDS has been its approach. Training and capacity building of NGOs and community-based organisations (CBOs), as well as, participatory assessment of the communities have been some of the means for involving communities. Further, through collectivisation and formation of groups, the affected communities have come together and voiced their concerns.

Alliance India has been undertaking Participatory Community Assessments (PCA) that bring communities together for sharing their experiences and knowledge, which helps them identify their own issues and needs. The information shared, collected and analysed through such PCAs contributes in attaining qualitative information that helps in designing the programme. With similar purpose, Alliance India conducted PCA at the implementation sites of its programme on SRH and HIV/AIDS integration. Qualitative information pertaining to community's perspective on HIV/AIDS and their needs regarding SRH and HIV/AIDS, were received from the women. In one such PCA, the widow of an injecting drug user stated – *"I inherited nothing but disease from my*

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*husband. After being totally depressed, I am trying to do my best. I might not come in the forefront but I will definitely try and explore options for good lives for at least my daughters…"* The NGO staff at the community level were also trained in participatory techniques so as to equip them adequately in conducting PCA effectively.

Taking the community-driven approach forward, Alliance India has been facilitating the formation of support groups for PLHA and children affected by HIV/AIDS; CBOs for sex workers and men who have sex with men (MSMs); and integration of positive people in existing self help groups (SHGs). Such support groups have also been formed involving WLHA and other vulnerable women. These community based institutions are now engaged in spreading awareness on SRH and HIV/AIDS, including information on available and accessible services, and providing care, psycho-social and income generation support. With a sense of togetherness, this process has provided social security to the affected communities and has been vital in reducing stigma.

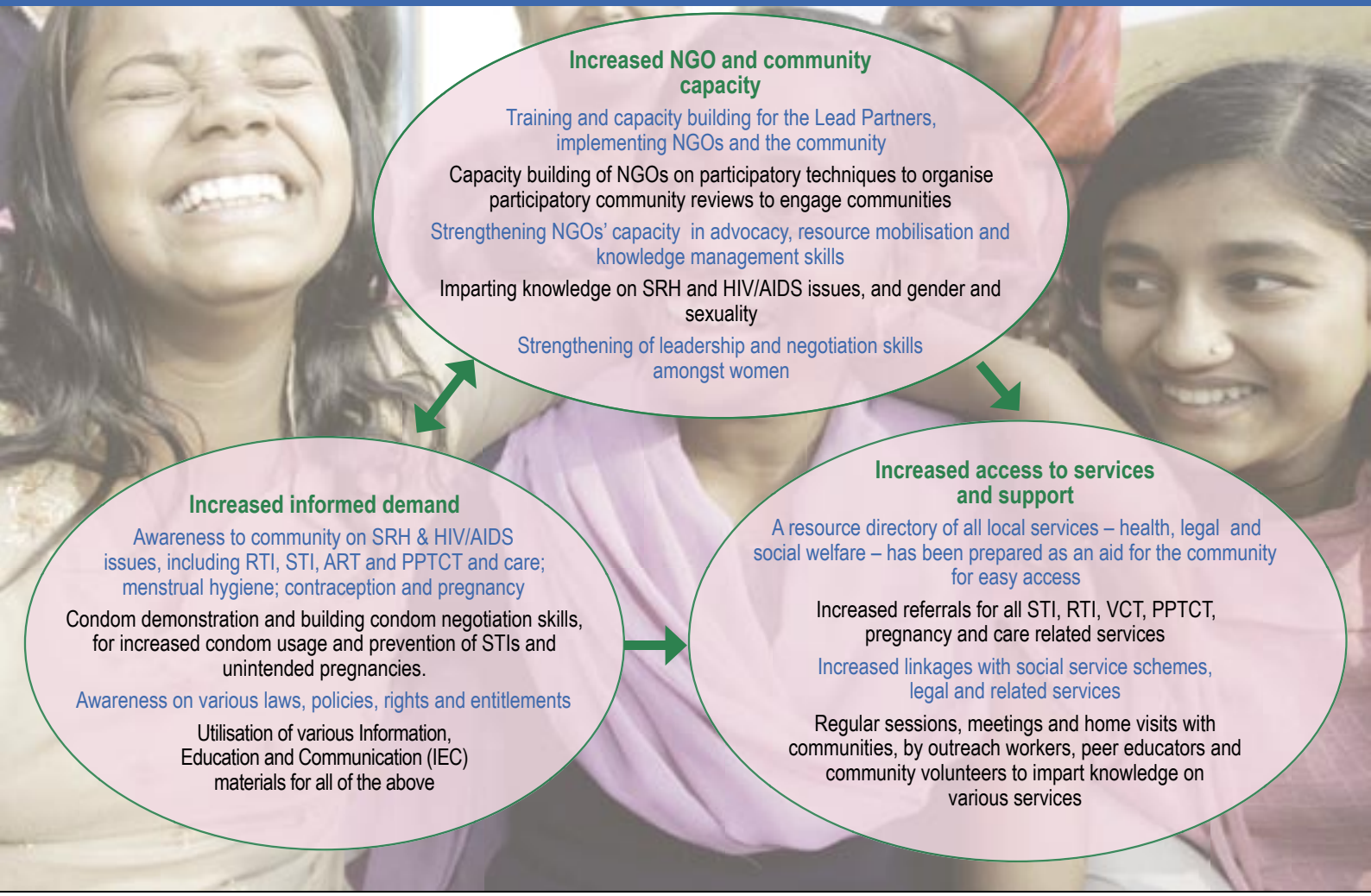
Alliance India has taken community involvement upto the stage of evaluation of its programme. Through the participatory evaluation technique of 'Most Significant Change', it has attempted to hear the voices of the communities in assessing the impact of its programme on SRH and HIV/AIDS integration. The impact has been gauged in terms of changes brought about in the lives of people, in the staff capacity in implementing the programme as well as the emerging needs of women.

