Stories of Significance: Redefining Change
An assortment of community voices and articulations

A report based on an evaluation of a programme on “Community Driven Approaches to Address the Feminisation of HIV/AIDS in India” by means of the ‘Most Significant Change’ Technique
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The India HIV/AIDS Alliance (Alliance India) 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 70 NGOs through a national Secretariat based in Delhi and six linking organisations (or, Lead Partners) and state partner organisations working in Delhi, Tamil Nadu, Andhra Pradesh, Manipur, Punjab and Orissa States.

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**Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronyms</td>
<td>5</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>6</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>8</td>
</tr>
<tr>
<td>2. The Most Significant Change (MSC) Technique</td>
<td>10</td>
</tr>
<tr>
<td><strong>MSC complements other M&amp;E methods and looks for the unexpected</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>MSC builds teams and encourages use of a diversity of views</strong></td>
<td>10</td>
</tr>
<tr>
<td><strong>MSC empowers and encourages reflection</strong></td>
<td>11</td>
</tr>
<tr>
<td><strong>MSC contextualises action or event</strong></td>
<td>11</td>
</tr>
<tr>
<td>3. Using MSC to Evaluate the Programme</td>
<td>12</td>
</tr>
<tr>
<td><strong>Process of using MSC in Alliance India</strong></td>
<td>12</td>
</tr>
<tr>
<td>4. Findings</td>
<td>15</td>
</tr>
<tr>
<td><strong>Domain: Changes in the quality of people’s lives</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>Domain: Changes in levels of people’s participation in the project</strong></td>
<td>19</td>
</tr>
<tr>
<td><strong>Domain: Changes in levels of support group influence on its members</strong></td>
<td>21</td>
</tr>
<tr>
<td><strong>Domain: Changes in people’s behaviour</strong></td>
<td>26</td>
</tr>
<tr>
<td><strong>Domain: Changes in staff capacity</strong></td>
<td>27</td>
</tr>
<tr>
<td>5. Reflections on Using MSC as an Evaluation Tool</td>
<td>30</td>
</tr>
<tr>
<td>6. Conclusions</td>
<td>32</td>
</tr>
<tr>
<td>7. Annex 1</td>
<td>33</td>
</tr>
<tr>
<td>Acronyms</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti Retroviral</td>
</tr>
<tr>
<td>DFID</td>
<td>UK’s Department for International Development</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>IGP</td>
<td>Income Generation Programmes</td>
</tr>
<tr>
<td>iNGOs</td>
<td>Implementing NGOs</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MSC</td>
<td>Most Significant Changes</td>
</tr>
<tr>
<td>ORW</td>
<td>Outreach Workers</td>
</tr>
<tr>
<td>PLHA</td>
<td>People Living With HIV/AIDS</td>
</tr>
<tr>
<td>PMO</td>
<td>Programme Management Office</td>
</tr>
<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission</td>
</tr>
<tr>
<td>RCH</td>
<td>Reproductive and Child Health</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
</tbody>
</table>
Executive Summary

This report provides an analysis of the experience of using the ‘Most Significant Change’ (MSC) technique to evaluate the project on “Community Driven Approaches to Address the Feminisation of HIV/AIDS in India.” The project is an initiative of the India HIV/AIDS Alliance (Alliance India) and is supported by the DFID Challenge Fund. This pilot project started in February 2006, and is being implemented in six states, including Punjab, Delhi, Tamil Nadu, Andhra Pradesh, Orissa and Manipur. The evaluation was done over a period of one month from 9th January till 3rd February, 2007.

The key findings of the evaluation are:

- The project has achieved significant impacts on people’s lives where it was implemented in conjunction with other ongoing programmes of the implementing organisation. For instance, Child Survival India (CSI) integrated the project with its longer term programmes on women empowerment and adolescent girls’ vocational skills training. Similarly, Social Awareness Service Organisation placed this project in those areas where their Care and Support programme with Injecting Drug Users (IDUs) were ongoing. Most of their ‘target population’, therefore, were wives of current IDUs or ex-IDUs. As a result, not only were the existing groups further strengthened by awareness on sexual and reproductive health issues, legal rights, and linkages with health care providers, but there was wider community acceptance and influence, as was seen in Delhi. In Manipur, this led to the affected women getting the much needed psychological support, awareness and opportunities for earning an income.

- Four out of the six Implementing NGOs (INGOs) chose a domain on ‘changes in quality of people’s lives’. The changes reported in this domain included, increased levels of confidence among target population to challenge stereotypes and stigma; enhanced ability to overcome fear of being deserted by family; and a more positive outlook towards life.

- Through stories it came out that total involvement of men in projects is very much important to mitigate tensions arising when power structures and institutional norms are challenged.
• Almost all stories from the different domains reveal the critical and significant role played by peer educators in increasing the project’s sphere of influence and acceptance within communities.
• One year is too less to gauge qualitative impact of a pilot project; however, it is evident that organisations who have placed this project with their earlier ongoing, longer term interventions, have shown significant changes in communities challenging social and cultural norms.
• Many stories in the document clearly reiterate the need for a longer term intervention plan especially on issues related to sexuality, gender and altering existing power equations. Moreover the use of this technique has clearly highlighted that enough efforts need to be invested in mobilising the whole community and not just the key population while pursuing such programmes. This will result in gaining the confidence of the entire community and provide enabling environment to women including adolescent girls.
The feminisation of HIV/AIDS is linked to a multifarious and compelling set of interactions among several disadvantages that are epidemiological, biological, socio-cultural, economic and political in nature. It is widely acknowledged that rates of HIV infection are increasing in women in every region in the world, and that these rates are often higher for girls and women than for men. Women, especially young women and girls, are vulnerable because of denial and neglect of their rights, gender inequality, social, cultural and economic factors, pervasive violence, and biology.

New research suggests that women's vulnerability begins at the earliest stages of development. Thus, for adolescent girls, the picture is even bleaker. Anatomically more vulnerable to contracting sexually transmitted infections than older women, girls also experience relatively greater difficulties negotiating safer sex practices with partners. This lack of economic and social power means that women often cannot control sexual encounters or insist on protective measures such as abstinence, mutual monogamy and condom use. Rates of new infection for women now exceed men's by up to five times in some countries.

For these reasons, creating informed demand for information and services amongst women, their families and their communities (including healthcare providers) in order to reduce stigma and discrimination and contribute to creating an enabling environment was a key activity of this pilot project on “Community Driven Approaches to address the Feminisation of HIV/AIDS in India.”

Given these dimensions, evaluating impact of such a project, using the Most Significant Change technology, was a challenging proposition. Challenging because it raised few pertinent issues:

a) What do you mean by impact in a project with a life cycle of one year? How do you evaluate impact of a project life cycle of less than a year?

b) How can you train teams in less than a day on effective facilitation and documentation so that they are able to collect significant change stories with requisite and relevant details?

c) How do you train teams with little or no prior experience in analysing data?

The existing M&E framework of the project has emphasis on quantity to gauge the measurable difference the project has made; this emphasis on results may not contribute towards insights into impact.

So the evaluation was undertaken with the following purposes:

a) To gauge the unintended outcomes and impact the project may have had on the lives of the target population; and

b) To reflect on and learn from the results.
However, it was made clear, that Most Significant Changes (MSC) should not be the sole technique for producing conclusive opinion on the overall success of a project. This evaluative exercise should be seen as complementing the other methods Alliance India would use for a final evaluation of the project. It was understood that stories could be a rich source of hypotheses about how things work in programmes.

