Peer Education

Outreach
Communication & Negotiation

Training Module
What is the International HIV/AIDS Alliance?

The International HIV/AIDS Alliance (the Alliance) is an international non-governmental organization (NGO) that supports communities in developing countries to make a significant contribution to HIV prevention, AIDS care and the provision of support to children affected by the epidemic. Since its establishment in 1993, the Alliance has provided financial and technical support to NGOs and CBOs from more than 40 countries.
## Overview

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Overview

Alliance’s Programme in Andhra Pradesh

HIV/AIDS is an unprecedented global development challenge that has already caused too much hardship, illness and death. The pandemic affects individuals, but also devastates households and communities, and threatens entire nations. The behaviours that spread HIV are fuelled by social, cultural, economic and legal factors which make it more difficult for people to protect themselves and which worsen the consequences of the epidemic. HIV epidemics start and spread in different ways in different places, but the epidemic is consistently accompanied by fear, blame and prejudice. In almost all cases, poor and marginalized people are disproportionately vulnerable to HIV/AIDS and its consequences. This is particularly true for girls and women, because of biological, cultural, legal and social factors.

The most successful responses to HIV/AIDS and other development challenges are built upon local leadership, commitment and responsibility, and are supported by knowledge, learning and resources from elsewhere. Local non-governmental organizations (NGOs) and community-based organizations (CBOs) are particularly well placed to facilitate community responses, as well as to effectively bridge the needs and capacities of poor people and poor communities with broader health and development efforts.

No one organization can respond to HIV/AIDS in isolation. The pandemic demands mobilization and collaboration at community, national and international levels. Government, civil society and private enterprise all have vital roles to play. Governments have a particular responsibility for leadership, but not at the expense – or to the exclusion – of leadership from other sectors. All stakeholders responding to AIDS must strive to complement each other’s strategies and to actively collaborate together, while respecting each other’s independence and acknowledging differences. Transparency, critical thinking, learning and sharing are essential elements of such successful partnerships, and of successful responses to AIDS.

The International HIV/AIDS Alliance (the Alliance) is an international non-governmental organization that was set up in 1993 by a consortium of international donors. It has its headquarters in Brighton, U.K. The Alliance was established to respond to the need for a specialist, professional intermediary organization which would work in effective partnership with NGOs and CBOs in developing countries, as well as with national governments, private and public donors and the UN system.
The Alliance’s mission is to support communities in developing countries to play a full and effective role in the global response to AIDS.

Alliance has been working in India for the last five years and has its India Country Office in New Delhi. In late 2003 it opened an office in Hyderabad, Andhra Pradesh. In India, the Alliance started with home and community based care and support programme and has now rapidly expanded its programmes to include focused prevention.

In Andhra Pradesh, the Alliance is providing (as of July 2005) strategic and programmatic leadership for implementation of the:
- Frontiers Prevention Programme (FPP) in 14 sites
- India AIDS Initiative (IAI – Avahan) in 56 sites

across the Rayalseema and Telengana regions of AP.

These projects are supported by the Bill and Melinda Gates Foundation, under the overarching guidance of the AP State AIDS Control Society and the Indian National AIDS Control Organization (NACO), within the National AIDS Control Programme (NACP).

Objectives of the Programmes
- Reduction of STI prevalence among sex workers, men who have sex with men (MSMs), injecting drug users (IDUs) and people living with HIV/AIDS (PLHAs) (key populations) in sites across Rayalseema and Telengana regions of AP by 2008.
- Increased condom usage among key populations in these sites.
- Increased condom usage and reduction of STI prevalence among clients of sex workers in these sites.
- Increased empowerment of key populations and creation of enabling environment at these sites.
- Increased capacities of Alliance-supported NGOs and CBOs to implement effective prevention and care programmes.
- Rigorous evidence-based impact monitoring and evaluation.

Across all the sites the key populations are receiving the basic package of services and interventions that will include:
- STI services
- Behaviour change communication (BCC)
- Condom programming
- Creation of an enabling environment.

The basic package of services is being complemented by a bundle of carefully planned community-led interventions aimed at:
- Community mobilization,
- Social capital building,
- Leadership training,
- Empowerment,
Voluntary counselling and testing (VCT) and Care and support.

**Purpose of the Manual**

Behaviour change communication (which includes peer education and interpersonal communication) have a crucial role to play in STI / HIV control, because access to information, health education, knowledge and skills are essential for STI / HIV control.

This training manual describes ways in which NGOs may design, deliver and manage training programmes for peer educators in specific and how to run an effective peer-education component in general. Its purpose is to assist Alliance AP partner NGOs to design and implement strategies and work-plans for peer education, as part of comprehensive sexual health interventions.

This training manual is ideal for use in groups of 15-20 participants.

**Organizing the Training**

### Organizing a Peer Education Programme

In organizing any training we have to consider the following:

- Who are the participants?
- Why are we organizing the programme? Define specific training objectives
- What are the role that they will be playing after they obtain the training?
- What are the knowledge, skill and attitude requirement to play the role?
- Training need assessment
- Who will be the people who will deliver the training?
- Where will the training be delivered?
- Is the training residential? This will decide the methodology to be used for the training.

### Starting a Session

The session can be started in several ways. There is no fixed rule. Sometimes, it can be done with a game, which is great to get people laughing and relaxed. At other times, it can be through relevant exercises. For example, to start a discussion on sexual behaviour, one can begin by asking the group to draw a picture of the male and female reproductive organs. The next step is to name the body parts in non-scientific language. This gets everyone involved and discussing. Whatever topic the session is on, it should include everyone and be simple enough to understand. Just remember that people learn best by doing. Every session should be a combination of listening, speaking, seeing and doing. Ensure that the trainees are comfortable in doing the activities that are asked of them.

### Facilitating Participation

Facilitating and enabling maximum participation by the group members is the prime responsibility of the trainer. This is possible with the use of various tools, such as small group discussions, games, role-plays, case studies and a host of
others. It is always useful to divide people into small groups, as this increases interaction between people and encourages shy people to contribute.

**Tips for the Trainer**

Peer education trainers need the skills that will bring out the views and concerns of the participants. It is important to realize that the trainer’s role is to give information, and let young people make their own decisions based on facts. The trainer should always avoid being directive and authoritarian. Make sure participants know that there will be no report of the session made. Ask them to try not to discuss the opinions of particular individuals outside of the group, but warn them that confidentiality cannot be guaranteed. The discussion should be conducted in a manner that is not personalized and specific. If possible, give out information about where individuals, who want to discuss a personal situation, can get confidential advice. At the end of the training, do not forget to ask them to fill out the evaluation forms you have prepared. It makes the work much easier the next time around.

**As a Facilitator**

Remember that the basic values of participation require you to adhere to the following:

- Avoid dominating behaviours.
- Allow the participants to share and learn.
- Deal with bias, start from where the participants are.
- Respect diversity.
- Start at a convenient time for the participants.
- Undertake sessions in a place that is convenient for the participants and follow a process.
- Focus on cumulative learning by all the participants.
- Seek out diversity – everyone is different and important.
- Emphasize the group learning processes.
- Use approaches that are flexible and adaptable to suit each new set of conditions and participants.
- Use participatory processes because they lead to discussion. Often, debate concerning change leads to a change in perceptions, and helps people contemplate action that can lead to changes in attitudes and behaviour.

Key characteristics of an effective facilitator are:

- A warm personality, with an ability to show the trainees approval and acceptance.
- Good social skills, including an ability to bring a group together and maintain control without causing adverse affects.
- A manner that encourages the participants to share their ideas and skills.
- Strong organization skills that maximize the use of resources.
- The skill to identify and subsequently resolve participants’ problems.
- Enthusiasm for the subject and the capacity to present it in an interesting way.
- Flexibility in response to the changing needs of the participants.
- Knowledge of the subject matter.
- Summarizing sessions and consolidating learning for the participants

**What Should go into Peer Education Training?**

The development of a peer educator involves the application of various methods such as counselling, training, personal orientation, exposure visits, improving social contacts, participatory planning and assessment.

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<th>Personal development</th>
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Session 1

Opening Session

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<td>To help participants to get to know one another</td>
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**Materials:**
Coloured cards, plain cards, marker

**Arrival, Registration and Handing Out Name Tags**

**Pre-Workshop Questionnaires**
Hand out pre-workshop questionnaires as participants register. Facilitators should collect and collate the questionnaires as they are filled out. The questionnaires are then analysed to establish each participant's entry knowledge, attitude and skills on HIV and AIDS and experience with peer education and peer educators' training.

**Welcome Address**
The Organization Coordinator welcomes the participants to the workshop. She gives a short introduction about the organization, the work that the Organization will be doing along with the peer educators and why the workshop has been organized.

**Introduction of Participants**

**Process**
This game is an ice-breaking exercise, which enables the participants to warm up and get to know each other.

**Game**
Divide the participants into two equal groups. Now call the members of one group aside. Give them the coloured cards. Then call the second group and give them the plain cards with the name of the colours written on it. In this way now pair the participants. Red coloured card will be paired with the card that has red written on it. Once they are paired the participants are given 10 minutes to know each other. (They should find out some basic information about his/her partner, such as the partner’s name, the name of his organization, number of years he has been working, his likes and dislikes about his/her work, etc.)
After the participants have spent some time getting to know their partners, invite each pair to come forward and introduce his partner to the large group. As a result of this exercise, the atmosphere is created and the participants can be relaxed. The group can now move on to the next session.

**Why Are We Here?**

**Specific Objectives**

Participants should be able to:

- Discuss what they intend to achieve at the workshop and what might hinder this;
- State their expectations about the workshop;
- State how these expectations will be used as tools in HIV prevention; and
- State two of their fears about the workshop.

**Process**

1. Introduce the session to participants.
2. Seat participants in semi-circle.
   
   Go around the group asking each participant the question “Why are you here?” or “What are you expecting from this workshop? Note participants’ responses.
3. Skip whoever is not ready during the first round to give time for them to think it through.
4. Revisit those who did not respond at first.
6. Do the third round in the opposite direction from the first round and ask participants to state clearly what they think can hinder their ability to function positively during the training.
8. The trainer should clarify issues by addressing any fears, providing information on areas of concern and noting areas of concern that require follow-up.
9. Review the workshop goal and objectives with participants.
10. Lead a discussion on what will indicate the attainment of these objectives by asking participants the question “How will we know that these objectives are being met?”
Session 2
The Importance of Working in HIV/AIDS Prevention and Control

Objectives:
By the end of the session participants will be able to appreciate:
• Why HIV/AIDS is a special public health and development concern.
• What is the social, economic and political impact of HIV/AIDS

Materials:
Flip chart and markers

Handouts:
As a Public Health and Development Issue
• Women’s vulnerability,
• Impact of AIDS
• Implication of HIV for the health system

Objectives:
By the end of the session participants will be able to appreciate:

Time:
60 minutes

Methodology:
Brainstorming followed by presentation

Trainer’s Preparation:
Information sheet on HIV as a development issue from the handouts.

Process
1. Ask the participants to discuss why they think HIV / AIDS is a very special public health and development issue. Devote around 30 minutes on this.
2. Note down the points raised by the participants on a flip-chart.
3. After the discussion is over, make the following presentation for 15 minutes.
4. Allow further discussion / clarifications / comments for 15 minutes.

Presentation by Facilitator

What Happens when Infected with HIV – The Impact of AIDS

• Disease, weakness and inability to work.
• Unemployment and loss of income
• High cost of treatment and care
• Financial stress in the family leading to poor nutrition, discontinued schooling for children.
• Death
• Orphans, child labour
• Social stigma, discrimination, violence
1. Why HIV/AIDS is a special public health and development issue

- HIV/AIDS affects the young and productive age group.
- In the long run there is no cure for AIDS.
- Anyone can get infected. It affects all of us especially those who are economically not so well off.
- The vulnerability factors are lack of knowledge, lack of access to medical / health services, presence of STIs, poverty and economical opportunities.
- High STI rates that go untreated, increase the risk of HIV transmission.

2. Women’s vulnerability is of special concern due to the following reasons

- Lack of power to negotiate in sexual situations and potential exposures through unprotected sex.
- High levels of gender-based violence, sexual abuse, rape and sex under coercion and threat.
- Biologically, women have a large mucosal surface area (i.e. thin wet skin that lines the vagina) and this increases the area of exposure and hence the chances of getting infected.
- Presence of STI/RTIs in women often go unnoticed and untreated, increasing the risk of HIV infection.
- Women have lesser access to health care, education and other social and economic services that make them more vulnerable.
- Women have poorer health seeking behaviour than men.
3. Impact of HIV/AIDS

Effects of HIV/AIDS on Individuals, Families and Households

- Sickness and death
- Increase in dependants
- Need for care and support
- Loss of income, increase in poverty, diversion of resources
- Loss of productivity
- Reduction in nutrition
- Breakup of families
- Orphaning
- Increased dependency ratios and pressure on surviving adults caring for additional family members
- Psychological losses and burdens related to sickness, death, decline in well being and increased insecurity
- Loss of the family’s adult members at their most productive ages

Effects of HIV/AIDS on Health Systems

- Increasing absorption of health resources such as hospital beds, personnel, drugs, and home care by provision of care for people with HIV/AIDS, which reduces the amount of resources that can be spent on other health services
- Growing burden of managing the occurrence of HIV/AIDS with other diseases, such as tuberculosis, and malaria
- Increased costs of reducing infant and child mortality
- Demoralizing effects of increased mortality and absorption of resources.

Effects of HIV/AIDS on Societal and Political Stability

- Population shifts due to both mortality and migration
- Increased violence associated with crime and stigma, increase in discrimination

Negative Effects of HIV/AIDS on the Productive Sectors

- Loss of human resources in vital industrial sectors
- Loss of human resources in subsistence and commercial agriculture and declining agricultural land base
- Loss of personnel in social sectors, including education and social services
- Increased labour costs and reduced profitability for private sector firms
Session 3
Peer Education – Introduction

Objectives:
- To introduce participants to the idea of peer education.
- Familiarize participants to the concept of peer educators.
- Participants are able to explain who peer educators are and what peer education is.

Time:
30 minutes

Materials:
Flip charts, markers and white board

Methodologies:
Brainstorming, discussion

Handouts:
“What is Peer Education?”, “Who are Peer Educators?”

Trainer’s Preparation:
- Write the working definition of peer education on a piece of chart paper.
- Make copies of the fact sheets for each participant.

Process
1. Ask participants, “Who is a peer?” Distribute a small blank card to each participant and ask them to write their answers.
2. Pin / stick all responses on a board/ wall.
3. Ask participants, “Who are peer educators?”
4. Write all responses on a chart paper and have a small discussion about the participants’ responses.
5. Ask the participants, “What is peer education?”
6. Write all responses on a flip chart and then present the working definition of peer education:
7. Conclude by providing them with the definitions of peer and peer education.

Introduce the following definitions:
A peer is a friend who has a similar background such as profession (or linked to the profession), age and language, lives in the same geographical area, has similar social status, etc.

Peer education is a process of carrying out informal or organized educational activities with individuals or small groups of peers over a period of time.
What is Peer Education?

Peer education is a process of carrying out informal or organized educational activities with individuals or small groups of peers, over a period of time. Peer education occurs in a variety of settings and includes many different activities.

The following forms of interaction between individuals and groups can be termed as peer education:

- Women from a women’s group making house-to-house calls to distribute leaflets and talk with homemakers;
- Sex workers discussing their problems with other sex workers and their groups on how to counter violence by clients.
- An injecting drug user discussing safe injection and substitution
- A man discussing the need to use water based lubricants with condoms during anal sex between men.

In all the above cases, peer educators are non-professional teachers talking to, working with and motivating their peers.

Regardless of where they take place and who is targeted, all peer education projects use trained people to assist others in their peer group to make decisions about STI/HIV/AIDS through activities undertaken in one-to-one or small group settings.
Who Are Peer Educators?

- A peer educator is a person who, in order to provide knowledge and bring positive behaviour change(s) related to STD/HIV, educates his/her friends individually or in a group by using different educational activities. For example, a peer educator can educate his/her friends by telling a story, playing a game, showing a picture, etc.

- Persons from any profession, such as sex workers or transport workers, men who have sex with men (MSM), injecting drug users (IDU) or people living with HIV/AIDS (PLHA) can be peer educators. A peer educator is also someone who is not a member of the community, but is closely linked to the community – for example Dhaba managers being peer educators in a truckers project.

- To be a peer educator, it is not necessary to leave one’s current job or profession.

- A person should receive peer educator training in order to be an effective peer educator.
### Session 4
**Identifying the Qualities of a Peer Educator**

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<th>Objectives:</th>
<th>Handouts:</th>
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<tr>
<td>• To arrive at a consensus on the qualities of a peer educator.</td>
<td>Qualities of peer educators</td>
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<tr>
<td>• To assess oneself against the identified qualities.</td>
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<table>
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<tr>
<th>Time:</th>
<th>Methodology:</th>
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<td>1 hour</td>
<td>Group work mapping and discussion.</td>
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<th>Trainer’s Preparation:</th>
<th>Materials:</th>
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<tr>
<td>Information sheet on qualities of peer educators</td>
<td>Flash cards, markers, stones/pebbles/seeds.</td>
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**Process**

1. Invite the participants to sit in a circle. Explain that a peer educator must have or develop qualities that allow him/her to work with people. This exercise will enable the group to discuss and list the essential qualities for a good peer educator.

2. Ask each participant to take a flash card and a marker, and ask them to close their eyes. You might want to play some soft music on a tape recorder. Explain that everyone should think of a person they love and can talk with.

3. After five minutes, ask them to open their eyes, and write the one quality they like the most in the person they just thought of.

4. Ask them to place their respective cards on the floor after they finish writing. Invite the participants to read the cards and group the cards that are similar.

5. Ask them to arrange the cards in a vertical line on the floor.

6. Ask each participant to take as many stones/seeds/leaves (marker) as there are cards. For example, there may be six cards on the floor so every participant must have six markers.

7. Start at the top of the vertical line. Ask the participant to think for a moment and place one marker in front of the card if they feel that they possess that quality. If someone feels that s/he does not possess that quality, they should not place their marker against it. Finish marking all the qualities in this manner.

8. Invite the participants to sit in a circle around the display, and facilitate a discussion based on what you observe. For example, Card #1 may have as
many stones as there are participants. This means that every one thinks they have the quality written on that card. Ask how this quality can help them in their own lives and when helping their friends. Cover all the cards in this manner.

9. Sum up the discussion and the results of the exercise, by emphasizing the importance of those qualities for a peer educator.

Notes for the Facilitator

This exercise is fairly simple and allows the participants to determine the qualities that a peer educator should have. You can use this exercise to focus on the qualities that need to be developed by a peer educator. Take this exercise a step further, and ask the participants to list the manner in which these qualities can be developed. Ask them to list the method for each quality. Once this is done, it will be easy for you to design a session for them. You could also undertake a similar exercise to determine the skills and knowledge required by a peer educator.
Some qualities that need to be developed by a peer educator in order to be effective in his/her work

- Ability to keep abreast of new information and knowledge in the area of HIV/AIDS and related subjects, such as reproductive health and family planning.
- Ability to listen and communicate effectively.
- Ability to deal with emotions and difficult situations.
- Non-judgmental attitude and ability to express emotions.
- Adaptive and flexible nature.
- Ability to encourage and provide support.
- Ability to lead by example.
- Ability to keep confidences and foster trust.
- Ability to look at things from various perspectives.
- Ability to make decisions and encourage others to do so.
Session 5
Responsibilities of a HIV/AIDS Peer Educator

Objectives:

By the end of this session participants will be able to:

- Describe at least five duties and responsibilities of peer educators; and
- Demonstrate at least four qualities required of peer educators.

Methodologies:

Group task (1 hour) followed by exercise (1 hour, 30 minutes)

Handouts:

- What does peer education in HIV mean
- Role of peer educators
- Criteria for selection of peer educators

Time:

2 hours, 30 minutes

Material:

Flip charts, marker, board, tape, paper and pen/pencils

Process

Group Task (1 hour):
1. Divide the group into two small groups.
2. Ask one group to list the qualities of peer educators.
3. Ask another group to list the roles and responsibilities of peer educators.
4. Provide flip charts and markers and give each group 30 minutes to discuss and 5 minutes to each group to present what they discussed.
5. Ask each group to appoint one person to present what they have discussed.
6. Have a discussion for 10 minutes after each presentation.
7. If necessary summarize by making a brief presentation on the responsibilities and qualities of a peer educator based on the handouts given.

Exercise (1 hour, 30 minutes)

Divide the participants into 2-3 groups, ask them to analyze the following case (1 hour).

Ask each group to present (to the larger group) their answer the questions given (10 minutes for each groups).
Case
The Ali (Hijra) community in Chennai represents the third gender in Indian society. The 500-600 Alis in Chennai are organized into small groups with their own Gurus and their followers called the Chelas. The community is highly marginalized and has developed its own language to protect itself from the outside world. Selling sex or begging remains the only source of livelihood for most of the Alis.

Due to their fear of prosecution they are often not open to the outside world and are a group that is very difficult to reach. Also the fact that their residence is spread out across the city makes meeting them very difficult and consequently even more difficult to provide health education. Initial attempts by researchers to reach them at their places of residence or places where they solicit sex did not yield any results. The fear that researchers were collecting information to prosecute them and also the fact that their Gurus had not approved contact with researchers impeded progress. The researchers then used some of the MSM community who had access to the Gurus and who were themselves members of the Ali Jamaat, to reach out to the Gurus. Once the Gurus were convinced about the nature of the project they were more open to interaction with the project staff.

Some of the Gurus and other Ali were selected based on their influence as community-based researchers who then went on to become peer educators with the project. Active involvement of the Gurus and peers from the beginning helped develop acceptance within the community in addition to developing appropriate strategies for interventions.

The PEs reached not only other Ali in the community but also interacted with their clients and other MSM community members. Ali PEs were extremely successful in their outreach as they had the blessings of their Guru and in this community the work of the Guru is supreme. The PEs were responsible for providing information on STIs and HIV, how it could affect the Ali and how it could be prevented, how and where to access STI care and to facilitate good quality and early treatment, promotion of condoms, including building skills in condom usage and negotiation.

Also over a period of time the Ali PE reached out to the various stakeholders including the police, to minimize prosecution. The PEs found the experience to be extremely rewarding as “for the first time people are telling us ‘you are doing a good deed’. It is also good for us to be able to walk into a bank, have an account, sign our name. We can also walk into a police station…as a community we have come together and evolved.”
Community Action Network, Madras 1997

Exercise questions
Read the case study provided and answer the following questions.

