



# Nambaduku Process

## Community Response to HIV Kalghatagi





Nambaduku Process

Community Response to HIV  
Kalghatagi

  
SAMRAKSHA

2011

Copyright © 2011 Samraksha

Information and illustrations contained within this publication may be freely reproduced, published or otherwise used for non-profit purposes without permission from Samraksha. However, Samraksha requests that it be cited as the source of the information.

#### Acknowledgement

We would like to thank Karnataka Health Promotion Trust who supported the publication and dissemination of this document.

We would also like to thank Deshpande Foundation who supported the start-up of *NamBaduku* in Kalghatgi taluk.

Documentation : Divya Sarma

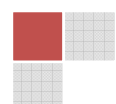
First published in 2011. For private circulation only

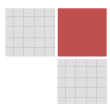


---

## CONTENTS:

INTRODUCTION.....	1
DEVELOPING A PROCESS FOR MEASURING SOCIAL CHANGE.....	3
STUDY METHODOLOGY.....	6
RESULTS AND DISCUSSION.....	10
CONCLUSION.....	20
ANNEXURE	







---

## LIST OF FIGURES

Figure 1: Self Assessment Process

Figure 2: Levels of Assessment

Figure 3: Village Self Assessment Scores

Figure 4: Distribution of Self Assessment Scores: Acknowledgement and Recognition Baseline

Figure 5: Distribution of Self Assessment Scores: Acknowledgement and Recognition Endline

Figure 6: Distribution of Self Assessment Scores: Inclusion Baseline

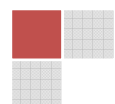
Figure 7: Distribution of Self Assessment Score: Inclusion Endline

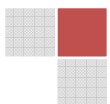
Figure 8: Distribution of Self Assessment Scores: Service Availability and Access Baseline

Figure 9: Distribution of Self Assessment Scores: Service Availability and Access Endline

Figure 10: Distribution of Self Assessment Scores: Understanding Risk and Vulnerability Baseline

Figure 11: Distribution of Self Assessment Scores: Understanding Risk and Vulnerability Endline









---

## INTRODUCTION:

Samraksha is a non-governmental organization which has been working on the issue of HIV since 1993. Samraksha's HIV interventions range across the continuum of HIV prevention, care and support. The work is guided by a firm belief in the capacity of the communities to make the most effective responses to HIV as is relevant to them. So, all interventions are focused on identifying strengths on communities and helping them to start responding to HIV, based on these strengths. This core belief guides our approach in working with different kinds of communities: people living with HIV and their families, people at increased risk of HIV such as women in sex work and sexual minorities and geographical communities such as villages or small wards in towns.

*NamBaduku* is one of Samraksha's core initiatives and was developed in 2001. *NamBaduku* works with entire village communities. The programme evolved from a growing understanding that an effective HIV response cannot be restricted to people who are perceived to be at risk or people who are already affected by it. All these groups exist within larger communities and the responsibility for HIV prevention, stigma reduction, care and support needs to be shared by the whole community. Moreover, HIV responses aim at making some fundamental behavioral changes, which though extremely personal and intimate, are also mediated by community norms. Hence it is only through the involvement of the larger communities that safe behaviors can be encouraged and continually reinforced to gradually become a behavioral norm. This engagement with the general communities could also help to create a more supportive environment for people living with HIV. By helping communities reflect on the impact of discriminatory practices and encouraging an inclusive attitude towards people with HIV, gradually a more accepting environment can develop.

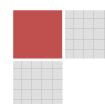
The *NamBaduku* programme was started with the key objectives of encouraging safe behavior in the communities, reducing stigma and discrimination and increasing community based support for people living with HIV. The approach chosen in order to achieve this was strengths-based and drew from Samraksha's firm belief in the capacity of the village communities to respond to HIV. It was rooted in the appreciation of community's strengths and resources: human, material and social.


Based on this approach, Samraksha devised a series of processes<sup>1</sup> which were facilitative. This helped communities to come together and reflect on various aspects of HIV: What constituted risk? How were they at risk? Who among them was most vulnerable and why? What could be done to reduce the vulnerability? What were the issues facing people living with HIV? How did discrimination within the community affect people with HIV? How could communities support people with HIV?

The process tried to reach all groups within the community and give them a comfortable space to discuss, articulate opinions and clarify doubts. It brought the entire community together to discuss key issues. During these discussions, individuals and groups would often make public commitments to promote safe behavior and be more supportive of people living with HIV. This became their stated position, which made it difficult for them not to adhere to it, at least, publicly.

---

<sup>1</sup> For more on the process, see Annexure 1.



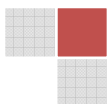


Over the years, Samraksha has used the *NamBaduku* process to engage with communities in different geographies and contexts. When the programme was started in 2001, Samraksha engaged with the village communities in Raichur and Koppal where HIV prevalence was high and beginning to be visible and communities were open to talk about their HIV risk. In 2007, Samraksha started engaging with communities in Kumta, in Uttara Kannada district, where the communities were conservative and less willing to acknowledge their HIV risk or speak openly about the issue. In 2009, Samraksha started engaging with the villages in Kalghatgi taluk in Dharwad, through this programme.

### **Objectives of the Programme**

The main objectives of the *NamBaduku* programme in Kalghatgi were:

1. To help communities gain a good understanding of HIV, the means of transmission, the ways of prevention, and services available for HIV prevention, care and support.
2. To create an atmosphere within communities where discussions on HIV and related issues of sex and sexuality could take place freely.
3. To encourage a sense of responsibility in the community towards people and families affected by HIV and to reduce HIV related stigma and discrimination.
4. To help communities identify their own risks and vulnerabilities and move towards safe behaviors.
5. To encourage communities to access HIV prevention, care and support services in the community and help generate community driven demand for services.





