

# Project Sakhyam

## Report on Awareness Campaign and Communication & Community Empowerment Plan

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Supported by LEPR



**i-land informatics Limited**  
58/114 Prince Anwar Shah Road  
Lake Gardens, Kolkata – 700 045

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## **Introduction**

Project Sakhyam being implemented by Lepira Society with support from European commission and Interact Worldwide UK as the lead partner aims to contribute to improved sexual and reproductive health status and reduced vulnerability for slum dwellers in Bhubaneswar city. In December,2008, i-land informatics limited (trading style banglanatak dot com) undertook awareness campaigns in the slums at Bharatpur, Saliasahi, Malisahi and Niladri Vihar slums to create awareness on importance of sexual and reproductive health (SRH) and goals and objectives of Project Sakhyam. The campaign created a platform for discussion and dialogue with the slum dwellers on their sexual and reproductive health status and has led to improved understanding of the ground realities and health communication needs. This report documents the project process, observations on awareness on sexual reproductive health and also outlines a plan for community skill empowerment for sustainability.

## **Project Overview**

The project targeted assessing behaviour change communication needs for slum dwellers with a focus on adolescents, women and youths and high risk groups like Injected drug users (IDUs), Men having sex with men (MSMs), Female sex workers (FSWs) and Persons living with HIV/AIDS (PLHAs) and design a communication plan for improving their health seeking behaviour and service utilization. Capacity building needs for empowering the slum dwellers for giving mutual support and advocating for equitable access to health services and upholding of their SRH and HIV related rights were also assessed.

The project commenced with slum visits for a rapid assessment of communication needs. Discussions were held with adolescent boys and girls, women and men of different age groups, school teachers, SHG members, members of Health Resource Committee (HRC) formed as part of Project Sakhyam, community mobilisers and peer educators working as part of Project Sakhyam and others. Community based organizations like Sakha working towards advocacy of rights of MSM community, Hope Foundation working with IDUs, Ashray working with female sex workers and KNP plus working with PLHAs were also consulted to understand issues and concerns related to key vulnerable communities. Consultations were also held with staff at ICTCs in Bhubaneshwar Municipal Corporation Hospital and Capital Hospital and Sankalp which runs a drug de-addiction centre.

At present IEC/BCC activities are being carried out by a team of eight community mobilisers (two at each slum, one male and one female) and twelve peer educators. There are four peer educators at Saliasahi, four at Bharatpur, three at Niladri Vihar and one at Malisahi. IEC material is available on causes and symptoms of STI/RTI, ways of transmission of HIV, ways of prevention of HIV.

Ventriloquism shows and street theatre shows were used to create an enabling environment for discussion on sexual reproductive health. The shows facilitated two way communication. The campaign informed the slum dwellers about the goals of Project Sakhyam and the need for community participation for the success of the project.



dwellers. Under the Sakhyam project the organization is currently providing free medicines of OIs to the PLWHAs. Moreover the councilors also visit the slums and occasionally arrange for trainings focusing on sexual health.

To assess communication needs for IDUs, discussions were held with Hope Foundation a community based organization formed by persons who have history of drug addiction but are now de-addicted. Twelve of them run the organization formed in 2007. Members contribute Rs.50 per month. There are around 500 members, some of who are addicted and under treatment. Members of Hope Foundation work with injected drug users (IDUs) across Bhubaneswar city to help them stop drug abuse. They set themselves as role models as they have been able to overcome addiction. Hope Foundation is working at Kalera, Dumduma, Mali Sahi, Vani Vihar, Niladri Vihar, Lakshmisagar , Bharatpur, Units 6 and 8, Station square. Hope Foundation provides services for harm reduction like abscess management, overdose management, creating awareness on safer injection, practice, needle exchange, promotion of substitute drugs, provides referrals to drug de-addiction centres. There are four drug deaddiction centres run by Odd Foundation (Nishtha Project supported by the Government), CYSD (Sahara project supported by the Government), Open Learning System (Sankalp Project funded by the Government), Purbasha (Sambhav project run with private support). Sankalp charges Rs 2100 for 30 days. Hope Foundation creates awareness on increased vulnerability to HIV for IDUs because of sharing of syringes. They distribute IEC materials supplied by LEPRO and OSACS. They also plan to organize meetings with members of families of drug addicts to sensitise people on the importance of family care and support for rehabilitation. Hope Foundation plans to induct a spirit of self help among drug users to overcome addiction.

Sakha is a recently formed (mid 2008) organization of MSMs with 100 members across Bhubaneswar. Sakha targets working with lesbian, gay, bisexual, transsexual, queer, and intersexed people. The organization members mentioned that they are working towards establishing networks with MSMs across the state and envisions establishing country wide network. They have also established linkages with SAATHI. As part of initiatives under Project Sakhyam , SAKHA has taken up condom and lubricant distribution. Sakha organizes informal meetings with MSMs to build awareness on STI and HIV/AIDS and to mobilize use of condoms and lubricants during oral and anal sex. Sakha also provides counseling services. They have started a help line number (0674-2742026) in collaboration with Hope Foundation and IDPR, which works every Tuesday, Wednesday and Thursday. Counseling on sexual orientation, information on SRH, HIV, STI , doctors, clinics etc are provided via helpline. So far not much effort has been made to create awareness on this help line service. Four members of Sakha are working as peer educators.

Discussions were held with members of Ashray an NGO formed with FSWs at Malisahi. There are around 100 female sex workers in one pocket of Malisahi. They have formed four Self Help Groups. They have tried alternative income generating options like phenyl making. They opened bank account and doing transactions. According to ICTC counselors there are few women among the FSWs who are HIV positive. As per Ashray , there is no new entrants in prostitution at Malisahi.

## Overview of slum communities

The slum dwellers are poor, largely uneducated people who toil hard to earn their daily bread. Oriya is the main language of the slum residents. Hindi is more or less understood by all. There are also Hindi, Telegu and Bengali speaking people. There are tribal people like Munda, Hol. There are different Mohallas like Telegu Sahi, Bangali Para, Marwari Basti, Muslim Colony, Christian Sahi, Rickshaw colony, Harijan Sahi etc. based on the profile of the community. There are Hindus, Muslims and Christians among the slum dwellers. Population in the four slums is as follows :

- Malisahi: around 12,000.
- Saliasahi: Population around 1,20,000.
- Niladri Vihar: Population around 50,000.
- Bharatpur: Around 35,000.

The following provides a slum wise overview:

**Saliasali** : There are 36 inter pockets in this large slum. There are both *pucca* as well as *kuccha* households. Water supply is quite good. More than hundreds of overhead tanks are present. People have formed user groups and maintain pumps, pipe line and stand posts. Tribals like Munda, Hole, Bhil live in this slum. Road condition is poor. There is no black top or cement concrete road within the slum. Electricity supply is good. Sanitation is extremely poor in areas like Keute Sahi, Mayfair Basti, Christian Colony, Adivasi Gaon. Most of the youths, men and women are construction labourers. Others are auto drivers, drivers, shop keepers etc. Average family earning is around Rs. 2,000 to Rs. 3,000 per month.