There is growing recognition of the need to take a multi-stakeholder approach to evaluation, which promotes local ownership and builds capacity for reflection, learning, improved performance and ultimately self determination. As a story based technique, the MSC approach helps to identify and lends value to changes that were unintended or unexpected but were nevertheless significant impacts for those involved.
Most Significant Change (MSC) is a participatory monitoring technique based on stories of important or significant changes – they give a rich picture of the impact of development work. MSC can be better understood through a metaphor – of a newspaper, which picks out the most interesting or significant story from the wide range of events and background details that it could draw on.

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. Rick Davies, the creator of MSC, reiterates how the emphasis on storytelling makes MSC different to formal monitoring techniques. Instead of introducing new professional skills, MSC takes advantage of everyday communication practices. “Every language has an expression for ‘What’s new?’” says Rick.

MSC complements other M&E methods and looks for the unexpected

MSC doesn’t replace other methods of monitoring and evaluation. In fact, it complements and works well in conjunction with other methods. MSC is best used to understand the unexpected outcomes as it is not based on indicators. Conventional quantitative monitoring of predetermined indicators only tells us about what we want to know and think we need to know. It does not drive us to explore beyond what is obvious – the indefinable, subtle and indirect consequences of our work. By getting this information on a regular basis, and taking time to reflect on what this means, organisations can adjust and modify their direction of effort so that they achieve more of the outcomes they value.

It emphasises story-telling as a form of participatory monitoring, unique in its ability to capture direct views of beneficiaries, including unexpected and evolving outcomes. It is also unique in presenting a methodical, systematic way of collecting and analysing individual stories and selecting the most compelling.

MSC builds teams and encourages use of a diversity of views

In many organisations, there are designated personnel involved in information collection, analysis and dissemination. Indicators are often identified by senior

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1 Dart, J. J. & Davies R.J, A Dialogical story based evaluation tool: Most Significant Change technique, America Journal of Evaluation
staff or the M&E specialist. In contrast, MSC gives those closest to the events being monitored (e.g. the field staff and participant communities) the right to identify a variety of stories that they think are relevant and important. These are then summarised by selection when other participants choose the most significant of all the stories reported. By valuing diversity of views, it gives an opportunity for organisations to decide what direction it wants to go and how. This enables having a more shared vision.

**MSC empowers and encourages reflection**

With predefined indicators, the nature of information and its meaning is largely defined from the beginning. With MSC, participants are encouraged to use their own best judgement in identifying stories and selecting stories collected by others. This involves the use of open-ended questions such as: "From your point of view, what was the most significant change that took place concerning the quality of people's lives?" This freedom empowers participants involved in the process to think and analyse deeper the nature and impact of their actions – field staff and target population do not only collect information (or give information), they also evaluate that information according to their own perspective, understanding and experience.

**MSC contextualises action or event**

MSC makes use of what has been called 'thick description': detailed accounts of events placed in their local context. Each MSC story has the storyteller’s interpretations of what is significant. This also enables a changing focus on what is relevant and important as the MSC process is dynamic and is responsive to the context in which it is used. Participants choose what to report within specified domains.

**In addition to its monitoring and evaluation functions, MSC can also help in**

- Fostering a more shared vision;
- Building staff capacity in monitoring and evaluation;
- Providing material for publicity and communications;
- Providing material for training staff; and
- Celebrating success.
Using MSC to Evaluate the Programme

Expected project outputs

- **Increased informed demand**
  Increasing awareness and knowledge of HIV/AIDS and SRH to reduce stigma and discrimination and to create demand for accurate information and quality services (health, legal and social services).

- **Increased access to services and support**
  Increasing linkages between women project beneficiaries and HIV/AIDS and SRH service delivery and support mechanism at the community level.

- **Increased NGO and community capacity**
  Increasing skills and knowledge of partner NGOs, women project beneficiaries and their communities to undertake project activities and contribute to increasing informed demand and increasing access to relevant services and support.

Alliance India (AI), with offices in New Delhi and Hyderabad has been facilitating the intervention on home and community based care, support and focused prevention programme since last four years, through a comprehensive programme of NGO support and capacity building. They provide technical, programmatic and financial support to four Lead Partner organisations and 70 implementing NGOs in the states of Delhi, Punjab, Andhra Pradesh, Tamil Nadu and Manipur. In 2006, with a grant from the DFID Challenge Fund, Alliance India started a project on “Community Driven approaches to address the feminisation of HIV/AIDS in India” with 19 partner NGOs, in 17 districts, across six states in India. The project is working towards strengthening and developing community centred approaches to meet the sexual and reproductive health and HIV/AIDS related needs of women in low-income settings.

Process of using MSC in Alliance India

**Step 1: Site selection**

In consultation with Alliance India staff, lead partners and iNGOs, the following sites were identified for evaluation:

<table>
<thead>
<tr>
<th>State</th>
<th>Organisation</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amritsar</td>
<td>All India Women’s Conference</td>
<td>2 colonies in Amritsar city</td>
</tr>
<tr>
<td>Delhi</td>
<td>Child Survival India</td>
<td>Narela</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>LEPRA SOCIETY</td>
<td>Puranapul, Hyderabad city</td>
</tr>
<tr>
<td></td>
<td>AIRTDS</td>
<td>Guntur (6 villages)</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>PACHE Trust</td>
<td>Madurai (2 villages)</td>
</tr>
<tr>
<td>Manipur</td>
<td>SASO</td>
<td>Imphal (3 Clusters)</td>
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**Step 2: Orientation and selection of domains**

Three days were spent with each iNGO. The first day was spent orienting and training iNGOs on MSC and establishing domains of change, and the next two days on story collection and selection.

Domains of change are loose categories of change used to distinguish different types of stories. Davies (1996) suggests that unlike performance indicators, the
domains of change are not precisely defined but are left deliberately fuzzy; and it was initially up to field staff to interpret what they felt was a change belonging to any one of these categories.

Each iNGO defined their own domains of change after lengthy discussions. Only in Amritsar, the domains of change were not predetermined. Each iNGO defined their own domains of change after lengthy discussions. Only in Amritsar, the domains of change were not predetermined.\textsuperscript{3} Domains were selected based on the kind of changes iNGOs wanted to measure. This was largely influenced by the project objectives and activities. The domains of change chosen for evaluation were: changes in quality of peoples’ lives, changes in levels of people’s participation, changes in support group’s level of influence on its members, changes in people’s behaviour, and changes in staff capacity.

**Step 3: Story collection, review and selection**

Field staff from partner organisations collected stories from target population by asking the most significant change that occurred in that particular domain during the project cycle as a result of the project, emphasising what it was that made that change so significant. An interview guide (Annex 1) was prepared to collect significant change stories. Stories were collected through individual interviews, group discussions and field staff writing from their experience.

The third day in each site was spent in reviewing the stories. Project staff and project volunteers reviewed the stories in each domain and selected one most significant story within each domain, including the rationale behind their selection.

\textsuperscript{3} Amritsar team is fairly new, in terms of work experience; hence, it was decided to collect stories without specifying any domain.
Only in Delhi, Madurai, Manipur and at Alliance India, the criteria for selecting stories were established prior to selecting the MSC story. In other sites, no predetermined criteria were defined at the outset – these emerged during the selection process through lengthy discussions on what constitutes the MSC. It was seen that having a set of criteria prior to selecting the MSC story in each domain, hastens the selection process and makes it more focused. Where criteria were not established, the selection process was longer and more exhaustive.