---

## DEVELOPING A PROCESS FOR MEASURING SOCIAL CHANGE:

Samraksha has been using the *NamBaduku* process with village communities in order to build perspectives on HIV since 2001. Although the process of community discussions and reflections has always been participatory and non-directive, initially, the tools for measuring how these processes result in changes in the communities' beliefs, thinking and action were drawn from more conventional methods. So, although some visible changes could be seen in the community, the existing documentation system could only capture certain concrete 'actions'. It would miss some deeper and at times, unexpected changes in beliefs, attitudes and day to day behavior in the community.

Conventional social science research methods like KAP (Knowledge, Attitude, and Practice) studies or even qualitative studies such as in-depth interviews were not suitable. While survey methodologies were expert-driven and lacked the facilitative spirit with which the *NamBaduku* programme operated, in-depth interviews focused largely on individual change. This was limiting, since *NamBaduku* aimed at stimulating change in behaviors and norms at individual as well as group and community levels.

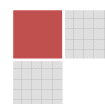
Samraksha tried to address this issue by using various participatory methodologies in the earlier reviews of *NamBaduku*. But again, these processes could only focus on the 'prescribed' or intended outcomes. These outcomes were decided by Samraksha, and the participatory processes only allowed for greater involvement of the community while collecting the data. Hence it remained externally driven.

While exploring participatory processes, Samraksha was also bothered by the possibility that participatory processes could ignore local power differentials and push through an externally decided agenda and give it legitimacy by claiming that it had been endorsed by the community (Cooke and Kothari, 2001)<sup>2</sup>. There was a lot of internal questioning and discussions with individuals and institutions who had been working on the metrics of change. To address this, we needed: a measurement process that could factor in a community-endorsed representation to review the change; and confirmation of the individual perceptions/ views of the change in the 'the community as a whole' by a larger body of people through open discussions.

In the search for such a methodology, Samraksha found the Self Assessment Framework of the Constellation for AIDS Competence (now the Constellation for Community Life Competence) very appropriate. This had been drawn from the experiences of many groups and communities working on community led processes. It been used in many different countries and contexts, and found to be very effective in empowering communities

---

<sup>2</sup> Cooke and Kothari (Ed) (2001) *Participation: The New Tyranny*. London. Zed Publications



(Duongussa U et.al, 2006)<sup>3</sup> and stimulating local responses. A review of the AIDS Competence approach and methodologies conducted by UNAIDS across different countries also found this to be effective in building on local knowledge and strengths and achieving effective HIV prevention (Gupta et.al. 2008).<sup>4</sup> Therefore, it was decided to use some of the tools and processes of the AIDS Competence approach with adaptations to the local context.

The major strength of this process was that it allowed communities to articulate their own dreams and then to measure their progress towards achieving the dream over a period of time. The desired outcomes were decided by the community and the assessment of the current situation was also done by the community. The domains that the assessment process would review were selected from the Self Assessment Framework. This was to ensure some common areas for review across communities. Within these domains the communities could reflect on a range of issues and changes that they perceived and there was no pressure to conform to a pre-determined set of indicators.

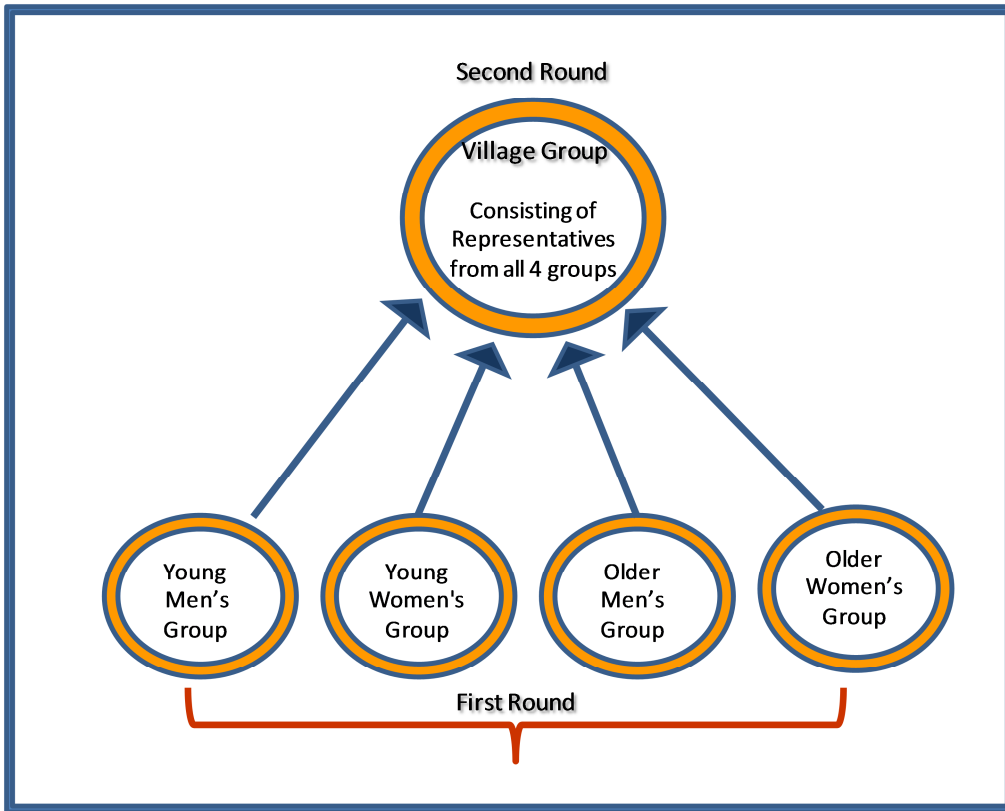
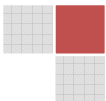


Figure 1 : Self Assessment Process

<sup>3</sup> Duongsaa U, Duangsa D, Rhucharoenpornpanich O, Kheyata P, Chuduong T; Self-assessment: An effective evaluation tool for promoting AIDS competence and taking prevention programmes to scale. *International Conference on AIDS* (16th : 2006 : Toronto, Canada).