## Addressing the Feminisation of HIV/AIDS in India

With the pressing need for integration of SRH and HIV/AIDS issues of women, Alliance India kept women's needs and rights as centric and brought in their active involvement. The programme has primarily reached out to women vulnerable to HIV/AIDS including WLHA within the low-income setting. Since, men's involvement and their partnership with women is crucial in promoting gender equity and enhancing health-seeking behaviour within families, some men have also been brought within the programme reach.

Through various activities, the community has been provided with information on issues related to SRH and HIV/AIDS. With increased awareness, women have been motivated to reduce the risk of transmission by demanding access to effective and adequate support services. The increased informed demand on the part of the community for more and accurate information and quality services related to health, legal and social welfare has created a ground for increased access to services and support. Women have been linked with SRH and HIV/AIDS services and various support mechanisms at the community level. Various trainings and capacity building activities have been undertaken with the implementing NGOs and communities. The increased NGO and community capacity through skill development and knowledge enhancement has helped them in contributing effectively to increase informed demand and increase their access to relevant services and support.

# KEY OUTPUTS






## Some Accomplishments

Alliance India and its partners share significant success in just over a year of implementing the programme for addressing the specific needs of women. The results demonstrate a significant change compared to the initial situation of women at the intervention sites, found through the KAP survey.

The programme interventions have contributed to considerable improvement in knowledge of RTIs: 94% women now know what an RTI is, with the corresponding number for men also showing an upward trend (67%). Amongst them, 91% women and 73% men are now aware that an RTI is curable. However, there remains a significant gap between men and women reiterating the need for more involvement of men in such programmes. In a similar trend, 91% women, as compared to 65% before the programme implementation, said that STI increases the chances of getting HIV.