Except in Amritsar, in all other places, the stories were selected using a facilitated process. The titles of the stories were written on flip charts under the respective domains. When all the stories had been read out, all the stories within one domain were considered. The facilitator asked a series of questions to prompt discussion before moving on to a vote by show of hands. When the vote was done, if there was no consensus, then further discussion was facilitated until an agreement had been reached as to which story should be selected. In AIRTDS, Guntur in one domain no agreement could be reached, therefore two stories were selected for review at the final level of selection. As well as selecting a story, the selectors were also asked to state why the story had been selected above the others. Much of the discussion revolved around explanations of why they thought one story was particularly valuable or particularly misleading.

**Step 4: Final selection at Alliance India**

A second and final level of selection happened at Alliance India headquarters in Delhi. Three staff constituted the selectors panel. The MSC story selected by iNGOs in a particular domain was considered for final selection. A facilitated selection process (described above) was used to select the most significant change story in the following domains only as these were common between iNGOs:

- Changes in quality of people’s lives
- Changes in people’s participation in project
- Changes in group’s influence on its members
- Changes in staff capacity
Findings

In this section there is an overview of the findings from using MSC to evaluate the project. Within the section there is an analysis of the specific findings from each domain.

Domain: Changes in the quality of peoples lives

All iNGOs, except CSI and PACHE Trust chose this domain. A total of 51 stories were collected: 23 from AIWC, three from LEPRA, 14 from AIRTDS, and 11 from SASO. At the final selection level at Alliance India, 4 MSC stories – one each from each iNGO – were reviewed.

At the final level of selection at Alliance India, the selectors drew up the following criteria for selecting one MSC story in this domain:

Organisational capacity to deliver: (two of the three selectors did not agree with this criteria as they thought this was for the domain on staff capacity. However, the selector who proposed the criteria defended it by saying that the changes at the community level are not happening in isolation – they are reflective of the organisational capacity and commitment to deliver. After a lot of discussion, there was a consensus on retaining this point).

Increased self esteem of individual/community and is reflected in evidence based action

Responsive service delivery by health care providers

There was no consensus at Alliance India on selecting one MSC story out of the four stories. One selector had selected STORY 2 and two had selected STORY 1 – appended below in boxes.

The reason cited by the one selector for choosing STORY 2 was that, in ten months, for a very new team like the Amritsar team, who did not have prior experience of working in the development sector, to have achieved what they have is significant. To this, the other two selectors responded that in Amritsar the project was based at the communities where AIWC were already working on Reproductive and Child Health. Moreover, for a woman to live in Manipur, an area with its multiple problems – social, economic and political – and to fight for her rights, including dominant societal norms and stigma, is significant. In the Amritsar story, it is not clear how the quality of life of the story teller has changed significantly. The fact that she is aware of the services and seeking them does not merit significance if compared with the Manipur case. Moreover, for a person to experience stigma and ostracism and have the courage to challenge and fight is in itself impressive.

The discussion remained inconclusive as no consensus could be arrived at by the selectors.
Story 1

“Will face life fearlessly”

Name : Thouchom Soni Devi, 36 years, married with one son and two daughters

Location : Kakwa Khongnang Pheidekpi, Imphal

Recorder : Kheroda, Peer Volunteer, SASO

I met a peer educator from SASO for the first time towards end of March 2006. In that small group session she gave me the information on STI/RTI, safer sexual practices, and demonstrated the use of condoms. She also gave me psycho-social support. After joining this project I was able to overcome all my fears over my health condition and able to meet people. I got the courage to live like other normal people. Being the wife of an IDU, everyone used to look down on me before. 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 sisters-in-law, 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, having 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 has 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. After meeting Manorama (a peer educator with SASO) there has been lots of changes in me. I was not able to share my STI problems with anyone. But, since becoming aware, I got my self treated under her guidance. Being able to come out and getting treated is almost like a big burden being lifted from my head. 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 me alone who is positive - there are many others like me and that together we have lots of strength in us. I am proud of it.

As my husband is on ART 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 told my mother-in-law that if they don’t want me to live with them, then I would go leaving behind my children to be looked after by them, as they belong to their son too. I also told her that when I came to their house I came alone. I have warned them that if they torture me in any way I’ll file a case against them. Women also have lots of rights, I told her.

One day a woman told my daughter that being the child of infected parents she also must be infected. I went to that woman immediately and confronted her. I asked her whether she had certificate to prove my child is infected. I warned her that if she continues harassing her, I would file for a case and seek compensation, which 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. If I have to borrow from others then I’ll have to pay an interest of 10%. But if a well to do person wants to borrow money he would get it at 3% interest.

Selection process

There were eight selectors, including the Project Officer, the Outreach Worker, and six peer educators and peer volunteers. Four people selected this story. The other four selected two other stories. But at the end, after a lot of discussion, the group established criteria for MSC and selected this story.

Reasons for selecting this story (at SASO level):

1. Project gave her the confidence to get tested and seek treatment.
2. She is empowered with the knowledge – not scared of facing any criticism or stigma from others. She confidently fights for her rights and self respect and that of her family.
3. She is educating others in the community.
Story 2
“My life has changed”

**Storyteller:** Pushpa

**Recorder:** Trita, Outreach Worker

**Location:** Gujarati Mohalla, Amritsar

**Date:** 10th January 2007

I have been involved in this project since the last 5-6 months. The outreach worker had come to my house to give condoms. She told me about the usefulness of a condom and the way I can protect myself from infections. When I heard this, I told her that my husband is always sick and he is HIV positive. I decided to be part of this project.

I am also HIV positive. My husband was unable to work and his business doomed. The medicines are very costly. We were having difficulty buying the medicines regularly. But now that I am part of this project, our treatment is free. In fact I went for my tests after becoming aware through this project. I have been tested positive. But the doctor has assured me that I may become ok by taking the medicines regularly.

Moreover, through this project, I learnt that the HIV test can be done in the medical college and that the Guru Nanak hospital conducts the CD4 count test. Earlier I was not aware of all this.

The most significant change that I have experienced is that my husband’s life has got a new lease. He had become depressed worrying about his poor health. He was always worried that he would die soon. The project helped him regain his confidence to an extent. His health has improved. He has also started working again.

I recommend that this project continues so that many more people would become aware like me. They would know where the services for testing and treatment are available. They would become aware of many issues of which they have no knowledge about now. Like me, their lives would improve too.

**Reasons for selecting (at AIWC):**

1. The project helped her husband regain his confidence. She and her husband are optimistic again
2. She is aware of ARVT, CD4 and HIV
3. She is in regular touch with AIWC
4. She did not hide her positive status
5. The couple, unlike others, do not curse each other for being HIV positive
6. She made a strong recommendation

The significant findings in the domain are:

All stories show participants had increased levels of awareness and knowledge on SRH, including PPTCT, HIV/AIDS, STIs and RTIs, menstruation, personal hygiene, legal rights and family planning methods. *This intervention is implemented here to prevent PTCT, inform about food practices during pregnancy. We have also been told about the impact of stigma on PLHA and have learnt to show affection and support to PLHA. We have also been told about HIV test for pregnant women, post natal care and use of pills for birth control. We have to use these tablets from the fifth day of menstruation cycle*, says Vamathi from Kolaloluru in Guntur.

Not only this, these women are also sharing this information with others in the community who are not directly part of the project. Like Reeta Rani from Dashmesh Nagar, Amritsar says, “Once after attending a group meeting, a woman told me that her husband died of AIDS. I advised her to get herself tested at the Guru Nanak Hospital. After listening to me she went there. Her test showed that she, too, was HIV positive.” In fact, all the 28 stories from Amritsar show that people are aware of HIV/AIDS, STIs and where the different health care services are available.
This increased level of awareness is reflected in women identifying the symptoms of STIs and RTIs. However, the shame and stigma attached to any STI is still so strong that women are unable to talk about it freely and seek treatment. As Urmila from Ghas Mandi, Amritsar says, “Whenever you (meaning the Outreach Worker) came to our locality and spoke about these issues, I used to listen. But I never shared my problems with you or anyone else. But today when you are asking me, let me tell you about my problems – I have some STIs. My whole body always wrecks with pain. I have lost all appetite for food. There is copious discharge from my vagina. I am so ashamed to tell this to anyone.”