**Niladrivihar** : There are six inter pockets in this slum. Slum dwellers have their own residence. Most of the houses are *pucca*, some are made of stone and mud. There are overhead tanks and stand posts for supplying water. There are few tube wells too. Sanitation is poor. Other than Sitanathnagar and Harekrishnanagar, rest of the slum has dirty and unhygienic condition. People living in areas like Rickshaw Colony and Panda Park are very poor. All houses are electrified. Slum dwellers earn as daily labourers, rickshaw pullers, cart pullers, maid servants, sweepers, small shop keepers etc. Few educated persons are service holder, businessmen, teachers etc. Average family income is around Rs. 2,000 to Rs. 3,000 per month.

**Malisahi** : There are six inter pockets. There is a pocket where around 100 female sex workers live. They mostly live in brick houses. Houses in Harijan Sahi and Rickshaw Colony are made of brick but most of the houses of Muslim colony and Shantinagar are *kuccha*. These areas are very dingy, dirty and unhygienic. Water supply is very poor. There is practically no sanitary latrines. There is one community toilet at Harijansahi. Electricity supply is there. Condition of roads within the slums is very poor. Level of education is very low. Many Kawariwalas live in Muslim Colony and Shantinagar areas. Others earn as rickshaw pullers, cart pullers, small shop owners etc. In Harijan Sahi most are sweepers. Average family earning is around Rs. 1,500 to Rs. 2,500 per month.

**Bharatpur :** Most of the households have brick houses though there are *kuccha* houses also where mostly tribal families live. Slum dwellers have their own residence. There are overhead tanks and stand posts for water supply. Most of the *pucca* houses have latrines. Other slum dwellers defecate in the open. All houses are electrified. Around 70% of youths are literate. Most of the slum dwellers earn by working as construction labourers. Few educated persons are Government service holders and insurance agents. Besides there are auto rickshaw drivers, shop keepers etc. Many unmarried youths out migrate for three to six months to Hyderabad, Bangalore, Goa and other parts of Orissa for work. Average family income is around Rs. 3,000 to Rs. 4,000 per month. Many families living here own television, CD player etc.

Overall health condition of the slum dweller is very poor. Children suffer malnutrition, skin diseases, anaemia etc. Common diseases are cough and cold, fever, diarrhea, stomach ailments etc. Filariasis is an issue. RTI/STI is prevalent among women. Anaemia is common among women. There are people affected with TB and Leprosy. Access to Government health service is poor in all the slums. There is one Homeopathy dispensary at Saliasahi run by Municipality. People lack awareness on schedule of visit of STI van run by LEPRO. Men avoid going to the van as the doctor is a lady. Muslim women are not allowed by their families to avail of services provided by the STI van.

## Consultations with Target Groups & Project Stakeholders



Discussion with representative of Sakha on the vulnerabilities of MSMs in Bhubaneswar



Mr Vikash of Hope Foundation explaining the reasons of high relapse among IDUs.



Understanding the perception of the adolescents on sex and sexuality



Meeting with HRC members at Bharatpur



Understanding the perceptions of women on STI/RTI



Discussion on SRH with slum dwellers



Slum women work as rag pickers



Discussion with SHG member



Interaction with young daily labourers



Unhygienic living condition at Saliasahi



Discussion with MSMs at Bharatpur



Malnutrition is common – a child at Niladrivihar

## Ventriloquism Shows

Ventriloquism is an effective non threatening communication tool. Ventriloquism shows were used to create an enabling environment for communication on sexual reproductive health. 60 ventriloquism shows were held between 18<sup>th</sup> and 29<sup>th</sup> December, 2008 at four slums. 30 shows held in Saliasahi in 30 different inter pockets and 10 shows were held at each of Bharatpur, Niladri Vihar and Malisahi. The shows reached out to more than 1400 adolescents and youths and altogether more than 5000 slum dwellers. Annexure – A provides details of locations, schedule and audience reach for all the shows. The following table provides slum wise details of audience reach.

	# of Shows	Total Reach	12-25 years			25-40 years			> 40 years		
			M	F	Total	M	F	Total	M	F	Total
Saliasahi	30	2260	366	271	637	355	305	760	158	203	361
Malisahi	10	996	131	114	245	124	127	251	53	45	98
NiladriVihar	10	930	152	133	278	104	127	231	73	71	144
Bharatpur	10	907	161	145	306	104	117	221	68	57	125
<b>Total</b>	60	5093	810	663	1466	687	676	1463	352	376	728

The ventriloquism shows informed the slum residents about the goals and objectives of Project Sakhyam. Messages disseminated were as follows:

- Sakhyam project targets improvement of sexual reproductive health status of the slum dwellers and reduction of their vulnerability to HIV/AIDS.
- The project is an initiative of LEPRAs supported by Interact & European Union.
- The project focuses on adolescents, youths and high risk groups like IDUs, MSM, FSW, PLHAs.
- The project is underway at Malisahi, Saliasahi, Niladri Vihar and Bharatpur.

Information was disseminated on drop in centre (DIC) operational at Niladri Vihar where MSMs, IDUs, FSWs & PLHAs can go and avail of counseling facilities or simply relax & talk to one another. People also learned that Health Resource Centres (HRC) have been formed with participation of slum community. Informative flex and posters on STI and HIV/AIDS are available in these information centres. People were encouraged to attend the monthly meetings at HRC for sharing their problems and concerns and exploring possible ways to address them. Names of the peer educators working in the slum and members of HRC were mentioned. Peer educators were also present during the shows. People were told about the mobile STI clinic which comes to the slum on fixed days and provides free treatment for STIs and counseling on hygienic practices, partner treatment etc.