During the baseline survey, it was found that although 95% of the population had heard about HIV, they had minimal knowledge on the modes of transmission. The end line survey revealed marked improvement in this knowledge: 96% of women said that there are methods to avoid transmission of HIV (against 86% women at the baseline). A considerable increase has been seen in the percentage of women having knowledge of preventing HIV by consistent and correct use of condom, from 70% before the programme initiation to 97% after it.

The programme, with its efforts on enhancing women's knowledge of various STIs/RTIs and HIV/AIDS as well as relevant rights and laws, contributed in increasing the percentage of women from 54% in the baseline survey to a noteworthy 74%, who agreed that women are justified to refuse to have sex with husband if he has an STI. Before the programme, 13% of women said that the decision of what contraceptive method to be used was mostly taken by the husband, whereas after the programme 71% women said that the decision is taken jointly with their husbands.

The use of contraceptives by WLHA for avoiding pregnancy increased to 51% by the end of project. Condom use amongst positive women has shown improvement: from 19% at the baseline to 22% at the endline. At the commencement of the programme, it was seen that the contraception methods undertaken by WLHA were limited to mainly sterilisation and condom usage. However, after providing them with information on varied methods through the programme implementation, the WLHA have now adopted different methods such as contraceptive pills, copper-T/ IUD, injectables, etc.

The endline survey revealed that there has been a tremendous increase in women having sufficient awareness on relevant laws, policies, rights and entitlements for PLHA and other vulnerable groups: 71% at the end of project as against only 6% at the baseline. Also, 57% of women had already received legal advice and/or support by the end of the project.

Since HIV is usually attached with stigma and people perceive it as the end of life, it was largely felt that a person living with HIV/AIDS by appearance always looks worn-out and unhealthy. Hence, the programme emphasised on community's sensitisation. As a result of sensitisation activities by Alliance India, 75% of women, before programme implementation, who said that a HIV positive person can also look healthy have increased to 86%. Also has been seen a tremendous increase in the percentage of women who have become members of Alliance India partners' facilitated support groups: from only 6% before the project to 89% at the end of the project. This improvement has ensured increased participation of women resulting in increased knowledge on and access to services related to SRH and HIV/AIDS, due to various information sharing activities undertaken amongst women within such groups.

### Empowerment with Information

Dhanalakshmi, 32, a resident of Kottampatti village in Madurai district of Tamil Nadu, lost her husband two years ago. Uneducated and unemployed, she was coerced by circumstances to resort to sex work to earn her livelihood. Dhanalakshmi never followed safe sex practices while engaging with her clients and, as a result, suffered from severe lower abdomen pain and heavy white discharge. PACHE Trust, an implementing partner of India HIV/AIDS Alliance in Tamil Nadu, came to her rescue and referred her to a nearby clinic for her STI treatment at an affordable cost. The clinic informed her about the ailment and remedies for STI and RTI; necessity of using safer sex practices to avoid these diseases; and basic facts about HIV/AIDS. An empowered Dhanalakshmi, since then, finds herself much enabled with improved health and a better negotiator with clients for practicing safe sex. She candidly informs, *"If they refuse to use condom, I also refuse to have sex with them. My fear of getting HIV/AIDS has also gone. Thanks to the PACHE team for providing me a new life".*

## Key Innovative Approaches

## *Support Groups: Catalyst for Social Change*

*"…now we have become the source of information, and this transfer of knowledge is actually a transfer of power"*, says a Community Social Volunteer. Participation of target population and local leadership, with their varied experiences, is crucial to the success of awareness initiatives, prevention, care and support (including treatment) and sustainability. They are rightfully equipped to identify underlying issues of vulnerability and offer relevant ways in dealing with the same as they themselves are affected. Through the formation of various support groups, Alliance India has been emphasising on building such social capital in the broader community and in particular, in engaging, empowering and mobilising the community through sharing of knowledge to advocate change at various levels.