Manemma, a mother of two daughters from Hyderabad says, “Now silent Manemma is talkative, interacting with others, gives suggestions on women’s health. Because of this programme, I learned women’s health issues, and have become outspoken. In spite of being uneducated and illiterate, I learnt such a lot.” Evidently, this is significant change for Manemma and numerous other women like her – significant because they have realised how much for granted they were taking themselves and their bodies.

The testimonies of the women from Manipur tell a different story. They show that the project has had significant impact on the lives of the participants by liberating them from their fears. Twenty-eight years old Ibethoi from Manipur categorically says, “Before this I was leading a miserable life – anxious about not knowing whether I got the infection from my husband and fearful of being ostracised by my family and community. Being the wife of an IDU, people were scared of giving me even a glass of water! My family did not want us to eat with them or use the common toilet. They were all afraid of us. People had branded us as having AIDS and used to tell others not to enter our house. My husband was so deeply addicted that he would not listen to me – he could not comprehend what I was trying to tell him. I bore all this silently, crying each day. But since I got tested and have been found non-reactive, the attitude of my family and others has been gradually changing. But important to me is that I am no longer scared. Meeting other women, I know I am not alone. There are many others like me.”

W. Sushila, a 38 years old mother of four children from Imphal further reiterates, “Since I have been part of this project, I have started thinking positively. With the help of Manorama (peer educator), I have sought treatment for the STIs I was suffering from. Earlier it was unbearable for me to see my children and me getting labelled and ostracised because my husband was using heroine. But now with the organisation’s help, he has been able to give up his addiction. He is a changed man. Earlier he used to get up at 10 a.m. But now he wakes up by 6 a.m. and helps with the children’s studies. He has started taking interest in them. He shares with me what he learns at the meetings he attends. Though he is not able to earn, he helps me a lot psychologically.”

All the eleven stories from Manipur reveal how coming together into support groups have been therapeutic for the women whose spouses are IDUs. The psychological support has been beneficial. They have found a release from their isolation, shame, fear and the stigma they experience everyday. Many of the women are HIV positive themselves, a fact they came to know after they got tested with SASO’s help. As 35 years old Sushila, a mother of a son and a daughter says, “The attitude of my
family members towards me and my son depressed me. Since they came to know that we have been tested positive, they have stopped sharing things with us. Now I don’t talk with them since they have labelled us as having AIDS. Joining this group has given me peace of mind. Now I am on ART and living with the hope that a curable medicine will soon be discovered.”

Widowed and depressed, 39 years old Bala Devi said she contemplated killing herself because of the burden of looking after a family as a single mother, and because of the fear of rejection by her community. But since she became part of the project, her outlook towards life changed: “The knowledge that I got from here has helped me not to be afraid of society. The services, but more importantly the psychological support, which the project offers has changed my life significantly. Now I also motivate other positive women like me to come out in the open, seek treatment and lead a better life.”

The stories from Manipur also show an increased level of confidence in the women, which has impacted their quality of life. As Sushila puts it, “Most of the time I don’t have any physical relationship with my husband. When he insists, I do it using a condom. Initially he refused. But I made it very clear to him that if he wanted to have sex with me, then he has to use condom because I don’t want any more of his virus entering me and increasing my viral load. I believe that as long as I am on ART and restricting the virus from my husband entering me, I will live and be fine.”

The fact that the project in Manipur also added an income generation component has been of immense value to the women – the financial independence further enhanced their self-confidence and self-esteem. The income generation programme (IGP) have helped these women, who are all wives of IDUs learn a skill and earn a stable income. Pramo Devi, a 34 years old mother of three children says, “Through the IGP, I am able to earn and maintain my family. This financial independence is important for me as I am no longer 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. My husband continues to use heroine, unfortunately.”

**Domain: Changes in levels of people’s participation in the project**

Only two iNGOs, AIRTDS and LEPR, Hyderabad chose this domain. AIRTDS collected 14 and LEPR collected four stories in this domain. At the final selection level at Alliance India, three stories were reviewed – one MSC story from LEPR and two from AIRTDS (since there was no consensus reached on one MSC story at AIRTDS level, it was decided to take both the stories for the final selection level).

Out of the three stories reviewed at the final selection level, there was a consensus on the story from Guntur, titled, ‘From alfa to omega’. This story showed that after attending the different sessions on SRH, the adolescent girl changed some of her practices – her menstrual hygiene improved. The story also reflected her high level of motivation to spread awareness. As part of the theatre troupe, she was playing her part in spreading awareness and information amongst the larger population.

In comparison, the other two stories were not clear at all – there was nothing about how peoples’ level of participation has changed, or what happened to them after participating in the project.

“Through the IGP, I am able to earn and maintain my family. This financial independence is important for me as I am no longer 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. My husband continues to use heroine, unfortunately.”
Experiences from the world over have shown, time and again, the value of community ownership and participation. Sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication. There are enough examples around the world to show that when communities have been made the agents of their own change, the impact has been beyond expectation. Again the same examples also show that projects or programmes, which are truly empowering, work on the principles of mutual respect, trust and belief – the focus shifts from transmission of information from outside “experts” to dialogue, negotiation and reflection with all concerned stakeholders.

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**“From alpha to omega in SRH”**

**Location:** Kolakaluru

**Storyteller and recorder:** Vijaya Durga

**Date:** 19th January, 2007

When AIRTDS first came to us and held a meeting, we, all children, attended it with the permission of our parents. We went there with a hope that it was a children’s meeting; but it turned out to be a meeting for adolescent girls. I asked her why it was only for adolescent girls. They informed that the meeting was in regard to adolescent care, personal hygiene, menstrual cycle and hygiene. I did not know how I should take care of myself during menstruation. I felt shy to ask about this to my mother. Therefore, when the aunt (Outreach Worker) called us for a meeting, I attended and learnt many things which we did not know earlier. For instance, I learnt not to throw the menstrual cloth away anywhere. I learnt to wash it carefully, dry it under the sun and keep it in a cover. I learnt that this is very important as we are using this regularly during menstruation. I learnt that we need to change the cloth every three hours. I also learnt how to 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 (Outreach Worker) asked if I could participate in role-plays. My friends and I agreed. I agreed because I had seen how an HIV infected person in my locality suffered. Of course, he was not aware of being HIV positive. I wanted to spread awareness on this issue to others. That’s the reason I joined and did role plays. I was a very shy girl. I never went out of my house. I did not talk with anybody. The aunts visited our village and shared this information. It occurred to me that these are important messages and should be widely disseminated. I have shared all this with my friends.

I always wondered why so many people are dying. Why are these people dying? We did not know. When I became aware about HIV/AIDS, I realised that no one should die because 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. Though you are kids, you have performed well. We have learnt about things we did not know earlier.”

This is the most significant change that has happened in my life. The fact that I have overcome my shyness and am doing my bit, is significant. I expect that the organisation should make me learn more stories for role plays. It is better if we continue these role plays in other villages apart from these six villages.

**Selection process**

The selectors included three Outreach Workers, three volunteers and two people from the Senior Management team.

**Reasons for selection:**

1. She is a young, adolescent girl (please note that the age is not mentioned in the story!). Yet she not only got motivated to attend the meetings, learn about the different SRH issues, but also convinced her family and is now educating others in the community. She overcame her shyness – understood the dreadful effects of HIV – decided to play her part in spreading awareness.