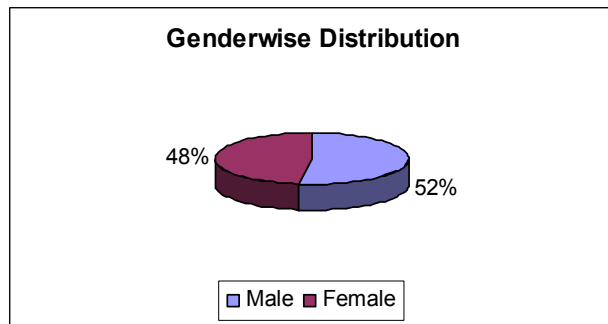
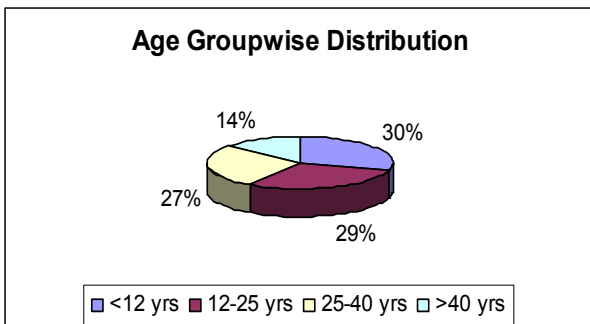
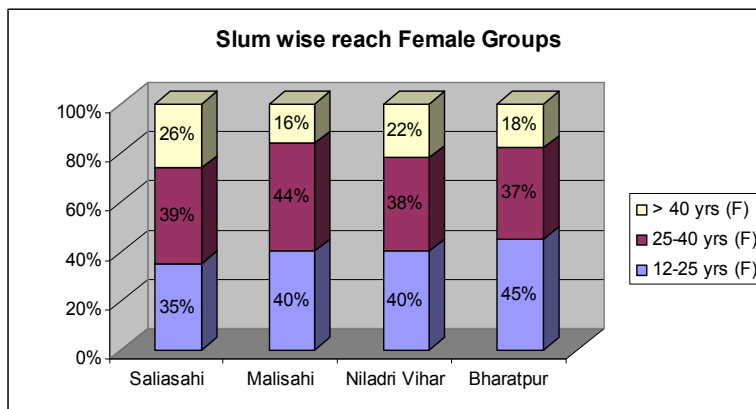
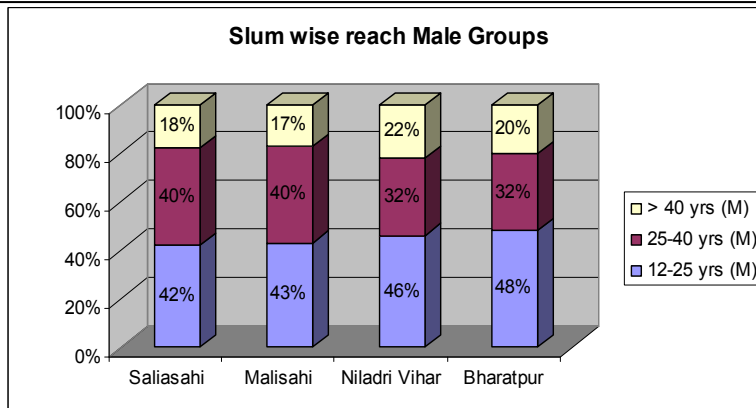
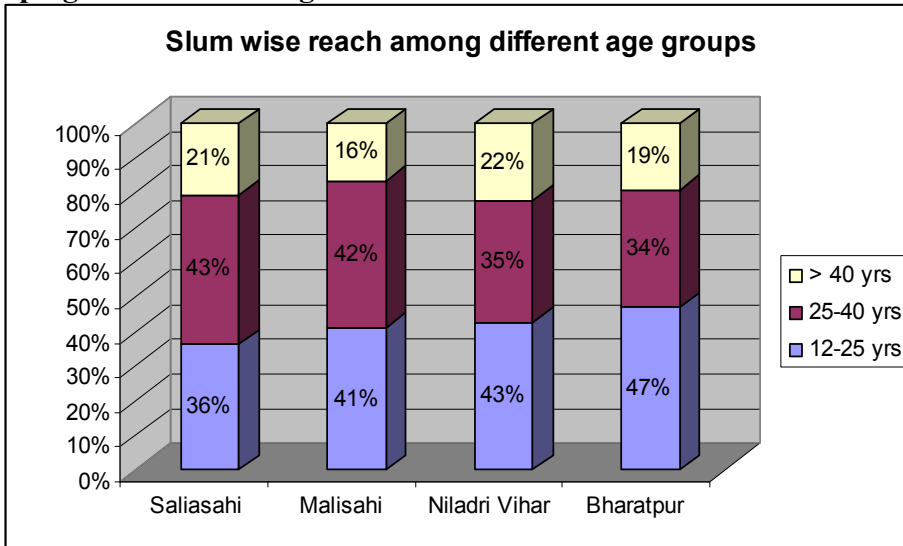
Besides information on the Project, the shows also delved into the theme of importance of sexual reproductive health. It was highlighted that the slum dwellers in general, and adolescents and youths in particular need to be aware of the importance of sexual reproductive health. The latter need to know about safe sexual practices as they are more vulnerable. Basic information on HIV/AIDS was also provided.

At the end of the shows, the talking doll asked the slum dwellers questions about project Sakhyam, Lepra Society, HRC, mobile STI clinic etc. Respondents were given token gifts to enthruse participation. Following are examples of questions asked

- What is the name of the health project underway in this slum?
- Why is community participation important for project success?
- How will slum dwellers be benefited from the project?
- Which organization is working in the project?
- What is HRC?
- Who are members of this HRC?
- Where is the HRC located?
- Where is the DIC located?
- What treatment is provided by the mobile van?
- On which days the STI van comes to this slum?
- How is HIV transmitted?
- Is HIV transmitted through touch?
- Is HIV transmitted through mosquito bite?
- Is HIV transmitted through sharing toilet?
- Is HIV transmitted by living together?

Many slum dwellers mentioned that they had learned about Project Sakhyam, Health Resource Committee (HRC) formed in the slum and about mobile STI clinic from the show. People acknowledged that they needed improved awareness on sexual reproductive health. They however pointed out that access to general health services is very poor. They sought clarifications on why it is important for adolescents to learn about SRH. They also shared their perceptions on issues in accessing health service for FSWs, MSMs, IDUs.

## Campaign Reach : Talking Doll Shows



## Ventriloquism Shows



Show at Bharatpur



Show at Malisahi



Post show interaction at Saliasahi



Distribution of gift to respondent in quiz at Niladrivihar



Show at Niladri Vihar



Interaction during show at Sailasahi

## Street Theatre based Awareness Campaign

*Capacity building of local resource groups:* Theatre workshops were held with two local theatre groups. Orissa Theatre Academy and Jagaran between 20<sup>th</sup> December and 23<sup>rd</sup> December, 2008. Jagaran is a community based theatre group formed with youths living in slums at Patharabandha.

*Campaign Process:* Eighty street theatre shows were held between 24<sup>th</sup> December and 31<sup>st</sup> December, 2008. Two theatre teams worked in parallel in the four slums. The shows reached out to more than 8000 slum dwellers and around 4700 adolescents and youths. The show locations and schedule was planned in consultation with community mobilisers, peer educators and HRC members. Annexure B provides details of locations, schedule and audience reach for all the shows. The following summarises slum wise reach among different age groups.