- What are the various roles peer educators can play?
- How many peer educators are required by the project?
- How will they be selected?
- What training will they need?
- How often should they be trained?
- How often should peer educators meet with their peers?
- What should they talk about with the community?
- How will the peer educators be supervised?

Note to the facilitator
Make the following presentation after the two groups have presented their analysis:
(15 minutes)

Peer education can help in HIV / AIDS prevention and care:

- By improving the confidence, self-esteem and sense of self-worth of peer educators, who then serve as role models for the rest of the community / key population group.
- By enabling members of the key populations to emerge as social change agents and health educators.
- By providing information about STIs, HIV/AIDS and behaviour related to the risk of infection.
- By helping each peer through discussions, sharing information and experiences related to risk behaviour of HIV infection and STI infection.
- By encouraging compassion and non-discriminatory attitudes and practices towards the persons with HIV/AIDS and their families including how to provide basic care for persons living with HIV/AIDS.
- By developing group norms among peers to support each other to resist behaviour that puts them at risk of infection of STIs and HIV.
- By holding awareness-raising campaigns and drives in the community.
- By developing a network for home-based care of people living with HIV/AIDS.
What does Peer Education in HIV/AIDS Mean

The use of members of the community or key populations (KP) such as sex workers, men who have Sex with men (MSMs), injecting drug users (IDUs) and people Living with HIV/AIDS (PLHAs) as agents of change in the community is known as peer education.

Peer education occurs in a variety of settings and includes many different activities. It is effective as the communicators share the same life experience as that of key population group and hence act as credible sources of information for behaviour change. Peer education can take place on a street corner, at a social club, in a bar, in a bus station, in a factory or any other place where people feel comfortable.

Peer education is effective because it is:

- Culturally appropriate – from “within”
- Community-based
- Accepted by the target audience / community
- Economically effective
- Enabling for the marginalized community.
Roles and Responsibilities of a Peer Educator

- Educating peers on STIs and HIV in one-on-one and small group sessions.
- Assisting peers to access condoms, STIs and voluntary counselling and testing (VCT) services.
- Distributing condoms / lubricants and demonstrate correct condom use
- Participating in HIV outreach awareness and other public events.
- Distributing educational materials.
- Training other peers.
- Holding regular meetings.
- Teaching peers to negotiate safer sex.
- Promoting condoms.
- Teaching peers how to do a personal risk assessment.
- Teach peers about home care for PLHAs.
- Supporting PLHAs’ efforts in living positively.
- Providing referrals to health care facilities.
- Functioning as leaders, change agents, role models and innovators in the community.
- Facilitating and catalysing the development of positive self image and self esteem within the key populations.
- Facilitating community mobilization and the process of individual and community empowerment.
- Training new peer educators from within the project and outside.
Criteria for selection of Peer Educators

- They should have the ability to communicate clearly and persuasively with their peers. They should have good interpersonal skills, including listening skills.
- They should be strongly motivated to work towards HIV risk reduction.
- They should have a socio-cultural background similar to that of the target audience (this may include age, sex, profession).
- They should be accepted and respected by the target group (their peers).
- They should have a non-judgmental attitude and should demonstrate sensitivity, care, compassion and respect for people affected by STI/HIV/AIDS.
- They should be self-confident and show potential for leadership. They should have the potential to be a “safer sex” role model for their peers.
- They should be able to get to the location of the target audience. They should be able to work irregular hours.
- They should be able to pass a practical, knowledge-based exam at the end of the training. If possible, they should have some minimum functional literacy.

Factors that Motivate a Peer Educator:

- Concern for other members of their own peer community,
- Desire to help other members to adopt safe sex practices,
- Appropriate understanding of STD/ HIV/ AIDS prevention and control
- Desire to acquire more knowledge/skill about STD/HIV/AIDS and their prevention and control,
- Recognition by their peers as an educator,
- Incentives,
- A desire to acquire a distinct identity with the project.
Session 6
Ready Body Test

Objectives of the Session:
Have each participant take the “Ready Body Test” and exchange ideas on its use.

Time:
1 hour

Materials:
- “Ready Body” handout
- Pen and paper

Methodology:
Questionnaire followed by discussion

Trainer’s Preparation:
Information sheet and presentation on ready body

Process
1. Introduce the objective of this exercise.
2. Tell participants to take a strip of paper and write down numbers 1 - 14 one below the other.
3. Tell them to write “yes” or “no” next to each number on the paper as you read out each of the following questions.
4. Inform participants that this is an anonymous test.

Ready Body Test
1) Do you exercise regularly?
2) Have you ever had sex?
3) Do you visit the dentist regularly?
4) Have you had many sexual partners?
5) Do you eat fruit and vegetables daily?
6) If you are sexually active, are there times when you do not use a condom?*
7) Do you get your eyes checked?
8) Have your partners had other sexual partners?
9) Do you visit a doctor when you are sick?
10) Do you drink alcohol more than twice a week?
11) Do you sleep eight hours a night?
12) Have you ever had “leak” or other sexually transmitted infections?
13) Do you feel good about yourself?
14) Do you treat yourself when you have leak and other sexually transmitted infections?

*Note: Tell participants to leave a blank space at questions 6, 8, 12 and 14 if they not sexually active.
1. Tell the group to go through each answer and put a * next to it if they answered “yes” to 1,3,5,7,9,11,13 and “no” to 2,4,6,8,10,12,14. Tell them that 13 or 14 * mean they are working towards having and maintaining a ready body. They should congratulate themselves! They are taking care of their selves and should feel ready to go to the moon!!

2. Tell the group that if they answered “no” to 1,3,5,7,9,11,13 and “yes” to 2,4,6,8,10,12,14 they may not have a ready body and need to work towards it.

3. Ask participants to define a ready body, based on their experience of the test. Note their responses and share with them the following definition:
   A ready body is a body which is able to keep away infections as a result of behaviours and attitudes the individual has adopted to prevent and seek timely care for infections.

4. Ask participants to take out their “Ready Body” handouts with the questions. Ask them to spend some time comparing the questions with their answer sheet.

5. Ask each participant to select one item where work is needed and publicly commit themselves in front of the group to make a change of behaviour.

6. Honour each commitment with a hug, a handshake or a round of applause.

7. Go around the circle, naming participants in succession: teeth, tongue, teeth; tongue, teeth; tongue . . . (or “big toe, little toe” or any other two body parts). Have teeth and tongue get together in pairs and come up with five different ideas on how the “Ready Body” test may be used in different peer education situations.

8. After about 10 minutes, have each pair share their ideas with the rest of the group. Everyone should be making notes of ideas for use and for inclusion in their peer educator exercise books.

9. Inform participants that the Ready Body concept underlies the work of peer education, as the peer educators provide information to the peers about making their “body ready.”
Day 2
Session 7
Sex and Sexuality

Objective:
- Participants will familiarize themselves with human sexuality, including anatomy and physiology.
- Participants become comfortable enough to refer to human sexual organs by their real names.
- Participants will get in touch with their own sexuality.

Time:
1 hour and 30 minutes

Methodologies:
Small group work, group discussion, presentation

Materials:
- Flip chart
- Markers
- Labelled and unlabelled diagrams of the male and female reproductive systems and cardboards to produce labels.

Trainer’s Preparation:
Diagrams of the male and female reproductive system, information sheet on the systems

Handouts:
Male and female reproductive system and their functioning

Process
1. Ask participants to define or explain the words “sex” and “sexuality,” noting the differences between the terms.
2. Note their responses.
3. Clarify by presenting and explaining the following information.
4. Now divide the participants into small groups – four groups may be made. Give two groups the task of drawing and labelling the male reproductive system and two groups the task of drawing the female reproductive system (it is left to the trainer’s discretion whether it is culturally appropriate to form separate groups for girls and boys).
5. Participants can then paste their drawings on a wall and walk around to view the other’s drawings.
6. Let the group settle down.
7. Ask participants what they learned or observed from the drawings. Note their responses.
10. Present a labelled diagram of the female and male reproductive systems; clearly identify the organs and explain their functions. (Do not use highly technical terms with some groups of participants as this can lead to confusion. See trainer's note.)

11. Present unlabelled diagrams of the male and female systems (internal and external) one after the other.

12. Ask participants to volunteer to label the individual organs and parts and explain their functions.

13. Summarize session by informing participants that the expression of human sexuality, especially as it relates to sexual intercourse, is at the heart of the spread of HIV. Further state that the lack of self-knowledge about human biology and chemistry further compounds the problem.

14. Ask participants to identify the relevance of this session to peer education.

15. In conclusion, the trainer should review the session objectives with participants.

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Sex refers to whether a person is male or female. This is defined by our physical characteristics, e.g. the male’s penis and the female’s vagina and breasts.

Sex also refers to an act of sexual intercourse and is an expression of love and intimacy between mature men and women.

Sexuality is how an individual thinks, feels and acts about his her own body and that of others. It is the totality of an individual as they are expressed.

Sexuality has components such as:

- **Sensuality**: This is about how people see themselves and how they feel about their body. This includes a sense of attractiveness and how it is displayed through dressing, dancing, and other features.

- **Intimacy** includes such things as friendship and sexual intercourse.

- **Sexual identity** indicates maleness and femaleness.

- **Sexual behaviour** and reproductive health is the process of reproduction and the care and maintenance of reproductive organs.

- **Sexualisation** is a negative behaviour, such as the use of sexual intercourse or attractiveness to manipulate others through rape, sexual harassment, seduction, etc.
Sexuality

Sexual orientation refers to the biological sex that we are attracted to romantically.

1. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex).

2. Acknowledge that some of the participants might have strong values about a person's sexual orientation. Tell the participants that you will respect every individual's right to his or her opinion. However, sexual orientation is important to discuss to ensure that the participants do not make assumptions about their clients' sexual activity and to ensure that they tailor their services and counselling to each individual client's needs and behaviours.

3. Draw a line across the top of a sheet of flipchart paper. Label one side of the continuum “Heterosexual” and the opposite end “Homosexual.” Label the middle of the continuum “Bisexual.” Use this diagram to explain that the range of sexual orientation, from heterosexuality to homosexuality, is a continuum. Most individuals’ sexual orientation falls somewhere along this continuum. While scientific studies have shown that an individual cannot change his or her sexual orientation at will, sexual orientation might change throughout a person's lifetime. So an individual's orientation can move along the continuum as time passes. Explain that a person's sexual orientation is often confused with other aspects of his or her sexuality. For example, people often mistake sexual orientation with gender roles.

To make this point, draw a second line below the first. Label one side “Masculine” and the other “Feminine.” Explain that gender roles are societal expectations of how men and women should act. Often, when a man acts in a feminine manner, he is assumed homosexual, but this may not be true because gender roles and sexual orientation are different. Explain that a person’s gender roles can also move across the continuum over time or can be based upon a given situation.

5. Another distinction to make is that a person's sexual behaviour does not always indicate his or her sexual orientation. To make this point, draw a third line below the other two.

Label one side “Sex with men” and the other “Sex with women.”

Explain that not all individuals who have had one or more sexual contacts with members of their own sex define themselves as homosexual or are considered homosexual by society. For example, some adolescent
boys who experiment sexually with other boys (for example, masturbating in a group) and some men who have sex with other men in isolated settings, such as prisons, do not consider themselves and are not considered by others to be homosexual. In addition, individuals who engage in same-sex sexual activity might not be exclusively attracted to members of their own sex and might not wish to engage in sex only with members of their own sex. Indeed, some married persons engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.

6. Conclude this activity by making the following points about sexual orientation. Give the participants an opportunity to discuss any of these points:

- Homosexuality is not a character defect or a mental illness. Scientific research has shown that people who have sex with members of their own sex can be just as emotionally healthy as those who have sex exclusively with members of the opposite sex.

- Sexual orientation is not something a person can change at will. No scientifically valid studies have indicated that people can change their sexual orientation by wanting to do so. However, an individual's orientation might change over time.

- Homosexuality is different from transsexuality. A person who feels that he or she was born into the body of the wrong sex is a transsexual. Being a homosexual has nothing to do with feeling that you are in the body of the wrong sex. Most homosexual men feel perfectly comfortable being male, and most homosexual women, or lesbians, feel perfectly comfortable being female.

- Children of homosexual or bisexual parents are no more likely to become homosexual or bisexual than children of heterosexual parents are. No scientifically valid studies have indicated that this is likely to happen.

- Focus on risky sexual behaviours, not sexual orientation, when counselling clients. When addressing a peer’s concerns, giving them health education or information, or providing services, peer educators must focus on the peers’ sexual behaviours, not his or her sexual orientation. It is the behaviours, and not the orientation, that puts individuals at risk of HIV infection and other STIs.
External (outside) organs of males and their functions

Penis: The main male sexual organ. It becomes stiff or erect when a man is sexually aroused. A man does not need to have sex just because he has an erection. The erect penis is used for sexual intercourse. Sperm and urine pass through the penis, but not at the same time.

Scrotum: This is found behind the penis and contains the two testes. The scrotum protects the testes from damage.

The internal (inside) organs of males and their functions

Cowper's gland: This gland secretes a watery fluid that activates sperm, making the sperm capable of fertilizing the female egg(s).

Seminal vesicles: These secrete a fluid that forms part of the semen and activates the sperm, making the sperm capable of fertilizing the female egg(s).

Testes: These are two round organs inside the scrotum that produce and store sperm cells and the male sex hormone (testosterone).

Urethra: This is the tube that passes through the penis and carries either urine or sperm.

Vas deferens: This is the long tube through which sperm pass from each testis to the urethra.

Anus: This is the opening through which faeces pass.
External organs (vulva) of females and their functions

Clitoris: This is the small, pointed organ that lies between the labia majora and labia minora and the most sexually sensitive part of a female. It is sometimes removed during circumcision.

Hymen: This thin membrane covers the vaginal opening. It is often used to define virginity, although it can be broken during other activities besides sexual intercourse. It may provide some protection from infection to the vagina before it is broken.

Labia majora: These are two folds of sensitive skin, one on either side of the pudendal cleft and immediately below the pubis or fatty pad. The labia majora cover and protect the labia minora, clitoris, urethra and vaginal opening.

Labia minora: These are the thin, soft inner lips. They are pinkish in colour and very sensitive, the labia minora further protect the urethra and vaginal opening.

Urethra: This is a small tube and opening below the clitoris for passing urine.

The vaginal opening: This is seen when a female is viewed externally and is between the clitoris and the anus.

Anus: This is the opening through which faeces pass.

The internal organs of females and their functions

Vagina: This is the organ and passage through which menstrual blood exits the body. It accepts the penis during sexual intercourse and functions as the birth canal during childbirth.

Cervix: This is the mouth of the uterus through which sperm must pass to fertilize the egg(s). During childbirth, it opens through muscular contractions.

Fallopian tubes: This pair of tubes is found on either side of the uterus and connects the ovaries with the uterus. Sperms travel up the tubes toward the ovaries, and the eggs pass down the tube toward the uterus. Fertilization normally takes place here. The fertilized egg passes through the fallopian tube to the uterus, where it implants and develops into an infant. When no fertilization occurs, the unfertilised egg passes through the fallopian tube into the uterus and is expelled with the uterine lining during menstruation.
**Ovaries:** These are two small, egg-shaped organs connected, via the fallopian tubes, to the uterus. The ovaries store and protect the female eggs (ova) and produce the female hormones, oestrogen and progesterone.

**Uterus or womb:** This is the organ in which a fertilized egg implants and the development of an infant takes place. Its lining is shed during menstruation. It contracts during labour to push out the infant.

**Vagina:** This is a canal running from the vaginal opening to the cervix and uterus. The vagina accepts the penis during sexual intercourse. Menstrual blood flows through the vagina during menstruation and an infant moves through it during birth.

**Menstruation**

Menstruation is a monthly bleeding that takes place when the egg is not fertilized. Each month, the uterus prepares a lining of blood and tissue, in case the fertilization of the egg takes place. If no fertilization occurs, the lining is shed through the vagina along with the unfertilised egg. During and shortly after menstruation, the cervix is opened and the vagina wall is soft and can easily be bruised. It should be noted that if there is sexual activity with an infected person during this period and the sex is “unprotected”, there is a much higher risk of transmission of HIV.
### Objective:
By the end of this session the participants will be able to:
- Explain the meaning of STIs
- Describe the four common symptoms of STIs;
- Explain methods of prevention of STIs:
- Explain the relationship between STIs and HIV infection;
- List it least four misconceptions about STIs and,
- Explain the consequences of STIs if they are not treated.

### Methodologies:
- Group work, presentation and discussion, visual-aids, question / answer, critical incidents.

### Handout:
- Sexually transmitted infections (STI)
- Types of STIs
- Signs and symptoms in men and women

### Trainer’s preparation:
- Write the definition and major symptoms of STI on a chart paper.
- Prepare a list of misconceptions related to STIs

### Time:
2 hour

### Materials:
Flip charts, markers, masking tape, board.

### Process
1. Explain to the group that you will be talking about sexually transmitted infections. Try to find out what words they use for STIs (formal or slang).
2. Divide the large group in five smaller groups, i.e. A, B, C, D, E
3. Write a question for each group on a card and distribute them. Allow 20 minutes to work on them.
4. Ask each group to present their answers to each group (five minutes per group).
Group A
1. What are sexually transmitted infections?.
2. What is meant by sexually transmitted infections and what are the common sexually transmitted infections?
3. What happens when one gets a sexually transmitted infection?

Group B
1. What are the common symptoms of STIs?

Group C
1. What do people think about sexually transmitted infections?
2. What are your beliefs about the transmission and treatment of sexually transmitted infections?

Group D
1. Where do people generally go when they have STI?
2. How should sexually transmitted infections be treated?
3. How can sexually transmitted infections be prevented?

Group E
1. What do you know about safe sex?
2. What do you know about unsafe sex?

Facilitator’s Note
- Visit each group to help them. Do not give answers directly. You can give clues.
- Encourage the participants from other groups to ask questions and encourage the spokesperson or his/her group members to answer. If they can not answer properly, discuss and explain the answer (see the fact sheet).
- Compliment the participants for their work and tell them that these issues will be taken up in detail in the subsequent sessions.

At the end, make a brief presentation based on the handouts provided (30 minutes).
Often during vaginal or anal sex, particularly when there is inadequate lubrication, the delicate lining of the vagina or the anus may have small tears.

This allows blood and genital fluids to mix and infections to be transmitted from the genitals of one partner to the other partner.

Such infections are called sexually transmitted infections (STIs).

What are high risk behaviours?

High risk sexual behaviours are behaviours that put an individual at higher risk or either getting or transmitting a sexually transmitted infection or HIV.

When a woman has vaginal or anal sex with a man without a condom and the man has some infection in the genitals, then the woman can also get infected.

Similarly a man can get infected from a woman.

When a woman has sexual relations and engages in unprotected (without a good quality condom) with many men, then the risk for getting infections increases many folds. The same is the case with men.
When a man has anal sex with another man without a condom and he is having some infection in the genitals, then the other man can also get infected.

When a man has sexual relations and engages in unprotected anal sex (without a good quality condom and water based lubricant) with many men, then the risk for getting infections increases many folds.

Types of STI

Symptoms in Men
- Discharge from the penis
- Pain during urination
- Sores or blisters around the genital area

Both Men and Women
- Sores, lumps, blisters or rashes in or near the sex organs or mouth
- Burning pain while passing urine or having a bowel movement; fever, chills and aches, like flu
- Unusual swelling and itching around the pubic area

STI in women
Many women and men however do not have any of the above symptoms but still may be having the infection and can transmit it. Therefore it is a good idea to consult the doctor, even if one does not have any of the above symptoms but has had sex without a condom in the past.

**Why is STI Treatment and Education Important?**

- STIs are a serious health problem.
- Most STIs increase the chance of transmitting and acquiring HIV.
- Untreated STIs can cause many problems, including infertility, ectopic pregnancy, and pregnancy loss.
- Infants born to infected mothers may contract syphilis and eye infection with the potential for blindness.
- So prompt treatment is extremely crucial.
Objective:
By the end of this session the participants will be able to
- The meaning of HIV / AIDS
- What is immune-deficiency
- At least three important reasons to learn about HIIV / AIDS.

Methodologies:
Question/answer, discussion, lecture, visual-aids

Handouts:
“Basics of HIV/AIDS” fact sheet

Time:
1 hour

Materials:
Chart papers, markers, masking tape and hoard

Trainer’s Preparation:
- Write out the full meaning of HIV in English on a chart paper.
- Write out the full meaning of AIDS in English on a chart paper.
- Write on a chart paper some important reasons to learn about HIV/AIDS

Process
1. Write the word “HIV” in English on the board and ask the participants to explain the full form and meaning. Write all responses on a chart paper and discuss them.

2. Post the chart paper with “HIV” (human immunodeficiency virus) in English and explain the full form and its meaning.

3. Write the word “AIDS” on the board and ask the participants to explain the full form and meaning. Write all responses on flip chart and discuss them.

4. Post chart paper with “AIDS” (acquired immune deficiency syndrome) and explain the full form and its meaning.

5. Ask the participants why it is necessary to learn about HIV/AIDS.
6. Write their responses on flip chart and discuss them.
7. Explain the five important reasons why we need to learn about HIV/AIDS.
   One should learn about HIV/AIDS because:
   - From the health-care perspective there is no cure, no vaccine, and the condition is always fatal.
   - From the social point of view there is prevalent discrimination and social stigma attached to the disease.
   - The disease has a long incubation period, but can be transmitted to others.
   - It affects most of the economically active population.
   - It is a hidden epidemic.
8. Distribute the fact sheet to participants and discuss it briefly. Explain that it is meant to reinforce what they have learned today.

**Process**
Presentation by facilitator (20 minutes) followed by discussion (10 minutes)

**Methodology**
Projection accompanied with narration:

**Narration (by the facilitator)**

1. Our body is generally protected from infection and diseases by white blood cells that are present in our blood. The white blood cells are the “defence soldiers” of our body.
2. Therefore when ever we are exposed to infections like diarrhoea, common cold or other infections, the white blood cells attack these infections and defend our body from these infections.
3. However when HIV enters our body, it goes and directly attacks the white blood cells, which are our defence soldiers.
4. After the white blood cells are destroyed, the body’s natural ability to fight diseases is destroyed.
5. For example, if a healthy person is attacked by the common cold virus he recovers after some days, but if an HIV infected person is attacked by a cold virus he becomes very sick and takes a long time to recover.
6. The body thereafter suffers from different kinds of diseases and eventually leads to disability and death.
Session 10
How does HIV/AIDS Spread

**Objective:**
By the end of this session the participants will be able to tell:
- The modes of HIV transmission
- How HIV is not transmitted.

