Training Module for use with the Peer Educators

Submitted to

Durbar Mahila Samanwaya Committee

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Section: 1 Introduction:

India has been living with the HIV/AIDS problem for as long as two decades now. In terms of the number of HIV positive persons living in a single country, India stands as the second largest country in the world. Densely populated with vast cultural diversities, India is the home of over 5 million HIV infected people and the number describes the magnitude of the problem in the country. The Government of India's policy on HIV/AIDS addresses concerns for prevention of HIV / AIDS in population groups at higher risk of contracting the virus and the general population as well. The Government has been increasingly acknowledging the contribution of the NGO/CBO sector in the policy development for intervention strategy formulation and as their main implementing arms. In order to programmatically respond to the pandemic, targeted intervention with communities at increased vulnerability to HIV has been identified as one of the core strategies for HIV prevention in the Phase II of the National Policy on HIV/AIDS control in India. In India the vulnerable groups are the sex workers, truck drivers, injecting drug users and MSM. However, the underlying factors which are embedded in social, cultural and political structures of any given society that govern people's lives, also influence the aspects of vulnerability of some population groups to HIV/AIDS. Effective targeted intervention programme must address these structural determinants going beyond the public health and behaviour change arena. It has been observed that if the community members themselves manage the structural intervention as the gatekeepers, the programme can attain its optimum efficiency of controlling HIV/AIDS. The concept of community-lead structural intervention (CLSI) stems from the following principles:

WHAT IS CLSI?

"INTERVENTIONS STRATEGISED AND IMPLEMENTED IN PARTNERSHIP WITH COMMUNITY TO ADDRESS STRUCTURAL ISSUES TO REDUCE INDIVIDUAL AND COMMUNITIES' VULNERABILITY TOWARDS HIV / AIIDS THROUGH A PROCESS OF ACTIVE PARTICIPATION AND OWNERSHIP BUILDING, (WITHIN AND OUTSIDE PROGRAMME) WHERE THE COMMUNITY GETS MOBILIZED AND EMPOWERED BY CHANGING EXISTING RELATIONS AT ALL THE POSSIBLE LEVELS"

WHY COMMUNITY LED STRUCTURAL INTERVENTION?

'CLSI ARE NEEDED TO ADDRESS THE CONTEXT OF BEHAVIOUR, PRACTICE AND THE UNDERLYING CAUSES OF THE VULNERABILITY (TO HIV), WHAT MAKES AN INDIVIDUAL (A GROUP / A COMMUNITY) INCAPABLE OF AND POWERLESS IN PROTECTING THEMSELVES FROM GETTING INFECTED AND ALSO FROM THE IMPACT OF THE DISEASE

CLSI WILL ENSURE ACTIVE PARTICIPATION OF THESE GROUPS BEYOND BEING" RECIPIENTS OF SERVICES" AND "BENEFICIARIES" RATHER WILL STRATEGIZE TO UNLEASH THEIR POTENTIAL POWER TO AFFECT CHANGE.'

How CLSI will help in reducing transmission of HIV?

"1. Influence socio-political context that shapes behaviour and practices

2. Addresses factors that make individual and community vulnerable to HIV.

3. Help removing barriers to avail and access relevant information and services

4. Enable individual/community to act based on their decision

5. Create an environment to sustain changed behaviour and practices."

CARE India proposes a five-year HIV/AIDS prevention and care programme, named 'SAKSHAM' , which means 'empowered'. The project takes a holistic approach to implement HIV/AIDS initiative through community based structural intervention. These initiatives aim at empowering the community and build capacity of the vulnerable communities to prevent the spread of HIV/AIDS and for better access to appropriate treatment and care. SAKSHAM focuses on capacity building of State AIDS Control Societies in six high prevalence states, programme managers of Avahan and the partner NGOs/ CBOs of the Gates Foundation India AIDS Initiative. SAKSHAM's capacity building initiatives will emphasize on creating enabling environment for HIV/STI prevention and treatment efforts, defining locally appropriate solutions, and to develop and implement strategies for bringing these efforts to scale. SAKSHAM aims at helping the partners in implementing the community led structural interventions through an array of capacity building processes.

Community led structural intervention among sex workers stands on three pillars; of creating enabling environment, community mobilization and control over access and utilization of services. These three components together is believed to be leading to the empowerment of the community and thus would decrease the vulnerability. Peer educators are the key to implement these three components and thus will play a pivotal role in community empowerment. Peer educators are the community representatives who are the key implementer of CLSI in various ways. Such peer educators would be the prime service providers to their own community and owing to their understanding of the prevailing sociopolitical and cultural context, they are regarded as the appropriate 'community consultants' to guide the programme to move on the right direction. The peer educators are regarded as the main change agents of community mobilization process to address the issues of structural determinants pertaining to their community. Finally, as the social

change agents, they will involve the community in the programme and take the ownership of the programme.

Keeping this in mind the present peer education-training module is prepared aiming at strengthening skills of peer educators so that they could perform better in service delivery, become active participants in the programme management and be the community leaders to bring social change. This manual allows the peer educators develop analytical skills that can help them identify and analyse situations and factors that can increase or decrease their vulnerability of getting infected by STD/HIV and reinforces their existing knowledge base.

This module can be used by the CLSI programme implementers working at grassroots level, outreach workers, programme facilitators as a quick guide. This curriculum must not be viewed as a 'stricture' but the facilitators should be flexible enough to explore and adapt to the local situations and keep convenience of the participants in mind. This training programme aims at bringing the sex worker community and non-community members together to create a collective learning environment and initiate a dialectical process of enhancing knowledgebase.

The curriculum development process

The manual will be developed in four phases.

Step 1: Drafting of the peer training manual;

Step 2: Consultation with the successful CLSI programme personnel on this draft manual (project personnel Durbar) and incorporate necessary modifications;

Step 3: Incorporating suggestions from the SAKSHAM officials;

Step 4: Pre-testing of the manual among the peer educators where the CLSI programme is being conducted (among peer educators of Rajamundry) and then incorporating pre-testing feedbacks.

Section II. Preparation and planning

Section II.1. Process of training

The entire training programme will be imparted in two phases. The first phase of training will combine workshop based in house training and field based experiential training.

The second phase of the training will be conducted after the peer educators are inducted into the programme, have understand their job and have been carrying out service delivery activities satisfactorily. The second part of the training can be conducted after six months of the first training or as deemed appropriate by the programme authority.

Section II.2.

Content of the first phase training workshop

- Introduction
- Objective of Community led structural Intervention
- Peer education strategy
- STIs and peers in STI management
- HIV and AIDS
- Condom promotion
- Communications skill
- Negotiation skill
- Sex and sexuality
- Self esteem
- Care for PLWHA
- Record keeping

Content of the second phase training workshop

- Networking

- Advocacy
- Community mobilization

Section II.3. Requirements of workshop supplies:

The curriculum is designed to require a minimum of workshop supplies. The facilitators should have:

- Small and large sheets (Chart paper)
- Marker pens
- White Board
- Slide projector and STD slides
- Flip Chart/pocket folders containing pictures of STIs symptoms, condom use
- Condoms and dildo
- Video and VCDS on networking, advocacy activities by DURBAR

Section II.4. Time frame:

Time frame has to be scheduled as per convenience of the peer educators. For example: 4 day in house training workshop for first phase training workshop can be scheduled if the peers can afford full daytime. It may be broken into two 4 half day sessions or may be arranged phase by phase. Field training can be scheduled for four weeks.