	# of Shows	Total Reach	12-25 years			26-45 years			> 45 years		
			M	F	Total	M	F	Total	M	F	Total
Saliasahi	35	3079	1078	1008	2086	452	516	968	238	287	525
Malisahi	13	1320	330	374	704	160	237	397	96	123	219
Niladri Vihar	12	1259	399	425	824	107	162	269	76	90	166
Bharatpur	10	2020	588	553	1141	266	304	570	152	157	309
<b>Total</b>	80	8178	2395	2360	4755	985	1219	2204	562	657	1219

*Message plan* The message plan was finalized in consultation with LEPRA based on the observations initial rapid study and LEPRA team. The theatre shows focused on sensitizing adolescents and youths (age group 12- 25 yrs) as well as elders on the importance of good sexual reproductive health to overcome inhibition or reticence in discussing SRH. Gender issues were also addressed. During the communication need study it was observed that parents marry off girls at a young age fearing they will get spoiled and also discriminate between boys and girls. The following risk behaviors observed during the initial communication need study was addressed:

- Poor personal hygiene.
- Prevalence of unprotected sex and multi partner sex.
- High rate of abortion.

Information was disseminated on health services by mobile clinic and also services available at Capital hospital and Municipality hospital. Slum dwellers were encouraged to seek treatment in these places. They were also sensitised on the fact that both partners need treatment for STI/STD.

*The following were the key messages :*

- Project Sakhyam targets improving sexual reproductive health of slum dwellers. Health is more important than wealth. All people are sexual and it is normal and healthy to have sexual desires. Respect your body's desires and your own ability to

make good decisions. SRH is not only related to sex. This is a holistic. It means positive physical, mental and social wellbeing.

- Adolescents and youths must maintain personal hygiene – wash clothes properly after bathing.
- By marrying off girls at a younger age their health is negatively affected. Child bearing at a tender age is bad for health of both mother and child.
- Use of condom prevents pregnancy as well as transfer of STI. Talk to your partner about use of protection. Better safe than be sorry.
- HIV is transmitted through unprotected sex.
- STI, RTI affects our sexual and reproductive health.
- Causes and symptoms of STI/RTI were mentioned. People were advised to go to doctor for continuous itching.
- Unprotected sex with affected partner leads to STI. Both partners must go for STI treatment.
- STI increases vulnerability to spread of HIV.
- HIV testing is done at ICTC at Capital hospital and Municipality hospital. Second testing is required after three months (Window period).
- Recurrent abortion affects women's reproductive health and may lead to infertility.
- Seek health services being offered by the mobile STI clinic from LEpra. STI/RTI treatment services are also offered at the Capital hospital and Municipality hospital. Confidentiality is maintained. Complete treatment.

### *Storyline*

The play starts with a Go as You Like competition where a couple has won to contest. They discuss whether money or health is more important. From this context the man shares how Lepra Society is working in the slums to improve sexual and reproductive health of slum dwellers as part of Project Sakhyam.

Mean while one of the young men in the slum, Devdas, comes and shares about his love for a fourteen year old girl in the slum. Devdas does not follow the rudiments of hygiene. His friends explain that he should not think of marriage as marrying off at such a young age is not good for the health of the girl. They also make Devdas aware of need for cleanliness and hygiene for being popular among girls. Another friend joins the discussion. He has many sexual partners. He shares that he got tested at ICTC of Capital Hospital and he is not HIV infected because he always use condom. But one of his friends who had not used condom was infected.

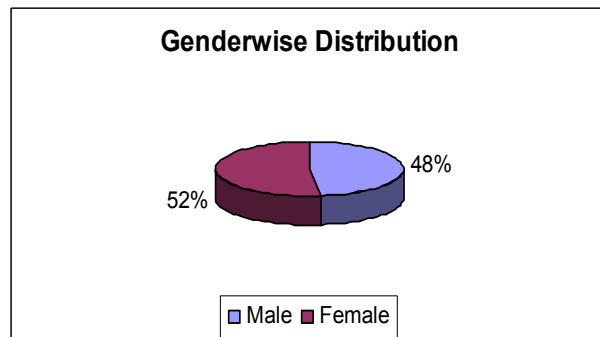
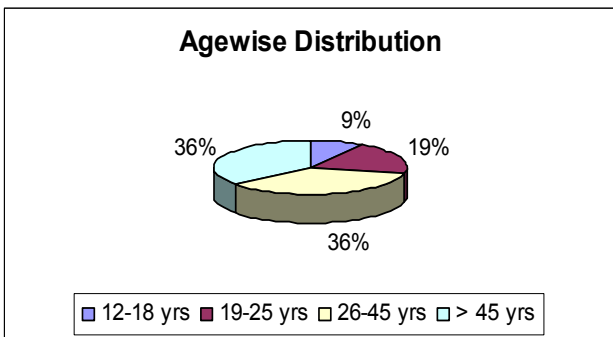
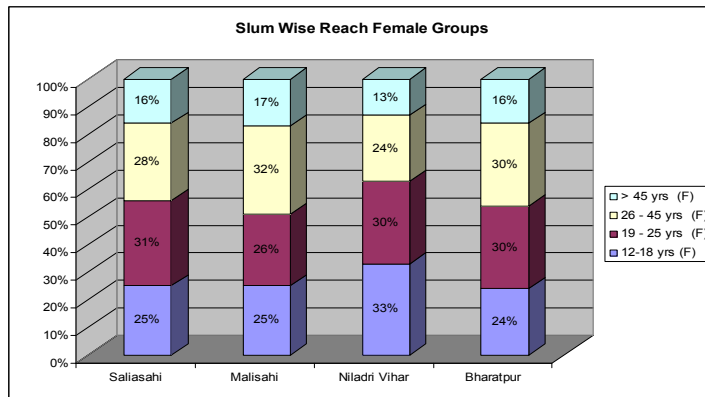
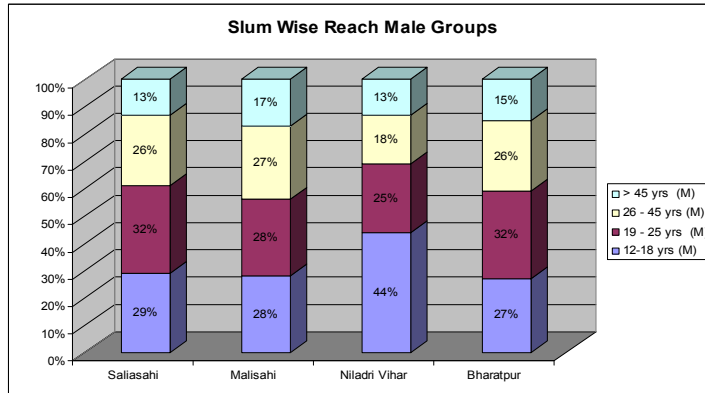
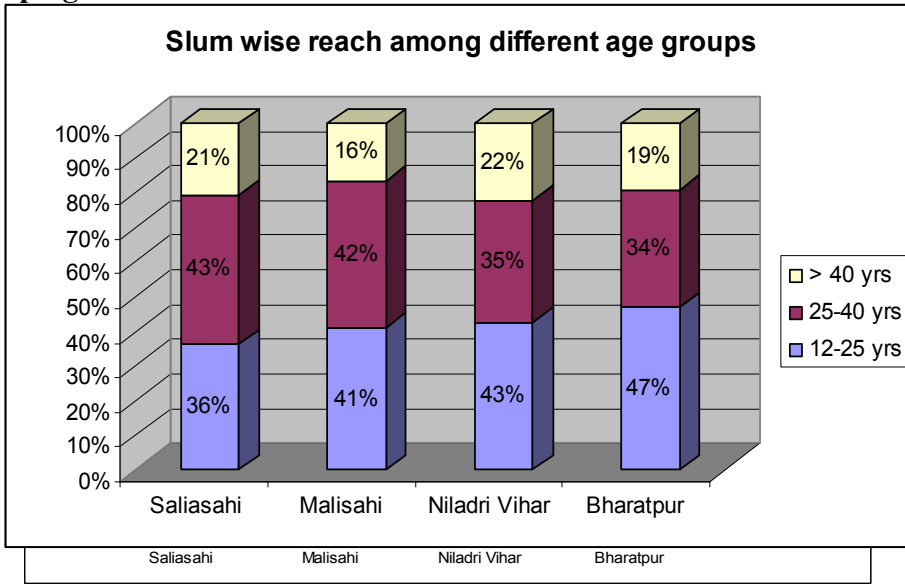
The young man who played the role of husband in Go As You Like actually wanted to marry the girl who enacted the role of wife. But the latter refused saying she is too young to get married and early marriage may affect her reproductive health. She shared how one of her older friends was suffering from RTI and her husband had STI. The young man then told that she should inform them of the services provided by Project Sakhyam on STI/RTI and risk of untreated STI.