**Methodologies:**
Group work, presentation and discussion, visual aids, question answer

**Time:**
2 hours, 30 minutes

**Materials:**
Charts, markers, tape, board

**Handouts:**
Story line on HIV/AIDS

**Trainer’s Preparation:**
- Presentations on “What is HIV” and “What is AIDS”
- Presentation on “Signs and Symptoms”

**Process**

**Group work and presentation**
- Divide the group into two equal halves and tell one group to list the modes of HIV transmission. The other group should write about the modes by which HIV is not spread.
- Give them seven minutes.
- Tell both the groups to present their findings.

**Story line, presentation and discussion: (1 hour, 15 minutes)**
- Project the visual provided and narrate the story along with the projection.

**Story Narrations**
1. Happy family - Husband, wife and young daughter.
2. One day, unfortunately the father has an accident.
3. He is taken to a hospital where he is given untested blood (which is infected with HIV) unknowingly.
4. As a result, the husband becomes infected with HIV, but is not aware of it because there are no symptoms in the initial stages and he feels perfectly healthy.
5. Husband and wife have sex without a condom and unknowingly the virus is transmitted from the husband to the wife, through the sexual route.
6. The wife then becomes infected with HIV, but is not aware of it because there are no symptoms in the initial stages and she feels perfectly healthy.
7. The wife becomes pregnant and unknowingly passes on HIV infection to her baby.
8. The baby boy born is infected with HIV.
9. Over a period of time, while the daughter is absolutely healthy, the husband, wife and the young boy fall ill because HIV has started destroying their bodies’ ability to fight even the common infections.
10. Husband, wife and son are all seriously ill and the daughter has to look after the family.
11. Eventually the husband, wife and son die, leaving the young daughter orphaned.

Story Narrations

- Manoj is a good-looking, strong, healthy and happy young man, who has a sexual preference for other men and has many male sexual partners. He works in a government office.
- Manoj is the only bread earner in the family and has sister and his aging parents to support.
- One day, unfortunately Manoj has a road accident.
- He is taken to a hospital where he is given untested blood (which is infected with HIV) unknowingly.
- As a result, Manoj becomes infected with HIV, but is not aware of it because there are no symptoms in the initial stages and he feels perfectly healthy.
- Manoj meets Ravi during a social function and they are strongly attracted towards each other.
- Ravi however is married to Maya and they have a young daughter Mira. Maya is a housewife.
- Manoj and Ravi meet up after office hours and have anal sex together, without condoms.
- As a result Manoj transmits HIV infection to Ravi through anal sex, and neither is aware of it.
- Ravi and Maya (his wife) have sex without a condom and unknowingly the virus is transmitted from Ravi to Maya.
- Maya then becomes infected with HIV, but is not aware of it because there are no symptoms in the initial stages and she feels perfectly healthy.
- Maya becomes pregnant and unknowingly passes on HIV infection to her baby.
- The baby boy (Suresh) is infected with HIV.
- Over a period of time, while Mira (the young daughter) is absolutely healthy, the Ravi, Maya and the young boy (Suresh) fall ill because HIV has started destroying their bodies’ ability to fight even the common infections.
- Ravi, Maya and Suresh are all seriously ill and their healthy daughter (Mira) has to look after the family.
- Eventually Ravi, Maya and Suresh die, leaving the young daughter - Mira orphaned.
Simultaneously, Manoj, who was extremely healthy and strong, starts falling ill and loses a lot of weight. He is unable to attend office and eventually loses his job.

Manoj's family faces extreme hardships and his sister has to be taken out of school because there is no money to pay for the fees.

They sell off their house to cover Manoj's medical expenses.

Manoj is looked after by his sister and aging parents and eventually Manoj dies.

Manoj's family is left behind – totally shattered emotionally and financially.

**Note for the Facilitators**

1. Project the above visual and narrate the story.
2. After you have narrated the story, ask the participants to identify the modes by which HIV is transmitted from the story.
3. Inform the participants that in addition to the modes depicted in the story, HIV is also transmitted through unsafe injecting equipment.
4. Inform the participants that before blood transfusion, it is important to ensure that the blood is procured from a registered blood bank and that it is certified as free from HIV.
5. Remind the participants that it is not possible to tell if a person is HIV positive by physical appearance. Therefore, Manoj transmitted the infection to Maya (his wife) and Ravi (his male sexual partner) without anyone knowing it.
6. Inform the participants that in case one is suffering from STI (ulcers and discharges in the genitals) the possibility of getting or transmitting HIV infection is extremely high because HIV is easily transmitted through genital fluids and blood. That is why it is extremely important to get prompt treatment if one has STI.
7. Also inform the participants that a person having a STI often does not have any symptom. Therefore a physical examination by a doctor and a few laboratory tests are often very important for diagnosing and treating STIs.
8. Point out that it is equally important to refer one’s sexual partner for prompt treatment in case he has any of the STI symptoms.
9. Emphasize that it is important to visit a qualified doctor once every month for a general check-up even if one is feeling perfectly healthy.
10. At the end of the session, ask the participants to brainstorm on what the impact of HIV is on the respective families.
How HIV does not spread
30 minutes

Process
1. Ask the participants how HIV is not transmitted.
2. Summarize the points and make a brief presentation.

Presentation
HIV is not transmitted through:

- Kissing
- Shaking hands
- Hugging / touching
- Sharing towels / linen
- Using the same toilet
- Sitting in the same place (for example on the same bench / desk / table / carpet / bed)
- Eating from the same plate or drinking from the same glass
- Sharing towels and cloths
- Sharing a swimming pool.

What is AIDS then?
Time: 30 minutes
Materials: Flip charts

Process:
1. Ask the participants to share what they know about the difference between HIV and AIDS.
2. Ask them about the common symptoms of AIDS
3. Ask them why it is important to make this distinction.
4. Then make the following presentation:

Presentation (by the facilitator)
1. In the initial stages when one gets infected by HIV, the person looks and feels perfectly healthy and can carry out all normal day-to-day functions.
2. However, over a period of time (4 – 8 years) as the virus starts multiplying in the body, the body becomes weak and susceptible to various diseases.
3. AIDS is therefore a combination of several signs and symptoms of diseases due to infection with HIV.
4. Some of the symptoms of AIDS are:
   ➔ Prolonged fever
   ➔ Abnormal and rapid loss of weight
   ➔ Repeated loose motions
   ➔ Repeated cough / cold which does not go away
   ➔ Any infection that is not getting cured despite taking medicines

**Facilitator’s note**

At the end of the presentation highlight the following:

- HIV can be detected only through a blood test. Otherwise it is not possible to say if one is HIV positive or not from one’s physical appearance (refer to Manoj’s story).
- The test is available at most government hospitals (Voluntary, Confidential Testing and Counselling Centres - VCTC)
- The test is confidential and the results are not revealed to anyone but the person tested.
- The counsellors at the testing centres are available to answer any questions.
Session 11
Difference between HIV and AIDS and the Importance of Understanding the Difference

**Objective:**

- Help participants understand the difference between HIV and AIDS.
- Help each participant understand why knowing the difference between HIV and AIDS is important.

**Methodologies:**

Role play, discussion, small group work

**Handouts:**

None

**Trainer’s Preparation:**

Presentation points for the three groups to be prepared on a chart paper.
Presentation points on why it is important to know about HIV/AIDS

**Time:**

75 minutes

**Materials:**

Flip charts, markers, pen, paper

- Form participants into three groups.
- Ask one group each to come up with three things that make HIV different from AIDS when they consider:
  
  **Group 1:** Things that are happening INSIDE the bodies of people with HIV and AIDS
  
  **Group 2:** Things that are happening OUTSIDE the bodies of people with HIV and AIDS
  
  **Group 3:** The different LIFESTYLES of a person with HIV and a person with AIDS
- Report as before, with each group adding only new points.
- After the groups have reported, present the information below. The groups’ three points on the differences between HIV and AIDS may have been organized in other ways. That is okay. The main point was to get every participant thinking about and discussing the differences.
- The points below can be linked to the ready body idea.
  
  **Group 1:** Various things are happening inside the bodies of people with HIV and AIDS.
  
  - HIV is the infection stage of the condition; AIDS is the disease phase.
  - When the virus enters the body, it comes into contact with the frontline of the body’s defence system. In the early stages of infection (during the first
few days or week) the infected person might feel as though the flu is coming on. HIV overpowers this frontline (made up of white blood cells called macrophages) and makes its way into other body cells, living on them, destroying them and multiplying at a rapid rate.

- Antibodies (chemical substances that a body produces to kill organisms attacking it) to the virus are produced. The body produces and releases antibodies into the bloodstream anywhere from six weeks to six months from the point of infection. This six-week to six-month period (shorter or longer depending on the particular body) is called the “window period.”

Note: The common lab tests look for the antibodies; they do not look for the virus itself.

- When the amount of viruses in the body reaches a high point and the amount of body cells that are supposed to fight off disease reaches a low point, the body is more open to other infections. HIV and various diseases then take over the body. This is when the person may be said to be living with AIDS.

**Group 2: The bodies of people with HIV and AIDS look different from each other on the outside. People with HIV look healthy, while people with AIDS look unhealthy.**

- You can’t tell when a person has HIV. A person who is HIV positive can look and feel as good as a person who does not have the virus. HIV-infected people can even look better, as many begin taking better care of their health and physical appearance.

- A person who is HIV positive can live for several years, looking just like a person who is not HIV positive. There are no signs on the person’s body to show that he or she is carrying the virus.

- People who are HIV positive develop AIDS (or can be said to “live with” AIDS) when they have three or more signs of the syndrome (collection) of diseases listed earlier. Those with AIDS may have signs such as significant weight loss, thinning hair and skin diseases. Other signs that may not be as obvious to another person are the frequent bouts of diarrhoea, enlarged lymph glands under the jaw, neck, armpits and groin. Thrush, a white furry coating on the tongue, the roof of the mouth and sometimes the vagina, is another sign. Note: No one of these signs by itself means that a person is living with AIDS.

- People who live with AIDS may not only look sick, but they may also feel sick. Diseases take over the body because HIV has broken down the body’s defence force or resistance (the immune system). These diseases are caused by “opportunistic infections.” They are called so, because when the body’s resistance is weak, infections of all types
take the “opportunity” to invade and take over the body. Usually a normally healthy person can “resist” these infections. The body’s immune system is designed to fight infections and disease.

- has not yet come up with a cure for HIV. A vaccine against HIV is now being tested.
- A person living with AIDS can return to feeling well when diseases are treated and symptoms disappear.
- People don’t actually die of AIDS. Death usually comes after a series of illnesses and when the body finally succumbs to (that is, is overpowered by) one or more of the diseases which take over in the AIDS stage.

**Group 3: Those with HIV and those with AIDS lead very different lives.** People with HIV can get on with their lives as usual, taking extra care with their health; those with AIDS may be too sick to carry on normally. They need care and medical treatment.

- People who are HIV positive have to make important changes in their sex lives.
- People who are HIV positive have to be careful not to infect others or to get re-infected with the virus. Every time an HIV-positive person is re-infected, the body’s resistance is weakened. AIDS will develop sooner because of this.
- Those who are HIV positive need to be extra careful not to pick up other infections. Every new infection, of whatever type, further weakens the immune system. We all know how easy it is to pick up a “bug” or virus when our resistance is low or down, and how hard it is to shake it off.
- Those living with AIDS need a lot of care and attention, medical and otherwise.
- Although both are infectious, a person who is only HIV positive is more likely to infect others than someone with AIDS, for two main reasons. First, the person with only HIV is more likely to continue to attract and desire sexual partners. Second, partners, caregivers and health care professionals are more likely to take risks with people who are HIV positive and don’t have AIDS because they look good and their status may not be known.
**Exercise 1: Why it is important to understand the difference between HIV and AIDS**

**Specific Objective**
- Enable each participant to understand why knowing the difference between HIV and AIDS is important.

**Time: 30 minutes**

**Materials: Pen and paper**

**Process**
1. Organize your large group into four small groups. Ask each small group to think of at least five reasons why it is important to know the difference between HIV and AIDS. If your group has already been “trained” or you think they are pretty sharp, give them a target of at least 10 reasons.
2. If you wish, you may tell them to find endings for this sentence: “Knowing the difference between HIV and AIDS, can help . . .”
3. Tell the pairs to appoint someone to report their answers. Each group will have to listen very carefully so that their reporter will only share those points not already made by others.
4. Add points from below that did not come up.
5. Add to your guide any points that came from the group (giving them credit) that are not listed below.
Knowing the difference between HIV and AIDS, can help people in the following ways

1. They understand that it makes no sense to look at a person’s face or “ready body” and decide to have sex. The ready body may not really be ready.
2. They pay closer attention to their own lives and bodies and the lives and bodies of potential sex partners.
3. They actively think about HIV before sex, before exposing themselves to the blood of others, and before (long before) having children.
4. They become conscious of the fact that anyone can have the virus: men in “good” positions and “decent” girls and young women.
5. They understand the dangers of making love in the dark – in places where they can’t see, with people about whose sexual parts and pasts they have no information.
6. They realize that one act of unprotected sex with an infected person may be all that is required for transmission of the virus. Even individuals who are usually careful about sex can become infected.
7. They start taking steps to protect themselves from HIV and other sexually transmitted infections.
8. Those infected with HIV learn to begin taking better care of themselves, physically and psychologically, including guarding against re-infection with the virus.
9. Those who test positive understand why they need to take personal responsibility for their health and their bodies.
10. Those who have tested positive for the infection have hope, because HIV does not mean death.
11. Those who do not have HIV take HIV seriously, because HIV does lead to dying before one’s time, and in what can be a very unpleasant manner.
12. They understand that it is less difficult to make changes in their lives and lifestyles now, instead of waiting until after being infected.
13. Those infected with HIV know that even if a test comes out negative (or non-reactive), they are infected and can infect others.
14. Those who have good reason to suspect that they may be infected understand that a negative test result does not mean that they are not infected, simply because they continue to look good and feel good. In other words, “negative” may not mean “negative.”
15. They understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks of the lack of an infection months ago, not an infection (or infections) that may be only a few nights old or a couple of weeks old.
16. They understand that they are not in danger of “catching or getting AIDS” from a person living with AIDS. This can help remove some of the stigma surrounding people who are living with AIDS. However, there may be other infections and communicable diseases affecting the person living with AIDS that a caregiver needs to guard against, for example, tuberculosis and hepatitis B.

17. They know that those with AIDS can return to being well if they are successfully treated for AIDS-related infections and diseases.

18. They understand that caregivers and health care workers can actively set out to obtain and deliver treatment to PLHAs, instead of abandoning these patients. PLHA can be encouraged to seek and take treatment, instead of just giving up.

19. They understand that young people should realize that it makes sense to put off sex until marriage or a permanent relationship with a faithful partner whose history is known and clean, that is, infection-free.

20. They understand that young people should start taking their lives, and the lives of others, seriously.
Day 3
Session 12
Window Period

**Objective:**
Help each participant understand and be able to explain the significance of the window period.

**Time:**
45 minutes

**Materials:**
- Pen and paper
- Calendar

**Methodologies:**
Buzz group, presentations

**Handouts:**
- Window Period
- Trainer’s preparation: Presentation on widow period, calendar to explain the window period

**Process**
1. Share the objective of this exercise.
2. Organize participants into pairs. Have one member of each pair, who thinks he or she understands the significance of the window period; explain it to their partner.
3. Ask those who think their partner did a good communication job to explain the answers to the following questions to the whole group: What is the window period, and why is it important to know about the window period?
4. Ask the rest of the group to listen carefully to see whether any important information has been left out of the explanations. They should also listen for any misinformation.
5. Correct any gross misinformation as soon as you hear it given, if no one else picks it up.
6. Have the group decide who was able to explain the window period best, and why that presentation was the best.
What is the Window Period?

- The window period is the time from HIV infection to when the usual lab tests can detect the antibodies to the virus in an HIV-infected person.
- The window period can last from six weeks to six months. Different bodies take different lengths of time to produce and release the antibodies, sometimes called “clues” to the virus.
- During the window period, the commonly used tests cannot detect the antibodies to the virus. Therefore, if someone is tested during that period, the test result will be negative even though they are infected. Some labs describe the findings as “non-reactive.”

Why is it important to know about the window period?

- During the window period, a person can be carrying the virus and not know. That person can unknowingly infect another person through unprotected sexual contact.
- People who know about the window period will know why one has to be careful about giving and taking blood. Those who are careful about remaining HIV-free will know of the importance of donating blood at regular intervals so as to maintain a good supply at the blood bank.
- If a person has been exposed to the virus and takes the test soon after, the test results may show up negative. People who do not know about the window period may think that they have not been infected. They may spread the virus to other people.
- Those who know about the window period will understand that they must take a second test after about six months to know if they are infected with the HIV virus or not.
- These people will know that they must abstain from sex, or practise very safe sex, until they learn whether they were infected at that time that concerns them.
- People who understand the significance of the window period cannot be deceived by another who produces a lab report in order to get unprotected sex. They will understand that a lab report verifying a negative test result, even if reliable and genuine, only speaks of an infection months ago, not
an infection (or infections) that may be only a few nights old or a couple of
weeks old.

These people will know that if they have unprotected sex while waiting to
have their second test, they are exposing themselves to HIV once again.
And, of course, if they were really infected in the first case, they will be
spreading the infection to other partners.

How to explain the window period
1. Ask the person or group how HIV is transmitted. Explain and correct where
necessary.
2. Explain what happens when HIV enters the body. (The frontline white blood
cells try to resist the infection, but they fail. The system continues to try
and resist. New forces come into the fight and antibodies to the virus are
produced and released.)
3. Explain that it takes six weeks to six months for the body to produce and
release antibodies to the virus into the blood system
4. Tell them, “Let’s say you had unprotected sex with someone on January 1,
and you are worried that you may have contracted the virus then. Don’t go
the next day or the next week for a test. That is too soon. The antibodies to
the virus will not have been produced or released into the blood yet, and
cannot be detected by the lab test.”
5. Explain that the test looks for the antibodies to the virus. It doesn’t
look for the virus itself.
6. Use a calendar or draw or count off the first six weeks – to mid-February, for example.
Explain that this would be a good time to go for a first test, but that the person must not
have unprotected sex between January 1 and mid-February. Any
additional exposure to infection by the virus would mean that
the testing process and time line
has to be started all over again.
That person must then count the
weeks and months from that new date.
7. But say that the test comes up negative. “Negative” does not mean the person is not HIV positive. It can simply mean that the infection is in the body, but the antibodies the test looks for have not yet been released.

8. This is why the person needs to go for a second test. Again, the person has to make sure that he or she does not have unprotected sex while waiting for the next test date.

9. Take the person through to the month of June. Explain that it has been known to take up to six months for antibodies to HIV to show up in some people’s bodies.

Note: If the person to whom you are explaining the window period is concerned about exposure to the virus on a particular date, use that date as your starting point.
# Session 13

## How to prevent HIV?

<table>
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<tr>
<th><strong>Objective:</strong></th>
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<tr>
<td>By the end of this session the participants will be able to:</td>
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<tr>
<td>• Tell what a condom is</td>
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<td>• List the advantages/disadvantages of condom use;</td>
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<tr>
<td>• Demonstrate the proper use of condoms on dildos;</td>
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<tr>
<td>• List the points that need to be considered while/before using condoms; and,</td>
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<tr>
<td>• List the reasons for not using condoms.</td>
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<table>
<thead>
<tr>
<th><strong>Handout:</strong></th>
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<tbody>
<tr>
<td>All about condoms, using a condom, advantages and disadvantages, condom care, condom negotiation</td>
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<table>
<thead>
<tr>
<th><strong>Trainer’s Preparation:</strong></th>
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<tbody>
<tr>
<td>• Preparation on prevention of HIV transmission</td>
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<tr>
<td>• Collect condoms for demonstration and display different brands.</td>
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<tr>
<td>• Collect dildos (at least 10).</td>
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<tr>
<td>• Write the meaning of condom, advantages of using them and reasons for not using condoms on a flip chart.</td>
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<tr>
<td>• Obtain a prize to give to the winner of the condom game.</td>
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<thead>
<tr>
<th><strong>Time:</strong></th>
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<tbody>
<tr>
<td>2 hour</td>
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<table>
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<tr>
<th><strong>Materials:</strong></th>
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<tbody>
<tr>
<td>Condoms, dildos, flip chart, marker</td>
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<tr>
<th><strong>Methodologies:</strong></th>
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<tr>
<td>Brief presentation by facilitator, question/answer, discussion, demonstration, condom game</td>
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## Presentation by facilitator (10 minutes)

- Sex does not only mean vaginal and anal sex which if had without a condom, carries the highest risk of STI / HIV transmission.

- Some of the safer sex practices include oral sex, mutual masturbation, thigh sex, breast sex, rubbing, kissing, etc.

- When it is not possible to abstain from sex or be faithful to one single sexual partner, the best option is to use a good quality condom along with water-based lubricant every time one has vaginal or anal sex.

- Condoms (along with a water based lubricant) are the safest means for protecting oneself from STIs and HIV infection.
**Process**

1. Show a condom to the participants and ask, “What is this?”
2. Distribute condoms to all participants and ask them to touch it, blow them up.
3. In a flip chart write down points to be considered while/before using condoms. Allow 10 minutes for discussion.
4. Divide the participants into groups of three.
5. Distribute condoms and dildos to each group.
6. Explain the proper procedure for using condoms and ask one participant to volunteer to demonstrate how to properly put on a condom (use the visual to depict all steps for correct condom use).
7. Observe the demonstration and correct if necessary.
8. Have the participants practice putting on condoms (on dildos) in role plays. Explain the roles to the groups: one person will act as a peer educator, another as the friend and the third person as an observer.
9. Explain that the PE will demonstrate how to use a condom to his/her peer, the observer will observe and provide feedback after the demonstration and the PE’s friend will learn from the demonstration. Have them rotate so everyone gets a chance to play all three roles.
10. At the end of the session, make a brief presentation on the benefits of using condom:
   1. Prevents STIs, including HIV/AIDS
   2. Prevents unwanted pregnancies.
   3. It is manly to use condoms – it can slow down ejaculation and enhance male performance.
   4. Condoms are sexy – it can prolong pleasure for both partners.
   5. Feels cleaner.
6. Feels more secure.
7. Shows you care about your partner.
8. No need to spend money on medications to treat STIs.
9. Saves you the cost and embarrassment of an STI.
10. Requires no medical screening advice - can use on your own.
11. They are often free or not very inexpensive.
About Condoms

The Value of Condoms

- The condom, when used properly, greatly reduces the risk of STD and HIV transmission between partners.
- It is also the ONLY contraceptive method that offers this protection.