2. Being a young person, she has her entire future ahead of her to do this work of spreading awareness.

3. She has shown a great deal of sensitivity. She saw people in her village suffer and die. Through the project she identified the causes of such deaths.
Ownership and participation are vital. What works is when the energy and mobilisation of civil society have been at the forefront of our responses. Too little in today’s response to AIDS fosters these dynamics.4

**Domain: Changes in levels of support groups influence on its members**

Ten stories, five each from Delhi (Child Survival India) and Madurai (PACHE Trust), were collected in this domain. The reasons why only two iNGOs chose this domain were that both these organisations have based this project in their ongoing longer term programmes. Child Survival India (CSI) implemented this project in the areas where it was already working with adolescent girls and women on vocational skill training, RCH and other women empowerment programmes5. For PACHE Trust, one of their approaches for project implementation was to ensure “sustainability through building social capital in the broader community”6. This, they did by mobilising adolescent girls and women into support groups.

At the final selection level in Alliance India, only two stories were reviewed, one each from Delhi (Story 1) and Madurai (Story 2).

**The selectors at the iNGO level in Delhi had drawn up the following criteria for the MSC story**

1. Changes reflecting increased knowledge
2. Changes reflecting key population accessing services
3. Apparent change in behaviour because of awareness and knowledge
4. Increased demand for services, like contraceptives, etc.
5. Increased level of confidence and self esteem

The selectors included, the Programme Director, Programme Coordinator, two Outreach Workers, Programme Support Officer and an adolescent girl from the community. They agreed that this story qualified as the MSC story because:

a) She got informed about her legal rights
b) She got the confidence to take decisions, when she found her husband’s extramarital affair
c) Confident to approach the Women’s Commission and seek justice

**At the final level of selection, the selectors at Alliance India selected Story 1 over Story 2 because:**

a) The story was a very powerful commentary on the role of the group and its impact in the community
b) The story was reflective of the “we” feeling, which is a requisite of any cohesive group
c) It was reflective of the role of the organisation in mobilising and strengthening the group
d) The story was well documented

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4 Missing the Message: 20 years of learning from HIV/AIDS, PANOS
5 Child Survival India, a brief about DFID supported intervention, CSI, February 2007
6 Community Driven Approaches to Address the Feminisation of HIV/AIDS in Tamil Nadu, PWDS, February 2007
I have several reasons for associating with this project. The situation was such that I felt compelled to join the project. And once I joined it, I realised the benefits – lot of information on women's programmes, vocational training (sewing) for adolescent girls, free education for the children, free medical check up for children and women, legal aid. All these activities have been extremely beneficial for us poor people, especially the women.

Earlier I was always house-bound – never went out anywhere. But since I joined the Mahila Panchayat, my thinking changed. I moved beyond just cooking, cleaning and sleeping to learning new things, – things which I had no idea of before. Not only did I become acquainted with the different laws, but I was told about different health issues – about my body and how to take care of it, about menstruation, about my sexual rights. I learnt that my husband could not demand sex whenever it suited him. Earlier I thought it was his right to demand and my responsibility to succumb. I thought that all husbands did the same with their wives. But now I know that my husband cannot force me to have sex. It is my right to say ‘No’.

From the other sisters in the group, I learnt a lot. Now I know what is right for me and what is not. The Mahila Panchayat is a forum where any woman can share her problems fearlessly, give her opinion confidently. My self confidence has certainly increased manifold. We share in each others’ joys and sorrows. We have been able to create a niche for ourselves in the community. Others in the community have started respecting us, saying, “These sisters take the right decisions”.

I like being part of the group because apart from all the information gained, we have a good time. We entertain ourselves and have fun – things, which we are unable to do at home. Since it’s an all-women’s group, we share our problems with each other and are able to ventilate our feelings. The group’s meeting timing suits me as I am able to finish my household chores and send off my children to school. We finish our meeting on time to return home and do the evening household work. This way our husbands are happy and we too are happy!

The most significant change I have experienced after joining the group is that I have learnt a new thing. I learnt that my husband has started living with another woman. I got the confidence to face my husband and ask him whether this was true or not. When I went to meet him, I saw him living with Radha and her family. I was shocked and saddened seeing this. ‘What was wrong with me that my man left me for another woman’, I thought.

I shared this with my sisters in the Mahila Panchayat. I told them that my husband, Shankar, is living and having sexual relations with Radha. The group members told me that I must make the decision – whether I accept my husband and continued living with him or break free. They also told me that if I decide to leave him, I would reduce the risk of getting infected by him.

I took the decision of leaving my husband and seek the court’s assistance in getting maintenance from him. I decided to seek legal help so that I could get justice. I went to the Women’s Commission and registered a case against my husband. For a moment, I was scared that my husband may become angry and beat me up or Radha may instigate my husband against me. But it was just momentous. I realised the strength I had in me. I realised I had the strength and courage to face everything, including my husband.

I would recommend that this project has more training on these issues, more of street plays to spread awareness and use other innovative methods of reaching out to people. I would want all these trainings to be held at the community itself – I always become sick whenever I travel outside. The training and awareness should be simple so that everyone can understand. I would want the Mahila Panchayat to continue. We can do it. We should be helping other women in need too. Other women should get the space to bring their problems to the Panchayat and get justice.
Findings

e) The story told that women had “fun” in the group. Traditionally women are not “supposed to have fun outside the house”

f) Reflective of an increased self confidence in the storyteller – she had the guts and the confidence to take the decision.

It is interesting to note here that there was consensus among selectors at the Alliance India level on this story. There was also consensus in opining on Story 2, which according to them did not merit as a significant change story because:

a) The storyteller used her knowledge (on the effects of unsafe sexual practices, like HIV/AIDS) to threaten her husband (“If you get infected with HIV, I will not take care of you”), instead of taking the opportunity to educate him. The selectors assumed that perhaps she is telling other women, too, to threaten their spouses instead of making them understand about the devastating effects of unsafe sexual practices.

b) The story does not have the requisite details for people to put it in context. There are gaps in the story – the ‘why’s’, and ‘how’s’ are missing. Also it does not fit into this domain. It is not clear how the group has impacted her. The story is all about her.

c) The story teller was biased and was passing a value judgement on others. She was quoting example of a young boy who died of AIDS because he had sexual relations with many women, to influence other boys. Again, here she was using threat to tell them about HIV/AIDS. She was not having a healthy discussion with them, and not encouraging them to open up to her and seek help if required.

It is important and also interesting to highlight the reasons why Story 2 got selected at the iNGO level. The selectors included the entire SRH project team, consisting of the PWDS Project Manager, PACHE Field Support officer, and three ORWs. There were four observers from the Care and Support project. There was a consensus on selecting this story.

1. Assertive skills in warning her husband (“If you get infected with HIV, I will not take care of you”)
2. Skilled in identifying risk behaviour and taking precautionary measures and educating those at risk (adolescent boys)
3. Demonstrating leadership skills in leading the women’s group, educating them and spreading awareness in the whole community
4. She used her knowledge and her skills in communication to change her husband’s attitude.

The difference in analysis at the two levels is worth noting.