Section II. 5. Profile, attitude and qualities of the facilitators

A multidisciplinary group of facilitators comprising of experienced peer workers and community members from successful CLSI programme, social workers, medical personnel having hands-on experience of working with the sex workers and other relevant resource persons could join in at appropriate times in course of this training.

- Facilitators should be familiar with CLSI issues and participatory methods of conducting workshop;
- Having positive non-judgmental attitude towards sex, sexuality and sex work profession is the basic attitudinal quality of the facilitators;
- To make the participants understand and feel comfortable the facilitators should use local terminologies. Preparation of a glossary of local terminologies is suggested;
- The facilitators should be sensitive towards participants' feelings and understanding and should be able to create an ambience where the participants can bring out the issues in open and speak freely;
- The facilitators should encourage participants to volunteer and speak out on the relevant issues, voice their opinion and not merely "answering question";
- Training has to be conducted in local language, devoid of medical and sociological jargons as far as possible;

- The facilitators have to acknowledge the feelings, assumptions and beliefs expressed by the peer educators which should be manifested in their verbal as well as nonverbal expression; and
- Facilitators must resist themselves to become more directive or too indifferent during group exercises. Ideally, they should stay with the group; listening, responding to the doubts and questions and help documenting.

Section III. The curriculum-Phase 1

Section IIIA: In-house training workshop

This section of the manual presents the curriculum in the order in which the exercises should be done. The order of the exercises is important because it allows the participants to gradually understand the concepts while the sessions in sequences are in progress. This is expected to help relating to their lives and social context.

Section III.A.1. Getting started: introduction to the workshop

Methodology:

- Begin by welcoming the participants and thanking them for their willingness to participate in the workshop;
- Participants then introduce themselves. Some ice-breaking activity must be planned at this time. This would entirely depend on the facilitator as to what s/he is very comfortable with doing with to the group so that it creates a "we" feeling among the participants and an ambience where they can talk freely;
- Briefly introduce the workshop objectives;
- Mention that this workshop will not include many lectures, instead the facilitators and participants will work together actively in a variety of exercises. The success of the training programme will depend on the participants' willingness to contribute their ideas and views.

Time: 30 minutes

Expected outcome:

- An ambience will be created where the participants will feel free to speak and share ideas, and
- Participant will understand the workshop objective.

Section III.A.2: Community led structural Intervention

Methodology:

- A participatory discussion on the perception of the programme is to be carried out on how the peer educators perceive the programme?

For example: o *A health service care Programme?* o *Space for their emancipation?* o *Programme inculcates sense of confidence and identity?* o *Or anything else*

- A participatory assessment of concerns of the participants (starting from the known issues/concerns regarding their community). Ask the participants to explore their concerns regarding their community. List out all the issues raised in the flip chart/board

For example:
• *HEALTH PROBLEM* • *POLICE ATROCITIES* • *HARASSMENTS BY HOODLUMS* • *UPBRINGING CHILDREN* • *FEAR OF DISCLOSURE OF IDENTITY TO THEIR FAMILIES* • *NO ECONOMIC SECURITY, MONEY LENDERS CHARGE EXORBITANT RATE* • *POLITICAL INTERFERENCE*

- Relate the concerns/ issues and participants perception with the CLSI objective. CLSI encompasses both macro and micro determinants that influence sex workers life and vulnerability to STI and AIDs. Explain how sex workers themselves could be able to take initiatives to identify the factors which control sex workers life, getting mobilized to improve their social, political and economic situations and thus moving towards a empowered community with decreased vulnerability.
- Sharing of experience by a peer educator from successful programme (Durbar).

Time: 45 minutes

Expected outcome:

- Participant will understand the CLSI objective and how it is relevant to their life

Section III.A.3: Peer education strategy

Concept:

Peer education strategy implies churning out pertinent knowledge base from the community and transformation of the same to implement workable solutions through organizational process. The peer educators being the community members are accountable to the community', the implementation managers and the facilitators need to harp on the issue of 'accountability to the community', which should stand out as one of the major ingredients of their motivation to work for the community. This would ensure the governance of the programme and high quality service delivery. In community led intervention programme peer educators play the most crucial role. Being the community members they interact with their fellow colleagues and with their in-depth understanding of ground-realities they could contribute to the programme as pathfinders. They would not only provide service for outreach activities as health workers but through getting involved in the organizational process they would also develop life and job skills and thus attain self esteem, self respect and confidence. It enables them to reconstruct their identity. Evidences have been established to show that the relative vulnerability of the sex worker community towards getting infection lies in the powerlessness of the sex workers as they remain at the bottom of the power structure of sex trade and positioned at the very marginal end of the broader society. Empowerment of sex workers is fundamental to achieve the success of any intervention programme. The increased magnitude of self esteem, self respect and confidence of peer educators facilitates the process of community empowerment and change their situation. Starting as health educator they could gradually become the community mobiliser, leader and thus the social change agents.

Methodology:

Step1. Explain the concept of peer education strategy.

Step2

In this session perception of the peer educators on their *role and responsibilities will be discussed*. Group discussion can be conducted on how the peers perceive their role.

For example

- *We are the friends of our fellow colleagues*
- *We stand beside them in their bad/awful days and are a part of their happiness*
- *We disseminate information on health care and personal well being*
- *We bring them to the clinic*
- *We motivate the sex workers and their clients to practice safe sex*
- *We try to persuade the madams on the aforesaid issues keeping in view the well being of the sex workers*
- *We have to protest against police/hooligan atrocities*
- *We can work out to monitor the quality of services provided by our programme.*

Step3

- Participatory Discussion on what they have to know for their effective contribution in the programme.

For example:

- *STDs*
- *HIV*
- *Condom promotion*
- *Communication skill,*
- *Negotiation skill and*
- *Sex and sexuality*
- *Self esteem*

Time: 45 minutes

Expected outcome:

- Participant will acquire broad concept on their role and be able to identify their requirement of knowledgebase.

III.A.4.: STIs and peers in STI management

Concept:

Regarding STI management in community led structural intervention among sex workers community the significant issues are:

- Community has to identify the core issues and generate options for solutions;
- The solutions have to be tailor made and integrated with greater adaptability and services have to be provided with active participation of the community;
- The community members would be in a position to monitor the delivery mechanism and quality of services;
- Clinic setting is not merely a place for treatment but needs to be positioned as a space for social interaction and nurturing relationship. In STI service delivery mechanism the structure and the processes needs to be largely designed and controlled by the sex workers community.

These are the basics to establish control over access and utilization of the services by the community. STI management approach in community led structural intervention calls for the 4'D"s.

Destigmatisation of sex and sexual illness:

The very fundamental prerequisite is to remove the stigma attached with the profession of sex work and develops a non-judgmental attitude towards sex and sexuality. There is nothing sinful if one acquires STI and he/she must have the right to get quality treatment.

Demystification of technical aspects of STI service:

Conscious efforts have to be made to demystify the STI management service. Treatment procedure has to be made very clear to the community members. They clinic attendees must have the right to know clearly about their illness and the treatment procedure. This is hardly practiced by the medical professionals and such information remains beyond the reach of the common people.

Decentralisation of STI management services:

Decentralise the STD management procedure from clinic to community level. Prescription is not the only component of treatment; the peer and outreach workers are made responsible for counseling, communication, compliance to treatment and condom promotion. Firstly the peer workers have to provide counseling and motivate the community members to avail the services. Secondly they have to establish communication to build confidence and trust among the community members so that they access the treatment and post treatment services in a continuum. To complete the entire treatment circle, partner notification component needs to be strengthened by the peer educators so that the synchronized effort of the treatment providers and the outreach helps achieving greater fallout of the STI control programme.