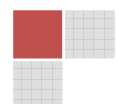
<sup>4</sup> Gupta GR, Parkurst J O, Ogden JA, Aggleton P and Mahal (2008) A Structural Approaches to HIV prevention *Lancet* 2008 372 pp764-775





Secondly, this process also tried to address the issue of power differentials in the community by ensuring that the voices of different sub-groups could be heard. As figure 1 illustrates, there was a two-step process. To help capture the different perspectives which were critical for the discussion, it was decided to have four groups. In the first step, certain groups came together for discussion and made an assessment. In the second step, representatives from each group came together for a village assessment, where they could share and articulate the positions of their group. There was further dialogue on this issue at the village level and based on the opinions articulated by all the groups a consensus was reached.

Interestingly, such a process for measuring change also served to strengthen the *NamBaduku* perspective building process itself. *NamBaduku* is based on facilitating reflection and dialogue in the community, helping communities arrive at a consensus and supporting community actions. The community self-assessment process, which was used for baseline assessment, set the stage for *NamBaduku*. It provided communities, the space to reflect on different aspects of the HIV issue. It allowed them to articulate their dreams and start taking ownership for achieving those dreams. It allowed communities to see the value of talking to each other and understanding and accepting different points of view and arriving at a consensus.





---

# STUDY METHODOLOGY

## Research Questions

The specific research questions for this study were:

1. To what extent do the communities feel that they have gained on their competence to respond to the different aspects of the HIV epidemic following the *NamBaduku* process?
2. What are the changes identified by the community related to the HIV response following the *NamBaduku* process?
3. Are these changes specific to certain individuals or groups in the community or have they occurred across the community?

## Universe

The study universe comprised of the villages which were part of the *NamBaduku* programme in Kalghatgi taluk. Of the 34 villages which were identified for the intervention, 32 villages were part of the study. Two villages were not considered for the study, since the *NamBaduku* process had not been completed there.

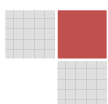
## Involving Different Groups in the Community in the Assessment

In this study, since the focus of discussion was HIV prevention, stigma reduction, care and support, it was important to get the perspective of both men and women and also of people in different age groups. Hence, the four smaller groups chosen to initiate the discussion were men, women, young men and young women. Later, representatives from these groups came together for a village level self-assessment.

## Development of the Assessment Tool

In order to guide the community assessment process, a modified version of the self-assessment framework developed by the Constellation of AIDS Competence was used. This framework has identified 10 important domains related to the HIV response, based on extensive work across the world and the hopes, concerns and dreams identified by different communities.

Samraksha's earlier experiences of using this tool indicated that while the competence of the community could be best captured by 10 domains, the methodology of discussion, debate and negotiation towards a consensus that this process required took several hours. The investment of that kind of time, consistently across all groups, was extremely difficult. So, some of these domains identified by the self-assessment framework to develop the community self-assessment tool were selected based on their overarching relevance and the





fact that they are the foundations of an HIV response: for prevention, care and stigma-reduction.

The four domains chosen were:

**Acknowledgement and Recognition:** This explores an acknowledgement of the community that HIV affects its life significantly and that it should be aware of this. It includes an openness to discuss it.

**Inclusion:** This looks at a supportive environment for people affected by HIV in the community, where there is no discrimination and communities reach out and support people with HIV.

**Service Availability and Access:** This looks at an understanding of the different HIV related services and where to access them as well as a willingness to access these services.

**Understanding Risk and Vulnerability:** This explores communities understanding their own risks and vulnerability, initiating behavior change and reaching out to vulnerable groups.

## Levels of Assessment

The community assessed itself on a scale of 1 to 5 moving from awareness to lifestyle change. Each level signified a certain stage towards achieving the dream which was level 5.

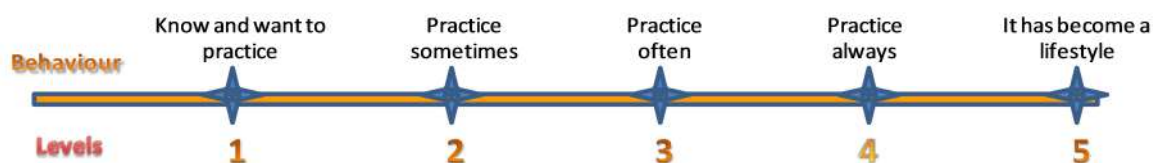


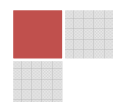
Figure 2 : Levels of Assessment


## Dreams identified by the Community

Based on the hopes and concerns which were discussed by them, the community developed certain dreams which were related to the four chosen domains. The community self assessment then took place, based on these dreams.

On the domain of **Acknowledgement and Recognition**, the community dream was that all members of the community had complete information on HIV so that they could protect themselves and there were opportunities for discussing this issue with each other so that people continuously learn from each other.

On the domain of **Inclusion**, the dream of the communities was that people affected by HIV should be treated well, just like others and with no discrimination. 4 communities had an





added dimension that there should be an environment where people could disclose their HIV status with no fear.

On the domain of **Service Availability and Access** the dream of the communities was that HIV related services should be available locally and be accessible to people. 6 communities gave an added dimension that people should be able to voluntarily seek these services.

On the domain of **Understanding Risk and Vulnerability**, the dream of the communities was that condoms should be available and used appropriately by all the people in the village. Around half the communities had an added dimension that there should be special attempts to reach people at risk like migrants and young people and help them reduce their risk. Seven of the villages had a further dimension that the hesitancy to speak about condoms in public should come down.

## **Self Assessment Procedure**

### **Baseline Assessment**

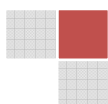
This was carried over a period of two days in the community. On the first day, there was an introductory session, where people from different parts of the village gathered for understanding the process. They discussed their dreams, concerns and hopes regarding HIV. Following this discussion, smaller groups of men, women, young men and young women were formed. Each group met and started with building a dream for each of the four domains: Acknowledgement and Recognition, Inclusion, Service Availability and Access and Understanding Risk and Vulnerability. After this, each group assessed itself on where it was currently, on a 1-5 scale in relation to the dream.