In the last scene, a clean Devdas comes and proposes this love and they take oath to create awareness among slum dwellers on Project Sakhyam and sexual reproductive health.

The street theatre shows were very effective in creating awareness on Project Sakhyam, the mobile STI clinic which visits the slum and familiarized the slum dwellers with the peer educators. Slum women acknowledged that many suffer from STI and RTI but they are ashamed to go for treatment. Many said that they were unaware of the importance of both partners getting treated. Adolescent girls appreciated the shows saying that they do not have any access to information on SRH. Youths acknowledged that multi partner sex is prevalent but they do not use condoms regularly. Many said that they have learned about the mobile STI clinic from the shows.

The project has been effective in establishing two way communications with slum dwellers on the issue of sexual reproductive health. While the slum dwellers learned about Project Sakhyam they shared their own concerns and acknowledged lack of awareness and vulnerability factors.

# Campaign Reach :Street Theatre Shows



## Street Theatre Shows



Show at Mundasahi, Bharatpur



Show at Bharatpur



Show at Niladri Vihar



Show at Science Park, Niladri Vihar



Show at Malisahi



Show at Muslim Colony, Malisahi

## **Communication Needs**

The communication needs presented in this section is based on inputs provided by different CBOs partnering with the Project Sakhyam team, community mobilisers of LEpra, health service providers, peer educators working under Project Sakhyam and the slum dwellers at large during and after the ventriloquism and street theatre shows. The following details communication needs identified for each target group along with information on sexual and reproductive health status and factors leading to vulnerability to poor SRH and HIV/AIDS.

### **1. Adolescents and Youths**

- 1.1. Early start of sex life, prevalence of multi partner sex and low use of condoms make the adolescents extremely vulnerable to poor SRH. Peer educators and adolescent boys mentioned that boys start having active sex life early. They experiment with sex with members from inside and outside the community. They visit commercial sex workers, sometimes in group. Casual sex with multiple partners in the slum is prevalent.
- 1.2. There is low risk perception among the adolescents and youths. Many commented that though they have sex with multiple partners, as the latter are known there is less risk.
- 1.3. Usage of condom is low owing to low risk perception and perceptions like condom causes itching, loss of pleasure, weakness in erection etc.
- 1.4. For girls, low age of marriage is a key vulnerability factor. A good number of girls are married off at around 12-14 years as parents feel daughters are burdens. Early marriage leads to poor reproductive and child health owing to low child bearing age and lack of nutrition of the young mothers. It was also learned that there is infant mortality owing to lack of awareness on new born care by the young mothers.
- 1.5. Lack of access to accurate information on ARSH (adolescent sexual reproductive health) is an issue.
  - 1.5.1. The adolescents are not very clear about sex and sexuality. They do not have any space to share these issues. Adolescents are very much inhibited to talk regarding these issues.
  - 1.5.2. Their parents do not discuss about these issues with them. Parents were found unaware of importance of making their children aware of sexual reproductive health. During our discussions we found that they are quite skeptic of talking of protected sex openly with young boys and girls. In Niladri Vihar, installation of condom boxes faced resistance and the boxes installed were broken.
  - 1.5.3. Most of the adolescents at Niladri Vihar, Malisahi, and Saliasahi are school drop outs and thus it is difficult to reach out to them. Reaching out to the out of school adolescent boys is a problem as most of them work to earn a living. At Malisahi boys and girls drop out after primary level of education. At Saliasahi girls out after class VI-VII while boys usually complete till secondary level. At Niladri Vihar most children go to school till secondary level. However many girls drop out even before. Only at Bharatpur rate of

drop out is low with girls completing education till school level and many boys going for college education. At Niladri Vihar most boys and girls study till secondary level. Many girls drop out even before.

- 1.5.4. LEPPRA targets reaching out to the adolescents and youths through peer educators and adolescent and youth support groups. The peer educators mentioned that they have initiated formation of adolescent and youth support groups. So far few such groups have been formed.
- 1.6. Alcoholism and drug abuse increase vulnerability. Country liquor (Handia) is popular. Youths mentioned that while in a state of intoxication one forgets about ensuring safe sex. Boys use opium, brown sugar and intra venous drugs.
- 1.7. Poor personal hygiene owing to lack of awareness and the extremely unhygienic living environment increase vulnerability to STI/RTI. People do not wash clothes properly. Poor menstrual hygiene leads to RTI among girls and women to RTI.
- 1.8. There is low awareness on contraception. Unsafe abortion by quacks lead to poor reproductive health. It was learned that a recent trend is use of i-pill by girls after unsafe sex to avoid pregnancy.
- 1.9. There is in general no awareness on nutrition. Malnutrition is high in all four slums.
- 1.10. Young girls suffer from anaemia. In Bharatpur, an NGO named Ashirbad provides iron pills to adolescent girls as part of RCH program.
- 1.11. Unprotected sex is common among adolescence, youths and adults. Some feel that condom may reduce pleasure. Youths of Saliasahi remarked that good looking FSWs are not infected.
- 1.12. Shyness also deters condom use. Young men in the slums said that they take condoms from the boxes in the evening.
- 1.13. Lack of awareness on sex and sexuality create confusion among the adolescents. Few boys aged 14 or 15 years said that they have had sex with men though they are not sure whether that is their sexual preference. These boys also faced harassment from families and neighbours.
- 1.14. Young girls and married women at Malisahi face sexual abuse by family members and neighbours.
- 1.15. Despite at risk behaviour few check their HIV status. They fear ostracisation and victimization besides being fearful about the disease.