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A support group is a group where members provide each other with various types of non-professional and non-material help for a particular shared issue. The help may take the form of providing relevant information, relating personal experiences, listening to each others' experiences, understanding others' problems, and establishing social networks. The group may also provide ancillary support, such as serving as a voice for the public or engaging in advocacy.[4] The formation of support groups for vulnerable women as well as WLHA, and facilitation of activities within them have been a key focus of Alliance India's programme on SRH and HIV/AIDS integration.

Apart from the much-needed psycho-social support that these women offer to each other within such groups, productive discussions are held and knowledge is shared. These pertain to condom negotiation with partners or clients, STI, RTI, HIV/AIDS, anti retroviral therapy (ART), prevention of parent to child transmission (PPTCT) and care, menstrual hygiene, contraception and pregnancy. They also share knowledge on relevant laws, policies and their rights and entitlements. The increased awareness and knowledge on SRH and HIV/AIDS

[4] Support Group Evaluation Report, Jan-Feb 2007, India HIV/AIDS Alliance

through such sessions have made the women sensitive towards their own issues and has had a positive impact on their health-seeking behaviour. As a result, many referrals have been made for STI/RTI and pregnancy-care related services for WLHA and/or vulnerable women. Many women have already accessed these services and have been linked to various social service schemes.

Findings from Alliance India's support group participatory evaluation have confirmed the positive effect of support group formation in the lives of the affected community. Many members of support groups for WLHA have said – *"We felt that the world has come to an end and we were constantly suffering from depression. The desire to commit suicide was very great. We have now learnt how to face life and also realise that we too have a right to live fully. We realised after being part of this group that our own personal problem was so small compared to what others were suffering".* It has been established as a significant strategy for involvement of the community in bringing about awareness and knowledge transfer. This empowers the individuals and the community, instilling in them the confidence to voice against the stigma and discrimination. The power that vulnerable women tend to attain through the knowledge and emotional support received from each other in their support groups helps them raise their status in the community. Such an empowerment makes them heard in the community and brings about awareness, including prevention. The vulnerable women, in turn, support the positive people and work towards their acceptance and mainstreaming in wider society.

## "Will Face Life Fearlessly"

I met Manorama, a peer educator from SASO (*Alliance India's State Partner in Manipur*), for the first time towards the end of March 2006. In that small group session she gave me psycho-social support, information on STI/RTI, safer sexual practices, and demonstrated the use of condom. I was then able to overcome all my concerns over my health and was able to meet people. I got the courage to live like other normal people. Being the wife of an IDU (*injecting drug user*), everyone used to look down upon me. I couldn't do anything except blame my husband for everything and bearing everything inside me with no one to share my problems. Once, after I shared my STI problems with my elder sister-in-laws, they wouldn't even collect my clothes which I left hanging outside to dry. They didn't want to be close to me, to share things together, have food from the same plate. Even my children were not spared. People won't say anything if a child from a well-to-do family has lots of skin infection but whenever one of my children had a slight fever they would say that my child must also be positive. Now I am aware. I also shared it with my family. They understood. Under Manorama's guidance, I received treatment and was partially relieved of a big burden. If I hadn't been part of this project, I would still have been in my earlier condition, living with all the fears and problems inside me, with no one to turn to for guidance and help. I have helped many women like me to come out and get proper treatment as I did. I met many positive people and I realised that it's not only me who is positive; there are many others like me and together we have lots of strength in us. I am proud of it.

As my husband is on ART (*anti-retroviral therapy*), now I am able to take proper care of him with the knowledge that I have gained. Now even the HIV virus is scared of me; it is inside my body as it does not have an outlet! I am ready to fight for anything…I have warned my in-laws that if they torture me in any way I will file a case against them; women also have lots of rights, I told them. Similarly, once when a woman told my daughter that being the child of infected parents she also must be infected, I asked her whether she had certificate to prove my child is infected, and that if she continues harassing her, I would file a case and seek compensation – something that she wouldn't be able to pay even after selling off her property!