On the second day, representatives from each of these groups came together for a village self-assessment. Based on their groups' dreams, they built some common dreams for the community. After reflections and deliberations and review of the discussions in each of their respective groups, they arrived at a consensus as to which level they stood as a community in terms of achieving their common dreams.

### **Endline Assessment**

This was again done over a period of two days. On the first day, there was discussion in smaller groups of men, women, young men and young women. An attempt was made to ensure that at least 30 % of those involved in the baseline discussion also took part in the endline discussion, in order to ensure that they had some familiarity with the earlier discussions. These groups looked at their earlier dreams and assessments and reflected on where they were, currently, in the journey towards achieving those dreams. Then, they analyzed the difference between the two assessments and discussed factors that could have influenced that change.

On the second day, representatives from each group came together once again for a village self-assessment and arrived at a consensus on where they now stood in terms of achieving







their dream. As in the baseline, they discussed the changes which had occurred in the different groups and how this influenced the assessment.

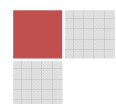
### **Understanding changes in levels and drawing themes of changes from the narratives of the community**

The position (level, indicated in the assessment) of the villages, in the journey toward the goal (dream) across the different domains on the baseline and endline were compared to understand the change in the different communities.

Further, the discussions in the groups regarding the basis of the assessments – why a certain level was scored - and the various illustrations given in support of each assessment were recorded as narratives and analyzed to identify dominant themes of change identified and discussed by the community.

### **Challenges in Using this Methodology**

Samraksha has used the self-assessment process in order to stimulate and connect local responses and to strengthen local responses, but this was the first time this methodology was used in order to systematically allow communities to assess themselves before and after a set of facilitative processes. As such it is still an evolving methodology and we are continuing to explore and refine this methodology.





## RESULTS AND DISCUSSION:

### Comparison of Self Assessment Scores in Baseline and Endline:

All the communities have reported substantial gains on each of the domains, compared to their baseline assessment. As can be seen from Figure 1, if the mode value of the self assessment on all domains is considered, most communities had felt they were at Level 1 on all the domains while doing the baseline assessment, while in the endline assessment, most communities felt that they were on Level 4.

### Village Self Assessment Scores in Baseline and Endline :

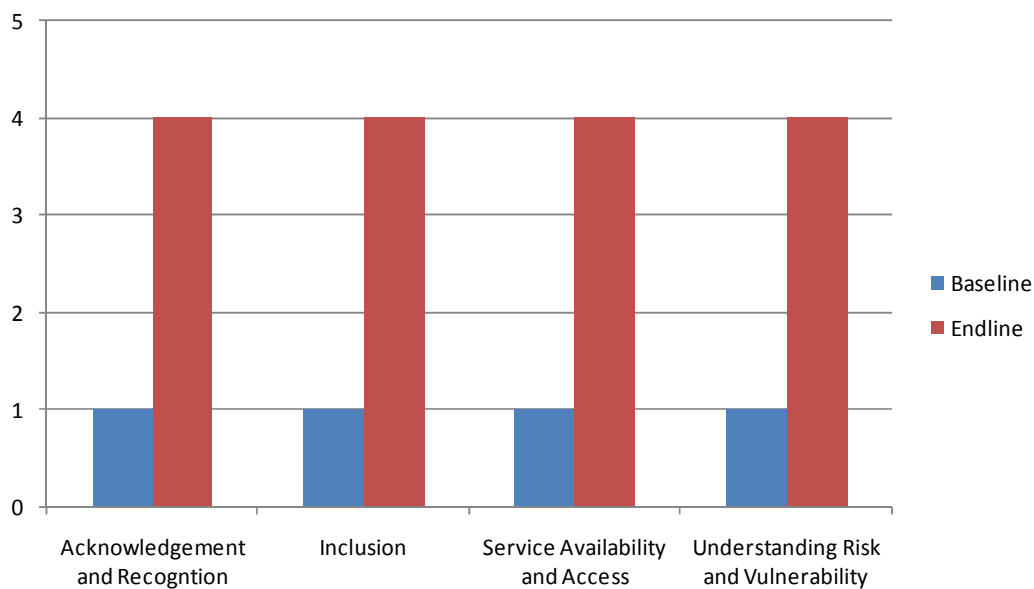


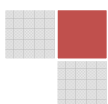
Figure 3 : Village Self Assessments

N=32

Mode Value of assessment taken

On the domain of Acknowledgement and Recognition, village self-assessment scores in the baseline ranged between 1 to 2. Mostly, the communities acknowledged that they needed to know more about HIV and also felt that they had some information on HIV. But this information was not complete and neither was it present equally in all groups in the community. They also felt that there was very little discussion on HIV in the community.

In the same domain, on the endline, village self-assessment scores range between 4 to 5. The communities now largely feel that they have much more information on HIV and there are now multiple spaces where they can discuss this issue with each other and also learn from





each other. In fact, 2 villages felt they have already attained Level 5, where learning and sharing with each other about HIV has become a life style.

But there are some differences in the group wise assessments. A larger proportion of men's groups and young men's groups feel they are on Level 4 and 5 of the men's groups and 8 of the young men's groups feel they have already attained Level 5 where discussions on HIV have become a part of the life style. However, the women and young women felt that they had to achieve much more. A majority of these groups also felt they were on Level 4, but about 7 of the women's groups and 8 of the young women's groups felt they were on Level 3, since although there were discussions on HIV in their group, spaces for discussions were still limited and they still hadn't reached a level of continuous discussion and learning.

On the domain of Inclusion, village self-assessment scores in the baseline ranged from 1 to 3. Communities acknowledged that they needed to be inclusive, but there were still some fears of transmission and they were not sure of their role in supporting people with HIV.

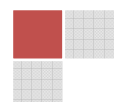
In the endline, the village assessment scores ranged from 3 to 5. All communities reported a change in attitude towards people with HIV and 4/5 of the community publicly reaffirmed their commitment to support people with HIV.