All peer educators must become skilled at handling, talking about and explaining the use of condoms. Since condoms are associated with sex, people often have tension and feel shy when talking about or handling them.

Proper Use of Condoms:

How to use a condom?
Visual: Pictorial demonstration of condom use: different steps.
Narration

Proper use of condom

1. Open the package carefully so the condom does not tear. Do not use your teeth as this tear the condom. DO NOT unroll the condom before putting it on.

2. Squeeze the tip of the condom, and put it on the erect (hard) penis. Continue squeezing the tip of the condom (this prevents air from becoming trapped in the end of the condom) while unrolling it until the condom covers the entire penis.

3. Always put the condom on before entering or coming in contact with your partner’s genitals, anus or mouth.

4. Use a good lubricant to ease the pain of insertion and to prevent tears and injury. The lubricant can be applied in the vagina and also on the penis after the condom has been put.

5. Do not use vaseline, grease, oil or lotions as they can weaken the condom.

6. After ejaculation (coming), hold the base of the condom and pull the penis out before the penis becomes soft. Tie the end of the condom and wrap it in a paper.

7. Burn or bury the condom with other garbage.

Condom Myths

- Condoms are too small.
- They decrease pleasure.
- They might fall off inside the woman.
- Condoms often break and are unreliable.
- Only “loose” women use condoms.
- Men can’t keep an erection if they put condoms on.
- It is difficult to ask one’s partner to use a condom.
- Condoms irritate the skin.

Advantages and Disadvantages of Condom Use
(for men, women and children)

Advantages

1. Prevents STIs, including HIV/AIDS
2. Prevents unwanted pregnancies.
3. Can slow down ejaculation and prolong pleasure.
4. Feels cleaner.
5. Feels more secure.
6. Shows you care about your partner.
7. No need to spend money on medications to treat STIs.
8. Saves you the cost and embarrassment of an STI.
9. They are widely available.
10. Requires no medical screening advice – can use on your own.
11. They are often free or not very inexpensive.
12. They encourage male participation in safe reproductive health practices.

Disadvantages
1. May provide less enjoyment due to decreased sensation.
2. Hard to bring up the subject of condom use.
3. Can interrupt love-making.
4. Have to plan ahead to buy condoms and have them ready.
5. Condom could slip off
7. Costs money.
8. Disposal may be a problem.

Condom Care
- Do not use condoms if packages are ripped or have a hole in them.
- Do not use condoms that are dry, dirty, brittle, yellowed, sticky or damaged.
- Do not unroll a condom to check for tears before putting it on.
- Do not keep condoms in a tight pocket or in a wallet for a long period - it is too hot.
- Condoms should be stored in a cool, dark, dry place away from sunlight, moisture, heat and insects/animals.
- Do not try to wash and re-use condoms. Keep plenty of fresh condoms available and dispose of them properly.
- Do not use grease, oil, lotion or Vaseline to make condoms slippery - these oils break the condom.
- Proper storage of condoms – discuss places in a typical Indian home where condoms might be kept.

Condom Availability
- Available FREE at government health centres, family planning clinics and hospitals and through village community educators, female community health volunteers and trained traditional birth attendants.
- Condoms are also available from many NGOs, from community health programmes and from community educators or NGO volunteers.
- Condoms can be purchased at a low price from medical shops, betel nut / cigarette shops, general stores, etc.

More about Condoms
- Condom is the only contraceptive tool that provides protection from unwanted pregnancies and STIs and HIV/AIDS.
Community educators and volunteers can provide very important information on the proper use of condoms, the advantages of condoms and where condoms are available in your community.

Community educators and volunteers can also explain to you and others in your community about “dual protection”. This means that even if a woman is using a temporary or permanent contraceptive method, if her partner has high risk behaviours, she may need to have her husband/partner use condoms to protect her against STI/HIV in addition to her contraceptive method for prevention of pregnancy.

**Dual use approach**

Another VERY IMPORTANT thing for peer educators to consider and discuss with their peers is that although there are many contraceptive methods for people to choose from in our country, if a peer or a person thinks they are “at risk” of becoming pregnant or contracting an STI or HIV/AIDS it is very important that he/she knows that condoms are the ONLY contraceptives that protect against these types of infections.

They must also consider the “dual-use approach” to protection – using one type of contraceptive for protection against pregnancy AND condoms as protection against STI/HIV/AIDS. It is especially important that women know and understand this. Even if they have elected to use voluntary sterilization, if they are “at risk” for contracting STDs or HIV/AIDS, they must ALSO use a condom for protection against STD/HIV/AIDS.

Since this may be confusing or difficult for people to understand, the peer educators must make it very clear and help the peers to recognize that the only protection from STD/HIV/AIDS is through the use of condoms and therefore they should advice using condoms along with their other chosen contraceptive method.

Discussing condom use and the “dual-use approach” with partners may be difficult for many people. It may be a difficult issue even for the peer educators to raise. When discussing HIV/AIDS issues a peer educator can gently ask individuals or group members if they think the threat of STD/HIV/AIDS infection is a common problem or if women in the group feel they may be at risk of HIV and/or STD infection even though they may be using another form of contraception. Provide the opportunity in a non-threatening way for peers to share their feelings and frustrations regarding this situation.
**Condom Negotiation**

**Meaning of negotiation**
It is a form of communication – persuasive communication in a word, bargaining.

Some possible points of negotiations and suggested answers to them.

Don’t you trust me?
Trust isn't the point, people can have infections without realizing it.

I can’t feel a thing when I wear the condom.
Maybe that way you will last even longer and that will make up for it.

I don’t stay hard when I put on the condom.
I will help you put it on, that will help you keep it.

I don’t have a condom with me.
I do.
I am on a pill you don’t need a condom.
I’d like to use it anyway. It will help to protect us from infections we may not realize we have.

But I love you.
Then you’ll help us to protect ourselves.
Just this once.
Once is all it takes.

**Issues and Myths around condoms**
Wearing more than one condom gives extra safety.

This is a myth as two or more condoms may be more harmful than good. There is a chance of slippage and the condom may get inserted inside the partner. There is also a chance of air getting in between the two condoms and increasing the risk of condom bursting.
Condom does not fit
All condoms have enough elasticity to take care of size. To demonstrate the feature a condom should be opened and worn on the hand.

With double condom pleasure persists for longer period.
The double shoe exercise can address the issue.

Condoms are of different sizes
All condoms are of the same size with little or no variation. However we do have baggy condoms and featured condoms.

STD is HIV/AIDS
A big myth, all STDs are completely curable if diagnosed properly and treated early. STD increases the risk of getting HIV infection.

Higher priced condoms/Imported condoms are of better quality
Myth, all condoms have the same specification and they only differ in packaging and branding. The featured condoms however do have special features like smell, flavour, dots, spirals, etc.

Condom is not good enough to prevent AIDS
This is a feeling which has been perpetuated because of a misinformation that virus size is smaller than pores in condoms. A simple exercise needs to be done to clear the myth. Take a condom and put it at the mouth of a bottle of water. Press the bottle so that around 500 ml of water enters the condom. Hold the open end tight and show it to all the participants. Stress on the point that even water is not coming out then how can virus which is carried by semen flow through this.

Lubrication is not enough
All condoms come with adequate lubrication. In case there is a felt need of extra lubrication any water-based lubricant can be used like glycerine, KY Jelly or saliva.
Anal sex does not need condom
This is a serious myth. Virus can gain entry from any part of the body. In fact, anal sex has a higher degree of chance to transmit HIV. So it is always advisable to use condoms while anal sex too.

Thicker condoms are required for anal sex.
Anal sex does require more lubricant as contrary to vaginal sex, anus does not produce any biological lubricant. It is advisable to use water-based lubricants to complement condoms while practising anal sex.

Oral sex does not need condom
Mouth is one place, which has the chance of having cuts and bruises or ulcers which can generate open wounds inside the mouth. Thus to prevent any kind of transmission of biological fluid it is advisable to use condoms for oral sex too. For oral sex various fruity flavoured condoms are very popular.

Putting condom in mouth is dangerous
Condom is made of latex and the water-based silicon lubricant is non-allergic, non-reactive and also biologically safe. Thus it is absolutely safe to take a condom inside mouth but certainly not safe to gulp it.

Oil based lubricants can be used for condoms
Oil-based lubricant can actually damage the condom and cause more harm than good. It is always advisable to use water-based lubricant like glycerine, saliva, etc.

Condoms can be washed and reused
All latex condoms are for single use only.
When to Recommend Voluntary Counselling and Testing (VCT)

**Objective:**
Enable each participant to consider reasons for and against recommending voluntary counselling and testing (VCT).

**Methodologies:**
Group work and discussion on questions put by the facilitator.

**Trainer’s Preparation:**
- Information sheet on counselling and testing
- Problems that can arise while recommending testing.

**Time:**
1 hour 30 minutes

**Materials:**
Pen and paper

**Process**

1. Share the general objective of this module and the specific objective of this exercise.

2. Ask each participant to think about a situation of someone they know who:
   - May be worried about STI or HIV infection;
   - Is engaged in behaviour that puts him or her at risk of contracting STI or HIV;
   - “Knows” that he or she has an STI or the HIV virus, but has not taken a test;
   - Wants to get married, start a relationship, or have a child;
   - Is expecting a child (mother or father-to-be) and may have been exposed to an STI or HIV; or
   - Is one of the above but lives somewhere in a locality where STI/VCT services don’t exist.

3. After participants have selected the situation they want to think about concretely, ask them to jot down points “for” and “against” recommending VCT.

4. After they have done this, ask them to decide on the following:
   - What action will they take?
   - How they will go about it?
   - What are the reasons for their decision?

5. If the group (or people in the group) are not comfortable writing, make it a thinking exercise and direct their attentions about what they should be
considering. Remind them from time to time about the exercise’s goal, to keep them on track.

6. Organize the group into pairs for sharing with partners. Tell participants to share enough information that the partner can have a sense of the situation, without revealing the identity of the person. Remind the group of the importance of maintaining confidentiality, even while seeking help.

7. Tell participants to use the opportunity to consult with their partner on the best way of approaching the situation.

8. Ask participants to take turns presenting to the whole group on the following issues:
   - The situation
   - The arguments for and against recommending VCT
   - What they decided
   - How they will go about it
   - Why they made that decision

9. Ask the group to listen carefully to make suggestions and add information after each presentation.

10. Add any further insights or guidance as necessary.
This exercise may be used in a number of different ways. You can look at one category of people at a time. Each situation, from (a) to (f), can yield several different situations, especially if different age, gender, faith and race groups are considered separately. There will be other categories and situations that you and your group can propose.

The following are points to consider when advising someone about whether to go for the HIV antibody test.

1. Try to find out whether a person is just worrying or really needs to take a test:
   - Has the person been having unprotected sex?
   - Has the person had sex with someone who is HIV positive?
   - Has the person had sex with someone who had an STI?
   - Has the person had sex with a male partner who has had sex with a male partner?
   - Has the person had sex with different partners?
   - Has the person had a blood transfusion?
   - Has the person shared a needle with a drug user?
   - Has the person had sex with someone who would answer “yes” to any of the above?

2. Know about the locations of VCT and other testing facilities, as well as the quantity and quality of their services.

3. What if the testing facility does not provide pre- and post-test counselling?

4. What if the person doesn’t take a test?

5. What if the test is positive?

6. What if the test is “negative”?
Session 15
Values, Attitudes and Behaviours

Objective:
- Enable participants to share and enlarge their understandings of values and attitudes.
- Enable participants to explore the myths and facts about sex and how these affect the personal and community attitudes about sex and the connections with HIV.

Methodologies:
Cards, exercises

Handouts:
Values and attitudes, counselling on positive life

Trainer’s Preparation:
Presentations on values and attitudes and how they affect behaviour change for HIV prevention.

Time:
2 hours 30 minutes

Materials:
Cards, pens, tape

Exercise 1: What Are Values? What Are Attitudes? (15 minutes)

Process
1. Share the objective of this exercise with participants.
2. Distribute the cards to the participants. Three different colours for three values – personal, family and social, and one colour for attitudes.
3. Ask participants to think about the word “values”, – their personal values, the values of their family, social values and attitudes.
4. After a minute or two of thinking time, ask the group to write down one personal value, one family value and one social value and two attitudes on their Cards.
5. Ask the group to put up their cards according to the colour on the board.
6. Let the group go around and look at the values that have been put up.
7. Assemble the group together. Ask them to describe what they felt were personal values as different from family or social values. What difference did they find in the attitudes?
   ➔ Values can be described as what we consider worthy, worthwhile, good or have a high opinion of.
   ➔ Attitudes can be described as those beliefs and opinions that make us tend to behave in certain ways.
8. Were there important differences between personal values and attitudes and family (or parents) values and attitudes? What accounts for some of the differences?
9. Sometimes people “talk the talk” but don’t “walk the walk.” Ask what participants
think this means in connection with values and attitudes. Get participants to look at “values” separately from “attitudes” and give examples to illustrate what they think. (The values may be a reflection of social or family values, but this is not reflected in the attitudes).

10. What are the implications of values and attitudes for HIV? The group can brainstorm this and see how values and attitudes are responsible for how we handle the situation of HIV infection in the family, how we treat a person who we know carries the infection or the family, which has an infected person.

Exercise 2: Building self-esteem

Session Objective
Enable participants to explain the word self-esteem and identify factors that contribute to high or low self-esteem.

Time: 35 minutes

Process
1. Share the objective with the participants.
2. Ask participants to think about the word “self-esteem.”
3. After two minutes of thinking time, organize the participants into pairs. Have each member in a pair (a) tell their partner how they feel about themselves and (b) tell their partner something positive about themselves.
4. When they have done that, ask randomly how a person felt while telling a positive fact. Ask how the partner responded.
5. After the plenary, explain to the participants that:
   - Self-esteem refers to the way we feel about ourselves, how we handle the way we feel about ourselves and how we handle the world.
   - How we feel about ourselves influences how others feel about us (how the partner responded).
   - Our performance is higher when we feel good about ourselves and vice versa (how we reported the conversation in the plenary).
   - Our relationship with others is affected by the way we feel about ourselves.

Factors that contribute to high self-esteem:
- Constant positive reinforcement for our achievement;
- Supportive environment, i.e., an environment full of love, warmth and wisdom,

Factors that contribute to low self-esteem:
- Lack of positive environment or one with constant criticism;
- Inconsistency in the nature of one’s upbringing;
- Socio-economic instability;
- Rejection and failure.

Evaluation
1. What is self-esteem?
2. List three factors that enhance the development of positive self-esteem.
3. List three factors that reduce one’s self-esteem.
Exercise 3: Attitudes: Yes and No

Objective

Enable participants to examine their attitudes privately and publicly on a number of sex and sexuality issues.

Time: 1 hour

Materials: Pen and paper

Process

1. Tell participants that you will read a number of statements. If they agree, they should write “yes”. If they disagree, they should write “no”. If they are not sure, they should leave a blank space.

2. Take either of the following 10-statement sets at a time or a session. See “Process continued” below.

I

1. I think that sex before marriage is a good idea.
2. I think love without sex between two partners is possible.
3. I think sex without love is okay.
4. I think sex with a child is nasty, sick and inexcusable behaviour.
5. I think some women who get raped ask for it.
6. I think oral sex is disgusting.
7. I think anal sex is okay.
8. I think that it is good to touch and stroke my own body sexually.
9. If I saw two women holding hands in public, it would not bother me.
10. If I saw two men holding hands in public, I would find it disgusting.

II

1. I would feel comfortable working closely with a male homosexual.
2. I would feel comfortable working closely with a female homosexual.
3. If a member of my sex made a sexual advance to me, I would be very angry.
4. I would feel comfortable knowing that I was attractive to members of my sex.
5. I would feel comfortable if I found myself attracted to a member of my sex.
6. I would feel nervous in a group of homosexuals.
7. I would feel uncomfortable knowing that my daughter’s teacher was lesbian.
8. I would feel uncomfortable knowing that my son’s male teacher was gay.
9. It would bother me to discover that my doctor was homosexual.
10. I would feel that I failed as a parent if my child was gay.
Process continued
1. Begin by asking participants who felt uncomfortable thinking about and responding to the statements to raise their hands.
2. Ask each person to talk for a minute or two about the discomfort.
3. Ask the group if they think that girls and women feel differently or more positively about these matters than boys and men. Ask for some of the reasons.
4. Write the words “Yes” and “No” in large letters and place them to the right and to the left on the floor or wall in front of the group.
5. Place a blank sheet of paper in the centre, between the designated “Yes” and “No” areas.
6. Tell those who indicated that they were comfortable (by not raising their hands) that you will be asking them to step forward to declare their “Yes”, “No”, or other positions openly.
7. If, at this stage, some participants have second thoughts, they should share them with the group.
8. Ask participants to say what they think is the purpose or objective of the exercise.
9. Ask participants whether they think it is important for trainers and peer educators to examine and openly discuss their attitudes on these matters.
10. Take the statements one by one and ask participants to take up their “Yes” or “No” or “in-between” positions.
11. Ask the three groups now in front to consult briefly and report on the arguments and views of their group. A representative of the “I don’t know,” “it depends,” “not sure” and “others” in between should also report on the group’s thinking.
12. Conclude by asking participants to say how this exercise can help them in their peer education work.

Note to the Facilitator:
1. Involve participants by allowing them to choose the statement or statements they want to start with or select for consideration during the session.
2. The statements can also be used singly or in pairs for discussion or to stimulate a whole group discussion.
Objective:
Enable participants to understand and list some steps in making a decision.
- Enable participants to describe some of the important factors considered in decision-making.

Materials:
- Flip chart or chalkboard, marker or chalk
- Handouts: Decision-making situation cards
Note: Prepare the situation cards before the session

Methodologies:
Exercises in small groups and presentations, situation analysis

Trainee's Preparation:
Presentations on decision making, steps in decision making and myths and facts on sex

Time:
1 hour 30 minutes

Exercise 1: Understanding the Decision-making Process

Process
1. Divide participants into five groups.
2. Give each group one card with one decision-making situation on it.
3. Ask the group to conduct the following exercises:

Part I
a. Meet and consider the situation as shown on the card.
b. List the steps involved in making and reaching a decision.
c. Discuss the situation and make a decision about the situation on the card.
d. On the flip chart or chalkboard, state what decision they chose for the situation and the reason for the final decision.

Part II
a. Have a reporter from each group present the group’s work to the larger group.
b. After the participants’ responses, discuss each situation.
c. Summarize the decision-making process and help consolidate all group ideas into one list of steps in making a decision.
d. Explain the tools of making good decisions as:
a. Self-awareness
Having high self-esteem helps in making good decision.

b. Clarified values
Understanding and being sure of personal and family values is important for good decision-making.

c. Information
Adequate and vital information and facts about all aspects of the issue gives one the opportunity to weigh the options and make an informed decision.

d. Clear values
Clear values are important for determining how to most effectively use the opinions and values of others.

List other factors influencing decision-making, such as religion, family, society, culture, government, policy, environment, climate, foreign influence and media.

Exercise 2: Model for Decision-making
1. Ask participants to practise a simple decision-making process with the following situation.
   “I’m going to have a party. I have many friends, but because of space and expenses, I can only invite a few people. How do I decide who to invite so that no one’s feelings are hurt?”
2. Have a reporter to present the group’s work.
3. After the participants’ response, explain the model for decision-making as follows:
   a) Identification of problems
   What exactly is the problem for which a decision needs to be made?
   b) Gathering information
   i. Consider your personal values, goals and other facts you need to know related to the decision.
   ii. Identify alternative solutions.
   iii. Consider the various solutions or alternatives that could be adopted.
   iv. Consider the advantages and disadvantages of each solution or alternative.
   c) List the advantages and disadvantages of the various alternatives.
   d) Choose a solution.
   e) Plan and take action.

Summary
- Decision-making is a day-to-day activity.
- There are many alternative solutions for every problem or situation.
- Every decision, including not making a decision, has a consequence,
- The best decision is usually one that is consistent with one’s own values.
- Better decisions result from the use of a conscious decision-making process that examines alternatives.
Decision-making Situation Cards

1. You are a 22-year-old man, and you have been recently married. Your wife is still completing her studies and you have just joined a job. You want to start a family, but you also want your wife to complete her course and you to get settled in the job. Your wife has suggested using the rhythm method.

2. You are a 22-year-old girl in a university. Your college anti-AIDS club has been very active lately and you have been thinking a lot about AIDS. You think that your past experiences may have put you at risk of contracting HIV, but you are afraid to know for sure. A close friend has suggested that you get an HIV test.

3. You are a 38-year-old woman, and you have five living children. You really do not want to get pregnant again, but your husband is opposed to using any contraceptives.

4. Your husband travels out frequently for work. You have been attending the women’s group meetings where the ANM talks about HIV and AIDS. You are not sure that your husband is faithful to you. You want to ask him to use a condom.

5. You have been married for the last five years. Your husband and his family are pressurizing you because you have not been able to conceive. You suspect that your husband has some STI and want to raise the issue of going to a doctor with him.
Objective:

Have each participant reflect on behaviours with respect to risk-taking.

Methodologies:

Small group work

Trainer’s Preparation:

Presentation on: What is risk?, What puts people at risk of HIV infection?

Process

1. Share the objective of the session.
2. Allow each participant to examine the word “risk” and define it.
3. Present a short definition of “risk” as “a situation taken that could jeopardize one’s health unknowingly.”
4. Distribute the following questions to all participants and have them anonymously answer “Yes”/“No”
   ➔ Would you take the risk of unprotected sex with someone who is HIV positive?
   ➔ Would you take the risk of having sex with a condom with someone who is HIV positive?
   ➔ Would you take the risk of unprotected sex with someone whose HIV status is not known to you?
5. Collect the completed questionnaires and count the responses.
6. Usually after the two days of input we will see that there are more “Nos” than “Yeses”. The Trainer can ask “Why is this so? Does it give a message of how important correct information is to take a decision”.
7. Ask the group to think how much it is possible for women and young girls to negotiate safe sex behaviours with men and their husbands.
8. What needs to be done to change this situation?
Process continues with next exercise

Objective

→ Have participants understand why different groups of people are at a greater risk of HIV infection.

Materials

→ Pen and paper
→ Chalkboard or flip chart
→ Three copies of “Cultural and Psychological Factors” and “Economic Factors”

Process

1. Divide your group into four work groups. Explain that:
   → Group 1 will list at least 10 reasons why young boys are especially at risk from HIV infection.
   → Group 2 will list at least 10 reasons why young girls are especially at risk from HIV infection.
   → Group 3 will list at least 10 reasons why women are at particular risk from HIV infection.
   → Group 4 will list at least 10 reasons why men are especially at risk from HIV.