## 2. Women

- 2.1. Low social status of women detracts ability to negotiate safe sex with partner and also affects health seeking behaviour. In Muslim families for example women are not allowed to take health decisions. It was observed that tribal women do not have any idea on condom.
- 2.2. There is no awareness on implications of low age of mother at child birth on her or her child's health. Women, usually married by 14 years, become mothers at 16-17 years of age. Lack of awareness on child care also leads to high infant mortality.
- 2.3. Girls and women lack awareness on their rights. No importance is given to the education of girl child. Daughters are treated as burden.
- 2.4. There is lack of awareness on contraception and safe abortion. During the shows women in Bharatpur and Niladri Vihar for example sought clarifications on

liagation / vasectomy etc. Women mentioned using Sukhi as a regular contraception. Violence against women is prevalent. Women mentioned that their husbands when drunk beat them.

- 2.5. Poor personal hygiene owing to lack of awareness and the extremely unhygienic living environment increase vulnerability to STI/RTI. People do not wash clothes properly. Poor menstrual hygiene leads to RTI among girls and women to RTI.
- 2.6. Multi partner sex is prevalent among women.
- 2.7. Women were found quite unaware of ICTC, ART, PPTCT services.

### **3. Injected Drug Users**

- 3.1. Drug abuse of different kinds is prevalent across the city and in the slums covered by the project. Other than intravenous drug use smack and brown sugar are also used. Malisahi is a drug peddling zone.
- 3.2. The youths are not aware of detrimental effect of drug abuse. Lack of employment, disillusionment among youths increase vulnerability to addiction. As per Hope foundation, 60% of IDUs are youths less than 30 years old. Around three fourth of the IDUs are unemployed. 75% of the IDUs are unemployed. Other do menial work, daily labour, run auto etc.
- 3.3. Vulnerability to HIV is high among IDUs as the practice of needle sharing is common. Risk perception is poor. As a result few test their HIV status. IDUs think that there is no risk if they share needle among themselves. They opine needle costs money. Secretary of Hope Foundation shared that they have information about around thousand IDUs at Bhubaneswar, around 90% of whom are HIV positive.
- 3.4. Slum communities do not have any empathy for the addicts. The slum dwellers said that the drug users are thieves and unsafe for the community as they can also affect other youths. They feel that the drug users should be handed over to the police. Peer educators commented that lack of support and mistrust by family members and neighbours, joblessness are barriers to return to normal ways of life.
- 3.5. There is lack of awareness on harm reduction, de-addiction and rehabilitation services.

### **4. Men having sex with men ( known as *Kotis* or *Chakka*)**

- 4.1. Vulnerability to STI and HIV/AIDS is high as MSMs often have unprotected sex.
  - 4.1.1. We learned from members of Sakha and MSMs who had come forward for post show interaction that MSMs think anal sex is safe sex and there is no need for using condom. Many do not use condoms during oral sex.
  - 4.1.2. Low use of condom is also due to their nature of sexual encounter. MSMs lack safe space. For many, their sexual partners are also irregular. As for example they have sexual encounters in public places like Indira Gandhi Park, Forest Park, Science Park, Vani Vihar, movie halls like Rabi Talkies, open spaces like Patra Para, garden of Linga Raj and Mousima temple etc. They mentioned that they usually do not have condoms with them during these unplanned encounters.
  - 4.1.3. Shyness is an issue. MSMs mentioned that they feel shy in taking condoms from the condom boxes.

- 4.2. Vulnerability to HIV is also high as MSMs have multiple and irregular partners. Some are bisexual. There are many sex workers among MSMs.
  - 4.2.1. Risk of secondary spread is also high. MSMs with wives mentioned not using condom with their wives.
- 4.3. Use of injected drugs and sharing of needles by MSMs further increase risk of spread of HIV.
- 4.4. Members of Sakha pointed out that lack of employment, discrimination at work place (even leading to loss of job), low level of education are factors which are pushing many into sex work. Many from low strata of society do not see value of education and thus have not completed even school level of education. A few are dancers, actors and singers. Some pose as transgender.
- 4.5. In general most of the MSMs who have declared their sexual preferences are of low economic status. Sakha members mentioned that the more affluent among the MSMs do not come out in the open. In general, compared to the situation few years back, with improved networking more MSMs are openly expressing their sexual preferences.
- 4.6. MSMs face much stigma and abuse. While discussing with slum dwellers it was found that there is little understanding or acceptance about their sexual preferences. In general people think that MSMs have psychological disorders. “*Nakhra kar rahein hain*” or “*Uta hai. Maar Khayega to sidhe raste pe ayega*”. It was observed and also learned from members of Sakha that MSMs are teased, sexually abused and face rude and unfriendly behaviour. Lodging complaints about sexual abuse to police does not help. Situations lead to violence and there have been cases where the MSMs have beaten up their abusers in public. There are also cases where the Police have abused the MSMs.
- 4.7. MSMs shared that they are unable to exercise their basic human rights. Sakha members shared various stories of discrimination like how people have lost jobs when their sexual preferences have been found and difficulty faced in reserving train ticket or examination forms. They said that discrimination begins from the family and immediate neighbourhood. If the families provide support they could have led a better life. But in many cases the MSMs have had to leave home and find refuge with other MSMs.
- 4.8. Health seeking behaviour is poor owing to discrimination faced from doctors. Cases of doctors refusing treatment were reported by Sakha. MSMs are stigmatized as source of STDs. Doctors often do not maintain confidentiality and tell people about their sexual preference and that they have STD. MSMs are thus reluctant to go to doctors and also ICTCs. This deters getting accurate information on HIV status among MSMs.
- 4.9. Lack of family support – MSMs believe that discrimination begins from the family and immediate neighbourhood. If the family comes up in defense, then they can live with the rights enjoyed by others. But in many cases the MSMs have to leave home and find refuge elsewhere along with other MSMs. During discussions MSMs felt that families and community at large need to understand that sexual preference is not a measure of personality or goodness.
- 4.10. During discussions with MSMs residing in the slum it was observed that they are not comfortable with other members of their society. Disclosure of

sexual preference has improved. MSMs were afraid of coming out in the open even a few years back. But now with active networks supporting them they are more confident in sharing their views about sexual preferences.

- 4.11. MSMs lack awareness on STI or HIV/AIDS.
- 4.12. Low level of awareness on use of lubricants.