On the domain of Service Availability and Access, village self-assessment scores in the baseline ranged from 1 to 2. Communities mostly did not have any idea about what kind of services was available for HIV and where it could be accessed. They had some basic awareness about PPTCT services and the need to test pregnant women.

In the endline, the village self-assessment scores ranged from 3 to 4. Communities feel they are now aware of basic prevention, care and support services and the nearest service points. Some of them have also experienced the service or referred people to it. Among the women and young women's groups there was a much deeper degree of awareness about PPTCT services and the women spoke of pregnant women routinely seeking testing.

On the domain of Understanding Risk and Vulnerability, village self-assessment in the baseline ranged from 1 to 2. They felt they had some understanding of condoms, but were not always sure of where to access them or even willing to use them. They also felt that there was a lot of hesitation to speak about condoms within the community. Communities had some basic understanding of what constituted risk and identified some people like migrants and young people who were more vulnerable but had not made any attempt to reach them.

In the endline, village self-assessments on this domain ranged from 3 to 5. Communities now feel there is a greater willingness to access and use condoms and also that hesitation to speak about condoms has reduced considerably. There was also an attempt to specially reach out to vulnerable groups in the community. Only among the young women, about 19 of the young women's groups felt that they were still on Level 3. They felt that they had understood a lot about condom availability and use and also spoke about it among themselves. But they still hesitated to publicly speak about condoms.





## Major Themes of Change which emerged from the Community Narratives

The major changes identified and discussed by the communities on each of the domains are discussed below.

### Acknowledgement and Discussion

As can be seen in Figures 2 and 3, while 65 % of the villages assessed themselves on Level 1 and 35 % on Level 2 on this domain in the baseline, in the endline, 94 % of the communities have assessed themselves on Level 4 and 6 % on Level 5.

## Distribution of Village Self Assessment Scores : Acknowledgement and Recognition

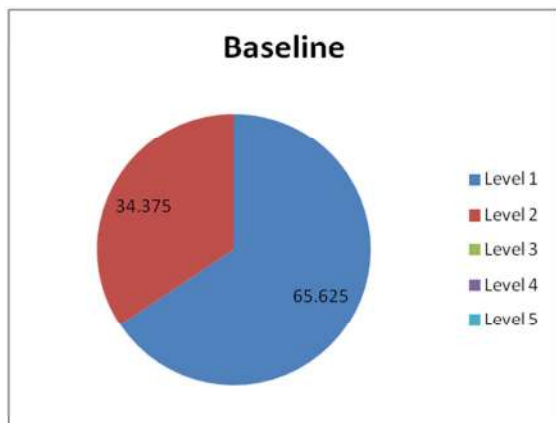


Figure 4 : Baseline Assessment: Acknowledgement and recognition

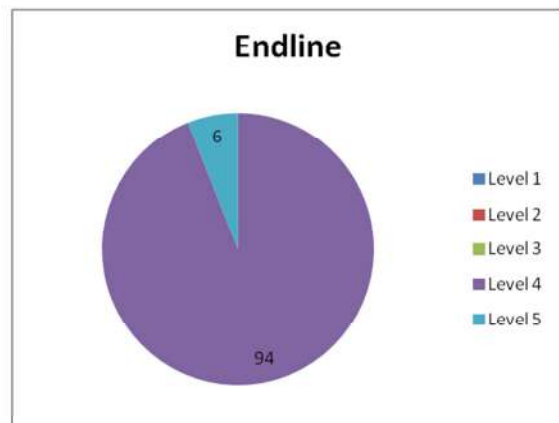


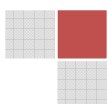
Figure 5 : Endline Assessment: Acknowledgement and Recognition


Some of the major changes identified by the community in order to support the improved assessments are discussed below.

### Increased understanding of HIV and Continuous Sharing of Knowledge within the community:

Almost all villages felt that there was improved understanding on the issue of HIV. The communities attributed this improved understanding to a direct impact of the Samraksha NamBaduku process as well as to constant reiteration by other media. Once this process was started, the villages felt that they had themselves initiated continued discussions after the primary process and this ensured that even people who were not reached initially also had better awareness. In 4 of the villages, they specifically identified some individuals who they felt were taking the initiative in starting discussions on HIV among themselves.

*Most of the people now know about HIV through the village process (NamBaduku process), and then also through TV. We are also discussing in the village, at our working place, home and hotel. After the programme we*





*discussed with the people who were not present here at that time.....  
Village level discussion at Masalikatti*

### **Openness to Discuss about HIV in Multiple Public and Private Forums:**

The communities also felt that there were multiple forums for discussion on the issue of HIV and the majority of the population was open to discuss it in these different forums, both public and private.

*In our village, anganwadi workers, ASHAs and other SHG leaders have been discussing regarding HIV and STI. Now more than 80% of the people discuss this regularly. We also educate our younger generation, and they again go and discuss with their friends. .... Village level discussion in Hatignala*

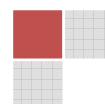
*Today you see so many people here, when there is a discussion on HIV. Four years ago, if you had said you wanted to discuss about HIV, no one would be here. Now they know it is important to know about this. That is why they want to learn..... Elderly Man in Somanakoppa.*

Gender does play a mediating role in the kind of forums which are open for different groups. While both young men and men speak about discussion among their own peer groups in various public spaces like the *Katte* or the playground, for women, the spaces tend to be their SHG meetings, or within their own homes. For the young women again the interaction is mostly with their peers, although the spaces for interaction may not always be within the community. For instance, most young women's groups reported that they discussed about HIV in their colleges, among their friends or with their teacher.

*We know about HIV, we all participated in the meeting held in the temple during the Samraksha process (NamBaduku process). We also discuss with our science teacher in our school. Sometimes we discuss it with our friends..... Young Women at Sangadevarakoppa.*

Interestingly, it is the women's groups which frequently mention discussion across different generations. The women's groups in 4 of the villages specifically mention discussion across different generations. While mostly this refers to the discussion between mothers and daughters, some of the groups have also spoken about discussions between mothers and sons. In four villages, the women even spoke about communication between couples on this issue. While this number may be small, the very fact that there is public acknowledgement about the discussion of such a sensitive subject between couples is significant.