Democratisation of STI management services:

From governance perspective community's control over STI management has to be ensured. STI management team can be built up comprising the representative from peer educators, doctors, counselors, paramedical staff etc. Information sharing mechanism between clinic and outreach staff has to be established as integral part for efficient service delivery.

Methodology:

Step 1:

Keeping this conceptual framework in mind the facilitators can start the discussion on STIs and its management. Then the peer workers have to be asked to speak about what do they know about STIs?

Different opinions may be:

- *STDs are sinful diseases;*
- *These symptoms should not be disclosed;*
- *If we disclose that we have STIs customers don't visit us;*
- *We are in sex work profession, STIs are professional hazards, etc.*

Based on the understanding of peer educators the next discussion could be carried out. Explain clearly what sexually transmitted diseases are. Elucidate project's non-discriminatory attitude towards STIs. STIs are viewed as occupational disease and explain vulnerability of sex workers to these diseases.

Peer Educators from successful intervention programme can share common and perceived attitudes towards these diseases.

Time: 30 minutes

Step 2

Ask the participants to discuss about their knowledge regarding the symptoms of STIs and local terminologies which are being used to denote symptoms of STIs. Record all the known symptoms in chart paper.

Start the discussion on STI symptoms correlating with their understanding. Make necessary clarifications where their knowledge on symptoms and the diseases is inappropriate or incomplete. Encourage the participants to raise questions where they feel uncomfortable. Avoid using too many medical terms and use local language.

This session can be arranged with a slide show demonstrating the symptoms so that with the visual impact peer educators can get a clear idea.

Symptoms

Genital ulcers-single painless, multiple painful

White discharge-vaginal(curdy, frothy, with offensive smell), cervical-mucopurulent

Urethral discharge

Burning sensation while passing urine

Pain in lower abdomen and deep dyspareunia

Scrotal swelling

Vulval swelling

Swelling of inguinal glands

Warts-pearly and cauliflower

Jaundice

STIs

Syphilis

Gonorrhea

Chancroid

Lympho Granuloma Venereum (LGV)

Bartholonotis

Trichomoniasis

Candidiasis

Chlamydia

PID

Herpes simplex

Warts- Condyloma accuminata, Moluscum contagiosum

Scabies

Hepatitis B & C

AIDS

Time:1 hr. 30 minutes

Game

TOPIC	**DETAILS**
Type of Activity	Game
Title	Musical Chair / any other
Time Required	10 Minutes
Material/Equipment Required	One Bell, Chairs, any other
Theme	Breaking boredom
Methodology	Arrange the chairs in training room. Let the one participant be the volunteer. Give her a bell. Put one / more chair(s) less than the number of participants. Tell the participants to move around the chairs when the bell starts & sit on the available chairs when the bell stops ringing. Do this until a single chair is remaining. The last person will get a gift.

Step 3:

Discuss the risk of STIs if remain untreated.

- *These can cause serious illness*
- *These enhance the chance of contracting HIV (ulcerative STIs)*

- *Untreated syphilis can lead to mental inertia*
- *Some of the STIs can be passed through next generation if the pregnant mother is infected. (Syphilis/Gonorrhoea)*
- *Longstanding gonorrhea can constrict urinary tract even can block it.*
- *Chronic cervicitis can cause infertility*

Participants are to be encouraged to ask questions and clarifications are to be given accordingly.

Time: 20 minutes

Step 4:

Participatory discussion on the *ways through which STIs are transmitted.* Presentation of pictures or animations on the issues can be arranged.

- *Unprotected penetrative sexual encounter with infected person*
- *From infected mother to child eg. HIV, Syphilis*
- *Use of infected blood for transfusion. eg. HIV, Hepatitis B&C,*
- *Through infected needle/syringe*

Talk about *why women are more prone to get infected by STIs/HIV than men*

Physiological factors

- Wider mucosal area in the reproductive area in women and semen remaining in vagina for long period of time
- Due to concealed nature of reproductive organs of women, the symptoms revealed after much delay

Social factor

- The family ignores or overlooks the health issues including reproductive health especially when they belong to low socio economic status. Even the women themselves hardly give attention to their health.
- Lack of information regarding the diseases
- Women have less control over their health reproductive

- STIs have linkage with sexual behaviour and thus it is not socially accepted that a woman can disclose her disease.

This session can be followed by a participatory discussion on *why the sex workers being women and more over being in the sex profession are the most vulnerable*.

Time: 30 minutes

Step 5:

In this session *STI management* would to be discussed. STIs are fully curable except a few. One should get treated as early as possible and complete the treatment cycle as per advice given by the doctors.

Treatment aspect

- *Need for regular health check up as the STIs remain asymptomatic in women, opportunistic screening through speculum examination and blood test for VDRL*
- *Getting treated immediately after occurrence of symptoms*
- *Compliance of treatment and consequences if not completed the treatment*
- *Follow up of treatment*
- *Treatment of partner*
- *Referral to higher institution if the symptoms recur or persist*

Prevention aspects

- *se of safer sex measure, consistent use of condom*

Time: 20 minutes

Step 6

A participatory discussion on *Peers role in STI management* has to be carried out

- *Disseminate information to sex workers and their clients regarding STI, counsel and motivate them to bring to the clinic for check up, and be alongside with the clinic attendees so that they can get confidence.*
- *Enquire and counsel them on compliance of treatment*
- *Put effort to bring the partners*
- *Provide counseling on consistent condom use*

- *Monitor quality of services-maintenance of confidentiality, privacy, pay attention to whether nonjudgmental attitude and friendly behaviour is extended by the project staff*
- *Being active member of clinic management team the peer educators will be well acquainted with clinical procedure*
- *Participate actively in the clinic meetings and provide feedback that will help in triangulating data gathered by the clinic team and outreach teem as well. For comprehensive management of STIs they will be the link between clinic and outreach team*

Step 7

In this session *reproductive health and its connection with STIs* is to be discussed. Briefly discuss the female reproductive organs. Relation of infertility with untreated STIs and repeated abortions.

Simple diagram showing male and female reproductive organs.

- *Basic reproductive anatomy and physiology of men and women Puberty, menstruation, menarche, menorrhegia, dysmenorrhoea etc.*
- *Common sexual concerns and problems such as pregnancy, the hazards related to early and teen age pregnancy, prevention of pregnancies, MTP.*
- *Common RTIs.*
- *Reproductive health and STIs-relation of untreated STIs and repeated abortion with infertility*

A participatory discussion on sex workers and their reproductive health right can be carried out after the session.

- *Sex workers must get immunization and other reproductive health facilities as mother*
- *Control over their decision on sexual and reproductive health*

Time: 1hr

Expected outcome

- Participants will understand that STIs are occupational hazards of the sex work profession;
- Participants will know the common symptoms of STI and their local terminologies;
- Participants will know the name of some common STIs;
- Participants will learn the risk of STIs if remain untreated, mode of transmission of STIs and its prevention;
- Participants will understand why sex workers are more vulnerable to STIs;

- Participants will learn about how to control STI- its treatment and its prevention;
- Participants will comprehend the role of peer educators in STI management; and
- Participants will know the very basics of reproductive health and reproductive rights.