2. Tell the group that they will be looking at the reasons why these different groups of people are at particular risk, from four different aspects:
   → Biological factors
   → Cultural factors
   → Economic factors
   → Psychological factors

3. After allowing about 15 minutes for small group work, find out which group has the longest list and congratulate them.

4. Begin with the group with the shortest list. Have them read out their points.

5. Have the other groups list new points as usual.

6. Consult the list below to add points not made by the group. Don’t read them out. Use them as talking points to get a discussion going. You can say, for example, “What about alcohol? No one mentioned it.”

7. Be sure to make a note of good points made by the group.
Session 18
Understanding Behaviour Change

<table>
<thead>
<tr>
<th>Objective:</th>
<th>Methodologies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have participants understand the various stages in the process of behaviour change</td>
<td>Small group work and presentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time:</th>
<th>Trainer’s Preparation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 hour</td>
<td>Chart on process of behaviour change and response of peer educator to a client</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Materials:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Flip chart and markers or chalkboard and chalk</td>
<td></td>
</tr>
</tbody>
</table>

Exercise 1

Process
1. Ask participants to think of any behaviour change in their lives. They can think of areas such as smoking, religious practice, alcohol or drug use, study or food habits, dress.
2. List the areas they come up with down one side of the flip chart.
3. Ask a few people to describe, step-by-step, why and how they changed their behaviours. Ask about cultural, health, information, partners, peer group, friends, family and other factors. List reasons for the change next to each behaviour area.
4. Ask the group to look at the similarities and differences that came up as participants spoke of the reasons for making a behavioural change.
5. Use the heads below to group the reasons:
   - Received additional information
   - Influence from parents
   - Influence from peers
   - Services and/or commodities were available
6. Take one of the examples and chart it along the Behaviour Change Process outlined below. Relate “influences” and “services” noted under #5.
7. Ask if anyone is able and willing to share a behaviour change experience connected to STIs or HIV and walk the group through the chart above.
8. Lead participants in identifying what the peer educator’s response should be to a client at each of the stages of behaviour change.
<table>
<thead>
<tr>
<th>The process of behaviour change</th>
<th>Response of peer educator to a client at each stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unaware</td>
<td>Provide basic information on situation, such as the causes and consequences of untreated STIs.</td>
</tr>
<tr>
<td>Informed</td>
<td>Encourage them to adopt positive steps and present them with behaviour change options.</td>
</tr>
<tr>
<td>Concerned</td>
<td>Tell them what to do next in changing their own behaviour, such as going to the clinic to receive STI treatment.</td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>Motivate the client to act, for example, by informing them of the benefits of attending clinic.</td>
</tr>
<tr>
<td>Motivated to change</td>
<td>Point or direct client to services and encourage their use.</td>
</tr>
<tr>
<td>Ready to change</td>
<td>Tell client the benefit of using the services.</td>
</tr>
<tr>
<td>Trial/assessment of new behaviour</td>
<td>Provide an opportunity to practice new skills and reinforce what the client will do to continue the new behaviour.</td>
</tr>
<tr>
<td>Sustained behaviour change</td>
<td>Tell the client they are doing the right thing. Create an environment that promotes the new behaviour.</td>
</tr>
</tbody>
</table>
### Objective:
By the end of this session, participants will be able to:
- Develop their interpersonal and mass communication skills;
- Identify the barriers of communication and ways of overcoming these barriers;
- Identify the elements of communication; and,
- Practise counselling and receiving feedback skills in small groups.

### Handouts:
- Communication (fact sheet)

### Trainer's preparation:
- Prepare a list of barriers to communication (from fact sheet).
- Make a list of strategies for overcoming barriers (from fact sheet).
- Prepare seven participants for two different role-plays (scripts are provided).
- Prepare a message for the rumor clinic game.
- Write the definition of counselling on a flip chart.
- Write the elements and definition of communication on a flip chart.

### Time:
5 hours

### Materials:
- Flip charts, markers, tape

### Methodologies:
- Small group work and presentation, role play, question/answer, discussion, visual aid, lecture, peer work

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**Process**

1. Share the objectives of the session.
2. Start the Chinese whisper game:

One message is written on a piece of paper. One of the participants is requested to come with the facilitator and read the written message many times until (s)he has it memorized. All participants are requested to stand in a circle. The participant who has memorized the message tells it to the next participant in his/her ear, so that others may not hear. In this way, the second participant passes the message to the third, and so on, until the message arrives at the end of the circle. The facilitator asks the last participant to say aloud what (s)he has heard.
Message
Raju was sent by his wife to the weekly village bazaar to buy vegetables, some fish and little bit of chicken. He forgot to buy vegetables altogether, bought a fishing net instead of the fish and bought some chicken eggs instead of the chicken. When he got back home, his wife was furious and threw him out of the house.

3. Ask the following processing questions and discuss:
   ➔ What was the first message?
   ➔ Why did the last person not receive the same message?
   ➔ What did you learn from this game?
   ➔ What does communication mean?

4. Relate the theme of the game with the elements and definition of communication, as follows:
Communication does not mean speaking or saying something. It requires a listener, a correct message, and a medium.

Present the elements of communication on newsprint and explain its process:

Share the following definition of communication:

Communication is the process by which two individuals try to exchange a set of ideas, symbols, feelings and meaning.

Ask the participants to spend the next 15 minutes brainstorming on barriers to communication. Note down points on a flip chart.

Then make the presentation on the barriers from the handout provided.

Role Play 1
Barriers to communication

Process
1. Call for six volunteers
2. Allot the following roles to them separately and pin their names on their cloth.
3. No one should know what the other person’s role is.
4. Everyone should know that Peddamma is a peer educator and is going to talk to a group of five sex workers.
5. Hand out the roles of each actor in a slip of paper and give them 10 minutes to prepare for their role separately.
6. Conduct the role-play in front of the rest of the audience.
Peddamma’s brief

Scenario
You are a peer educator. Without making any introductions, building up rapport and enquiring about the general welfare of the other women, you will directly start explaining about the transmission of HIV / AIDS to her peers. You should say,

“There are several modes of HIV transmission.

Sexual mode is the most common.

When HIV enters into the body it destroys our “immunity”.

It is a very dangerous “virus”.

We need to be careful, especially when having “unprotected” sex with strangers.

There are five peers (KP representatives)
As the peer educator Peddamma, your role is to ensure that no one leaves while you are talking because you want to communicate an important message.

Meena’s brief
Meena’s response: “I have already heard this many times.” (she requests the peer educator, Peddamma, to speak about another topic. When Peddamma does not do so, Meena quietly slips away.

Surya’s brief:
Surya does not understand the meaning of many words like immunity, unprotected sex, etc. She first asks Peddamma what these words mean and when she doesn’t get an answer, she switches off and starts thinking about something else, not paying any attention to what Peddamma is saying.

Devika’s brief:
“This is a worthless thing to listen to! My husband will beat me up and throw me out if he finds this out. I can not listen to this!” and walks out in a huff.

Waheeda’s brief:
“ Ayyo! Chi! Chi! This is a shameful thing to listen to! How can I listen to these things from someone I don’t know? I feel embarrassed; what kind of a person would dare to talk about such private things?”

Allow for about 10-15 minutes for the role play. Then ask the following questions to the observers:

1. What was the peer educator’s initial behaviour?
2. What were the behaviours of the individual participants? (Narrate their statements.)
3. Why did they leave the room? What problems did they have?
4. What could the peer educator have done to overcome these problems?
5. Then make a presentation of the following table, explaining that the strategies listed below are very essential to a peer educator while educating his/her peers.
<table>
<thead>
<tr>
<th>Barrier</th>
<th>Strategy to overcome the barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of adequate rapport and</td>
<td>Adopt a friendly approach, exchange pleasantries first, enquire about their welfare, start with a discussion of general problems and then introduce health issues, including reproductive health, and then narrow down on STI / HIV / AIDS</td>
</tr>
<tr>
<td>confidence building / HIV / AIDS</td>
<td></td>
</tr>
<tr>
<td>Denial</td>
<td>Be patient, persistent.</td>
</tr>
<tr>
<td>Prejudice</td>
<td>Listen to these persons, ask them about their views, respect them, use them as resource persons.</td>
</tr>
<tr>
<td>Interruptions</td>
<td>Explain the objectives of the exercise; manage the interrupter.</td>
</tr>
<tr>
<td>Difficult Language</td>
<td>Use understandable language.</td>
</tr>
<tr>
<td>Fear</td>
<td>Listen to them, try to reassure them and see how they can be empowered through information, mutual support. Talk to men as well as women in a gender sensitive and culturally appropriate manner.</td>
</tr>
<tr>
<td>Cultural Values</td>
<td>Do not try to challenge these views; ask them questions about their views in order to hear these persons articulate them; provide them several alternatives to these views; maintain confidentiality.</td>
</tr>
<tr>
<td>Lack of Trust</td>
<td>Create a supportive environment; find local persons who can talk to them; talk about your family; be informal; keep messages simple.</td>
</tr>
<tr>
<td>Shyness</td>
<td>Give examples, communicate with them separately.</td>
</tr>
<tr>
<td>Lack of time service to their door.</td>
<td>Ask if you can schedule a more convenient time and place; even bring the service to their door.</td>
</tr>
<tr>
<td>Too much information</td>
<td>Make messages short and concise; build on what they know; focus on what they must learn.</td>
</tr>
</tbody>
</table>
The Basic Rules of Receiving Feedback

Inform the participants that:

- Feedback from another person is one important source of data which helps tell you how your actions are affecting others.

- Even if you “disagree” with the feedback, it is important for you to hear it clearly and understand it. If nothing else, it will tell you how that individual sees your actions and gives you the choice of trying to change your behaviour.

- People act on their perceptions of your actions and you may be coming across in unintended ways.

Following are some useful hints which will help you be effective in receiving and giving feedback:

1. Remember that it is one person’s perceptions of our actions, not the universal truth.

2. Feedback will be received less defensively if it is descriptive rather than evaluative. To describe a person’s behaviour or to describe one’s reaction to it, such as “I felt left out when you cut me off”, is more useful than “you always cut people off”.

3. Feedback should be useful and meaningful. It should be important enough to affect the receiver and directed towards behaviour which can be changed. When feedback is too shallow, it is useless; when directed towards behaviour that cannot be changed, it only leads to frustration.
Role Play: Communication and Negotiation
Ask for volunteers who can act well. Distribute the following roles to the volunteers.

Scenario: Saif is a MSM. He has heard about HIV/AIDS, but all he really knows is that it is a serious disease without a cure. He is interested to learn about it in more detail because he has heard many stories about people in Africa and millions of Indians dying from AIDS. One day, Saif happens to meet Ravi, a staff member of an NGO that works for HIV prevention. Saif tells Ravi that he is interested in learning about HIV/AIDS. Two months later, Ravi invites Saif to participate in a five-day, peer educators’ training organized by Ravi’s NGO in Ramagundam. During the training, Saif learns how HIV is transmitted, and the roles and qualities of a peer educator. Saif is very happy to get this opportunity. He begins, explaining about HIV/AIDS and distributing HIV/AIDS IEC materials to his friends.

Role Play
One day in Ramagundam, Madhu, a friend of Saif, comes to him and tells him that he thinks he might have contracted an STI because he has been having sex with other men without condoms and recently he has been having some discharge from the anal region. Saif listens to Madhu and appreciates the fact that Madhu has confided with Saif. Saif then goes on to explain the effect of untreated STIs (including the fact that it will make him more vulnerable to getting HIV infection) and the need to get early treatment. He then refers his friend to a doctor for a check-up and keeps a record of the referral.

Saif also explains Madhu that till he has got cured, it is best not to have any sexual encounter. However if he still chose to have sex, he must use a condom
and a lubricant. Saif then does a condom demonstration, ensures that Madhu has learnt how to use a condom through a reverse demonstration and then handover few condoms and lubricant sachets to Madhu.

Questions for the group:
→ Who is Saif? What is his role?
→ What did Saif do after the training he underwent at the NGO?
→ How did Saif help his friend?
→ As a peer educator, what did you learn from Saif’s actions?

Scenario
One winter evening in Ramagundam, Saif and a few friends were drinking beer in a restaurant. Saif’s friends were talking about a transgender sex worker they knew who recently died of AIDS.

Role Play
One of his friends, a bus driver, asks Saif about how HIV is transmitted. As Saif explains this to his friends, two men (MSM) walk in and start to make fun of Saif. One of the men says, “Hi, AIDS Man!” They don’t listen to what Saif is saying and try to interrupt him. They tell him that there is no disease called AIDS, it is all just nonsense. Saif just smiles, he does not get angry. After a few minutes, Saif asks these men what they know about HIV/AIDS. When they don’t answer, he gives them some booklets to read. The next day, both of these men come back and ask Saif to explain more about HIV/AIDS. Saif is happy to help them and explains to them as much as he knows about the disease, its transmission and prevention.

Questions for the group:
→ What was Saif doing in the restaurant?
→ What problem did he face there?
→ How did Saif react?
→ As a peer educator, what did you learn from Saif’s behaviour?

Scenario
One week later, Saif meets another friend Akshay in Ramagundam.

Role Play
Akshay tells Saif that last night, while he was having sexual intercourse with a guy he picked up in the park, the condom got torn. Akshay is afraid he might have become infected with HIV. Saif listens to his friend’s story and first tells him how to use a condom properly. Then he encourages Akshay to go to the Mythri clinic in Ramagundam to visit the doctor and then meet a counsellor.

Process questions:
→ What is Akshay’s problem?
→ How did Saif help Akshay?
Additional Role Play

Role Play: Negotiating Skills

Condom negotiation
Kalyani is a sex worker. One of her regular clients always has sex with her without using a condom. Kalyani has requested her client to use a condom but has failed to convince him. She knows that using condoms helps in preventing sexually transmitted infections. Salma is a peer educator and is a close friend of Kalyani. Kalyani comes to Salma for help and advice since it is well known that Salma does not entertain a single client without a condom. Salma is some kind of a role model for the sex workers.

Note to the facilitator

The above scenario has to be enacted. Kalyani needs to articulate her problem. Salma then needs to tell Kalyani how to negotiate condom use with clients, including demonstrating correct condom use.

STI Referral
Rani and Jessie are friends and work in the same locality as sex workers. Jessie is a peer educator. Rani does not use condoms regularly. Rani tells Jessie that a few of her clients have complained of having some irritation as well as sores in their genital areas.
**Note to the facilitator**

The above scenario has to be enacted. Rani needs to articulate her problem. Ideally, in the role play Jessie should tell Rani that it is very likely that some of Rani’s clients are having STIs and they might have transmitted the infection to Rani since she does not use condoms. Without causing any fear, Jessie then needs to tell Rani the importance of using condoms in every sexual encounter, how to negotiate condom use with clients, including demonstrating correct condom use. Jessie then needs to refer Rani to the nearest Mythri clinic and convince Rani that it is very important to go the Mythri clinic once a month to get a general check-up even if one is feeling perfectly healthy. Jessie also should tell Rani that free STI treatment services are available in the Mythri clinics.

**Partner notification**

Mala is a peer educator. Madhuri is a friend of Mala and is a sex worker. Madhuri complains to Mala of lower abdominal pain. She also complains of pain during sex. A few of her clients have complained of having sores in their genital areas.

**Note to the facilitator**

The above scenario has to be enacted. Madhuri needs to articulate her problem. Ideally, in the role play Mala should tell Madhuri that it is very likely that some of Madhuri’s clients have STIs and they might have transmitted the infection to Madhuri since she has all the symptoms of STIs. Without causing any fear, Mala then needs to tell Madhuri the importance of using condoms in every sexual encounter, how to negotiate condom use with clients, including demonstrating correct condom use. Mala then needs to refer Madhuri to the nearest Mythri clinic and convince her that it is very important to go the Mythri clinic once a month to get a general check-up even if one is feeling perfectly healthy. Mala also should tell Madhuri that free STI treatment services are available in the Mythri clinics.

Finally, Mala should tell Madhuri that she should discuss the following with her clients: They might be having an STI since they have sores in their genitals. It is important for them to protect themselves and their families back home. Therefore her clients should consider visiting the Mythri clinics where free and confidential treatment is available.

**Injecting Drug User**

Amir and Ajay are childhood friends. Recently while going through Amir’s jacket pocket for a match box Ajay finds a syringe and a bottle of medicine. When Ajay asks for the reason Amir says it was for another friend. But Ajay has seen a few marks around Amir’s arm that could be needle marks.

**Note to the facilitator**

The above scenario has to be enacted. Ajay needs to initiate a discussion to find out if Amir has a drug problem.
Day 5

Session 20

Dosage of Messages in the Peer Education Process

**Objective:**

By the end of this session, participants will be able to:
- Understand what peer educators need to communicate
- Understand the importance of communicating in dosages.
- Gain information and skills to train their peer educators in outreach and giving messages in dosages

**Time:**

4 hours

**Materials:**

Flip charts, markers, tape

**Methodologies:**

Small group work and presentation, role play, question / answer, discussion, visual aid, lecture, peer work

**Handouts:**

Dosage of Messages

**Trainer’s Preparation:**

- Check out if everyone has read and understood the hand-out properly and encourage them to ask any questions
- Provide any further information required by the participants and encourage the group to have a general discussion (max 20 minutes) on the approach (dosage of messages).
- Organize a role play to reinforce the dosage approach:

**Process**

1. Inform the group that peer educators are expected to make new and repeat contacts every day as they do their outreach work. During their encounter with the KP members they are expected to give a series of messages, in graded dosages that are aimed at increasing awareness, improving health seeking behaviours and increasing condom use.

2. Divide the group into three sub-groups and ask each group to discuss what message should a peer educator give out to a KP member whom she/he is meeting for the first time and what additional messages should be given in the subsequent (follow-up) meetings.
3. Ask each group to make a presentation.
4. End this part of the session here and give the handout on Dosage of Message to each group. Ask them to read the handout thoroughly, discuss it with their colleagues and seek clarification from the facilitators during the evening/over dinner, if necessary.

**Role Play on Dosage of Information**

**Role Play 1**
- Ask for five volunteers for a role play.
- Ask one person to play the role of a peer educator and the other persons to play the role of sex workers.
- Ask the group to enact the first, second and third encounter respectively as described in the handout in three separate and successive one-act plays.
- The role of the peer educator is to break the ice, gain trust and confidence and then give out the information, and the role of the sex workers is to do what is expected and normal – i.e. show disinterest, add relevant as well as irrelevant questions, get angry that personal issues are being discussed, or be pleased that someone is talking about their genuine problems.

**Role Play 2**
Ask for five more volunteers for the second role play.
Ask one person to play the role of a peer educator and the other persons to play the role of MSMs.
Ask the groups to enact the first, second and third encounter respectively as described in the handout in three separate and successive one-act plays.

The role of the peer educator is to break the ice, gain trust and confidence and then give out the information, and the role of MSMs is to do what is expected and normal – i.e. show disinterest, add relevant as well as irrelevant questions, get angry that personal issues are being discussed, deny that they are having sex, or be pleased that someone is talking about their genuine problems.

**Ask for feedback from all the actors:**
- How did it feel to be a peer educator?
- How did it feel to be a KP and a recipient of information?
- What were the challenges / difficulties on either side?
How did the persons enacting the role of the KP feel, particularly on being asked so many personal questions?

How long did the process take?

Did the KPs receiving the information feel that all their information needs were met?

Ask for feedback from the observers on the following specific aspects:
- Were the dosages of messages given completely and correctly?
- Is there a need to modify / change the dosages, add / delete any messages?
- What were the shortcomings?
- How can this process be improved?
- Is everyone confident that they can now go back and train their peer educators on outreach and giving out messages in doses?
Dosage of Messages

Background
Peer educators are expected to make new and repeat contacts every day as they do their outreach work. During their encounter / interaction with other KP members, they are expected to give a series of messages, in graded dosages that are aimed at increasing awareness, improving health-seeking behaviours and increasing condom use.

In addition to being health educators, more importantly, peer educators need to be leaders, role models and change agents within their communities. Therefore along with health education messages, the peer educators need to give messages on improving self-esteem, empowerment and collective action.

It is expected that:

- Each peer educator will reach out intensively to a cohort of around 30-40 members of his / her community.
- The peer educator will meet and interact with these 30-40 members at least once a week.
- While health education messages need to be given out in dosages, the messages on empowerment and mobilization need to cut across each interaction.
- While this handout specifies a particular progression, dosage and flow, the peer educators will have to take the final call on the message to be given based on the situation, time available, receptivity, etc.

I) Cross-cutting messages on empowerment and community mobilization:

- We need to empower ourselves in order to assert ourselves and refuse sex when we don’t want it.
- We need to counter violence, individually as well as collectively.
- We will form support groups and networks in order to derive strength from and support each other when in need.
- We need to increase our awareness levels
- We need to build skills in communication,
We ask for social and economic security, including access to credit, health care and all other services that are available to others.

We ask for recognition and the opportunity to participate in decisions that affect us.

Above all we seek our right to self determination and to conduct our work safely.

- This will help not only in fighting HIV/AIDS but will also in asserting ourselves as individuals in the society.
- The Mythri Drop-in centre is a space that is available to us and managed entirely by us.
- Please come to the drop-in centre frequently. We can use this space to meet, interact, work together and address issues that are important to us.

We need to get together, collectivize and organize ourselves so that:

- We can derive support and strength from each other and from our collective.
- Form our organization that will develop norms and regulate our work.
- We can plan and implement programmes on HIV/AIDS, and social and economic initiatives on our own and mobilize resources for this.
- We can negotiate with different power structures to make sex work safe.
- We can contribute to the overall development of the community and towards the realization of a more just society.
Mythri Mahila Samgam (MMS) is a registered network of women like us who are engaged in sex work in the Rayalseema and Telengana regions of Andhra Pradesh. It has a central coordination committee and various district coordination committees in which members are elected on a regular basis through a democratic process.

Let us all become active members of MMS and contribute to its growth and development.

It is one of the most practical ways to gain visibility, voice and space for ourselves.

II) Dosage of health education message for new contact – first encounter

In the first contact, particularly if the peer educator and the peer have never seen each other before, it is important to begin with rapport building, exchanging pleasantries, enquiring about their welfare, and then starting with a discussion of general problems and gradually introducing health issues, including reproductive health and finally narrowing down on STI / HIV /AIDS.