*After the village process we got to know more regarding condoms and have been discussing about condoms also. The women in our community have knowledge about condoms, house wives have been discussing about it with their husbands and other men in their house..... Women in Sangadevarakoppa*





## Inclusion

As can be seen from Figures 6 and 7, in the baseline while over 80 % of the communities assessed themselves on Level 1 on the domain of inclusion, in the endline, around 90 % of the communities have assessed themselves on Level 4.

### Distribution of Village Self Assessment Scores : Inclusion

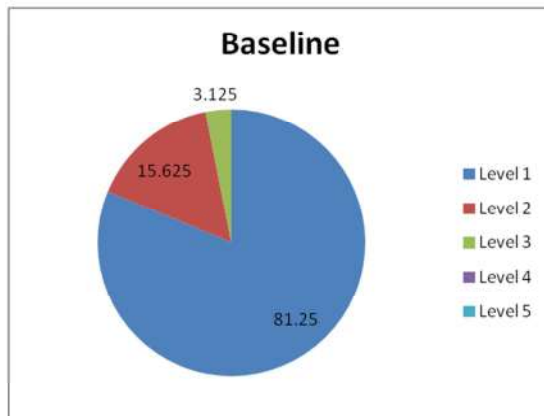


Figure 6 : Baseline Assessment: Inclusion

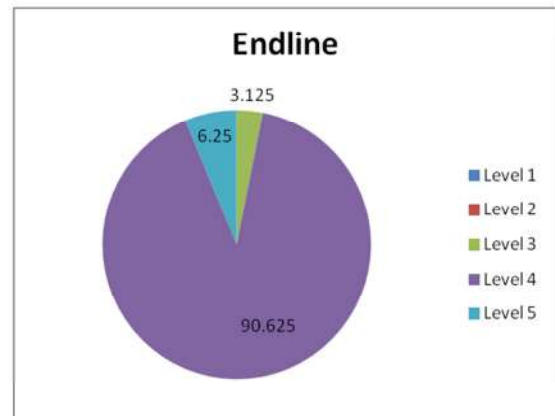


Figure 7 : Endline Assessment: Inclusion

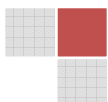
Some of the major changes identified by the community in order to support the improved assessments are discussed below.

#### Change in Attitude towards people with HIV

In all the villages, the communities reported that they have been able to overcome the fear of casual transmission, thanks to the repeated discussions and the opportunities they got to clarify their doubts. The change in attitude is borne forth by the testimonies of affected people also.

*There has been a lot of change in our village in the last two years. First people were scared to even come for a haircut to me. Now, because of the process they have understood about HIV. Now I roam about freely in the village. I drink tea; I sit and talk to people. They are all coming back to me for haircut..... An affected person*

*There are people with HIV in our village and we won't hurt them. We will give them support. When some people had misconceptions and hesitated to touch an infected child, we told them that if they behaved like this, it will hurt people with HIV and they will get worried. We need to take care of them..... Woman's group in Galaginagatti*





*Earlier, people in my village used to discriminate against me. But during the process, there was a meeting in the temple and I also attended the meeting. Now I feel there is a change in the way they treat me..... Affected woman*

Once the fear of causal transmission is addressed, communities have also gone beyond just non-discrimination to a genuine acceptance of people with HIV. They regard people with HIV as one of them and want to support them. In 22 villages, people spoke about the need to reach out and support people with HIV. All communities also made a specific commitment to be supportive of people with HIV in the future also. Additionally, about 8 of the communities have also spoken about the need for confidentiality and affirmed that they would maintain privacy and confidentiality.

*We know that if we abuse them or disclose their status they will get worried, so we should be careful and not hurt their feelings. Love and affection is very essential for PLHIVs. If we hurt them in any way, they will get worried and die early..... Women in Sangadevarakoppa*

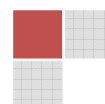
Some communities have also intervened in instances of stigma and discrimination within the family, and encouraged family members to support affected people.

The change in attitude can be amply demonstrated in this instance of personal sharing of loss due to HIV and the change in attitude. Although such instances are reported only in few villages, the very fact that affected people are able to share about themselves in an open forum is a significant gain.

*5 years ago my brother got infected; we cared for him because the doctor told us it won't spread even if we provide care. During that time, people used to discriminate against me also. Many times people hesitated to share my food while working at field. But after the process (Samraksha process) people are aware and so are not discriminating. I now use my story to share in places where others are discriminating, so that we can learn that discrimination will harm to PLHIVs and good care and support will help to lead the happy life.....Affected person*

### **Service Availability and Access**

As can be seen from Figures 6 and 7, in the baseline 97 % of the villages have assessed themselves on Level 1 on the domain of Service Availability and Access. In the endline, the community has felt that there have been some gains and about 56 % have assessed themselves on Level 4 and 44 % on Level 3.