The significant findings in this domain are:

Everybody interviewed reported an enhanced self-esteem and self-confidence. As Anita, a 26 year old sex worker remarked, “Since we formed the group, we have started helping each other. Earlier we used to fight over customers. But now we unite, especially on serious issues. For instance, we are now aware that the police cannot arrest us without any reason. We have found strength in this collective. Seeing this, even the police, who used to harass us earlier, hesitate from doing so now.” Sheela, 16 years old says, “My group members are not only my good
friends, but my confidence booster too. Now, along with them, I am confident of doing anything. This is a significant change for me because earlier I hardly left my house. I am also confident of passing on the information I have gained to others – this, too is a big change from a shy me to a confident me. "Shakuntala, a 23 year old from Madurai passionately described the way she evolved as a person. “Just like the more you polish and clean bronze, the more it shines, we are becoming more knowledgeable with these trainings. Not only this, we now want to reach out to hundreds and thousands of women. If each one of us educates ten women, and they in turn educate ten more, can you imagine how many women we would be able to educate?”

This increased self-confidence has been attributed to their increased knowledge on different issues, including their legal rights, on safe sex practices, etc. This is getting reflected in their practices and behaviour. As Anita succinctly put it, “we are in a dangerous profession, where the risk of getting infected and falling sick is very high. It is also dangerous for our customers. Now we are all the more careful about protecting ourselves. Earlier, we used to get tempted by the extra money offered for having sex without condoms. Now it is non-negotiable.” Selvi, a married woman with two children in Madurai said how she has realised the importance of menstrual hygiene and is now consciously saving from her daily wage to buy sanitary napkins. This has also helped her realise the value of savings. She hoped to inculcate this habit in her children too.

Peer support in the groups has led to stronger collectives. As Shabnam, a 24 year old married woman in Narela, Delhi says, “In these group meetings we listen to each other and we share our joys and sorrows. I feel light every time I share my concerns in the group.” Asha, 26 years old, reiterates that her group is so strong that whenever they come across any woman in their colony facing any problem, the group gets together to help her out. “Our group is more than a family. It is our strength.” Chandra, a 29 year old from Therupatti in Madurai said how everyone in her village used to criticise the women for gathering and conducting meetings. However, they stuck to their purpose and patiently explained to anyone who criticised or taunted them. They made their group meetings transparent and invited anyone who was interested to listen to what they discussed. This helped in gaining the confidence of others in the village, she said.

The groups have been therapeutic and supportive. All the people interviewed in this domain said how much they appreciated being part of the group as they got a forum to share, listen, get heard and feel good. Nisha, a 30 year old HIV positive woman in Delhi said that she used to visit the organisation often. But since she has joined the PLHA group which the organisation formed, she feels less depressed and unhappy. “I feel that I have a family whenever I am in the group. I feel reassured that I am not the only one who is sick and infected. I gain strength in seeing the other members living happily.” Chellamal, 30 years old, living in Therkuppati, Madurai and married to a migrant construction worker said that whenever her husband came home once a month, he used to force her to have sex. He did not care for her feelings nor was he considerate that their two grown up daughters were present. She was also aware that her husband was having sexual relations with other women when he was away from the village. She shared her problems with another group member, Kumari, who is related to Chellamal’s husband. Kumari counselled him, explained
to him about the consequences of unsafe sexual practices, HIV/AIDS etc and how he could be vulnerable and make his wife vulnerable too and how this could affect everyone in the family. Chellamal said that the counselling helped as her husband was sensitive to their daughters’ presence and also started using condoms while having sex with her.

“I feel important”

**Project location**: Holambi Kalan, Metro Vihar, Phase II, Delhi

**Date of recording**: 17th January, 2007

**Name of storyteller**: Asha, married, 26 years

**Name of recorder**: Rekha, Community Facilitator, Child Survival India

One day I was up on the terrace, drying the clothes when I saw a group of women gathered near-by. I left the clothes and went down to ask what was happening and was told that issues of women’s health are being discussed. I stopped and listened to the discussions and was impressed. I realised it is useful for me and requested to be part of the group.

In the beginning we had problems in locating a place for meeting. After discussions amongst ourselves, we decided to hold the meeting at our houses – each member would host the meeting once in her house. We have come closer as a group and have found our strength in the group. Today, if some woman in the community, who is not a member of the group, is facing any problem – whether health related or domestic, the group members get together to help her out, which includes taking a sick woman to the hospital if the need be. Our group is like a family. We share in each others joys and sorrows, which earlier we were not doing. This certainly has been a significant change for us in the group. We joke and share stories in the group – this is something which we can not do in our homes. We make the time to meet regularly. The group meetings are not only informative but entertaining too. We now know about the different facilities available in hospitals. We knew about some of it but were ignorant about how to access the different facilities; we did not know which room to go in for a particular check up.

Now I not only tell other women, but also tell the men about the different information I have gathered and the different things I have learnt in the group meetings. I feel extremely happy that I am able to give information to people now. I feel important that I am also able to counsel many. I am happy that I am useful in the community.

I am a Muslim and therefore cannot get the ‘bachchonwala operation’ (meaning tubectomy) done. But many women in the group boosted my confidence, saying they would accompany me to the hospital for the operation. I declined the first time. But when Rekha, Community Facilitator, CSI, too explained to me the benefits of an operation, I decided it is better to get it done. I already have four children. I tried to explain this to my husband. I told him if we have more children, how will we be able to take care of them. We have a small house. He understood what I was saying and accompanied me to the hospital for the operation. This to me is the most significant change because I could persuade my husband, explain to him and with his support get the operation done despite religious taboos for the same. I am hoping many more women would learn from me and take such a decision. Had I not been part of the group meetings, who knows, I would continue having more children, perhaps 7-8 and unable to take care of them; I would continue being dictated by traditional beliefs and practices. I hope such meetings continue, especially in Muslim localities so that women there get benefited the same way I did.

The selectors had drawn up the following criteria for selecting the MSC story:

1. Increase in knowledge level
2. Accessing services
3. Apparent change in behaviour because of awareness and knowledge
4. Increased demand for services, like contraceptives, etc
5. Increased level of confidence and self esteem

The selectors included, the Programme Director, Programme Coordinator, two Outreach Workers, Programme Support Officer and an adolescent girl from the community. (Interestingly, the last criteria on increased self-confidence and self-esteem were put forth by the young girl).
Domain: Changes in people's behaviour

Only one iNGO, CSI, chose this domain. They wanted to see beyond ‘just awareness’ to ‘so what if awareness’ by asking what possible behaviour changes have happened because of all the awareness and information sharing. A total of five stories were collected in this domain through individual interview and group discussions. Their rationale was that often in projects such as this, the emphasis is on information dissemination, and the distribution of health messages. An inquiry into this domain of change, they thought would help them learn what strategies work and how it would help them know whether awareness is leading to behaviour change.

It is clear from the MSC story in this domain that changes in behaviour have happened when information is passed between people, rather than been directed at them. The women got a safe, non-threatening, non-hierarchical space in the group to ventilate, share, talk and learn. It is evident from the stories in the domain that awareness and information sharing through pictures, flip books, etc in groups have been beneficial. These groups are seen as not only information sharing and gaining forums, but also as an opportunity to meet other girls and women in the locality, share each others’ problems and concerns, ventilate and derive strength in numbers.

All the people interviewed in this domain have reported an increased self awareness because of the knowledge on different SRH issues. As Shabnam, a 24 years old married woman from Narela, Delhi put it, “I realised how we women foster so many diseases and infections within us. We take our bodies so much for granted. I have realised the importance of getting the right treatment at the right time from a qualified doctor.”

Many of those interviewed said how recreational these sessions have been for them. “Earlier I used to just watch TV. I was not interested in others in the locality. But since I have been part of the group sessions, I am much happier. I get to discuss various things with other women – get to hear what they have to say, and also make my point on issues” as 28 years old Sunita describes it.