Once initial rapport is built up, the following messages have to be given out.

1. AIDS is a disease that is caused by a virus called HIV.
2. There is no cure for AIDS and when one has AIDS, one’s body is unable to fight diseases.
3. As a result one gets various infections and diseases (diarrhoea, TB, pneumonia, cancer) and eventually dies in a very slow and painful way.
4. In the early stages of infection, a person is healthy and it is not possible to tell if a person is infected (carrying the disease) or not.
5. HIV is spread from one person to another person through:
   - Unprotected (without a condom) sexual intercourse with an infected person.
   - Transfusion of infected blood, i.e., blood unknowingly collected from a person who
     is carrying the disease.
   - Sharing used needles potentially having residual infected blood from a previous
     infected person on whom the needle was used.
   - From mother to unborn child

A person is highly vulnerable to getting HIV when:
   - One has vaginal and/or anal sex with more than one regular partner or with
     strangers and one doesn’t know if the stranger is having any diseases, particularly
     STIs or HIV.
   - When one has an STI (symptoms such as discharge, ulcers, boils, blisters in the
     genitalia) while having sex.
   - When one has sex without using a condom.

One can protect oneself from getting infected with HIV by:
   - Using condoms in every sexual encounter.
   - Detecting and treating any STIs early and being in good health through regular
     health check-ups.
   - Getting one’s partner detected and treated for STIs early.

In addition the peer educator needs to:
   - Demonstrate correct condom use using the two finger technique or with a penile
     model if available/feasible
   - Give out condoms, reinforcing the message that condoms have to be used in
     every sexual encounter.
   - Give the complete address/directions to the project-run clinic and encourage
     the person to visit the clinic for a free general check-up/get a health card,
     even if they feel perfectly healthy.
   - Give the complete address/direction to the project-run drop-in centre,
     informing that they can come there to meet other peers, discuss problems
     and seek support, take rest, avail basic recreation facilities, etc.
III) Dosage of message for repeat encounter - second encounter

- Reinforce the messages given in the first encounter.
- Enquire if that person has visited the clinic and / or drop-in centre.

Additional messages / inputs in the second encounter would be:
1. In case the person is currently having any of the symptoms associated with different STIs, the peer educator should encourage the person to come along with him/her to the clinic for a free check-up and treatment.
2. Asking the person to encourage his/her client / sexual partner to avail free health check-up services from the project-run clinic.

IV) Dosage of message in the third encounter

Based on the stage at which the person is in, the peer educator can skip points 1 to 5 of the first message dosage and focus only on reinforcing safer sex messages, demonstrating condom use and distributing condoms.

- In the third and subsequent encounters the peer educators should enquire about general welfare and health status of the person and his/her sexual partner.
- Enquire if the person has visited the clinic and / or drop-in centre and repeatedly encourage the person to go for periodic general health care check-up even if the person is feeling perfectly healthy.
- Take feedback on the quality of services available at the clinic and drop-in centre, particularly if the person is satisfied with the health care provider, clinic timings and other access issues and discuss any barriers he/she is facing in accessing services either from the clinic or the drop-in centre.

Note: Anytime between the first and third encounter with a particular person, the aim of the peer educator should be to ensure that the person actually visits the clinic and is registered using a format provided for the purpose.

In the clinic the registration process will include getting some basic information (with the informed consent of the person) on
- Which place the person belongs.
- On an average, how many sexual encounters the person has in a week.
- What percent of the sexual encounters (in the past week) were made without a condom.
- Whether they are using / negotiating with their clients to use condoms.
- What barriers they are facing in terms of consistent condom use.

Before asking the person any questions, the peer educator should assure the person that the information will be confidential and not linked to the particular person.

Following the registration, the person will be given a Health Card with a Confidential Personal Identification Number (CPIN), as well as referral cards for their sexual partners.
Session 21
Role of Drop-in centres

Objective:

By the end of the session, the participants will be:
- Familiar with the role of a drop-in centre
- Management aspects of a drop-in centre
- Meeting of strategic and practical needs (vis-a-vis HIV) of the community through the drop-in centres

Time:

30 minutes

Materials:

Flip Chart, markers and Presentation

Methodologies:

Presentation and Question and answer

Trainer’s Preparation:

Prepared presentation on role of drop-in centres

Process

Brainstorm with the participants on the following issues:

- Is there a need / value for the drop-in centres?
- What should the objectives of the Drop-in centres be?
- How should these centres be managed?
- How should the NGO ensure that these centres are actually meeting the strategic and practical needs of the communities?

Inform the participants that initially the drop-in centres will be organized by the local NGOs in terms of renting, refurbishment, renovation, etc. However the day-to-day management of these centres will be the responsibility of selected KP representatives who would be trained by the NGO on managing these centres and sensitized on their rights and duties / obligations around the management of these centres.
Further, every effort should be made by the NGO to create a sense of belongingness and community ownership of the drop-in centres and the KPs should be encouraged to develop these centres according to their own collective agenda.

The local NGO will play the role of a facilitator and every effort will be made to ensure that no gate-keepers (with personal vested interests) are created around the drop-in centres.

### Objectives of the drop-in centre:

- To create a safe physical and social space for the KPs to meet with each other, discuss problems and possible solutions.
- To have spontaneous discussions – moderated/ facilitated / controlled by the KP members themselves.
- To bond, create a network for mutual support and build social capital, i.e. work towards collectivization, group formation and developing a collective agenda for the KPs.
- To create a safe space for rest, recreation, awareness raising, health education, counselling and in many cases even for general health care (where the clinic and drop-in centre are co-located)
- To create a space for training and capacity building, particularly around communication, negotiation, advocacy, occupations skills and violence reduction.
- To create a space for any other community development activities like non-formal education, care of infants and children (crèche), income generation activities or any other productive social agenda as decided and agreed upon by the KPs.
Objective:
At the end of this session participants will know
- Definition of Counselling
- Aims and objectives of counselling
- Goals of HIV counselling
- Pre-requisites of a counsellor

Time:
2 hours

Materials:
Flip chart, markers

Methodologies:
- Presentation and question and answer

Handouts:
- Counselling definitions, supportive intervention, sympathy and empathy

Trainer’s Preparation:
- Prepare matrices on support, sympathy and empathy, definition of counselling and steps in the process

Process
Explain that counselling is NOT:
- Telling someone what to do
- One-way teaching
- Giving advice
- Demanding
- Being judgmental
- Imposing
- Criticizing
- Interfering
- Prescribing

Definitions of Counselling involve some or all of the following:
- Two people are present
- The process leads to action on the part of the client
- The counsellor is the person who listens
- The client can be trusted to find their own solutions
- Personal growth of the client usually occurs
- Resolution of the problem is an expectation.
Counselling is not usually concerned with:
- Advice-giving on the part of the counsellor
- Psychotherapy
- Treatment of severe mental illness
- Solving all life’s problems

What does counselling do?
- Help people
- Understand and define the nature of problem

→ Achieve confidence to make, life style changes
→ Make realistic decisions (what they can do to reduce impact of the problems on themselves, their family and friends)

Counselling seeks to:
- Enhance self-determination
- Boost self-esteem
- Improve family and community relationships
- Improve quality of life

Goals of HIV/AIDS counselling
1. Forming a helping relationship by
   - Clarifying and addressing problems.
   - Establishing goals.
   - Providing information on alternative resources.
   - Selection of realistic alternatives.
   - Stimulation of motivation and decision-making.
   - Helping clients to develop competence.
   - Recognizing / diagnosing signs of physical and mental distress and providing support.

2. Building trust and confidentiality by ensuring that:
   - Whatever is discussed will be kept private
   - When a client refuses to inform sexual partner of infection and refuses to use preventive methods, confidentiality may be broken
   - From confidentiality only we can move to trust

3. Empathy and controlled emotional involvement
   Empathy is the ability to understand and relate to another person's feelings and experiences.

**Role Play: Empathy**

**Process**
1. Call for two volunteers
2. Give them the following script and ask them to prepare for a role play. Give them 10-15 minutes to prepare.
3. Conduct the role-play in front of the rest of the audience.
Script

Durgamma and Lavanya are friends. One day Durgamma comes to meet Lavanya, who is working as a peer educator. When Durgamma meets Lavanya, Lavanya pretends to be busy knitting a sweater for her child.

Durgamma says: “I have severe pain in my back.”

Lavanya says “Oh! That is too bad”, but she never looks her in the eyes.

Durgamma gets uneasy and feels a bit insulted since Lavanya is not paying attention. She moans a bit because of the back pain, hoping to catch Lavanya’s attention.

Lavanya then says, “Go ahead, I am listening to you…”. 

Durgamma speaks a little louder and more earnestly, so that she can draw Lavanya’s attention.

But Lavanya says, “Quiet down, I am not deaf… and stop that moaning. I am fed up with all the moaning and cribbing I keep hearing from you all.”

Durgamma keeps on talking. She says how she fell down the stairs and injured her back. But she had a lot of house work to do and two clients to attend to. Therefore she could not take rest. Now her pain is very severe and she asks if she could get some pain killer or balm from Lavanya.

Lavanya says distractedly, “I am sorry, could you repeat your problem?”

Durgamma is disappointed and starts to cry and yell at her peer.

Process the role play with the following questions to the group:
(a) How did Lavanya behave?
(b) How did Durgamma behave?
(c) What problems did you see in the role play?
(d) Why was there a problem?
(e) How did Durgamma feel?
(f) What could Lavanya have done to prevent this situation?

Note to the facilitator:

Participants may not be able to answer all these questions. The facilitator must explain that listening and empathy are very essential skills for a peer educator. Communication starts with listening. If and when a peer comes with problems a peer educator has to listen to her/him and has to be empathetic.

After the role play, make the following presentation:
A counsellor demonstrates empathy by listening attentively to what the client says, what the client does not say and what feelings the client expresses verbally or non-verbally.
<table>
<thead>
<tr>
<th>Empathy</th>
<th>Sympathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>I appreciate what you are going through.</td>
<td>Poor you! It's really sad that this should have happened to you</td>
</tr>
<tr>
<td>I understand how you must be feeling.</td>
<td>I know how you feel, I was in the same situation once.</td>
</tr>
<tr>
<td>I accept that you are very scared</td>
<td>Don’t be scared I will help you.</td>
</tr>
<tr>
<td>Just sitting in silence while the patient expresses sorrow by crying.</td>
<td>I am feeling very sorry for you.</td>
</tr>
<tr>
<td></td>
<td>Don’t cry.</td>
</tr>
</tbody>
</table>

**Principles of Counselling**

- Unconditional positive regard and non-condemning attitude.
- Treating the person as special within the relationship.
- Must not express disapproval of the person.
- Must not blame the person related to causes and effects of the problem of infection.
- Must not pass moral judgments.
- This helps clients feel free to talk, accepted and worthy of attention.
HIV Counselling

HIV counselling is a process of communication which involves two people who meet to resolve a crisis, solve a problem or make decision involving personal intimate matters and behaviours. The same process is used while counselling HIV affected.

The WHO defines HIV/AIDS counselling as a dialogue between a client and care provider aimed at enabling the client to cope with stress and to take personal decisions related to HIV/AIDS.

Counselling aims at enhancing the decision-making capacity of the counsellee. Education about health forms an integral part of counselling in health related areas. However counselling is not a synonymous with health education. The counselling process goes beyond education and facilitates the making of choices for action behaviour for the counsellee.
HIV/AIDS Counselling Targets

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>For those who are not infected</td>
<td>For those who are infected</td>
</tr>
<tr>
<td>With high risk behaviour</td>
<td>For family members</td>
</tr>
<tr>
<td>Without high risk behaviour</td>
<td>For health professionals</td>
</tr>
</tbody>
</table>

HIV/AIDS Counselling includes

<table>
<thead>
<tr>
<th>Preventive Level</th>
<th>Supportive Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information on HIV/AIDS and risk behaviour</td>
<td>Identifying the psycho-social issues due to infection.</td>
</tr>
<tr>
<td>Modes of transmission and Assessing the presence of risk behaviour</td>
<td>Fear of prevention infection</td>
</tr>
<tr>
<td>Facilitating changes in life style to prevent infection</td>
<td>Dealing with them effectively</td>
</tr>
<tr>
<td></td>
<td>Empowering the client to live with HIV/AIDS</td>
</tr>
</tbody>
</table>

1. Constructive enrichment
2. Authority over life
3. Authority over decisions
4. Continuing a normal life
5. Developing coping and strength

Pre-requisites of Counselling

- Time
- Acceptance
- Accessibility
- Confidentiality
- Consistency
- Accuracy
Why is Counselling important? Ask the group

List all responses given by the participants, making sure to incorporate the following points if they do not come up.

- To ease, to know, to understand, to establish better communication
- To help to feel relaxed, to develop a relationship
- To motivate, to learn
- To show empathy, to influence
- To show concern, to encourage, to build trust

Exercise 1

Divide participants into small groups of three and provide the following scenarios to help them practise counselling as well as receiving feedback skills. One participant will be a counsellor, the second will be a counsellee and the third will be an observer. The observer will provide feedback on the performance of the counsellor. The participants will switch roles until they have enough practice.

1. Your peer Sunil is scared to have an HIV test. You are a peer educator. How would you help Sunil?
2. Your peer Shilpa has had lower abdomen pain for the last three days. Shilpa comes to you to talk about her problem. As a peer educator, how would you help Shilpa?
3. Hema (one of your peers) suspects she may have an STI infection and comes to you for help. As a peer educator, how would you help Hema Malini?
4. Salmaan suspects he may be HIV-positive. He comes to you for support. As a peer of Salmaan, how would you help him?
5. Sharukh, one of your best friends, comes to you crying and says his wife is HIV-positive. As a peer, how would deal with Sharukh in this situation?
6. Urmila is your neighbour and friend. She is in a dilemma over whether to give birth to another child, because she is HIV-positive. If she comes to you, how would help her?

Alternative Session on Messages

Expected Outcomes
Participants will design messages using the principles of communication learnt in earlier sessions.

Modes of Transmission

Objective: To prepare and deliver a message on ways in which HIV can be transmitted.

Materials: Left to the discretion of the users.

Time: 2 hours.
Process
1. Ask the participants to form four groups.
2. Explain that each group will use one particular method to deliver their message on ways in which HIV/AIDS can be transmitted.
3. While one group presents, the other three will observe the content, method of delivery and use of language in the message delivered. The observers will provide the presenters with feedback on the three criteria.
4. The four groups can choose from the following methods, or the facilitator can assign one method to each group:
   - Posters
   - Presentation using transparencies or flip charts
   - Role play
   - Jingle or song
5. Give the groups 30 minutes to prepare their presentation.
6. Each presentation should not be longer than 10 minutes.
7. Invite the observers to give feedback after each presentation. Explain that the feedback should be on the presentation, not on the presenters.
8. Allow 10 minutes for feedback after each presentation.
9. Conclude the session with your observations on the presentations and highlight the positive points of each presentation.

Notes for the Facilitator
This exercise builds skill for effective communication. You could make the exercise more interesting by asking the observers to rate the four presentations on a scale of 1 to 5. They could also set their own criteria for rating. You could invite an expert on communication to come and give his/her feedback on the presentations.
Material for reading, preparation of handouts and facilitation of session

Feedback is the most important element affecting the communication process. Feedback is a mechanism by which the initiator can understand the impact of his/her communication on the receiver.

Feedback is most effective when it is:
- Non-judgmental – gives descriptive feedback on the content, process and method rather than on the communicator.
- Specific.
- Useful and usable – the receiver should be able to use the feedback to make corrections or changes. The feedback should contain proactive suggestions.
- Accurate.
- Delivered in the first person, that is, uses “I” statements.

Some basic principles of communication while dealing with sensitive topics, such as HIV/AIDS, reproductive health and drug use:

Respect
The receiver should feel respected and trusted if s/he is to communicate. If not s/he may want to end the conversation and leave as soon as possible.

Safety
Safety is important, as one is discussing personal and intimate matters. The person needs to know that s/he will not suffer negative consequences for the information being shared, for example, s/he will not be sent to jail because s/he is using illegal drugs, or s/he ill not be stigmatized because s/he is HIV positive.

Non-judgmental attitude
Do not moralize or lecture people about their life choices. Give factual information without personalizing it, and do not be shocked, disgusted or alarmed at the information shared.

Confidentiality
This is an important issue. People infected with HIV/AIDS, using drugs or discussing any other private matter need to feel assured that their information will not be shared with anyone else. The choice of sharing or not sharing the information must be left with the individual.

Sensitivity
Be aware of the comfort and discomfort of the person speaking with you or to whom you may be speaking. Learn to read body language and take cues that inform you about a person feelings and emotions.
Privacy
In cases where the issues being discussed are private and personal, make sure these are discussed in private. If you are in a group meeting and personal issues emerge, establish that these will only be discussed after the group meeting and in private. Do not refer to personal information in public forums. Do not give examples using names and places.

Cultural and religious sensitivity
HIV/AIDS, sexual health, and reproductive health are all sensitive subjects. They are often mired in religious and socio-cultural taboos and beliefs. Therefore, it is very important that you become aware of these dimensions. Religious beliefs are an important part of the cultural identity of many people. Freedom of thought and religion is a basic human right recognized in the Universal Declaration of Human Rights.

Most religions and cultures of the world promote tolerance and love. These should be used to help overcome the discrimination and stigmatization associated with HIV/AIDS and other sexual and reproductive choices, such as homosexuality and use of family planning methods.

General reading material for the peer educator that may also be used to make posters. Some pointers for an effective question and answer session:

1. Listen to the questions.
2. Observe the tone and the manner in which the question is asked.
3. Repeat the question as you understand it, and ask if you got it right.
4. Answer if you can and cannot involve others in finding an answer.
5. Speak clearly and confidently.
6. Do not fidget or read from a paper. If you need to consult your notes, say so.
7. Establish eye contact with as many people as possible.
8. Be aware of your body language. Do not point or lean threateningly.
9. Involve the participants in seeking answers. Ask for their opinion and knowledge.
10. Allow time for questions and answers.

Some practical points for working in different socio-cultural and religious settings:

1. Do not address religious or sensitive socio-cultural issues without setting the stage first. Try to form alliances with people already working at the location, especially youth groups.
First, find out what is possible, and what is already happening on the issue of HIV/AIDS, sexual health and reproductive health.

Contact existing open-minded religious leaders and groups because they might lend you their support.

Gather knowledge and information about the social, cultural and religious practices and beliefs of people; research their scriptures and holy books.

Confrontation can be counter-productive.

Remember that all religions are in favour of tolerance, respect for all God’s children and caring for the weak and the sick.

Present facts and avoid getting into arguments.

Start with simple, non-threatening activities, such as group discussions on what is culturally acceptable concerning sexuality or reproductive health.

Some people feel that anonymous telephone helplines are a useful initial step.
Exercise:

Ask the group “Why are counselling skills important for a peer educator?”
List all responses given by the participants, making sure to incorporate the following points if they do not come up.

- To understand, to establish better communication
- To help to feel relaxed, to develop a relationship
- To motivate, to learn
- To show empathy, to facilitate change
- To show concern, to encourage, to build trust

Role Play

Divide participants into small groups of three and provide the following scenarios to help them practise counselling as well as receiving feedback skills. One participant will be a counsellor, the second will be a counsellee and the third will be an observer. The observer will provide feedback on the performance of the counsellor. The participants will switch roles until they have enough practice.

- Your peer Sunil is scared to have an HIV test. You are a peer educator. How would you help Sunil?
- Your peer Shilpa has had lower abdomen pain for the last three days. Shilpa comes to you to talk about her problem. As a peer educator, how would you help Shilpa?
- Hema (one of your friends) suspects she may have an STI infection and comes to you for help. As a peer educator, how would you help Hema?
- Salmaan suspects he may be HIV-positive. He comes to you for support. As a peer of Salmaan, how would you help him?
- Abhishek, one of your best friends, comes to you crying and says his wife is HIV-positive. As a peer, how would deal with Abhishek in this situation?
- Urmila is your neighbour and friend. She is in a dilemma over whether to give birth to another child, because she is HIV-positive. If she comes to you, how would help her?
Counselling tips

(From Making Sex Work Safe, Network of Sex Workers Project, 1997)

1. Counselling should always emphasize choice rather than push sex workers in a particular direction.
2. Counselling should not be moralistic and should not include religious or spiritual ideas unless it is clear in advance that the counselling is of a religious nature.
3. Issues should be dealt with as they are presented by the sex worker.
4. Counsellors should check that the sex workers have adequate knowledge and skills to deal with personal safety, safe sex, STI treatment, the law, contraception, drugs, torn condoms, unwanted pregnancy and other relevant tissues. Therefore, counsellors must have good knowledge of these issues and / or be able to refer sex workers to appropriate sources of information.
5. There can be many practical outcomes from counselling. For example, counselling can assist sex workers to learn to cope with stress, deal with relationships, avoid violence and overcome fears about seeking health services.
Objective: Enable each participant identify some common HIV and AIDS symptoms and provide information on how to treat them.

Time: 45 minutes

Materials: Flip chart, markers

Methodologies: Group work, group discussion

Trainer’s Preparation: Information sheet on Home based care

Process
1. Have participants list the common problems AIDS patients encounter.
2. Jot down their responses.
3. Organize their responses into seven major sections:
   ➔ Nutrition
   ➔ Infection control
   ➔ Skin problems
   ➔ Fevers and pain
   ➔ Cough, difficulty in breathing
   ➔ Sore mouth and throat
   ➔ Diarrhoea
4. Let participants form seven groups and assign a section to each group. Allow them to work on this for five minutes. The participants should state clearly how to carry out basic care at home.
5. Present the outcomes of group work in plenary.
6. The facilitator should clarify and include points if not mentioned during presentation, on the following topics:

Nutrition
   ➔ Examine the source of income.
   ➔ Conduct a market survey on protein-rich foods in protein, available in the community and their cost.
   ➔ Plan the food within the family income.
Infection control
- Help the person with hygiene and personal care.
- Always wash hands with soap and water before cooking, eating and after going to the toilet and coughing.
- Wash clothes, linens and cloth with soap and water.
- Dispose of urine and faeces in the toilet or burn in a container. Avoid contact with blood and other body fluids and wash hands with soap and water immediately after handling soiled articles.
- Always wear gloves before handling any body fluids.

Skin problems
- Wash open sores with soap and water, and keep the area dry.
- Use slightly salted water as a disinfectant.
- For rashes, apply local remedies and oils, such as coconut oil or calamine lotion.
- Gently rub skin that is dark, reddened or irritated.
- To prevent bed sores, change the patient's position every two hours if the patient is too weak to do so.