Section III.A.5. HIV and AIDS

Methodology

Step 1:

- Ask the participants whether they have any knowledge on HIV/AIDS
- Start the discussion on *what is HIV and what is AIDS*

The term AIDS means

A = acquired; not born with

I = Immuno-body's defence system

D = deficiency-not working properly

S = syndrome-a group of signs and symptoms

AIDS is not a single disease, but a syndrome that is a group of signs and symptoms resulting from weakening of body's defense system, which is caused by a virus. HIV is the name of the virus causing AIDS

- *Being a HIV positive person does not mean he or she has developed AIDS.*
- *HIV: Human Immuno Deficiency Virus. The microorganism that causes AIDS*
- *No curative treatment for AIDS has been discovered so far and thus AIDS is fatal*
- *Treatment for AIDS patient can extend the life span, but it is too expensive*
- *Once a person gets HIV infection, he/she remains infected and infectious throughout his/her life.*

Step 2

- In this session *signs and symptoms of HIV* will be discussed with slide presentation

- At the first stage when HIV infects a person there may be some signs or no signs but virus multiply in the body (window period).
- At the second stage HIV infected person has no symptoms
- At third stage AIDS related symptoms occur. These are, severe weight loss, persistent diarrhoea, night sweating, persistent fever, tuberculosis etc.
- At the fourth stage the person becomes the AIDS patient. Recurrent opportunistic infection, cancer, severe weight loss, fatigue, exhaustion, and finally death

- At all stages the infected person can transmit the virus through sexual route or through blood contact to another person.

Participants could be asked whether they had any questions or required clarifications and a small question answer session may be continued.

Step 3

Participants could be asked whether they knew the *mode of transmission of HIV.* Listing out all their conceptions, Discuss on the misconceptions.

Myths

- *Insect bite*
- *Sharing common toilet, bed, common clothing*
- *Casual contact e.g. hand shake, hugging, kissing*
- *Eating together*
- *It is not air borne or water borne*
- *Using common toilet*
- *While taking care of the HIV infected persons*

The issue of '*How HIV can be transmitted' will be discussed in the following section.*

- *Unprotected sex*
- *Blood and blood products*
- *Sharing of infected needle/syringe*
- *Infected mother to child*

Step 4

Participatory discussion on *how to prevent HIV transmission* will be undertaken:

- *Practicing non penetrative sex and use of condom for every penetrative sex. This is understood as 'safe sex'.*
- *Use of screened blood and blood products*
- *Use of sterilized needle and syringe*
- *Getting treatment of STIs as early as possible*

Step 5:

Participatory discussion on the *social dimension of HIV* will be conducted. Ask the peers what would their attitude and behaviour if they come to know that any of their colleagues is HIV+.

Role play can be arranged on what should be the attitude towards a HIV positive person.

Individuals with HIV or AIDS are kept isolated from society and alienated even by their family members. This creates tremendous emotional and psychological stress, which may lead to extreme depression, fear and guilt.

Time: 2 hours

Expected outcome:

- Participants will learn what is HIV and what is AIDS;
- Participants will know the signs and symptoms of HIV infected person;
- Participants will know the mode of transmission and prevention of HIV; and
- Participants will understand what should be the desired attitude towards the HIV positive persons.

Section III.A.6. : Condom promotion

Methodology

Step 1:

Facilitator can ask the participants to speak on what they know about condom. What terminology they use to define condom. Ask them to explain what condom is.

- *It acts as a barrier against STI and HIV/AIDS transmission*
- *It acts as contraceptive device*
- *It is a rubber sheath. It is long thin tube when rolled out. At the lower end it is closed and has a teat which collects the semen. Condom acts as a wall and prevents the sperms and STD causing germs and HIV from entering into the vagina, and from female genital parts to the penis.*

Display the condom and give condoms to each participant so that they can see and feel the condom.

Step 2:

This Session will make the trainee to know about the *correct use of condom.* Ask the peers to demonstrate putting on a condom on a dildo. Then the facilitators will show the correct condom use using the dildo.

- *Improper use of condom can damage the condom resulting in tearing of condom and contracting HIV/STI or having unwanted pregnancies. Care should be taken while using condom.*
- *While giving the condoms to the sex workers peers should see the expiry date.*
- *Open the pack carefully without damaging the condom. Wear the condom only after the penis becomes fully erect.*
- *Hold the tip of the condom ensuring no air bubbles form inside and slowly unroll it to full length so that the penis is completely covered.*
- *Ensure that the condom is in right position before commencement of sexual intercourse.*
- *Immediately after ejaculation withdraw the condom from penis*
- *Remove the condom carefully without spilling the semen.*
- *Tie a knot so that the semen can not spill out and then dispose it off in a dustbin.*
- *Do not reuse the same condom.*

Step 3:

Participants will be asked about their knowledge regarding the reasons for not using condoms and the *misconceptions about using condoms.*

For example

- *Using condom during sex is irritating*
- *Condom will tear during intercourse*
- *Condoms reduce sexual pleasure*
- *Condom is sticky and oily*
- *Erection goes before using condom*
- *Problem of buying*
- *Double condoms will provide better protection*
- *Use of condom implies lack of emotional feeling of her love for the partner*
- *Condom is barrier of 'mistrust' between two partners*

Clarify misconceptions

For example, condoms are soft and lubricated, proper use of condom does not cause irritation. If one uses condom after expiry date or does not remove the air properly, condom may tear. The process of condom wearing also is pleasurable as the sex workers put the condom on to his clients as a loving gesture. Sex worker has to convince the client that if he uses condom he could enjoy more freely without any tension or apprehension of getting infected by STIs/HIV.

Arrange role play

Ask a peer to put a condom on a finger. Tell the peer to touch a few other materials with that particular finger. Ask her whether she will be able to differentiate between the various materials she touched. Explain that condom does not create any barrier of feeling.

Sharing of practical experiences

Sharing of experiences by the Sonagachi peer educators on what do they do in these situations.

Step 4:

In this session *availability of condoms* is to be discussed. Peers are to be asked where the condoms are available. List them all.

- *With peer educators*
- *Medicine shops*
- *Other shops*
- *Clinic*

Steps 5:

Condoms should be stored in a cool dry place. A participatory discussion can be carried out *how and where the sex workers can store the condom.*

Time frame: 2 hours

Expected outcome:

- Participants will understand what condom is and use of condom
- Participants will learn about the proper use of condom

- Participants will learn some of the processes of how to convince the clients for condom use
- Participants will know about the availability of condom and condom storage

Section III.A. 7. : Communication skill

There are various means of how the knowledge of vulnerability and its consequences could be disseminated in the sex worker community. But the most effective one is when the community members themselves take the responsibility to make them aware and enable them to take appropriate actions. Peer education strategy is the most efficient mode of communication in HIV intervention programmes, provided the peers acquire and develop good communication skill. Being the member of the primary target audience they are the best available resources who can provide inputs in designing the communication strategy and development of communication tools. This session is to be conducted to improve the communication skills of peer educators, which is a basic requirement for their effective service delivery and a value addition in the same.

Methodology

Step 1:

- Participatory discussion needs to be carried on the necessity of communication and identification of the target audience with whom peers have to communicate. List all the names.

- *Sex workers*
- *Clients*
- *Madams*
- *Fixed partners*
- *Youth groups*
- *Pimps*
- *Police*

Step 2:

In the next session, a *participatory communication need assessment* will be carried out through a group discussion. Group discussion can be conducted on what would be the messages to be disseminated to different target groups. One group can discuss on what messages to be given to sex workers and madams, other group may discuss on what would be the messages for youth group, police and so on. After group presentation summing up the discussion will be conducted. List will be prepared. The list of messages / issues as it deems appropriate will be developed and fine-tuned in consultation with the recipients of this training during the pre-test exercise. The list may be as follows. This list may be treated just as an example.