My husband is very weak now. He is not able to do any kind of work. So I would like some kind of financial help. Even though the father was not a good person I want my children to become good when they grow up. But I have financial problem, I need money for it...

***… Thouchom Soni Devi, 36 years,***
***married with one son and two daughters;***
***from Kakwa Khongnang Pheidekpi, Imphal***

# Theatre Campaign

## *Building Awareness and Reducing Stigma*

The theatre, a participatory tool of edu-tainment, that is, education through entertainment, can effectively approach communities that are quite new to HIV/AIDS and related issues. Thus, Alliance India adopted theatre campaign as a potent means for building mass awareness on SRH and HIV/AIDS, for ensuring increased level of information and enhancing access to appropriate services. Theatre eased the connection with the community giving an easy inroad in view of the sensitivities attached to these issues. Alliance India took theatre, including a number of street plays and talking-doll shows, into the slums of Amritsar (Punjab) and Bhubaneswar (Orissa). It was successful to an extent in shattering some of the misconceptions and myths.

Through the ongoing stories in the street plays, necessary information on SRH, HIV/AIDS, testing and treatment

facilities in the area with contact details, drug abuse and its linkage with HIV/AIDS was communicated to the community. The plays, very significantly, conveyed messages about hope, empathy and support. Short feedback sessions with the community after each show helped in lively discussions with them on SRH and HIV/AIDS issues.

The theatre technique was also successful in increasing community participation as local people were trained to perform as part of the theatre groups. They were also trained on different aspects of the technique (script writing, talking-doll shows, etc.) for ensuring sustainability of the medium. The shows were constantly monitored for value addition. Rapid appraisals, training of NGO staff, and capacity building of outreach workers, peer educators and community volunteers on theatre techniques, were other components of the campaign. A post-campaign survey was conducted to understand the outreach and awareness level.

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# Community's Perception of Change

The key steps for any project cycle involve planning, implementation and monitoring & evaluation. Alliance India applied the technique of Most Significant Change (MSC), a qualitative participatory monitoring tool based on stories of important or significant changes, as the last step for the project cycle completion of its programme on convergence of SRH and HIV/AIDS. Community involvement was the essential element of this process. Community's participation in the evaluation of programme activities, as also in the planning and implementation, gave a correct picture of the impact of development work undertaken by Alliance India. Such an evaluation through MSC technique reiterated the significance of ensuring community's participation at every stage of project cycle including

## AT A GLANCE: Key MSC Findings

- The SRH & HIV/AIDS integration programme, in conjunction with Alliance India's other ongoing programmes, has significantly impacted the lives of people in the community. This has not only strengthened the existing groups further by awareness on SRH issues, legal rights, and linkages with healthcare providers, but also invoked wider community acceptance and influence. For instance, the Child Survival India, an implementing partner in Delhi, integrated the programme with its longer term programmes on women empowerment and adolescent girl's vocational skills training. Similarly, the Social Awareness Service Organisation, Alliance India's state partner in Manipur, placed this in areas of their ongoing Care and Support programme.
- The programme has been able to bring about notable changes in the target population's quality of lives. Quite prominently, it has given a massive boost to their level of confidence and has strengthened their voice against stigma and stereotypes attached to SRH and HIV/AIDS issues. They have now, to some extent, been able to overcome the fear of desertion by family and/or rejection by society. An optimistic approach towards life is an important change brought about.
- Involvement of men in the programme has been identified as one of the important prerequisites. The target population, that is, the women at risk, WLHA and adolescent girls spelt out stories of the ridicule and violence inflicted on them while attempting to challenge gender stereotypes and patriarchal norms. Thus, it was found that participation of men in such a programme is necessary to mitigate such resentment arising in families and communities.
- The staff capacity of the implementing NGOs, following various capacity building exercises on various issues alongside the programme, have shown a remarkable change. All the staff have shown a distinct transformation of their perspectives and mindsets. There has also been a notable rise in the awareness and confidence levels of the field staff and volunteers. Peer educators' role has been critical in increasing the programmes's sphere of influence and acceptance within communities.
- One year has been seen as too less a time period to gauge a qualitative impact of the programme. However, the programme's amalgamation with the other ongoing and longer term interventions of Alliance India's partners has been able to bring about noteworthy changes in communities.

the planning and designing of any programme.