## Distribution of Village Self Assessment Scores : Service Availability and Access

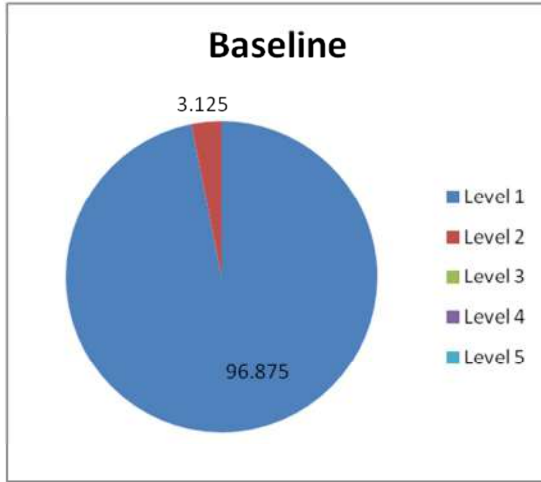


Figure 8 : Baseline Assessment: Service Availability and Access

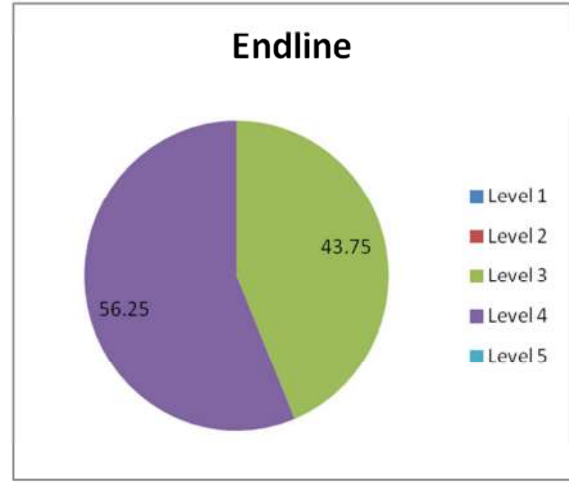


Figure 9 : Endline Assessment : Service Availability and Access

Some of the major changes identified by the community in order to support the improved assessments are discussed below.

### **Awareness about Services:**

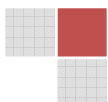
Nearly all communities are aware of the basic HIV services which are available. They know that testing services are available in Kalghatgi and in Hubli and also that ART services are available in Hubli.

They understand the benefits of ART for people with HIV. They also understand the nature of ART treatment- that it is meant to control rather than cure the infection and that it needs to be taken for life and requires complete adherence. A few communities shared that they have supported people to access ART and they have also seen improvements in health of people, after starting ART.

*We got to know about ART treatment available in Hubli. We have referred people from our village there, and after taking ART, their health has improved. Sometimes, we have also supported them by giving money for the bus fare to go and get ART medicines..... Women in Ramnala.*

### **Voluntary Access of Services:**

In 10 of the villages, communities shared that there were instances of voluntarily access of testing services. In about 6 of the communities, people spoke about referring people for testing, if they felt that they had some degree of risk. However, communities strongly believed that testing needs to be done voluntarily and while they could refer people, each person as an individual could make a choice whether or not to test.







*Marriage is depends on faith so we won't say get test for HIV before marriage, but voluntarily people still go for testing..... Full session in Bisaralli*

*I had the unsafe sex so by myself I got tested for HIV. Many young men get tested voluntarily because we can diagnose the infection only through testing. I know more than more than 10 people {our friends} who have tested for HIV..... Young man*

There is also awareness about the need to test pregnant women in all villages. Communities speak about pregnant women testing practically as a norm in their villages. Knowledge about availability of PPTCT services and what it involves is understandably more among the women and young women.

*We knew one pregnant lady who was positive and we sent her to the PPTCT services. Now she has a baby, and both mother and baby are doing fine..... Full session in Devikoppa Thanda*

*All the pregnant women have been getting tested for HIV so that they can protect the new born babies. If any woman tests positive, then her husband*

#### Understanding Risk and Vulnerabilities

As can be seen from Figure 8 and 9, around 78 % of the villages felt that they were on Level 1 on this domain in the baseline. In the endline, around 90 % of the communities felt that they were on Level 4.

### Distribution of Village Self Assessment Scores : Understanding Risk and Vulnerability

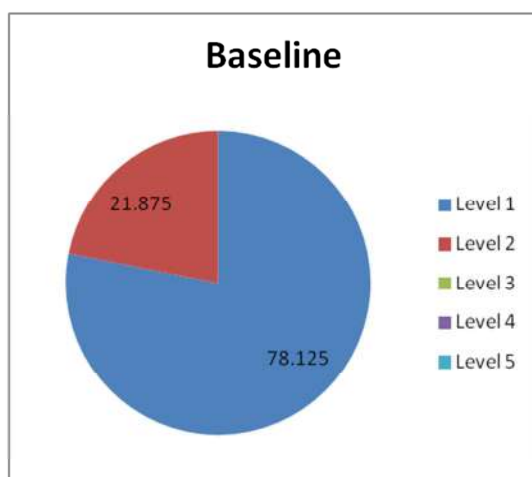


Figure 10 : Baseline Assessment: Understanding Risk and Vulnerability

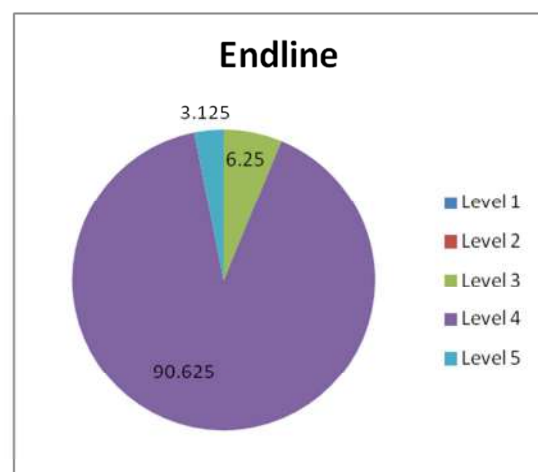
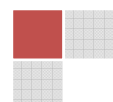



Figure 11: Endline Assessment: Understanding Risk and Vulnerability





Some of the major changes identified by the community in order to support the improved assessments are discussed below.

#### **Acknowledgement of risk and promotion of condom access and use**

26 village communities report better condom access and more than half the communities report that there is an openness to talk about condoms in different groups. Hesitancy to talk publicly about condoms was reported only in the young women's groups and that too only in 6 of the villages.