Sore mouth and throat
- Rinse the patient's mouth with warm salt water four times daily.
- Have the patient suck pieces of ripe tomatoes or a lemon for thrush if it is not painful.
- Have the patient eat soft foods that are not too spicy.

Fevers and pains
- Wash the patient's body in cool, clean water or wipe the skin with wet cloth.
- Have them drink a lot of water, tea, broth or juice.
- Remove thick clothing and blankets.

Cough or difficulty in breathing
- Cover mouth when coughing.
- If the person has a bad cough lasting more than three weeks, refer them to health worker to tuberculosis or pneumonia.
- If the patient develops fever and chest pain, encourage the patient to see a health worker.
- Keep windows open to allow fresh air.
- Keep client in a sitting position, whenever possible, to encourage easier breathing.
Diarrhoea

- Treat immediately to avoid dehydration by using oral rehydration salts or home made sugar and salt solutions.
- Ensure copious fluid intake.
- Continue eating frequent regular meals, such as mashed bananas or porridge.
- Wash the buttocks and anus with warm soap and water after each bowel movement and keep the skin clean and dry.
Session 24
Problem Solving-Difficult Questions and Difficult Situations

Objective:
Enable participants to answer difficult questions and deal with difficult situations.

Methodologies:
Individual assignment, discussion in plenary

Trainer’s preparation:
Situation to be given to the participants, brief of the different possible situations that they can face

Materials:
- Pen and paper
- Newsprint or chalkboard

Process
1. Introduce the specific objective of this exercise. Make the point that because of the difficulties others have faced and their failure to stop the increase of HIV infection in India and the rest of the world, peer educators have been recruited for this work.

2. Have participants write down the three most difficult questions they have faced, or expect to face, in their work.

3. Have participants share their questions. As each question is shared, ask those who have been faced with it to raise their hands.

4. Write the questions as they are read out. Note the frequency with which each particular question or issue arises.

5. As each question comes up, ask participants who think they have good answers or ideas to share them. Confirm, correct, add or substitute as necessary, but only after you have given the group an opportunity to learn from each other. Be sure to lead a round of applause for especially creative solutions.

6. Repeat exercise for “difficult situations.”

7. Close the exercise by telling group that joint problem-solving is one of the real values of a participatory approach to education. Tell them of the “two ideas” African proverb.

“If I give you one egg and you give me one egg, you will have one egg and I will have one egg, but if you give me one idea and I give you one idea, we will both have two ideas!”
Session 25
Making a Resource Chart

**Objective:**
Participants will know what support and resources they require

**Time:**
45 minutes

**Materials:**
Flip charts, markers.

**Methodologies:**
Mapping of resources

**Trainer’s preparation:**
Knowledge of resource mapping

**Process**
1. Invite the participants to convert their activities list into a table with columns and rows.
2. The table should have four columns and rows corresponding to the number of activities (an example is provided below):
   - Activities
   - Time: (when will it be undertaken)
   - Responsibility (who will do it)
   - Resources (what will be required to do it)
3. This table may be done collectively, in small groups or individually, depending on the process followed in the goal, objective and activity setting exercises.
4. If it is an individual or small group exercise, ask the participants to display the outcomes on the wall to share. However, if it is a collective exercise, do it on the floor with chalk in a participatory manner.

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1 You can use the link to this document for accessing the Resource Kit on Mapping
Resource Kit- PSA Tools.doc
## Note for the Facilitator

This exercise is useful for personal, group and organizational planning. It is simple and can be done individually or in a participatory manner. It is your responsibility to ensure that the columns are filled in specifically i.e., in the time column, specific dates/weeks/months should be filled in. Keep in mind holidays, weather constraints, availability of other people and places. Similarly, the responsibility column should be specific in stating the name of the person, or organization or group that has been assigned the responsibility. The resources column should include finance, material and human resources. If you think it would be useful, you could sub-divide the fourth column into three divisions.

### Resources and Support Table

**Expected Outcomes**
Participants will be able to identify things they can do on their own and things they require support for.

Peer educators will be able to use this exercise for planning his/her schedule of support and future activities.

**Objective:** Making the match

**Materials:** Flip charts, markers

**Time:** 30 minutes

**Process**
Invite the participants to examine their time, responsibility and resource chart (outputs of earlier session) Explain that on the basis of this chart they should make another chart in order to access the resources required for each activity. This could be done using a matrix similar to the one shown below:

<table>
<thead>
<tr>
<th>Resources Needed</th>
<th>Can do it myself/ourselves</th>
<th>Need support from family/peers</th>
<th>Need professional support</th>
</tr>
</thead>
</table>

**Note to the Facilitator**

The planning exercises can be brought to a close with this final matrix.
Session 26
Reducing Opportunity Gap in Peer Education

Objective:
By the end of this session the participants (peer educators) will be able to:
1. List the people they have to reach out
2. Develop a strategy for outreach

Time:
1 hour, 30 minutes

Materials:
Chart papers, markers

Methodologies:
Mapping of sensitive places

Trainer’s preparation:
Knowledge of mapping as PRA tool, statistical information on the place where the peer educators will be working.

Process
Use the following table to map the hot-spot (s) and the distribution of the cohort (30-40 KP members to be outreached intensively and repeatedly at weekly intervals) and create a brief profile of the hot-spots.

Prepare a geographical and network-map if possible.

<table>
<thead>
<tr>
<th>Hot-spot (for example, cinema theatre, park, bus stop, market, brothel etc)</th>
<th>No. of sex workers (and the category)</th>
<th>Period of work during a 24-hour period.</th>
<th>Peak working hours in the day (period during which maximum sex workers are available in the hot-spot)</th>
<th>Peak working period in the month</th>
<th>Broad characteristic of the hot-spot (profile) and common problems faced by the sex workers in the particular hot-spot.</th>
</tr>
</thead>
</table>

- List all the KP members of their cohort (30 to 40)
- Categorize the members in terms of (1) Initial contact established, (2) Moderate rapport established and (3) Very good rapport established.
- Categorize the members in terms of current level of understanding of project purpose and empowerment issues.
- Categorize the members in terms of (1) Visits the Mythri clinic once a month, (2) Visits the clinic less than once a month, (3) Has not visited the clinic at all.
Based on the above, develop an outreach and communication strategy such that over a period of time:

1. Very good rapport is established with each of the 30-40 members of the cohort such that the members start increasingly discussing non-project, contextual issues with the peer educators.

2. Each of the 30-40 members are visiting the Mythri clinic at least once a month and the drop-in centre at least once twice week.

Use the following matrix:

<table>
<thead>
<tr>
<th>Name of the KP member / location / category / any distinguishing feature of the person / PIN (optional).</th>
<th>Level of rapport (Initial contact / Moderate rapport / very good rapport)</th>
<th>Current frequency of clinic visit (not visited / visiting the clinic less than once a month / visiting the clinic once a month)</th>
<th>Current frequency of visit to the Drop-in-centre (not visited till date / less than once a week / more than once a week)</th>
<th>Current levels of understanding (currently does not understand either the purpose of the project or issues around empowerment and mobilization/ Understands the project purpose but not the need for empowerment and mobilization / Understands fully the project purpose as well as the need for empowerment and mobilization)</th>
<th>Intervention strategy and objective for interpersonal communication.</th>
</tr>
</thead>
</table>

Basic tips for outreach

(From Making Sex Work Safe, Network of Sex Workers Project, 1997)

1. Schedule and possibly advertise visits to sex work places at regular times so that sex workers can plan to see outreach workers. If possible, schedule teams to visit the same places, whether brothels or more informal settings, at different times to reach all sex workers working there.

2. Keep initial contacts short and ensure that the outreach workers are available for more detailed conversation at a more convenient time or place.

3. Be considerate when contacting sex workers. Develop ways to contact sex workers such that the visits do not intrude on work time, frighten clients away, or cause friction with fellow workers or managers.

4. Be prepared to work with clients and influencers and learn how to relate to the people around sex workers. Outreach workers should not be seen by sex workers either to be hostile to these groups or to collude with them.

5. Working in pairs may be more effective, both in terms of the personal safety of the outreach workers and in their ability to relate to a diverse target audience.
Theme For A Dream

Objective

To dream a dream.

Materials: Flip charts, markers/crayons.

Time: 30 minutes.

Process

1. Invite the participants to sit in a circle.
2. Explain that planning is an important element of this training and of life. In order to plan, one must have a dream. One must have a vision of where one wants to be. This vision may be of an individual for himself/herself, or it may be the vision of a group for the group.
3. Ask the participants to work individually and arrive at a vision for themselves.
4. Explain that they should each draw a picture of, or create in words, a dream that they would like to realize for themselves. Something that represents the life they want to have for themselves. Allow the participants 20 minutes for this exercise.
5. Invite them to share their vision with each other through a presentation.
6. Ask them to put their “vision” up on a wall so that everyone can see it.
7. After everyone has heard and seen all of the visions, facilitate a short discussion using the following questions:

- How did it feel to dream and share the dream? Why?
- Can dreams come true? Why/why not?
- How can you make your dream come true?

**Note for the Facilitator**

This is a simple exercise used to encourage dreaming and setting a vision for oneself. This can be altered to suit the needs of the participants. For example, if you are in a training session for young people to work as peer educators, you could ask them to dream about the kind of peer educator they would like to be. This can also be used for a group, community or organizational dream. Just remember that it is essentially about dreaming, and therefore, allows space for imagination. Do not decide what can and cannot be dreamt.

A dream, or a vision, is usually a distant goal that one strives for. It is, therefore, more an aspiration than a reality. However, the dream can be further broken down into achievable and time-bound objectives. Encourage and commend the participants on their dream. Their responses to the two questions should be enough to indicate whether the dream is achievable, or not. Take this opportunity to explain the difference between a dream/vision and an achievable goal and objective.

**Goal Setting**

**Expected Outcomes**

Participants will learn to set achievable goals for themselves.

Participants will be able to apply this method in their day-to-day lives.

**Objective:** Setting a goal

**Materials:** Flip charts, markers

**Time:** 30 minutes

**Process**

1. Invite the participants to sit in a circle on the floor.
2. Explain that everyone tries to set goals for himself/herself in life, but goals must be realistic. For example, the goal of this training programme is to change at least one unsafe behaviour of young people in order to reduce their chances of contracting HIV/AIDS.
3. Similarly, the participants must set some goals for themselves, that take the goal of this training further.
4. Encourage the participants to ask questions and clarify their doubts.
5. Give the participants 10 minutes to discuss and individually set their goals.
6. Remind them that goals should be realistic and time-bound.
7. Invite the participants to present their goals.
8. Ask the participants to read each other’s goals and see if they have shared goals.
9. Invite the participants to discuss whether they can help each other to achieve their goals.

### Note for the Facilitator

Depending on the objective of the exercise, it may be done in the large group with all of the participants or individually. If you expect the participants to set at least one individual goal for themselves, to be reviewed over a period of time, then you should ask them to do this exercise individually. On the other hand, if you want them to have common goals (as a group or as an organization) this exercise can be done in the large group. Since the training primarily focuses on behaviour change, individual goal setting may be more useful. In either case it is up to the facilitator to decide.

### Learning to Set Objectives

**Expected Outcomes**
Participants will be able to set achievable targets for themselves.

Peer educators will be able to use these objectives for monitoring the progress of the participants.

**Objective:** Setting objectives

**Materials:** Flip charts, markers

**Time:** 30 minutes

**Process**

Invite the participants to place their goals before them and think about **SMART** objectives. Explain that objectives need to be:

- S  Specific
- M  Measurable
- A  Achievable
- R  Relevant
- T  Time-bound

The goals that they had set for themselves earlier can be further broken down. For example, a goal of giving up cigarette smoking can have multiple objectives, such as reducing the number of cigarettes to five a day within the next week, thereafter to three a day in the next one week, and so on.

Give the participants 10 minutes to set their objectives. These can either be common or individual.

Invite the participants to share the objectives.
Note for the Facilitator

Objectives are important for follow-up and monitoring an activity. Therefore, these need to be very specific, time-bound and, if possible, measurable. You may want to start the planning cycle from this point onwards, and ignore the dream and goal setting exercises. As mentioned earlier, these exercises are to be used at your discretion. If you feel that the participants only need to plan for a short period, then it is advisable to start with the objective exercise. If the participants are expected to plan for a behaviour change, then it may be useful to start with the dreaming exercise.

Breaking down the Objectives into Activities

Expected Outcomes
Participants will list specific activities that they will undertake for each objective.

Peer educators will be able to use these activities for follow-up.

Objective: Making the activity chart

Material: Flip charts, markers

Time: 45 minutes

Process
1. Invite participants to place their objectives before them.
2. If the objective setting was done collectively, this exercise should be done collectively. However, if the objective setting was done individually, or in small groups, this exercise should be done accordingly.
3. Ask the participants to draw up a list of activities that would have to be done to achieve each objective.
4. Give the group 30 minutes to do this exercise. Facilitate the activity, and encourage the participants to make a detailed chart specifying all large and small activities required to achieve their objective.
5. Invite them to present their activity list if it is a common list, or ask them to put it up on a wall. Ask them to view each other’s list.

Note for the Facilitator

Activity lists should include all of the activities required to achieve a particular objective. These may be activities that the participants will do alone or will seek support for doing. They may need to ask someone to do it for them. Whether you make this an individual exercise, a small group exercise or a collective exercise is your choice.
Session 28
Making a Commitment

Objective:
Participants will realize that commitment is essential for achieving goals.
Participants will need to keep to their plans and promises.

Materials:
Flip chart and markers

Methodologies:
Presentation

Time:
45 hours

Trainer’s Preparation:
Commitment statement

Process
1. Invite the participants to stand in a circle.
2. Explain that the personal commitment of everyone is of great value in the collective fight against HIV/AIDS. Throughout this exercise, the participants will be able to pledge their commitment and support to the struggle.
3. Start at one end of the circle, and ask the participants to complete this sentence “I will…”
4. Put up a flip chart and record the participants’ responses.
5. If you plan to monitor the progress of the commitment, ask the participants to specify the time within which they hope to fulfil their commitment.

After the exercise, this information should be typed and distributed. Alternatively, put up a list of the participants’ and record each one’s commitment beside their name.

Note to the Facilitator
This is a simple exercise and its seriousness depends on how it is facilitated. It is also possible to use this activity as a session closing exercise. However, if you wish to follow up on the commitments, make sure that these are documented beside every participant’s name and have a definite time-frame.

The trainer may give the post-test questionnaire and close the training.
Annexure 1 : Peer Educators/ORW Daily Register
Annexure 2 : Group Education Sessions Format
Annexure 3 : Group Sessions Register - Reporting Format
Annexure 4 : Reporting Form: One to One Register
Annexure 5 : Reporting Form: Reach Register
Resource Pack
Peer Educators/ORW Daily Register

Formats:

<table>
<thead>
<tr>
<th>Peer Educators/ORW Daily Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of the Peer Educator/ORW:</td>
</tr>
<tr>
<td><strong>Type of contact:</strong> (please circle one):</td>
</tr>
<tr>
<td><img src="image1.png" alt="Image" /></td>
</tr>
<tr>
<td>Name of the Hotspot:</td>
</tr>
<tr>
<td><strong>Type of contact:</strong> New:</td>
</tr>
<tr>
<td><img src="image2.png" alt="Image" /></td>
</tr>
<tr>
<td>New to Service:</td>
</tr>
<tr>
<td><img src="image3.png" alt="Image" /></td>
</tr>
<tr>
<td>Repeated service:</td>
</tr>
<tr>
<td><img src="image4.png" alt="Image" /></td>
</tr>
<tr>
<td>Date.___________________________</td>
</tr>
<tr>
<td>ID number(s) ____________________</td>
</tr>
</tbody>
</table>

Please tick on the following as appropriate codes

1. Condom promotion & distribution: Out reach worker explaining on the condom and distributing

2. Condom Demonstration: The out reach worker demonstrating the condom

3. Education on STI / HIV: The out reach worker educating on STI and HIV issues.

4. Out reach Worker educating on risk behavior

5. Health seeking behaviour and Referral to Mythri Clinic

6. Referral to Voluntary Confidential Counseling and Testing Center (VCCTC):

7. Community Mobilization - empowerment related information/skills provided

Number of condoms/Lubricants distributed (number in pieces):
Group Education Sessions - Format 1
(To be filled at the end of the group education session)

Group sessions can be held in sex workers’ homes or workplaces, or in other local community venue that are safe and preferred by the sex workers. The time and place of the sessions must be acceptable to the sex workers and can be negotiated with them in advance. Group sessions can be an effective alternative or addition to peer education because they provide an opportunity for sex workers to share experiences and knowledge with the project.

Group sessions can cover issues of concern to sex workers and ensure that correct information is shared. They must also ensure that confidentiality of participants is not breached.

Sex workers will not automatically talk openly about personal matters, especially in cultures where people do not speak openly about sex generally. Discussions in groups can be intimidating. In some cultures women are not encouraged to speak, especially about sex. Role plays, where members of the group act out an imaginary scene have been found to work well in these circumstances.

Nor will sex workers always arrive at the scheduled time to participate in a pre-set agenda. So scheduling “workshops” to discuss sexual health often fails as a strategy. Spontaneous group discussions are often the most productive way and should be encouraged.

This is one of the roles of drop-in centers and sex workers meeting spaces. The most productive discussion groups are moderated / facilitated by sex workers themselves. Professionals can be a resource, for example, by providing accurate medical information, rather than controlling the tone and content of discussions.

Performances, videos and puppet shows have all been used as discussion starters. Humor is one of the best ways of breaking down inhibitions. Sex can be funny and the group education session can and should include laughter.
Annexure 3

Group Sessions Register - Reporting Format
(Separate sheet for each Group Session)

Name of the Outreach Worker/TSS responsible for organizing the session:

Planned/Unplanned Group meeting:

Name(s) of other project staff: _____________________________ Date: __________

Purpose of the group session:

Number of Participants (Planned):

Number of Participants (Actual):

Venue:

Starting Time: _____________________________ Ending Time: _____________________________

Participants and services provided

<table>
<thead>
<tr>
<th>Unique ID Number</th>
<th>Services provided / Remarks if any</th>
<th>Materials/Commodities Distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Type of Materials</td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Topics Discussed in detail:

Description of achievements?

Problems encountered in holding the group session/meeting and what action you feel/felt to take to consolidate or improve?

Signature of the staff person organizing the session
Reporting Form - Group Sessions Register

Guidelines for filling the reporting form

Who and When: NGOs usually plans on an average 2 to 4 planned group meetings in a month with a specific purpose/agenda. Also at times, it may happen that an unplanned meeting is called to address certain issues. This happens when an outreach worker goes with an intension of addressing to individuals but 2 or more persons gather to listen to the outreach worker/s. Such meetings are also included in group sessions register. The information recorded will be compiled at the NGO and sent to you Alliance AP in the prescribed format as given in Process Monitoring Tool (PMT).

How

Where two or more persons are addressed on an issue is recorded in this format. It is expected that an outreach worker/s will be able to cover on an average 2-4 planned meetings / interactions with the KPs in a month. The outreach worker will maintain a separate sheet for each site and for each meeting.

Name of the Outreach Worker responsible for organizing the session: The key person for organizing the meeting or session will write his/her name.

Name of other project staff: The outreach worker will write the name of other project staff who has accompanied him or her to address the group meeting.

Date: The outreach worker will enter the date and month in which the meeting was conducted.

Purpose of the group session: The outreach worker will enter the purpose of the meeting. For example, the purpose could be solidarity building, behavioral change communication.

Venue: The outreach worker will enter the name of place where the meeting was conducted. For example, the meeting could be conducted at the bus stand etc.

Type of meeting: Normally planned group meeting are held twice or thrice in a month where the targeted group knows about the meeting date, objective of the meeting etc. In a unplanned meeting/session, the outreach worker goes with an intention of meeting one individual but few more join on the spot.

Number of participants (planned): Normally in a planned meeting, the number of participants attending the meeting is well known. The outreach work will write the number of persons likely to attend the meeting.

Number of participants (actual): The outreach worker will enter the number of persons actually attended the meeting. There could be a possibility that all expected participants may not attend that particular meeting for some reasons.

Starting time: The outreach worker will note the starting time of the meeting and enter the exact time started by watch.

Ending time: The outreach worker will note ending time of the meeting and enter exactly the time by watch.
Participants and services provided: The out reach worker will enter the unique ID of each participants who have attended the group meetings, makes a note of the services provided (Referrals, counseling etc) to the participants.

Materials/Commodities distributed: The outreach worker will enter the details of materials and commodities distributed during a meeting to the participants. The materials could be Literature developed by the NGO, Pamphlets etc. & commodities like condoms, syringes etc.

Topics discussed: The out reach worker will write the specific topic or topics discussed with the group. Description of Achievement: The outreach worker will enter the key achievements made while conducting the meeting. For example, influencing on the BCC campaign; feedback from the group was positive; could generate multiplier etc.

Problems encountered in holding the group session and what action you feel/felt to take to consolidate or improve? : The outreach worker will write the problems faced in conducting or during the process of meeting. For example, needed update information on a given topic, more skill development so that the issues could be addressed much more professionally etc.

After completing the reporting form for all the meeting held in a month, the outreach will sign at the bottom of the sheet in token of having checked and complete in all respect. The project coordinator should ensure the quality of reporting and authentication of information provided before an outreach worker submits to the NGO. The out reach worker will handover the original form to project coordinator of the NGO on weekly/fortnight basis (as per the norms laid within the NGO set up for the project).

Usefulness of the information in the format

- Helps in knowing the number of group meeting conducted in a given month.
- Also helps in knowing number of planned and unplanned conducted.
- Helps in knowing the type and nature of participants attended the meeting.
- Helps in knowing the nature of referrals and referral details made from his or her worksite.
- Helps in knowing the type and number of materials distributed in each of the meeting and in a given month.
- Help in knowing the average time taken during each meeting and for the topic discussed.
- Helps in providing timely interventions based on the feedback or comments received during the interaction by the project coordinators/programme officers.
## Reporting Form: One to One Register

(To be compiled once a week by the outreach workers from the daily diaries given under format 1)

### Name of the Outreach Worker/TSS: ____________________________

### Name of the Site/Sub Site: ____________________________

### Period: ____________________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Unique ID Number</th>
<th>Topics discussed * (enter Codes)</th>
<th>Materials / Commodities distributed</th>
<th>Number distributed</th>
<th>Type of Referrals</th>
<th>Place of Referrals</th>
<th>KP Status</th>
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Discussion, Emerging issues, feedback, Remarks:

- Condom
- IEC
- Others

- STI
- Counseling
- VCCTC
- Care & support

Discussion, Emerging issues, feedback, Remarks:

- Condom
- IEC
- Others

- STI
- Counseling
- VCCTC
- Care & support

Discussion, Emerging issues, feedback, Remarks:

- Condom
- IEC
- Others

- STI
- Counseling
- VCCTC
- Care & support

Discussion, Emerging issues, feedback, Remarks:

- Condom
- IEC
- Others

- STI
- Counseling
- VCCTC
- Care & support

Discussion, Emerging issues, feedback, Remarks:

- Condom
- IEC
- Others

- STI
- Counseling
- VCCTC
- Care & support
* **Topics discussed**: The outreach worker to write down the topics discussed in brief: Examples of topics could be – Condom promotion, condom demonstration, Highlighting STI problems, STI referrals, VCTC referrals, General HIV/AIDS awareness, Barriers to condom use including availability, Accessibility to health services, Barriers to accessibility, Condom use negotiation skills, Follow-up contact etc.