Target audience	*Messages*
Sex workers	• *STIs and its symptoms* • *Acquiring STI is not a sin rather it is a occupational hazard, immediate treatment and consistent condom use are utmost important* • *Importance of getting recovered from STIs and living healthy* • *Available treatment facilities and how to access it* • *Necessity of health check up* • *Need for the compliance with the treatment* • *Necessity of consistent condom use* • *Proper use of condom*

Target audience	*Messages*
Sex workers	• *How to negotiate with their clients on condom use* • *How to bring the fixed partners to clinic, if the girl is infected with STI* • *What to do when the sex workers face violence from different players of sex trade* • *How the sex workers will be able to value themselves as human being and as worker*
Madams	• *Necessity of sending the girls to clinic for health check up* • *Why is it necessary to use condom (from long term perspective, if the girls remain healthy and free from HIV/STIs they could be able to earn more)*
Clients	
Fixed partners	
Youth group	
Police	

Step 3:

A participatory discussion can be conducted on different mode of communication.

- *Interactive-interpersonal communication(one to one/group)with the explanatory communication materials such as poster, leaflet, pamphlet, flip chart ,pocket folder etc*
- *Audio-visual-TV, VDO, theatre, drama etc.*

Step 4:

In the following session, another participatory discussion needs to be carried out on how to communicate. Based on the previous discussion participants will be asked to determine the *tools for communications*.

Target audience	***Massage***	***Proposed tools of communication***

STEP:5

This session can be followed by a role play where some of the situation from the above can be reflected upon and the participants will perform on how to communicate with the listed target groups in a given situation.

Role play demonstrating pocket folder (or any other methods) can be arranged

Step 6.

In this session discussion will be conducted *on the issues of communication in which peers have to especially pay attention on.*

- *To be a good communicator a peer should have clear understanding on the issue in which she is communicating and she should be able to articulate her understanding in an informal manner.*
- *She should be positive, confident, respectable, encouraging, friendly, showing concern even by her nonverbal expression.*
- *To be a good communicator a peer should have skill to build up rapport with her fellow colleagues.*
- *In the beginning peer educator should express her concern over the general well being of sex workers and gradually start talking about STIs and other information.*
- *The information should be given in local language*
- *The messages need to dispel myths and misconceptions so as to offer an environment of support and empathy.*
- *Too much information at a time should not be given*
- *When the person becomes sensitized the peers have to support him/her so that he/she could get the right service and could do the necessary action.*

Time frame: 2 hours

Expected outcome

- Participants will understand why communication is necessary and with whom peer educators have to communicate;
- Participants will understand what kind of messages they have to disseminate to different target audience;
- Participants will have a broad understanding on the mode and tools of communication; and
- Participants will have overall understanding on how different tools of communication they have to use for different group of audience.

Section III.A.8: Negotiation skill

This section deals with how the peer educators will help the sex workers to improve their negotiation skill. Providing information on safer sex practices to the sex workers is not enough to ensure the behaviour. It is not the question of the attitude and behaviour of the sex workers; rather it is the clients' choice. Even being fully aware of the necessity of using condoms, a sex worker may be compelled to jeopardize her health in fear of losing the customer. Sex workers may not even be in a position to try and negotiate with her clients as the exploitative madams or pimps control them. In most of the cases a significant share of sex workers' income goes in the hands of madam, pimps or other power brokers leaving them with meager resources. In this situation a sex worker can not refuse her clients. If she refuses she may not be able to earn her livelihood. The sex trade is a buyers' market and dictated by the will of the clients and the 'fallen women' practically have very less control over setting terms with the clients and deciding the modalities of the trade. Moreover, being in the sex work profession, most of the sex workers think that they are less dignified than others. So, if they don't value themselves as normal human being, how will they take actions to protect their health? Discussion on negotiation skill has to be carried out keeping in mind the context where the sex workers have to negotiate.

Methodology:

Step 1:

Participatory discussion on what are the issues that *hinder safer sex practices by the sex workers.* List all the issues raised by the peer educators.

The following issues may come up:

- *Clients are not willing to use condoms*
- *Madams/pimps force the sex worker to practice unprotected sex*
- *Sex workers don't know how to negotiate on condom use with their clients*
- *Some of the sex workers are utterly depressed and think that being a sex worker there is no difference between life and death*
- *Sex workers can't take decision on their life*
- *Local hoodlums, power brokers force us for having sex without condom*
- *Sex workers have limited income opportunities, they are afraid of losing customers*
- *If a street based sex workers keeps condoms in her bag, police arrests her and want money to release*
- *When police raids the quarters of sex workers there is sharp decrease in number of customers. Whoever visit at that time, sex workers don't bargain with them due to fear of losing the customers*

A participatory discussion on how to resolve the situations may be conducted. Take the points one after another, determine the stakeholders with whom sex workers have to negotiate and identify the probable solutions. Most of the issues may not have any immediate solutions. Issues of collective bargaining empowerment of sex workers, improving self-esteem, solidarity among sex workers for collective bargaining; advocacy, need for more economic options etc. may come up.

Experience sharing by sex worker trainers from Sonagachi

Role-play on how a sex worker could negotiate her client on condom use

Time frame: 1.30 hrs

Expected outcome:

- Participants will identify the factors that hinder sex workers to negotiate with their clients on safer sex practices;
- Participants will identify some of the issues to improve the power of negotiation of the sex workers;
- Participants will learn the basic negotiation skills.

Section III. A.9 : Sex and sexuality

With the onset of HIV, various fundamental socio-political issues related to human life has been brought forth. The aspect of sex and sexuality has remained as secret subject for long years. With the emergence of HIV this issue has appeared in the forefront as an area of prime concern. The concept of sex and sexuality is deeply entrenched in the social, cultural, and historical construct of a given society exceeding its biological arena. In our Indian society sex and sexuality is seen as necessary evil and it has no social sanction beyond reproduction within the marital boundary of man and woman. Society doesn't acknowledge the aspect of pleasure, comfort, happiness and intimacy which are intrinsic to sex and sexuality. Any sexual practice beyond the reproductive cause is perceived as moral sin. Owing this contextual background sex work profession is considered as a sinful profession. The women engaged in sex work profession are rarely seen as an occupational group. Rather they are categorized as a group of women who poses threat to sexual morality and social stability. Though sex work is an age-old profession but the sexworkers are the discursively invisible part of the society. As the whole structure and mechanism of this trade are kept hidden behind the facade of sexual morality, unlike other professions there is no transparency in this trade and no legitimacy too. In this milieu of sex trade the sex worker have no scope to raise their voices on the issues related to their life. Moreover the sex workers think themselves as bad and fallen. Most of the sex workers have low social class and economic background and being in this socially unaccepted profession they have very low self-esteem. These are the critical concerns while dealing with the lives of sex workers.

This session of sex and sexuality will be conducted having bearing on this conceptual framework. It is necessary to differentiate and discuss on the meaning of the term 'sex' and 'sexuality'.

STEP:1

- Participants will be asked to brainstorm on *the terms they know which are somehow related to sex.* List all local terminologies they know about it including slang.

For example:

- *Sexual encounter*
- *Menstruation*
- *Man and woman*
- *Woman give birth to child*
- *Penis*
- *Vagina*
- *Anus*
- *Pubic hair*
- *Vaginal sex*
- *Anal sex*
- *Homosexual*
- *Male who have sex with males*
- *Persons who like to have sex both with male and female partner*

- *Masturbation*
- *Sex worker*
- *Clients of sex workers*

Step 2.