*All the villagers have known the condoms which are available in Government hospitals. We even put a condom outlet box in our village, but children used to get the condoms and play with it by making balloons. So we removed the box. But some people are still stocking condoms.... Village Session in K Hunashikatti*

*External contacts may still happen, but the usage of condoms has also increased. Condoms prevent HIV, STI and unwanted pregnancy and we are all openly discussing about all this..... Full Session in Bhogenagarakoppa*

*We used to laugh if we spoke about condoms. We didn't know how to use it. Now it is available in the village itself and we all know how to use it. When we get together as friends, we are talking about this and promoting its use..... Man in Devikoppa Thanda*

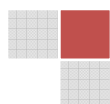
#### **Communities reaching out to vulnerable groups with information on safe behavior:**

The community awareness of risk and vulnerability goes beyond just condom awareness. They all acknowledge the vulnerability of migrant workers and also actively try to reach out to them. Almost half the groups speak of specific attempts to reach out to migrants, give them appropriate knowledge and help them adopt safe practices when they are away. This is seen both in the men's and women's groups.

In their attempt to reach out to migrants, sometimes even the gender and age boundaries are transcended, with mothers advising their sons to be safe.

*We are telling our young men at home about being safe. Children go to other places for education and for work also, who knows, who has risk and who doesn't have it..... Women of Bisaralli*

*Before their migration and after they get back also, we discuss with the people. Most of them know about condoms because we told them. They are using it when they are away from here....Full session.*



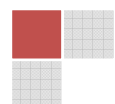


### **Behavior Changes in the Community**

Six of the communities also discuss about gradual norm changes in the community, promoting safe behavior, and safe migration, reducing number of partners and reducing risk taking behavior among people and encouraging each other to be safe.

*If we find any risk in our friend's behavior, we educate them and advice to use condoms..... Young men of Junjunabailu*

*We all knew about condoms, its available in all government hospitals, medical stores, and petty shops. Youth have also been stocking the condoms. We also banned all arrack and brandy shops since it increases risk..... Young men in Hindsageri*





---

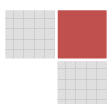
## CONCLUSIONS:

When Samraksha started the NamBaduku process in Kalghatagi, it was with the objective of demonstrating community competence in evolving local responses to address HIV issues in a sustainable manner. The NamBaduku process appears to offer the kind of structural intervention that is critically needed to complement individualized behavior change programmes. Structural interventions have been conventionally seen as seeking to bring changes in the law, policy or social and institutional systems that reduce marginalization and power differentials. The perspective that community mobilization for a transformational change in attitudes (Gupta et.al, 2008) is also a structural intervention is new. Its potential in releasing the social capital of communities towards creating sustainable local responses could be seen in Kalghatagi.

Changes in the community never take place in a linear fashion or at a definite point in time, but are staggered and often occurs as a series of incremental steps. The self assessment process provided the flexibility of design to capture these changes, both anticipated and unanticipated. It also offers a community controlled tracking mechanism to capture a continuous process of change in a dynamic setting such as the community.

The NamBaduku process in Kalghatagi has had some tangible outcomes:

1. It has been able to involve multiple groups in the discussion on HIV and strengthen understanding in all groups. There is now an environment, where discussions on HIV are possible within the community, and these discussions are then able to continuously reinforce learning within the communities
2. It has addressed the fear of transmission through casual interaction within communities and reassured them that interaction with people with HIV will not harm them. In all communities there is a change of attitude towards people with HIV.
3. It has helped communities to recognize their capacity to support people with HIV as well as their responsibility to do so. There is now an inclusive spirit in the communities, as they no longer see people with HIV as an 'undesirable other', but realize their own role in caring for and supporting them.
4. It has helped familiarize the communities with HIV prevention, care and support services. Currently, communities know about the services and are willing to access or refer people to them whenever appropriate.
5. It has considerably increased communities' knowledge about condoms and also a willingness to talk about it. Consequently, condoms are reported to be more readily available and accessible in the community. Communities identify groups like migrants and young people to be vulnerable, and have also taken initiative in addressing their vulnerability by speaking to them about the issue, giving advice before migrant workers or students move away and developing peer groups who advice and promote safe behavior among each other.





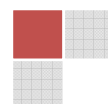
---

# ANNEXURE 1

Samraksha's *NamBaduku* process of perspective building involves a series of community engagement processes which can loosely be seen in three distinct stages

1. **A Social Mapping of the Village**, which helps the team of 5-6 catalysts from Samraksha to understand the social dynamics of the village, identify key opinion leaders and also identify the community resources and the unique strengths of the community. The opening session is a meeting with all the opinion leaders, which introduces the issue to the community and initiates a discussion on whether they think this is relevant and whether they want to do something about it. If yes, the team requests the community to host it for 3-4 days – food and shelter and accompaniment for 6-8 community volunteers.
2. **Perspective Building Process** where the team attempts to cover the entire village through one-one or one-group discussions, informal meetings, street level discussions, games and interactive activities and an interactive street play. Here, there are no “educational sessions”, but the team initiates and facilitates dialogue and discussions and derives responses from the community itself
3. **A Social Action Process**, where again the entire community gets together for a concluding meeting, reflecting on what they have learnt and understood over the past few days, make a commitment for action, and draw up an action plan.

Following this primary process, follow-up visits are made to identify and appreciate community capacities and the changes which they have already achieved.







Samraksha started in 1993 as the HIV/AIDS sector of a larger developmental organization, Samuha. Now an independent trust, its goal continues to be to prevent the transmission of HIV and reduce its impact on the people vulnerable to and affected by it. Its current areas of operation are Raichur, Koppal, Gadag, Haveri, Dharwad and Uttara Kannada districts of Karnataka.

Samraksha believes that individuals and communities, if armed with information and power, can and will take responsibility to halt the spread of the epidemic. It believes that it is critical to empower entire communities to act.

It also believes that it is the right of every person living with HIV and AIDS to access care and support in public, private and social sector. It is the responsibility of individuals, communities, private sector and the State to ensure this. Its belief in a prevention to care continuum has led to a range of initiatives across this spectrum.

Samraksha,  
17, 1st Cross, 3rd Main, SBM Colony,  
Anand Nagar, Bangalore - 560 024.  
Karnataka.  
Phone: +91-80-23545161  
e-mail: [samraksha@samraksha.org](mailto:samraksha@samraksha.org)  
Website: [www.samraksha.org](http://www.samraksha.org)

Publication and Dissemination of this document is supported by Karnataka Health Promotion Trust