## 5. Female Sex Workers

- 5.1. Members of Ashray – a NGO formed by the sex workers mentioned that the women use condoms with clients. However they do not use condoms with regular partners or husbands.
- 5.2. As per the peer educators, the flying sex workers women do not practice safe sex and are not aware of HIV/AIDS.
- 5.3. FSWs were found quite aware of contraception, STI, RTI and HIV/AIDS. Knowledge of safe abortion is low. They go to private clinics and Capital Hospital for STI/RTI treatment. Some times they use services of quacks.
- 5.4. Awareness on safe abortion is low.
- 5.5. At Malisahi it was learned from the slum dwellers that children of FSWs are discriminated against at school or hospital.

## 6. PLHAs

- 6.1. Slum dwellers need to be made aware of ways in which HIV does not spread. A common misconception is HIV may be transmitted via mosquito bite.
- 6.2. Stigmatisation and discrimination deters testing of HIV status as well as disclosure. KNP+ mentioned stigmatization and discrimination against spouse and children of PLHAs. Discrimination is also faced at work place, in neighbourhood and at market places. Doctors and medical staff harass PLHAs. They use gloves and masks creating misconceptions about ways of transmission of virus. Often PLHAs are given beds in unhygienic / unclean conditions.
- 6.3. There is need to stop stigmatization of PLHAs. The more aged slum dwellers were found to have a bias against PLHAs. They mentioned that PLHAs are bad examples (immoral) and should not be allowed to live in the slum. The youths mentioned that PLHAs have got infected owing to unsafe practices but they should be taken care of.
- 6.4. Youths mentioned that health looking persons will not be HIV positive.
- 6.5. There is little awareness on testing, treatment, care and support services. The only ART service is at Berhampur.
- 6.6. Economic burden of HIV/AIDS is high. PLHAs in the slums have lost strength to work as they are affected with TB.

The following table summarises behaviour change communication (BCC) and skill empowerment needs for different target groups and KVCs along with a cross referencing with the detailed observations presented in the previous section.

<b>BCC / Capacity Building Needs</b>	<b>Detail Ref</b>	<b>Target Group</b>
Gender roles – addressing stereotypes, Gender Rights	1.4, 1.14, 2.1, 2.2, 2.3	Adolescents, Youths, Women
Effect of early marriage on reproductive health as well as health of children	1.4	Adolescents, Parents
Nutrition, signs and symptoms of common nutritional deficiencies	1.9, 1.10	Adolescent boys and girls, Women, Mothers
Hygiene & Sanitation	1.7	Slum dwellers
Saying no to drugs, alcohol, experiment with sex, resisting peer pressure	1.1, 1.13, 3.1	Adolescents, Youths
Use of condoms in all sexual encounters for protection against STD/HIV	1.3, 1.8, 2.1, 4.1, 5.2	Adolescents, Youths, Tribal women, MSM, Flying sex workers
Negotiating safe sex – use of condoms with husbands and regular partners	1.2, 4.2, 5.1	Adolescents, Youths, Women, FSW, MSM
Adopting safe and responsible sexual behaviour – the need to abstain, being faithful, delaying sexual debut and avoiding experimentation, casual and commercial sex, overcoming shyness as barrier	1.11, 1.4, 1.12, 2.4, 2.6	Adolescents, Youths, Men, Women
Menstrual hygiene	1.7, 2.3	Girls, women
Contraception methods and services	1.8, 2.2	Girls, Women
Safe abortion	1.8, 2.2, 5.3, 5.4	Girls, Women, FSW
Prevention and management of STI/STD	1.5, 2.3, 4.11	Adolescents, Youths, Women, MSM
Symptoms, causes and treatment of RTI	2.5	Adolescent girls, Women
Transmission of HIV through sharing of needles	3.2, 3.3, 4.3	Youths, Adolescents, Drug users, MSMs
Accessing de-addiction and harm reduction services for IDUs / drug users	3.5	Drug users & families, Youths, Adolescents
Supportive environment for IDUs, MSMs	3.4, 4.5, 4.6, 4.7, 4.9	Family and immediate neighbours
Basic Awareness on HIV/AIDS, misconceptions on HIV/AIDS	1.3, 1.6, 1.8, 6.1, 6.4	Adolescents, youths, slum dwellers
Risk Perception of HIV/AIDS, voluntary testing	3.3, 4.8, 4.11, 5.2	Adolescents, youths, FSW, MSM
Care and support for PLHAs	6.3	Slum dwellers
Prevention of discrimination in health care settings	4.8, 5.5, 6.2	Doctors, medical staff
Availing of ICTC, PPTCT, ART services	2.7, 3.3, 4.8, 6.5	FSW, MSM, PLHA, Slum dwellers
Not stigmatizing sexual choices and preference	4.10	Slum dwellers, MSM

## **Communication Plan**

The following plan is in line with the programme priorities of NACP- III where prevention is the mainstay of the strategic response to HIV/AIDS. NACP-III places the highest priority on preventive efforts while, at the same time, seeks to integrate prevention with care, support and treatment.

### **Strengthening access to information**

A first step towards strengthening access to SRH information and services could be establishing a routine of operationalising information centres at the HRCs and DICs already established and also scheduling visit by the IEC van at fixed time and days of the week. Information on timing of information centres should be disseminated using posters, banners, wall writing and miking. The schedule for STI clinic visit to the slum should be similarly planned and communicated. The IEC van and the resource centres need to be equipped with printed IEC material with adequate illustrations. Currently posters are available only on STI, ways in which HIV is transmitted and ways in which it is not. Informative material (leaflets, booklets) on causes and symptoms of STI, RTI, posters addressing myths associated with HIV like HIV is transmitted through mosquito bite or a health looking person is not HIV positive may be addressed by appropriate posters. It is also necessary to develop age appropriate communication material for adolescents. Other areas where IEC material needs to be developed are nutrition, contraception, proper use of condoms and lubricants (for MSM), effect of drug abuse and safe abortion.

### **Capacity building of peer educators**

The community mobilisers and peer educators are working hard to educate the slum dwellers. However the presently used target oriented approach of making a number of house visits or talking to a set number of persons needs to be changed into one of inspiring change and creating motivation for improving access to health services. Skill building is needed in non threatening approaches of behaviour change communication and also for developing leadership skills, communication skills etc.

### **Improving reach among target groups**

Reaching out to the youths, adolescents and women in the slums and mobilizing behaviour change within a specific time frame is difficult owing to their large number, reluctance or inhibition in participating in discussions on issues like SRH and lack of time owing to their schedule of work. Innovative strategies are thus needed to maximise reach. It is suggested that sports events be regularly organized on Sundays and holidays to assemble young boys and youths. This will greatly strengthen the nascent process of forming adolescent groups. Similar events may be organised for assembling women and girls where competitions like garlanding, vegetable cutting, conch blowing etc. may be undertaken. These assemblies may be then used for motivating participation of adolescents, youths and women in Project Sakhyam.