Group discussion on *how the sex workers perceive on their sexuality and sex work profession*. Encourage them to raise questions and myths regarding sex and sexuality. Group presentation and listing all the raised issues will be done.

The issues that may be discussed are:

- *Clients are sinners and we have to engage ourselves to met up their sinful desire*
- *Clients visit us to fulfill their sexual desire; there is nothing wrong about it.*
- *Masturbation is abnormal specially women should not do this act.*
- *Menstruation is curse*
- *Sex is unclean and genitals are dirty*
- *Sexual urge is biological and emotional need. We the sex workers are giving sexual services, we should be considered as professionals*

Step3:

Discuss the *dominant discourse on sexuality*. How society perceives sexuality?

- *Sex is sin*
- *One should not discuss about sex*
- *One should not learn about sex*
- *Sex is necessary only for procreation*
- *Any sexual activity without the cause of reproduction is morally unacceptable*
- *Having sex beyond the marital relationship should be banned*
- *The persons who visit sex workers are doing wrong as this behaviour denies socially sanctioned sexual rules.*
- *If at all there is any acknowledgement of sexual needs beyond procreation it is only for the man. Women should always be faithful to a single man.*
- *Social practices strictly prohibit the expression of women sexuality. For generations of women sex has tended to be more a duty than a pleasure.*
- *Sex workers are morally corrupt as their sexual behaviour is something different from the socially accepted sexual rules*

Step4:

Discuss *what is sex and what is sexuality*

- *Sexual desire is very fundamental need of human being as a biological creature. Sex has the component of mutual pleasure, comfort, and satisfaction. Fulfillment of sexual desire makes a person healthy. One of the results of sexual intercourse between man and woman is giving birth to baby.*

- *Sex is the biological attribute that identifies a person as male, female or transgender. The points like, man and woman, women give birth to child, menstruation, the terms denoting sexual organs all will come under sex.*
- *Sexuality refers the manifestation of one's own sexual preferences and behaviour. The points like, anal sex, homosexual, male who have sex with males, persons who like to have sex both with male and female partner, all will fall under sexuality.*
- *The understanding of sex and sexuality is deep rooted in the social, cultural, and historical construct of a given society. In our society sex and sexuality is seen as sin and only necessary for reproduction. Any sexual activity beyond the periphery of reproduction is not sanctioned by the society. The aspects of mutual pleasure, comfort, happiness is never been acknowledged by the society. But these are very basic biological need of human being.*

Participatory discussion will be carried out what are the *appropriate notions* on sex and sexuality and what are not.

Step 5 :

Participatory discussion on different type of sexual activities

- *Different kind of sexual activities*
- *Penetrative ,non-penetrative and safe sex*

Time frame: 1.30 hrs.

Expected outcome

- Participants will identify different local terminologies related to sex and sexuality;
- Participants will understand society's perception on sex and sexuality; and
- Participants will understand the broad concept of sex and sexuality, and what should be the attitude towards sex, sexuality and sex work profession.

Section III. A.10 : Self esteem

Sex work emerges as an ancient profession in the social history of human beings and at the same time regarded as one of the most undesirable social phenomenon. In most of the societies across countries all over the world, sex work is associated with the degenerated values and morale in a given social paradigm. The people in the sex worker community live on as *less human* in a parallel society. Away from the mainstream, the sex workers here address to the outer world as "the gentleman's society". There is an invisible boundary separating these two societies. Historically the sex workers are the socially branded human beings, deprived of the minimum social security measures provided by the country's fundamental rights and the international human rights. The sex workers mostly come from very low economic and social class as well as caste background. Their class, caste, gender, and occupation corner them at the most marginalized position. Moreover, the sex workers experience intense feeling of rejection and severe guilt as 'morally corrupt' women. The marginalization coupled with guilt feeling brings about a negative attitude towards life and very low self-esteem. It is thus extremely crucial to uphold the dignity of the sex workers so that they could be able to value themselves as human being. This session will be an endeavor to boost the morale and self worth of the sex workers.

Methodology

STEP1:

Participatory discussion on what the peer educators think of themselves will be carried out. Discuss different *aspects of self-esteem* following the matrix. List may be more exhaustive.

Aspects of self esteem	*What we think of ourselves*	*What our family and society think of us*	*What we have to do to enhance our self esteem*
Ability to take decision on mental and physical well being • *Do we think that we can take decision on entertaining customers when we feel sick?* • *Do we take decision on our treatment seeking?* ▪ *Do we think that we should get equal and nondiscriminatory health services by the health service provider?* ▪ *Do we think that we should have right to*			

information			
As a human being • *Do we think that we can express our dreams and aspirations* • *Do we think that we should have right to live with dignity*			

Aspects of self esteem	What we think of ourselves	What our family and /society think of us	What we have to do to enhance our self esteem
Social identity beyond this particular "occupational being" ▪ Do we think of ourselves to be responsible towards social causes			
Our legal status ▪ Do we think that we can ask police about the cause of arrest or raid ▪ Do we think police should not harass us during raids only because we are the sex workers ▪ Do we think we must have the receipt of house rent when we are paying for that			
Our political status ▪ Do we think all of us should have ration card, voter identity card ▪ Do we think we are the voters of our country and we should have enjoy our rights			
Our civic amenities ▪ Do we think we should get basic civic amenities as any other citizen of the country			
As mother ▪ Do we take decision regarding the life of our children ▪ Can we admit our children in school with only the mother's name as legal guardian			
As workers engaged in sex trade ▪ What do we think of ourselves –as sinner or as worker who earn their own subsistence			
As peer educator ▪ A respectful health educator ▪ Community representative ▪ Community organizer ▪ Responsible social being			

The next discussion will be on what *actions need to be undertaken to strengthen confidence enhance the self esteem*.

The issues of empowerment of sex workers may come up:

- *Strengthening information base on the issues concerning their health and rights as human beings.*
- *Creating space so that they could articulate their needs and demands within the programme, within sex trade and within broader society.*
- *Making the sex workers more visible in public sphere as persons with social responsibility and dignity*
- *Building up community feeling through networking and collectivization*
- *Enabling them to take decision as an individual and as community.*
- *Supporting them so that they will be able to take actions on the basis of their decisions-through Self help group formation*

Sharing of experience by DURBAR members on how they have gradually become more confident and attained self respect.

Time: 1.30 hrs

Expected outcome

- Participants will be able to identify the factors behind the low self esteem of sex workers; and
- Participants will be motivated to initiate the process of boosting up their self-esteem.

Section III. A.11 : Care for PLWHA

HIV/AIDS has emerged as a major social problem as acute as clinical challenge. The stigma attached with the disease causes social discrimination and alienation of the person living with HIV/AIDS and their families too suffer from social ostracisation. Denied from their employment, housing and basic social amenities the persons are ostracized by the society. Even the health care providers discriminate them due to their very disease. All these create tremendous psychological pressure on the persons and their families leading to severe depression and even to suicidal attempts. Care and support for the persons living with HIV/AIDS has become a significant concern in HIV/AIDS intervention programme.

Methodology

STEP 1

Participatory discussion on social and psychological problems faced by the PLWHAs.

Sharing of experience of DURBAR members in this issue.