All the stories reflect an increased self confidence in the storytellers as a result of attending group meetings and participating in different awareness sessions. As Sheila, a 16 year old in Narela, Delhi says, “I am now more self assured and confident of helping not only myself but others in my family and community. When I could confidently take my mother to the hospital when she was very sick, I know now I can do anything. Earlier, it was not so. I used to hesitate leaving the house or the colony.” Sunita, a 28 years old married woman feels she has changed a lot because of the knowledge gained. She is confident of going to the hospital for her check ups on her own. Earlier her husband had to take leave from his office to accompany her. This was not only inconvenient for her husband but she missed out on many vital check ups because of his inability to take leave sometimes. Not only this, her increased self confidence is also reflective of the fact that now she takes care of all those domestic chores, which only her husband used to do – like paying the electricity bills, getting the gas connection, taking the children to the hospital when they are sick. She says her husband is a happier man as he does not have to take leave for these chores, and thus, save on his meagre earnings.
50% of the story tellers in this domain have recommended that such awareness sessions should also be done with adolescent boys and men. Shabnam, categorically says, that, the NGO should make attempts to talk to her husband and other men in her locality on Sundays “so that they appreciate the value of women’s health and use condoms regularly. This will not only help the women but will also strengthen the project.”

The project has realised the importance of partnership between men & women and conducted sensitisation meetings, couple counselling meetings in case of HIV positive women. However, these were not sufficient to mitigate tensions emanating from entrenched power structures and rigid institutional norms. While the intended project objectives and intervention design did focus on the integration of men-folk to an extent but the emerging lessons from this pilot project clearly point towards a much deeper engagement than what was purported initially.

**Domain: Changes in staff capacity**

A total of 14 stories were collected in this domain. One MSC story was selected by Alliance India. A lot of discussion ensued, including discussing what is meant by ‘capacity building.’ There was a consensus amongst the selector that capacity building included not just structured trainings and sessions, but also informal meetings and interactions. The criteria listed for selecting the MSC story were:

- Internalisation of learning being reflected at two levels through practice – self and family
- Increase in knowledge, which is reflected in evidence based action
- Increased community acceptance of NGO, staff and project

There was consensus on selecting Rekha’s story (appended on next page) as the most significant change story in this domain.

Some of the significant findings in this domain include:

All staff revealed that they have undergone a distinct change in their perspectives and mindsets because of the various training programmes and exposure to different issues. Undoubtedly, people working in this sector need space to explore and understand their own values, attitudes, beliefs and experiences of gender, sexuality, and related issues. As Chitra, Field Support Officer, PACHE Trust confirms, “Since I joined this project, my life took a new direction. Everything that I had learnt and internalised had to be un-learnt. My perceptions of PLHA changed completely. I realised I was biased and was stigmatising them. Though I could provide care and support to all other patients (Chitra is a dietician and was earlier working with cancer patients in a hospital), I was not sure whether we should be helping PLHA. I rationalised thinking I could never be with my husband if he goes and gets this disease. I could never forgive him. But after hearing so many positive people telling me how they suffer because of lack of love and affection from their family, rather than financial reasons, I was moved and started to think from their perspective.”

Several staff revealed that they became more self-assured in both their personal and professional lives. After discovering their identity and sense of self and understanding that it is their right to defend it, a few women revealed ways they had taken the initiative. As Rekha, a community facilitator with CSI, says, “I have
I am an Outreach Worker and have been with CSI for three years. I joined as a cutting and tailoring teacher in the adolescent girls vocational skills project. I also used to teach them about the physical changes they are experiencing. With the addition of the SRH project, now I facilitate the support group meetings of adolescent girls and women and give them information on HIV/AIDS, menstruation, pregnancy, if they have any problems related to their bodies, where they can go, etc.

I attended a peer educators training in Sodhi Lodge for three days. I learnt how to select peer educators in the community. I also attended a training on gender and rights here in CSI. I have also been trained on PPTCT, HIV/AIDS, and reproductive rights.

I have experienced many changes since I joined CSI. I got married at an early age – when I was 18 years - and had kids immediately after marriage. I had no knowledge about menstruation, reproductive health, HIV and AIDS, vaccination, etc. Now I tell others.

I have realised the impact of sex discrimination on girls and boys. Now I do not discriminate between girls and boys. I grew up being discriminated. I led a very restricted life. My mobility was restricted – I could not go out. Now I go out confidently and don’t have to seek my husband’s permission for every place I go to.

When I told the adolescent girls about HIV/AIDS, many of them said they wanted to get tested. I also educated their mothers. I have explained that HIV spreads through different ways. One way of getting infected is through infected blood. In emergencies, after accidents, the chances of infected blood transmission may be high. In fact, after learning about HIV/AIDS, I got myself tested.

Now I cite my example and have motivated many girls and women to get tested too.

When I go to the community, they immediately identify me with the NGO, which works on SRH, the person who shares all the information with them. They look forward to my visits and share their concerns and issues with me.

The most significant change in me has been my increased mobility. I am empowered with knowledge and information, which in turn has given me the confidence to move about freely. I have become aware of my sexual and reproductive rights. I have told my husband to always use condom during sexual intercourse. Earlier, I used copper T which did not suit me. Earlier my husband used to force me to have sex with him and I was unable to say ‘No’. But now, when I confidently say ‘No’, he listens. He also uses condom. I am protected. Even if he has sex outside, I know I am protected. In fact, he commented, “you have become so informative, that you are teaching me!” Now he sometimes asks me about certain issues related to SRH.

Reasons for selection:

- Could clearly and strongly negotiate with her husband on condom use and sexual rights
- Increased knowledge is reflected in her increased self-confidence and a greater sense of self awareness. She has understood the value of good health and is prioritising her health
- The only story out of the fourteen, where she is self reflective and is making efforts to change herself and her family
- She is leading by example – got herself tested and is encouraging others too
- In a strongly patriarchal community where she belongs and lives (Narela), she has been able to challenge patriarchal norms
- Her acceptance in community is high – she gained respect not only in her family but in the community too
become aware of my sexual and reproductive rights. I have told my husband to always use condom during sexual intercourse. Earlier, I used copper T which did not suit me. Earlier my husband used to force me to have sex with him and I was unable to say no. But now, when I confidently say ‘No’, he listens. He also uses condom. I am protected.”

This transformation led to many staff becoming role models for others in the community. Many stories reveal staff leading by examples. “I have explained that HIV spreads through different ways. One way of getting infected is through infected blood. In emergencies, after accidents, the chances of infected blood transmission may be high. In fact, after learning about HIV/AIDS, I got myself tested. Now I cite my example and have motivated many girls and women to get tested too”, says a proud Rekha.

All the stories in this domain reveal staff taking pride in their work. As Sarita, Programme Support Coordinator, with CSI says, “The sex workers I work with have started negotiating condom use with their clients. They told me that even when men offer them more money to have sex without condoms, they refuse. I am glad I decided to pursue a second master’s degree and did Masters in Social Work. I am glad I joined CSI.” Again, this is further reinforced by Janani’s (Outreach Worker with AIRTDS) statement, “training on different concepts and issues of SRH has made me more determined to help women by providing them with information and helping them access services. Now I don’t look at this as my ‘job’ but as my service to society.” Manga, an Outreach Worker with LEPRA, Hyderabad simply says, “this project has made a normal school teacher Manga to become a good community worker. Now I fulfil my intention to work for the needy. I am really proud of my work.”

It is evident from the stories that wherever staffs have experienced an effective work environment and supportive organisational culture they have not only enjoyed working, but have become more skilled and confident. “In our organisation there is no difference like ‘the boss’ and ‘workers’. All are treated equally”, says Pasupathi, an Outreach Worker at PACHE Trust. This is further reiterated in the quality of the selection processes in the different iNGOs. It was observed that in organisations with lesser hierarchy and more openness, Outreach Workers and volunteers were more proactively participating and giving their opinion. In contrast, in few of the iNGOs, it was observed that field staff was less comfortable and more hesitant to disagree with their supervisors.
This section provides a reflection on the insights gained from using the MSC approach to evaluate the project.