A tremendous community based resource available in slums like Saliasahi and Bharatpur are the self help groups of women. There are 106 self help groups at Saliasahi and 80 at Bharatpur. SHGs are also present at Niladrivihar and Malisahi. Focused interventions

need to be taken to sensitise these women on the importance of SRH and their role in mobilising change. Skill empowerment workshops are needed to build their awareness on SRH, HIV/AIDS as well as to strengthen their communication skills and leadership skills. Theatre in Development methodologies may be used effectively for life skill building as well as awareness generation of these women who lack formal education. The user groups who manage the water supply system at Saliasahi may also be mobilized to work with Sakhyam team for reaching out to the slum community.

### **Focus Group interventions/ Workshops**

Besides mass awareness campaigns targeted interventions via focus group meetings and workshops is needed for mobilizing behaviour change. Detailed discussion on sex and sexuality for example may be held with adolescents in a workshop held at HRC or DIC. A strategy for improving reach among the target groups has already been outlined. Workshops may be held with boys and men to empower them to resist peer pressure, say No to drugs and alcohol etc. Workshops with girls may target building confidence, self esteem awareness on rights etc.

The skill empowerment for MSMs, IDUs, PLHAs have to be planned in close coordination with the CBOs. Capacity building workshops should be held with CBO members to develop leadership and communication skills. Detailed plan of action for reaching out to KVCs need to be drawn up through consultative workshops with CBOs, peer educators.

### **Awareness Campaigns**

There are plans to show informative audio visuals using IEC van. It is recommended to use interactive street theatre as a primary communication tool. Approaches like magnet theatre may also be explored. An effective strategy will be training youths and adolescents in the slums to communicate using theatre on health issues. The next section suggests a phased communication plan to address the diverse communication needs already discussed.

### **Research needs**

Unemployment is a key problem for the target communities. An action research is suggested to determine ways for addressing livelihood issues for youths, women, FSWs, MSMs as well as PLHAs.

## Campaign Plan

Phase	Theme	Slum	Messages
I	Nutrition, signs and symptoms of common nutritional deficiencies	All	<ul style="list-style-type: none"> <li>▪ Symptoms of malnutrition</li> <li>▪ Causes of malnutrition</li> <li>▪ Effects of malnutrition</li> <li>▪ Good food habit</li> <li>▪ Common and less costly nutritious foods available</li> <li>▪ Health and hygiene</li> <li>▪ Prevention of Anaemia</li> </ul>
	Hygiene and sanitation	Malisahi, Saliasahi, Niladri Vihar	<ul style="list-style-type: none"> <li>▪ Lack of sanitation and unhygienic life style leads to wide prevalence of stomach ailments.</li> <li>▪ Skin disease are common because of poor hygiene.</li> <li>▪ Unhygienic lifestyle leads to a number of diseases, including STI</li> <li>▪ Hygiene is an issue for the female in the time of menstruation, pregnancy and post pregnancy care</li> </ul>
II	Gender roles – addressing stereotypes, Gender Rights	All	<ul style="list-style-type: none"> <li>▪ Treat girl child with the same care as boy child.</li> <li>▪ Let the girl child complete her education.</li> <li>▪ Men have an important role to play to improve the women’s status</li> <li>▪ Sexual abuse with women and girl must be prevented by community</li> <li>▪ If given equal chances and opportunities girls can also achieve anything and bring pride to their families.</li> </ul>
	Effect of early marriage on reproductive health as well as health of children	All	<ul style="list-style-type: none"> <li>▪ Legal age of marriage of girls</li> <li>▪ Early marriage disturbs the natural growth of women</li> <li>▪ An unhealthy mother in turn, gives birth to an unhealthy child.</li> <li>▪ Repeated abortion in early age can lead complication in reproductive health</li> </ul>
III	Family planning and Contraception	All	<ul style="list-style-type: none"> <li>▪ Methods of family planning</li> <li>▪ Use of condom.</li> <li>▪ Knowledge on pills</li> <li>▪ Repeated use of emergency</li> </ul>

			<p>contraceptive pills may create complications.</p> <ul style="list-style-type: none"> <li>Family planning is important for better RCH</li> </ul>
	Use of condoms in all sexual encounters for protection against STD/HIV	All	<ul style="list-style-type: none"> <li>Safe and responsible sexual behaviour is needed to protect our family</li> <li>Condom protects from risk of spreading HIV, STI, STD</li> <li>Condom helps in preventing unwanted pregnancy</li> </ul>
	STI/STD	All	<ul style="list-style-type: none"> <li>STI is Sexually Transmitted Infection.</li> <li>STIs are curable.</li> <li>STIs have identifiable symptoms.</li> <li>Untreated STI increases risk of contracting HIV.</li> <li>Treatment of both the partners is important for complete cure.</li> <li>Complete medication for cure.</li> <li>Awareness on Mobile STI clinic and the services offered</li> <li>How to access testing and treatment services</li> </ul>
IV	HIV/AIDS Risk Perception of HIV/AIDS, Misconceptions on HIV/AIDS ICTC, PPTCT, ART services	All	<ul style="list-style-type: none"> <li>Four routes of HIV transmission</li> <li>It can happen to me</li> </ul> <p>Addressing Misconception like Persons affected with HIV/AIDS has weak physique, shivers etc., HIV is transmitted by mosquito bite., HIV is transmitted by sharing of towels., HIV is transmitted by sharing toilet., An HIV infected person can be identified by looks., One can detect HIV/AIDS from urine test., Sex within close group does not spread HIV, Unprotected sex with good looking FSW is safe.</p> <ul style="list-style-type: none"> <li>Blood test is the only way to find out if a person is infected with HIV</li> <li>ICTC services available at Bhubaneswar</li> <li>If a pregnant mother is infected with HIV, then the child will not be infected if PPTCT services are availed</li> </ul>

			<ul style="list-style-type: none"> <li>▪ PPTCT services available at Bhubaneswar</li> <li>▪ If a person is infected with HIV then also the person can live for years if ART facilities are availed.</li> <li>▪ ART services available at Orissa.</li> </ul>
V	De-addiction and harm reduction services for IDUs / drug users	All	<ul style="list-style-type: none"> <li>▪ Drug addiction is dangerous.</li> <li>▪ Drug addiction affects health and ultimately leads to death.</li> <li>▪ Addicts lose human values. Addicts are prone to committing crime and violence against women and children.</li> <li>▪ Resist peer pressure.</li> <li>▪ Injected drug increases the risk of HIV/AIDS.</li> <li>▪ Community must be vigilant and stop drug abuse and peddling in their area.</li> </ul>
	Care & support for HRGs	All	<ul style="list-style-type: none"> <li>▪ Confidentiality</li> <li>▪ Reducing Stigma and peer stress</li> <li>▪ Other health precaution</li> <li>▪ Information on services available</li> </ul>