**NOTE**: It is expected from the project coordinator that they should guide the outreach worker to decide the code to be given, of the topic discussed from the list of intervention provided in Annexure 1 with pictorials. The project coordinators are also expected to group the information on the topic discussed as per the clusters listed below while reporting in the PMT:

**Reporting Form: One to One Register**

**Guidelines for filling the reporting form**

Who and When: On daily basis, the outreach worker/s will note the details of their interaction in their dairy and fill up the reporting form from the filled in dairy. For each category of the KPs, separate sheet should have been designed. Use each form as per the category of KPs contacted with. If an outreach worker/s is illiterate, Please use the pictorial list of activities as in Annexure 1. The pictorial with the codes are given for the “type of contact” and “topic discussed”. The concerned agency or NGO should ensure to assign a point person in guiding the illiterate ORWs in filling up the information. The information recorded will be compiled at the NGO and sent to you Alliance AP on the monthly basis as well as in the prescribed format as given in Process Monitoring Tool (PMT).

**How**

Only one to one contact/interactions and unplanned/informal group meetings made are to be recorded in this format. One to one means that – meeting one individual KP at a time. Unplanned / informal group meetings means, where an ORW unexpectedly meets a set of KPs in a group and addresses the program issues. Each row represents information to be filled up for each meeting/contact as below: It is expected that an outreach worker will be able to cover on an average 30 interactions or meetings with different type of KPs in a month. The outreach worker will maintain a separate sheet for each site and for each type of KPs as shown above.

**Name of the outreach worker**: Outreach worker will write his/her own name. The TSS/outreach workers are those who are actually conducting meeting or interacting with the KPs.

**Name of the site**: The outreach worker will write the name of the site where they have been assigned to work or carry out the FPP activities.

**Period**: The outreach worker will enter the month name in which the activities have taken place.

**Date**: The outreach worker will enter the date of interaction or conducting meetings with KP/s.
**Unique ID No.:** The outreach worker will enter the unique ID No. of the KP by looking at the ID card provided to him/her. If the KP is a new contact to the programme he/she will issue him a Unique ID card and note down the number along with entering it in the reach register.

**Topic discussed:** The outreach worker will enter the details of discussion made land then with the help of project coordinator will give the code as per the classification given in the annexure. Annexure 1 lists out the topics to be covered or discussed. Each topic is codified for the convenience of the outreach. He or she will write the topic code only. For those out reach worker who is illiterate, will use the pictorial chart and give the code accordingly the topics discussed. In such cases, he or she will share the discussion of the topics with the project coordinator to ensure that the codes have been correctly entered.

**Type of materials distributed:** During a given contact or meeting, if the outreach worker has distributed any materials with the person contacted, he or she will enter the type of materials distributed. The type of materials could be – condom; Lubricants; Syringes; IEC; any other materials other than mentioned above.

**Number of materials distributed:** During a given contact or meeting, if the outreach has distributed materials as mentioned in column 9, he or she will write the number of materials distributed. He or she to ensure the correct number of materials distributed. This will help in stock balancing as well as for PMT reporting.

**Type of referrals, if any:** The outreach worker will enter if any, nature of referrals made during a contact or meeting. The possible response could be – referral for STI, referral for counseling at the NGO, referral for VCCTC, Referral to care & Support center.

**If referred – name and place of referral:** In case of any referral made during a contact or meeting, the TSS/outreach worker will write the name and place where the referrals were made.

**KP status:** The out reach worker will enter as N or R (N = new and R = Repeat). If the out reach done for providing of services* with the community member/s is for the first time then it is treated as new to the utilization of services from the prevention program. The out reach is treated as “new.” The rest of out reach is treated as “repeated”

**Discussion, emerging issues, feedback, remarks:** The outreach worker will note the feedback or comments received on the topic discussed in their dairy and then in brief, will write in the column of the format (Outreach worker will take the help of the project coordinator in filling up this column).

> After completing the reporting form for all the contacts or meeting made during a month the outreach will sign at the bottom of the sheet in token of having checked and complete in all respect. He or she will handover the original form to project coordinator of the NGO on weekly/fortnight basis (as per the norms laid within the NGO set up).
Usefulness of the information in the format

- Helps in knowing the number of individual contacts or meetings made in a given month.
- Helps in knowing the nature of referrals and referral details made from his or her worksite.
- Helps in knowing the type and number of materials distributed in a given month.
- Helps in providing timely interventions based on the feedback or comments received during the interaction.

* Availing of services by a KP includes
  1. Visiting drop in centres;
  2. Availing clinical services
  3. Sharing of IEC/BCC materials/information on prevention by the ORWs or by the program staff.
**Annexure 5**

**Reporting Form 1: Reach Register**
(To be compiled once a week by the outreach workers from the daily diaries given under format 1)

Name of the outreach worker/TSS:  
Name of the Site:  
Period:  
Responsible/Reporting Agency:

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<th>Sl. No.</th>
<th>Date</th>
<th>Unique ID Number</th>
<th>Name</th>
<th>Gender</th>
<th>Age (as reported)</th>
<th>KP group</th>
<th>Sub group</th>
<th>Residential Area (Optional) (if available)</th>
<th>Hot spot</th>
<th>Remark</th>
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Reporting Form: Reach Register

Guidelines for filling the reporting form

Who and When: This report will be used for those KPs who have been contacted for the first time in the site and introduced to FPP/AVAHAN program. They are called the new contacts. On daily basis, the outreach worker will note the details of such interaction in their dairy and fill up the reporting form with the help of project coordinator from ORWs respective filled in dairy. If the TSS or outreach workers are illiterate, the concerned agency or NGO should ensure to assign a point person in filling up the information. The information recorded will be further compiled at NGO.

How

There are 11 sets of information to be recorded for each contact. Each row represents information to be filled up for each new contact as below: There is a provision for entering the details for 30 new contacts per page. The TSS/outreach worker will maintain a separate sheet for each site.

Name of the outreach worker: Outreach worker will write his/her own name. The outreach workers are those who are actually conducting meeting or interacting with the KPs.

Responsible /Reporting agency: The outreach worker will write the name of the agency or NGO under whom they are working or associated.

Name of the Site: outreach worker will write the name of the site, where they are assigned or performing the activities

Period: The outreach worker will enter the period of interaction with the KPs and getting the new contacts.

Sl. No. : The serial number is already printed, hence no to be filled up. Each serial number pertains to the details of one new contact in the site.

Date: The outreach worker will enter the date of the new contact made.

Unique ID number: Each contact is given a unique id number (a pocket size cards are printed and given to each NGO to be given to each new contact person who will retain with him or her).

Name: The outreach worker will enter the name of the KP who is a new contact in the site and to the program.

Gender: The outreach worker will enter the gender of the KP. For example whether the person is male, female or trance gender (TG).

Age: The outreach worker will ask the age of the KP and will note down the age.

Area to which he belongs or represents: The outreach worker will enter the details of area to which he belongs to or resides. Some times, it could also be possible that they don’t give their residential but give their operational area name. The outreach worker to probe and give the area name.
**KP group:** The types of population could be - Sex worker (SW); Injecting Drug Users (IDU); People Leaving with HIV AIDS (PLHA); Men having Sex with Men (MSM); Gate Keepers (GK).

**Sub group:** The sub groups could be – Street based, Home based, secret based, Kothis, panthis, double duckers etc.

**Remarks:** The outreach worker will give details, of the KPs in terms of his previous residential or area/s from where he migrated and when he migrated to the present site etc.

- After completing the form for all new contacts, the outreach worker will report or hand over to the project coordinator the copy of the filled in form on monthly basis. He will sign or give thumb impression at the bottom of having checked information noted.

Usefulness of the information in the format:

- Helps in knowing the number of new contacts made during a given month in the site.
- Helps in knowing the number of new contacts versus the number of KPs existing as per Participatory Site Assessment (PSA) and to know how many have been targeted.
- Helps in knowing the type new contacts made by the outreach worker.
- Helps in knowing the basic characteristics of the KPs contacted.
- Helps in knowing the number of migrated KPs.
- The unique ID numbers will be useful for analysis purposes and identification of the person for future program purposes.
Participatory Tool cards for Interpersonal Communication and facilitating behavior change

(This module is based on Participatory Site Assessment (PSA) methodology that was pioneered by the Alliance and the “First generation IPC methods” developed by PATH, under the AVAHAN program in India.)

In this section, a few Interpersonal Communication (IPC) methods have been described and these methods can be used to stimulate dialogue, debate and problem-solving for HIV/STI risk reduction with key populations (KPs). IPC methods aim to move beyond message delivery to dialogue based methods that promote critical reflection, enquiry and collective analysis. Through face to face interaction, dialogue and critical reflection, IPC helps KPs identify barriers to STI/HIV risk reduction, to analyze these barriers and plan ways to address them.

IPC outcomes
IPC for HIV/STI risk reduction with key populations aims to strengthen the:

1. motivation of KPs for HIV/STI prevention
2. skills and knowledge for KPs to be better able to reduce risk behaviour
3. ability of KPs to access (and demand) necessary prevention services and interventions
4. ability of KPs to access necessary peer (and social) support to reduce risk behaviour
5. analytical skills of KPs to be better able to address other barriers to health and well-being

1 Tools, methods and resources designed by the PATH Inter-Act project for strengthening capacity in interpersonal communication (IPC) in HIV/AIDS work
Tool card 1: Community mapping

Introduction

What is mapping?

Community mapping involves community members drawing a map of their community and marking on important features, for example religious institutions, markets, schools and health centers.

Why is mapping a useful activity?

Using a mapping activity with communities can:

Be a useful starting point to encourage people to start thinking about their local community and can be the basis for future tools.

Provide a non-threatening way to start discussions about sexual behaviour and sexual health. It encourages community members to think about where sexual activity takes place and who is involved.

Help groups to identify existing services and gaps in services in relation to sexual health and HIV prevention;

Highlight the different views of a community. For example, a group of young people might draw a different map to a group of older people;

Example: Uva Govijan Kandraya, Bandarawella, Sri Lanka

During a community needs assessment workshop, members of Uva Govijan Kandraya, an NGO working with young people in schools in Bandarawella, drew a community map to show the places where sexual activity took place, health services and NGOs in their community. They then used the map to discuss a range of sexual health issues, for example, sex tourism.

Time: 1 hour

Materials

- A large piece of paper (about 1 square meter), marker pens of different colors.
- Alternately an open floor area where the participants can make drawings, colored chalks.

Instructions for Facilitators

1. Ask participants to think about what aspects and features of their community it will be useful to map, for example religious institutions, local health centres and areas where sexual activity takes place.
2. Find a place to create the map - such as an open piece of ground or a large piece of paper.
3. Encourage participants to draw a map, showing the different features of their community – for example by marking them on the ground or drawing them on the paper.
4. When the map is complete, encourage participants to explain what they have drawn and why. Ask participants to think about what information the map provides about people’s risk of HIV infection and STDs, and about local services and needs.
5. Ask participants to write their names on their map and to keep it in a safe place. It provides lots of useful information about the community, which will be useful to refer to in future, either when designing projects or when monitoring the project’s development. If the map has been drawn on the ground, ask for a volunteer to make sure that it is copied onto paper.

Facilitators’ Notes

1. Encourage participants to draw their map imaginatively. For example, they might draw a picture of a mosque, temple or church to represent a religious organisation. This makes it more fun and interesting.
2. Try to make sure that everyone in the group is involved and contributes to the activity. For example, ensure that the tool used for drawing – such as a pen or stick – is shared among participants. Also, encourage participants to reach consensus about what to map and why.
3. Allow the group to create their own map. Support them by asking probing questions, but try not to interfere with the process.
Tool card 2: Body mapping

Introduction

What is body mapping?
Body mapping involves community members drawing a “map” of a human body and marking on the body parts that are relevant to HIV/AIDS and sexual health.

Why is body mapping a useful activity?
Body mapping can help communities to discuss:

- Sensitive issues in a non-threatening and fun way.
- Their understanding of how their bodies work, especially in relation to sexual activity, reproduction and sexual health;
- Differences between biological facts and people’s beliefs, and how this might affect HIV prevention work;
- Different perceptions of the body – for example, men and women’s views of what parts of the body are important for sexual desire, reproduction and sexual health.

Example: Association Mouvement Twiza, Morocco

During a training workshop on sexual health for young men, members of Association Mouvement Twiza, used body maps to help identify the different reproductive organs of men's and women's bodies. The body maps were then used as a starting point to begin to discuss sexuality.

Time: 1 Hour

Materials: Large chart papers, marker pens

Instructions
1. Divide participants into two groups. Ask the first group to draw a picture of a naked man and the second to draw a picture of a naked woman – for example by asking someone to lie down and then asking another member of the group to draw round them.

2. Work with participants to decide what parts of the body it will be useful to map in relation to sexual activity, sexual health and HIV/AIDS. Ask them to either draw these straight onto the map or to draw them on pieces of paper and then stick them on.

3. When they have had a chance to do this, ask participants to explain what they have drawn on the map and why. Encourage others to ask questions about the drawings and to make any comments.

Facilitators’ Notes
1. Think carefully about how to introduce body mapping – because it can raise sensitive issues. For example, it might be useful to divide the group according to gender – to reduce participants’ embarrassment.

2. Pay particular attention to creating a non-threatening atmosphere for this activity. For example, encourage participants to share their ideas rather than worrying about whether things are “right” or “wrong.”

3. Allow the group to create their own body map. Support them by asking probing questions, but try not to interfere with the process.
Took card 3: ‘Why Is It So?’

Introduction
This tool helps KPs analyze why risk behaviors occur and what can be done to reduce it and hence can be the starting point to initiate dialogue and discussion or risk reduction strategies. For using this tool, facilitators need to be knowledgeable about high risk, low risk and no risk behaviors, difference between risk behaviors and vulnerability factors and a very good knowledge about the KP context.

Time: 1 hour

Materials: Chart paper, marker pens.

Instructions
1. Explain to the participants that this activity will look at the different ways in which their KP group is vulnerable to HIV/STD infection. This is in order to better understand how the interventions can benefit them
2. Ask participants to name the different kinds of behaviors that put people at risk of HIV/STI infection. Correct any misconceptions.
3. Pick one of the following risk behaviors: anal sex without a condom, vaginal sex without a condom, sharing of needles and syringes.
4. Ask them to draw a symbol of this risk behavior in the centre of the flipchart inside a circle.
5. Ask ‘why is it so?’ and ask them to draw and or write the reasons for the risk behavior in balloons.
6. Keep asking ‘why is it so’, adding further reasons in connecting balloons until they can think of no more.
7. Ask the participants what the diagram says about:
   ➔ What are the most important reasons (vulnerability factors) for risk behavior?
   ➔ What are the ways that the KP group already try and reduce risk behavior?
   ➔ What would further help the KP group avoid the risk behavior in the diagram?
   ➔ Why does the KP group want to reduce their risk of HIV and STD infection?
8. Finish the session by asking the group to reflect on what they had shared and learned during the session that would be useful for them.
9. Record main points of this discussion on the flipchart. When finished, label the chart with the site team, the KP group, number of participants and the date.
Example of ‘why is it so?’ Diagram
Tool card 4: Vision diagramming (Visions of interventions)

Introduction
Vision diagramming is a tool in which people use their imagination to draw a picture of a positive future for their community. This tool can be useful when people are working together to identify new activities, services and resources that are needed to address HIV/AIDS in their community. For example through the use of this tool with people living with HIV the need was identified to set-up drop-in centers run by and for people living with HIV.

Why use it?
• To imagine a positive future where HIV/AIDS is being easily dealt with by the community.
• To identify appropriate services, activities and resources which may be needed to achieve this.
• To identify who can be involved in providing these.
• To identify what might be the difficulties in bringing about the ‘vision” and to decide how these difficulties might be solved.

Time: Approximately 2 hours

Materials
A quiet place to reflect is especially important for this tool. You will also need materials to draw the vision.

Instructions
1. This tool can be used with up to twelve participants.
2. If participants have not already done so, ask them to think of the current HIV/AIDS situation in their community. Who is affected and how? What HIV/AIDS services exist? What is the quality of these services?
3. Now ask participants to close their eyes and imagine a time in which all of the community is easily coping with HIV/AIDS. People are preventing HIV, caring and supporting all those affected by HIV, and receiving treatment for HIV. Everyone in the community is in someway involved in dealing with HIV. Imagine that time is now, today.
4. Ask each participant to draw this vision.
5. When participants have drawn their visions, ask them to share their pictures with each other in small groups.
6. Ask them to discuss the following questions:
   ➤ In their visions, what new activities, services and resources exist?
   ➤ Who is involved in carrying out the activity or service?
   ➤ Who was involved in starting and planning the activity or service?
   ➤ What were the difficulties in implementing these activities and services? How were these difficulties overcome?
   ➤ When the drawings are complete, encourage groups to explain to the other groups what they have drawn and why.
7. Encourage others to ask questions about the drawings and make any comments or suggestions.
If the drawings are made on something which cannot be kept, for example the ground, it is useful for someone, when it is finished, to make a copy of it onto a piece of paper for future reference

**Facilitator's notes**

- It is important that participants feel relaxed in this exercise and that they take the time to imagine a very positive future.
- Encourage people to think as widely as they can but at the same time recognise that people may find it difficult to imagine a service or project they have never seen

Vision from AP, India
Tool card 5: Play safe

Introduction
This tool helps participants to explore and understand different safer sex techniques. For the facilitators, it requires very good knowledge of safe sex strategies and techniques, comfort with talking about sex and with explicit demonstrations of safe sex.

Time: 1 hour

Materials
Enough space for participants to act out different situations

Instructions
1. Divide participants into two teams. To up the stakes participants can be divided into one male-only and another female-only groups.
2. Ask each team to prepare and simulate a situation where they demonstrate sex acts that are safe
3. One group demonstrates
4. After the demonstration, the other group analyses the simulation to check:
   ➤ Whether the sex acts demonstrated are really safe
   ➤ Whether they are realistic and practicable
   ➤ Whether they can be practiced in any situation or would they require special circumstances
   ➤ Whether anything can be done to make the act even safer
5. The second group demonstrate and the other group analyses using the same set of criteria
6. Based on the assessments the groups are awarded points
7. Finish the session by asking the group to reflect on what they had shared and learned during the session that would be useful for them.

For repeat use, the groups can be asked to demonstrate sex acts of particular categories, such as vaginal, anal, oral, physical but non-penetrative, non-contact
Tool card 6: Chakra Wheel

Introduction
This tool can be used to help KPs identify and plan ways to address barriers to STI/HIV risk reduction. For the facilitators, it requires Knowledge of HIV/STI prevention methods and of KP context in relation to HIV/STI risk reduction. This exercise can be done outdoors in impromptu locations if the location is not right within the public domain.

Time: 1 hour

Materials
The wheel can be drawn in the dust with a stick or with chalk on concrete, alternatively use markers and flipchart.

Instructions
1. Settle the group in with an icebreaker.
2. Ask the group to brainstorm ways in which their KP group or sub-group can reduce the risk of HIV/STIs. Correct any misconceptions, challenge any prejudices. Get the group to settle on 8 important risk reduction methods or strategies.
3. Ask the group to draw a circle and divide it into 8. Assign one risk reduction method or strategy to each segment of the wheel using a symbol or object agreed by the group. Now ask the group to discuss how easy it is for their KP group or sub-group to use these methods or strategies and shade in the segment accordingly. If it is very difficult for the KP group to use the method or strategy then only a small part of the segment is shaded in.
4. When the wheel is complete, ask the group to reflect on the segments that have least shading. What action would need to happen to make it easier for the KP group to use that risk reduction method or strategy? Who would need to be involved in that action? What first steps could be taken immediately and by whom?
5. Finish the session by asking the group to reflect on what they had shared and learned during the session that would be useful for them. If necessary, offer one-to-one work with people who may have specific and personal concerns.

Adaptation for repeat use: Keep the original charts or ask the KPs to keep them and work on a different risk reduction method at each meeting.
Tool card 7: How hot is the spot?

Introduction
This tool can help KPs identify and plan ways to address barriers to HIV/STI risk reduction. It requires the facilitators to be knowledgeable about the KP context and of relative risk of particular behaviors.

This activity generates information that may cause sensitivities between KPs and the authorities, so some privacy is required.

Time: 1 hour

Materials: Chart papers, marker pens

Instructions for the facilitators
1. Settle the group in with an icebreaker.
2. Ask the group to draw a map of the local area, including any local landmarks to orient the map. Now ask them to use a symbol to indicate on the map the locations where behavior occurs that puts their KP group at risk of HIV/STI infection.
3. Now ask the group to rank the locations using symbols for 'high', 'medium' or 'low' according to the level of risk behavior in each location (in terms of numbers of people or frequency of risk behavior occurring).
4. Ask the group to look at the locations ranked as 'high'. Ask them to discuss what change needs to happen generally to make the location into a 'medium' or 'low' rank. Then ask what individual KPs or small peer groups could do to reduce risk behavior in these locations.
5. Finish the session by asking the group to reflect on what they had shared and learned during the session that would be useful for them.

Adaptation for repeat use: This activity is long and can be broken up with repeat use. Keep the chart papers to continue the discussion in the next session. Use original papers after some time and ask participants what may have changed in the site.
Information presented in this manual is supported by


3. How to create an effective Peer Education Project – Guidelines for AIDS Prevention Projects, AIDSCAP.


5. Friends Tell Friends — Program on AIDS, Chaiyapet et.al Thai Red Cross Society, Sasathorn Chaiyapet et al.


8. A training module for building communication skills of outreach workers — NACO (New Delhi) & Xavier Institute of communications, Mumbai.


14. Peer Education Module UNAIDS.

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