STEP 2

Discuss on the services needed by the person living with HIV/AIDS

- *Medical care-general treatment, blood test with pre and post test counselling, treatment of opportunistic infection, ART etc.*
- *Legal support*
- *Psychological support –counseling-coping up with trauma, maintenance of health and hygiene, Nutrition, safer sex practice, testing of spouse and care for expectant mother etc.*
- *Social care-restoration of human rights-at family, immediate community and society*
  at health care service institutions
  at workplace

STEP 3

Participatory discussion on what would be the peer educators' *attitude and role towards PLWHA*

- *We will stand by the HIV+ person and their families*
- *We will be the last stage counselor*
- *We will motivate people specially the persons having persistent STIs, spouse of HIV+ to undertake VCTC*
- *.We will take them to doctors and counselors for referral to VCTC*
- *We will help them to cope with HIV status*
- *We will counsel the family members with the permission of PLWHA so that they can provide support the person to cope with the situation*
- *We will arrange awareness programmes against the discrimination*
- *We will liaison with health care service providers so that they can get proper treatment and nondiscriminatory behaviour.*
- *We will help the person in getting proper treatment*

Discuss the *available VCTC centre in their operational area*, outpatient and inpatient services for the treatment of general ailments, opportunistic infections and anti-retroviral therapy

Time: 1hr.

Expected outcome:

- Participants will understand what kind of psychological stress PLWHA have to face;
- Participants will understand what kind of support the PLWHA need;
- Participants will know the role of peer educators in PLWHA care and support; and
- Participants will get an idea of available facilities for the PLWHA in their operational area.

Section III. A.11 : Record keeping

Record keeping is the main method of systematically documenting continuum of events and processes. This has high contextual relevance particularly for the organizations that strive to establish community based decentralized entities and self governance. While the peer educators are being enabled to spearhead this 'change process', it is of seminal importance that they learn the reporting mechanisms and the skills of record keeping. Contrary to this assumption, the documentation work is usually done in isolation by an outsider. a 'non-community member'. Such documentations may only provide factual details devoid of the insight, sensitivity and the critical focus with which the community members perceive an issue close to their life, work and sentiment. Information is the life-blood of an organization. Keeping the CLSI approach in mind, it may be appropriate to think that the peer educators must be encouraged to start thinking and taking decisions on how and what kind of information needs to be generated, nurtured and processed that would set a direction towards achieving community ownership and self governance.

One of the important aspects in this regard is, as the peer educators have to document the activities at primary level, the system should be designed in very user-friendly manner keeping in mind the writing ability of the peer educators.

Methodology:

STEP 1.

Participatory discussion on the *necessity of record keeping* will be carried out.

- *Get clear idea on what we are performing as peer educator*
- *If we keep records it will help us understand how much we have achieved and how the services can be improved.*
- *If we maintain records it will help us to identify problems while performing our daily activities*
- *It helps us to plan for the follow up activities*

STEP 2.

Group discussion on what are the *different activities peer educators perform*.

Group presentation and summing up of the activities.

The activities may be:

- *How we make rapport and friendship with our fellow colleague*
- *How we disseminate information on different aspects of STI/HIV*
- *How we motivate sex workers/clients for health check up*
- *How we motivate sex worker /clients to use condom*
- *How we distribute condoms to sex workers, clients.*
- *How we communicate with other stakeholders*
- *How we take sex workers/clients for VCTC and provide possible support for HIV infected persons among the target community.*
- *How we protest against violence on the sex worker community.*

STEP 3

In this session *maintaining record of the activities* performed by the peer educators will be discussed. Based on the writing skill of the peer educators record-keeping procedure should be designed. Participatory discussion on the ways of record keeping will be conducted.

What are the information which need to be recorded. These may be as follows

- *No. of STD patients-sw,cl,other*
- *Treatment completed-sw,cl,others*
- *Follow up patients*
- *No of persons communicated-sw/cl/others*
- *No of condoms distributed*
- *No of persons referred to VCTC*
- *Violence handled*
- *No. of meetings arranged with community members*

If the peer educators have low writing skill, documentation can be done using pictures or colours. For example, different colours/pictures may be used to denote sex worker, client, general patients, treatment completed, referred to VCTC etc. Document can be done in following manner.

Name of the peer: *date:*

Symbol of condom to denote number of condom distributed	▪	▪	▪	▪	▪						
Symbol denoting sex worker with STI	▪	▪	▪								
Symbol denoting client with STI	▪										

This means number of condoms distributed-5packs

Sex worker with STI-3

Client with STI-1

Time: 1hr

Expected outcome:

Participants will understand the need for record keeping;

Participants will understand the activities, which need to be recorded; and

Participants will understand the process of record keeping

Section III B: Field based training

Any orientation exercise that envisage concept, skill and motivational improvement to value add in service delivery needs to check the proximity of such assumptions, approaches and plans to the actual live situations. The training curriculum of the peer educators must adapt with and take cognisance of the locally appropriate situations, which is not possible to achieve in a classroom setting. For that matter, the trainee peer educators must be encouraged to identify the specific issues requiring field reconnaissance in every single aspect of this module. This is expected to make this training more acceptable, practical and actionable.

Some of the aspects of field training:

- Duration of the field-based training can be four weeks.
- A work plan for field training has to be made based on the learning of in-house training and the field situation.
- Participation of DURBAR team with the peer educators in their field activities for some days will be effective.
- Before starting of the field activities the concerned supervisors have to make them understand what the peers have to do.
- If possible small sessions (15-20 minutes) on different aspects of jobs can be discussed before starting field activities.
- Supervisors will help the peer educators in performing their activities.
- After completion of the field work a small session can be arranged to discuss the issues raised by the peer educators.

Section IV: The curriculum- Phase II:

When the peer educators are well acquainted with their job and supposedly making use of the first training curriculum, the second phase of training could be imparted after three months of the first phase of training. The second phase of training can be for four days. First two days will be scheduled for the refresher of first phase training. In the following two days training will be conducted on networking, advocacy and community mobilisation.

Section IV:A. Networking

Improving the quality of life and strengthening social security is the fundamental requirement to reduce the vulnerability of sex workers. Owing to this perspective empowerment of sex workers is the most crucial aspect for the social intervention. Empowerment of sex workers primarily aims to promote positive self-image, self-esteem and confidence among the sex workers so that they can articulate their needs better and are in a position to set terms with the broader society on the issues of protection under human rights and law of the land. Networking is a process of empowerment, which helps them to be unified as community and enable them to taking up initiatives for the betterment of their life.

Methodology

Step1:

Participatory discussion on *why networking is necessary*. Brainstorming by the participants and listing out all the points.

Following issues ma come up:

- *Networking will bring all the sex workers from different red light districts together/different settings together*
- *We can share our problems pertinent to our life.*
- *We can assess the needs and aspirations of sex workers of different areas and identify the appropriate actions to respond to the needs.*
- *We can evolve strategies on how to move ahead to improve our situation*
- *Networking will widen our allies' circle and thus enhance our support base, which will help us to forge ahead with our demands.*
- *Networking is extremely important to instill confidence among the sex worker commnity*

Step2:

Interactive session will be conducted on *with whom the sex workers do the network*. List all the names raised by the participants.

- *Sex workers at local, district state, national and international level*
- *Children of sex workers, fixed clients*
- *NGOs/CBOs working in similar field*
- *Other vulnerable groups and marginal communities*

Step3:

Group discussion on *strategy of networking* could be carried out. What will be the different strategies to build network with different groups will be discussed. Group presentation and summing up the points raised by the participants

The points may be:

- *Visit the sex workers of different red light districts, know about their problems and need assessment*
- *Arranging information sharing meetings with sex workers in regular interval*
- *Exposure and exchange visits*
- *Developing system of communication for regular information sharing*
- *During any emergency situation immediately extend support for the concerned group*
- *Creating forums for networking with different groups*
- *Team building for networking with different groups*

Step4:

Discuss on the issue what the peer educators expect as *outcome of networking*

- *Formation of district and state level networks of sex workers and ultimately sex workers' collective will be formed*
- *Designing detailed plan of action*

Sharing of experiences by the Durbar facilitators on their networking activities.