Dynamic values inquiry is a central and critical part of MSC. When key stakeholders select stories of significant change, they participate in an ongoing process of deliberation about the value of individual outcomes. Designated groups of stakeholders continuously search for significant programme outcomes and then reflect on the value of these outcomes. This process contributes to both programme improvement and judgement. In the MSC process, the emphasis on storytelling makes it different from formal monitoring techniques.[5] In this process, the indicators, nature of information and its meaning are predefined. The participants, that is, the field staff and target population not only collect information but also evaluate it on the basis of their own perspective, understanding and experience. In this way, they are able to give a deeper thought to the nature and impact of their actions in the community. Such a process becomes a source for their empowerment.

## Community Elders Learn from Adolescents

When an aunt (*outreach worker*) from AIRTDS (*Alliance India's implementing partner in Andhra Pradesh*) first came to us and held a meeting, we, all children, attended it with the permission of our parents. We were informed that the meeting was in regard to adolescent care, personal hygiene, menstrual cycle and hygiene. I did not know how to take care of myself during menstruation and felt shy to discuss with my mother. Therefore, when the aunt called us for a meeting, I attended and learnt many things which we did not know earlier. I learnt not to throw the menstrual cloth away anywhere and to wash it carefully, dry it under the sun and keep it in a cover. I also learnt that this is very important as we are using this regularly during menstruation and that we need to change the cloth every three hours, maintain personal hygiene during menstruation and afterwards. We need to wash hands after going to toilet. We also came to know about HIV.

Once the aunt asked if I could participate in role plays. My friends and I agreed because I saw how an HIV infected person in my locality suffered as he was unaware of being HIV positive. I wanted to spread awareness on this issue to others. I was a very shy girl before, never went out of my house and hardly spoke to anybody. It occurred to me that information given by the aunt on HIV/AIDS was important and should be widely disseminated. I have shared all this with my friends. I always wondered why so many people are dying of HIV, but once aware, I believed that no one should die of HIV. Therefore, I, along with my friends, perform these role plays in many places to spread awareness. Many have appreciated our efforts. People say, *"We have come here to see these children perform. We are learning a lot from them, through these role plays, things which we did not know before…"*

This is an important change that has happened to my life. I am content that I have overcome my shyness and am doing my bit. I expect that the organisation should make me learn more stories for role plays. It would be better if we take these role plays to other villages apart from these six.

***…Vijaya Durga, from Kolakaluru, Andhra Pradesh***

# SRH and HIV/AIDS Integration: Charting a Future Course

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Alliance India's ground experience, while addressing the issue of feminisation of HIV/AIDS, says that it is not only the policy makers who feel that integration is effective to provide holistic services to PLHA and reaching out to general population, but the community feel the same. The women from the community have voiced that financial independence is critical for them to lead a confident, fearless, less stigmatised and empowered life. Various evidence-based studies as well as testimonies of several women reinforce this. Therefore, an integrated programming, which includes components such as vocational training, financial aid, market linkages, is critical to fight this epidemic.

The World Health Organisation's policy briefing on integrating SRH-care services highlights the need for a policy change at the national development planning level. The brief says that linkages and coordination with income-generating activities for women, community forestry projects, work-based social insurance schemes and other similar activities implemented by the various ministries of Indian Government outside the health sector, can serve as entry points to reach women along with health information, and as a means for increasing their capacity to have resources so as to access services which could improve their health as well as that of their families.