Using the MSC technique in evaluating this project was an exciting experience for most participants. By engaging in collective dialogue about a story or a question, we build our understanding of it and locate the significance of that story or question in the larger context of our work. Even when there is not a clear problem or question driving reflection, it is through the exploration of stories and the practice of dialogue that we can unpack the richness of experience, and evaluate which issues emerging from that experience we need to pursue. In deeper forms of reflection, it becomes possible to identify learning edges, those questions or issues that an individual or group is seeking to understand in order to advance their work.\(^7\)

What is evident that this process has been a different experience for all participants involved. Different in terms of:

- A deeper engagement with their communities – they were listening to what their clients had to say. Many were taken by surprise in the process!
- Not only collected information but jointly analysed – this in turn helped in further reflection, debate and inquiry
- A sense of achievement was experienced by most field staff – their “hard work has paid off”

Broadly, this experience revealed the value and power in working in groups, in engaging with different stakeholders, in “handing over the stick”, as Robert Chambers puts it.

It was also seen as a vital capacity building exercise. All field staff reported how they benefited from being part of this exercise as their capacity in evaluation was enhanced. In fact, MSC can help to build the capacity of programme staff to identify and make sense of programme impacts. Many organisations struggle to demonstrate the impact of their work. MSC is an excellent way to encourage a group of people to focus on the impact of their work. The feedback loops within MSC can ensure that people continuously learn and improve their skills in articulating instances of significant impact.

Few Alliance India staff said how they have the stories provided insights into ways of making their ‘technical support (TS) visits’ more effective. As one staff puts it, “In my TS visits, I know what to probe on and how I can get ideas from the communities.” In fact, MSC provides excellent material for training staff. The stories themselves can also be used to show new staff how the programme works, and what things yield desired results. These stories can be used as case studies in training workshops and participants can be asked to respond to how they would respond if they were working in the situation described in the case study.

\(^7\) ‘What is Reflective Practice’, Amulya Joy, Center for Reflective Community Practice, MIT
Reflections on using MSC as an evaluation tool

**Alliance India (AI) staff’s reflections**

“I am feeling good. AI’s main area is building partners capacity for effective programme development, implementation and monitoring. I am feeling good because through the numerous stories from the field I can see how this capacity building has been used. However, I am also getting many questions: why only in that organisation do we have a staff who has shown such significant changes in her attitude and behaviour? What led her to be so empowered than others, who got the same inputs as her? How can we have many more such empowered field workers?”

- Programme Officer, AI

“I have mixed feelings. Is it easy to change ourselves and communities in just 12 months? I know that differential learning happens and I am also aware that we need to contextualise change. I am happy about certain stories, certain changes. But also feeling low – am I expecting too much?”

- Senior Programme Officer, AI

“Why did we have such pathetic stories from some places? Perhaps they are not good storytellers? Perhaps the stories have not been recorded carefully and properly? Perhaps staffs were conscious of being evaluated? Maybe they are just used to reporting numbers? Maybe they just did it because they had to? The story selection process and the subsequent reflection woke me up to the importance of constantly reflecting on my own attitude and behaviour. I am reiterating what I should and should not do while in the field.”

- Senior Programme Officer, AI

**Partners’ reflection**

“I was scared what communities would report. I had to prompt them to refresh their memory. Many of their responses came as a surprise. I was surprised to know that young girls did not want to “see” condoms. They did not want condom demonstration. They just wanted information. Girls who had boyfriends were scared that if they were caught seeing condom demonstration, they may be forced or cajoled by their boyfriends into having sex with them. Many girls said that their parents and others in the communities have asked them not to go for condom demonstration classes.”

- Outreach Worker, Hyderabad

“I had the opportunity to listen to the women – what they felt and thought. Few women told that this exercise pushed them to think and think! Almost every one of them was feeling important that they were asked to think and choose.”

- Outreach Worker, Guntur

“I was humbled and surprised that they remembered all those things we told months ago!”

- Volunteer, Guntur

“I never realised that our programme had such deep impact. Such details and such stories never came out in our earlier monitoring.”

- NGO staff, Delhi

“I interacted more deeply with the community today. I never did it earlier. The experience was different. I learnt an enormous lot. I never realised that these people are in turn reaching out to others and making them aware. I learnt today that many clients are using the legal knowledge – this is a surprise for me. It has helped me know what they think about certain issues. It’s helped me release the impact of my own hard work and am happy that my hard work is changing lives.”

- NGO staff, Manipur
The fact that there are now over 42 million people living with HIV/AIDS is a testimony to a failure by national and international agencies to combat the epidemic. The sheer number of people dying from AIDS – more than three million in 2002 alone – urges a rethink in the response to the pandemic.

When asked, the project participants – adolescent girls and women – gave some strong recommendations. These are summarised below:

- Financial independence for women affected and living with HIV/AIDS and vulnerable women is critical for them to lead a confident, fearless, less stigmatised and empowered life. Testimonies of several women reinforce this point. An integrated programming, which includes components of vocational training, financial aid, market linkages, is critical to fight this epidemic.

- Sensitising, building capacities of and making health care providers accountable though a systematic intervention plan.

- The importance and value in engaging with boys and men, community and religious leaders and other power structures. As Bala Devi from Manipur succinctly puts it, “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 about to be married is important. Reaching out to those women who are not able to come out of their houses is important.”

- The critical need for safe, non-threatening and non-hierarchical spaces for discussing issues of power, gender and sexuality.

- Many have also recommended the use of different media to disseminate information to different sections of the population. In Amritsar, street theatre has been very successful.

The stories throw insight into the need for ‘bottom-up’ advocacy, and on more innovative and sophisticated relations with the media. Of course, any strategy designed would need to be rooted in an understanding that the spread of HIV/AIDS is inextricably linked to issues of gender inequality, discrimination, poverty and marginalisation.

Monitoring and evaluation offer valuable learning opportunities that can be used to strengthen stakeholder accountability. Using MSC in evaluating this project clearly demonstrated the value of tracking change and understanding impact through dialogue and a democratic process to learn from each other, to strengthen accountability and to change power relations between stakeholders.

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8 UNAIDS (December 2002) AIDS Epidemic Update, Geneva

Outline of interview

a) Project Location:
b) Date of recording:
c) Does storyteller want name on the story __ Yes ___ No
d) Name of the storyteller:
e) Marital status:
f) Gender:
g) Age:
h) Name of the person recording:
   Organisation:
   Position:
i) Date of intervention:
j) Reason for the intervention:
k) Description of the intervention:

Q1. When and how did you get first involved in the project?

Q2. DOMAIN: From your point of view, describe the most significant change that you have experienced in quality of your life because of your involvement in the project? Please be specific and give examples.

Q. DOMAIN: From your point of view, describe the most significant change you have experienced as a member of the support group? Please be specific and give examples.

Q. DOMAIN: From your point of view, describe the most significant change you have experienced in your behaviour since you have been part of the project? Please be specific and give examples.

Q. DOMAIN: From your point of view, describe the most important negative impact of the project that you have experienced? (This question was also phrased as: If you were asked to start the project from the beginning, what would you do – which activities would you include and why and which ones would you not include and why?).

Q3. Why do you think this change has been significant to you? Or why are these change and not the other changes important for you?

Q4. What recommendations do you have for the project and what could be done differently to improve the quality of the project?