Video show on networking activities by DURBAR

Time: 3.00 hrs

Expected outcome:

- Participants will understand the necessity for networking;
- Participants will get an idea on with whom the sex workers have to network and the strategies of networking; and
- Participants will get an idea of outcome of networking.

Section IV: C Advocacy

Advocacy involves influencing policy, be it in organisation level, government level or societal level. Advocacy is the mechanism to convince relevant groups so that they profess the view of empowerment of sex workers and thus influence to bring change in policy matters. . The most vital advocacy issue in this regard is locating intervention within the framework of empowerment. In the context of HIV/AIDS intervention among sex workers advocacy means systematically enabling the key players to understand the core social, economic, political, legal, and sexuality issues linked with sex workers life and to act accordingly.

Advocacy activities have become imperative to create an enabling environment for the sex workers and to change the milieu of negotiation. With their in-depth understanding on their own life, the community members themselves could carry out effective advocacy activities rather than it is being carried out by the advocacy 'experts'. This session will focus on how sex workers can take on advocacy activities by themselves.

Methodology:

Step1:

Discuss on *why advocacy is needed*.

- *To convince different bodies/individuals on the rights and demands of sex workers*
- *To convince policy makers and larger society on the importance of empowerment approach in intervention programme among the sex worker*
- *To influence policy, which keeps sexworkers, excluded from policy consideration*
- *Advocacy is an effective medium to increase social acceptance of sex workers and create public opinions*
- *To open dialogues to deal with the issues related to social moral values and practices in connection with sex , sexuality with reference to AIDS epidemic.*

Step2:

Participatory discussion on *identification of the key actors* towards whom advocacy efforts need to be directed. Category wise distribution of different agencies with whom sex workers will advocate.

Level	Functions	Decision making bodies
Government	State legislature-ministers	Ministry of Health
		Ministry of social welfare
		Ministry of law
		Ministry of labor
		Ministry of panchayat
		Ministry of Home
		Ministry of information
		Ministry of cooperative
	Implementers	Secretariat
		Directorate
		District level health officers
		Law enforcement officials

Opinion leaders	Political personnel	Local elected representatives- councilors, municipality chairpersons etc.
		Other political party members at local level
		State elected persons-MLAs
		Other political party members at state level
NGOs		Working in the field of HIV/AIDS
		Working in the field of health
		Working in the field of Human rights
		Working in the field of childrens'rights

		Working in the field of Women ‘s rights
Media		Mass media
		Other media planners & publishers
Donor agencies		
Trade unions		
Others		Intellectuals, Influential persons, democratic fronts, Research and academic organizations, religious leaders
Autonomous body		Women's' commission, Bar council
Corporate house		

Participatory discussion identification of different groups for the respective district and state with whom advocacy could be carried out (Rajamundry)

Step3

Discussion on *how to carry out advocacy programmes for the different groups* organized by the community members. Discuss on the specific and distinct strategies for advocacy for each set of key players.

- *Preparation of materials documenting real situation of sex workers' life, their demands and endeavours undertaken by sex workers' collective*
- *Team building from among the sex workers for advocacy*
- *Capacity building for advocacy*
- *Organizing meetings, seminars, workshops with the key actors*
- *Invite the key actors in different programmes organised by the sex workers.*
- *Organizing rallies, campaigns, street corners, signature campaign, circulation of pamphlets, leaflets*
- *Organizing Press meet*
- *Involving sex workers in various activities against social injustices to enhance their social acceptance.*
- *Participating in different forums and enhancing interaction with the key actors*

Sharing of experience by the facilitators of DURBAR on advocacy

Video show on advocacy programmes by DURBAR

Time:3hrs

Expected outcome:

- Participants will understand the need for advocacy;
- Participants will be able to identify with whom advocacy should be done; and
- Participants will get an idea on what would be the strategy for advocacy

Section IV: B Community mobilisation

Asymmetrical power equation within the sex industry itself and social exclusion pose major threat to the life of sex workers. Empowerment through community mobilization is the only way by which sex workers could gain greater control over their own income, protection of their body, health, and life. Peer educators act as community mobiliser to inculcate confidence to their fellow colleagues and ignite their inner selves. The latent desire and demands of the sex workers when collectivized results in challenging the social system and barriers which control their life. As a fallout of the community mobilization a sex workers collective may be formed. The collective would be emerged aiming at the all-round development of the sex worker community and will ultimately be responsible for managing health and social intervention programmes.

Methodology:

Step1:

Group discussion on *need for collectivization and formation of self help groups*. Note all the issues that the peer educators will raise on how sex workers collective will help in improving their condition.

The issues may come up.

- *If we unite under a collective we will feel more confident*
- *We can protest against all sorts of atrocities and injustices inflicted on us by various power mongers*
- *We will raise our voices and demands on various issues pertinent to our life*
- *We can ensure safe sex, we would have the right to say 'no"*
- *We will be able to prevent the entry of minor and unwilling women in sex trade*

Step2:

Participants will be asked to discuss on the issues on developing *action plan for the formation and functioning of collective.* Peer educator trainers from DMSC will facilitate to discuss on the issue.

- *Selection of executive body, secretary, president, office bearers and spokespersons.*

- *Registration of the collective*
- *Fund mobilization*
- *Administrative aspects*
- *Documentation of the activities*

Step3:

Group discussion on *proposed activities to be undertaken by the sex worker collective.*

Group presentation and summing up

The following issues may come up:

- *Health care service for the sex worker community*
- *Endeavors to create more economic opportunities and financial security*
- *Initiative for the education and proper upbringing for the children of sex workers*
- *Arrangement for alternative occupations for the sex workers who leave the profession*
- *Undertake need-based programmes for the sex worker community.*
- *Undertake large-scale programmes to make the general people aware of the multifarious problems of sex workers.*
- *Fight for more secure legal status*
- *Undertake advocacy programmes with power brokers, opinion leaders and policy makers for the legal and social recognition*
- *Provide legal support to the sex workers*
- *Undertake care and support programme for the HIV+ persons and their families*
- *Undertake initiative to prevent forcible entry of unwilling women and minor girls in sex trade.*
- *Undertake protest against all forms of oppression*
- *Coordinate local struggles at micro level and build collective network at national level.*

Peer educators from DMSC could share their experience on how DMSC has formed and what are the activities are being undertaken by DMSC.

Video show on DURBAR activities. Documentary film "DURBAR the end begins' can be shown, if possible with subtitle in Telegu.

Time: 3.30hrs.

Expected outcome:

- Participants will understand the need for collectivization and formation of self help group;
- Participants will develop an action plan for the functioning of the collective; and
- Participants will design the plan of activities by the sex workers collective.

Annex:

A very simple evaluation exercise can be carried out after completion of the in house training programme. It will help to improve the training design.

Evaluation format of the training programme may be as follows.

1. How far you like this training? (not much/to some extent/very much)
2. Do you think this training will help you to perform better?
3. Which topic did you like most?
4. Which topic you didn't like much?
5. Was the choice of resource persons for the sessions appropriate? (not very much appropriate/some appropriate, some may be changed/quite appropriate)
6. Please suggest any changes that you like to make in topic selection.
7. Please list down five points that you have learnt from this training programme.
8. Was there any memorable experience during this training?
9. Please put down your suggestions to improve the training programme further?

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