[5] Evaluation of Alliance India-DFID Challenge Fund Project on "Community-Driven Approaches to Address the Feminisation of HIV/AIDS in India" using the Most Significant Change Technique, February 2006, India HIV/AIDS Alliance.

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Since integration would also involve the services of the healthcare providers from both HIV/AIDS and SRH programmes, their adequate sensitisation and capacity building through a systematic intervention plan becomes indispensable for making them accountable to the community. Apart from building the capacities of healthcare professionals on technical areas, efforts should also be made towards their attitudinal change so as to provide quality care to women in need. Majority of HIV positive women in Alliance India's programme sites have mentioned that they have been facing stigma and discrimination while accessing healthcare services. They have also shared that the existing reproductive health programme within the government set-up does not cater fully to their needs. For instance, they are usually referred to HIV specific healthcare centres, which are often at a geographically distant location. This makes them reluctant to access services for long intervals of time; and many times they do not even access them. The integrated programme along with sensitised staff would thus contribute greatly in increasing women's access and ensuring quality health services.

Keeping in view the gender inequality and patriarchal set up in societies, which often obstructs women in accessing, on their own, health, social welfare and legal services, creating an enabling environment is the foremost need. Specific interventions should be designed in a way that friction created while challenging the dominant power structure and prevalent institutional norms, is mitigated. Many women from the community have suggested greater involvement of adolescent boys and men, community and religious leaders, and other so called powerful pillars in the community. As highlighted in the report, *"Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals"*, given the opportunities and support, men are interested and motivated to adopt more equitable and healthful alternatives. There is a need for community participation and enhancing cultural sensitivity. The local buy-in and investment in functional health systems and the mobilisation of support from the wider community has the ability to produce dramatic results. There is no denying that culturally sensitive approaches assess the role and power of different actors and look at how it is possible within these structures to affect policies, priorities and behaviour.

*"Giving information and knowledge not only to the affected groups but to the general community at large is vital. Reaching out not only to the newly married but also to girls to be married is important. Reaching out to those women who are not able to come out of their houses is important."* says Bala Devi from Manipur. Thus, it is clearly evident from the field experience that integration is necessary not only at the health system level to avoid duplication of activities, but also at the community level reaching out to every woman. This is an important step towards prevention of HIV transmission by individuals and reduction of stigma and discrimination.

Vijayrani, on being asked for recommendations for the project, said, *"I feel that this type of education on sexual and reproductive health should reach all men and women, because in a male dominated society like our villages, women are totally deprived of knowledge like this. If such kind of information is provided, we will be benefited; women will improve their health seeking behaviours, and men will understand the value of women."*

The component of income generation incorporated in Alliance India's SRH and HIV/AIDS integration programme, added a new dimension to the lives of women. The financial independence gained through this, enhanced their self-esteem and confidence. In the words of Pramo Devi, 34, a mother of three children in Manipur, *"Through the IGP, I am able to earn and maintain my family. This financial independence is important for me as I no longer am dependent on my in-laws. I can now voice my feelings openly. I am also able to support my husband's expenses. I am not afraid of facing anyone now."*

# Our Publications

**Flipbook on Basics of SRH & HIV/AIDS:** Covers information related to SRH and HIV/AIDS to help outreach workers and other health educators to enable discussion with women's groups on the same.

**Flipbook on SRH Needs of Women Living with HIV/AIDS:** It will address the specific SRH needs of women living with HIV/AIDS for improving their SRH, treating HIV and preventing new infections. It covers information on all dimensions – family planning, pregnancy, antenatal and post natal healthcare requirements, child birth, breast feeding, use of contraception, exposure to, diagnosis and treatment of STIs, etc.

**All Together Now! Community Mobilisation for HIV/AIDS:** Through a process of starting together; assessing & planning together; acting together; monitoring, evaluating and reflecting together; and scaling up together; the toolkit will help NGOs in mobilising communities for HIV/AIDS prevention, care, support, and treatment and impact mitigation.


**Tools Together Now! 100 Participatory Tools to Mobilise Communities for HIV/AIDS :** It provides a selection of 100 Participatory Learning and Action (PLA) tools that will help organisations and community groups to learn together about HIV/AIDS in their community, develop a plan, act on it and evaluate and reflect on how it went. This toolkit is designed to help put 'All Together Now! Community Mobilisation for HIV/AIDS', into practice. Used together, these two resources will provide a powerful way for organisations and communities to work more effectively together to address HIV/AIDS.

**Advocacy in Action - A toolkit to support NGOs and CBOs responding to HIV/AIDS:** It sets out to build practical skills and provide a training resource to support NGOs and CBOs to carry out advocacy activities.

**NGO Capacity Analysis - A toolkit for assessing and building capacities for high quality responses to HIV/AIDS:** It will help organisations to identify their capacity-building needs, plan technical support interventions, and monitor and evaluate the impact of capacity building.

For referring to other publications/documents of Alliance India, its partners as well as other organisations working on similar issues in India, please visit: **SETU – the India-specific virtual resource centre** of Alliance India at: **www.aidsallianceindia.net**

# The Alliance in India

The **Vision** of the International HIV/AIDS Alliance is of a world in which people do not die of AIDS.

For us this means a world in which all human rights are respected: a world where every person can live with dignity, regardless of their gender, religion, class, race, ethnicity or sexual orientation; and where communities have brought HIV and AIDS under control through promoting and facilitating access to affordable and appropriate prevention, care, support and treatment information and services.

**The International HIV/AIDS Alliance** was established in 1993 with a Secretariat in Brighton, UK, the International HIV/AIDS Alliance is a global partnership of people, organisations and communities working towards a shared vision that supports effective and integrated community responses to HIV and AIDS. This approach is based on the belief that those at the frontline of the struggle against HIV and AIDS must have the resources to take on the challenges that the epidemic presents. **The India HIV/AIDS Alliance** was established in 1999 to expand and intensify the International HIV/AIDS Alliance's global strategy of supporting community action to reduce the spread of HIV and mitigate the impact of AIDS. Since its inception, the Alliance has been committed to fostering and supporting the development of community-driven approaches to HIV/AIDS prevention, care and support and impact mitigation in India, with an emphasis on local leadership and responsibility.

Alliance India currently provides programmatic, technical, strategic, organisational development and financial support to a country-wide network of over 110 NGOs through a National Secretariat based in Delhi and six linking organisations (or, Lead Partners) and state partner organisations in Delhi, Tamil Nadu, Andhra Pradesh, Manipur, Punjab and Orissa. Alliance India is currently undertaking the Home and Community-Based Care and Support programme; Focused Prevention programme; and Sexual and Reproductive Health and HIV/AIDS Integration programme. Through these programmes, Alliance India and its partner NGOs are reaching out to people living with HIV/AIDS, children living and/or affected by HIV/AIDS, sex workers, injecting drug users and, men who have sex with men.

The India HIV/AIDS Alliance NGO Partners in its SRH and HIV/AIDS Integration Programme:

**Delhi**
Child Survival India
Salaam Baalak Trust

**Andhra Pradesh**
LEPRA Society
Vasavya Mahila Mandali
Action for Integrated Rural and Tribal Development Society
Green Vision
Mahila Mandali
Shadows

**Tamil Nadu**
Palmyrah Workers Development Society
Association for Integrated Rural Development,
Community Action for Social Transformation
Native Medicare Charitable Trust
Imayam Social Welfare Association
PACHE Trust
Society for Serving Humanity

**Manipur**
Social Awareness Service Organisation
Sneha Bhawan
Manipur Voluntary Health Association

**Punjab**
All India Women's Conference

**Orissa**
LEPRA Society

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This publication was made possible through the support of Department for International Development (DFID). The opinions expressed herein do not necessarily reflect the views of this donor.

DFID Department for International Development