

Training Module  
for


# Peer Educators in MSM Interventions



**National AIDS Control Organisation**

India's voice against AIDS  
Ministry of Health & Family Welfare, Government of India  
[www.naco.gov.in](http://www.naco.gov.in)





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## FOREWORD

The National AIDS Control Organisation (NACO) has been implementing exclusive Targeted Interventions (TI) for the high-risk group of Men having Sex with Men (MSM). There are 149 exclusive MSM TIs covering 2.38 lakh MSMs. The capacity building of the various functionaries of TIs is being carried out through the State Training Resource Centres (STRC), but has always been a challenge in absence of formal training modules for MSM TIs. To address this, NACO has come out with a set of training modules designed for different cadres involved in implementing NACP. These modules have been developed with rigorous consultation and deliberations with experts, and involvement of community members over a period of time.

The seven training modules for Doctors, Program Managers, Counselors, Out Reach Workers (ORW), and Peer Educators (PEs); and the training modules on Advocacy and Induction are developed for ensuring sensitive and quality service delivery to the target group.

I would like to acknowledge the effort that has gone into developing the modules. The contribution made by the Targeted Intervention (TI) and National Technical Support Unit (NTSU) Divisions of NACO for developing and coordinating with the various stakeholders to bring to fruition these training modules is also recognised. I am grateful to all the community leaders and members who have contributed to the development of the various chapters. I would also like to acknowledge the technical and financial support of UNDP in developing and printing these training modules. I would also like to acknowledge the State AIDS Control Societies (SACS), Technical Support Units (TSUs), State Resource and Training Centres (STRCs) for providing relevant input in the modules.

I hope that these training modules will help upgrade the skills of the frontline workers and thereby bring improvements in implementation in the TIs and in all spheres of MSM interventions.

(N.S. Kang)

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अपनी एचआईवी अवस्था जानें. निकटतम सरकारी अस्पताल में मुफ्त सलाह व जाँच पाएँ

# Abbreviations and Acronyms

AIDS	: Acquired Immuno Deficiency Syndrome
ANM	: Auxiliary Nurse Midwife
ART	: Anti Retroviral Therapy
CBO	: Community-based Organisation
DIC	: Drop-In-Center
FSW	: Female Sex Worker
HIV	: Human Immuno-deficiency Virus
HRG	: High Risk Group
ICTC	: Integrated Counselling and Testing Center
IDU	: Injecting Drug User
IPC	: Inter-personal Communication
LAP	: Lower Abdominal Pain
MSM	: Men who have Sex with Men
NACO	: National AIDS Control Organisation
NACPII	: National AIDS Control Programme Phase 2
NACPIII	: National AIDS Control Programme Phase 3
NGO	: Non-Government Organisation
NSEP	: Needle and Syringe Exchange Programme
ORW	: Outreach Worker
OST	: Oral Substitution Therapy



## Training Module for Peer Educators in MSM Interventions

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PE	: Peer Educator
PLHIV	: People Living with HIV/AIDS
RTI	: Reproductive Tract Infection
SACS	: State AIDS Control Society
SPYM	: Society for the Promotion of Youth and Masses
STI	: Sexually Transmitted Infection
TG	: Transgender
TI	: Targeted Intervention

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# Introduction

The prevention of new infections in High Risk Groups (HRGs) and in the general population is a major thrust in the National AIDS Control Programme (NACP). The most effective means of reducing HIV spread is through the implementation of Targeted Intervention (TI). The National AIDS Control Organization (NACO) and the states place a high priority on full coverage of High Risk Groups by TI projects.

This manual is intended as a resource for organizations working with this most-at-risk population. Initial training of peer educators and outreach workers on this resource is required, followed by periodic continuing education. A participatory learning approach is presented; the participants — whether peer educators or outreach workers — will have much to share. The objective of this training module is to benefit Peer Educators (PEs) of the TI projects. They are the ‘backbone’ of the project and it is their commitment and initiative that will go a long way in determining the successful outcome of the projects. Depending on your audience, you will pick and choose what is relevant in this resource to make your own training program. It is not necessary for a trainer to start at the beginning and work his way through the entire manual.

## Several assumptions have been made when developing this manual

- I) Some of the peer educators themselves will be low-literate. Outreach workers and trainers will need to walk with their peer educators through the various activities in “Tools for MSM Peer Educators” to ensure that they are both knowledgeable and comfortable presenting the material.
- II) MSM are hard-to-reach group where stigma, discrimination, harassment, and abuse all contribute to high at-risk sexual behaviour. Any activities that are conducted with MSM must be discreet. Thus, visuals that peer educators use are pocket-sized when meeting their peers one-on-one.
- III) The majority of MSM also have sex with women and may be married or have girlfriends in addition to having male partners.

This training module has been developed in response to the need felt to provide a comprehensive curriculum for training on Peer Education in MSM interventions. It covers a broad spectrum of content designed to develop and broaden the perspective of the participants on their role as Peer Educators. The focus of this training is on building the knowledge and skills of PEs.



## Scheduling

The module has been designed for a 4-5 days training workshop for MSM interventions. It is preferable that participants devote this time at a stretch in the training workshop. Each session has been planned with time for open discussion and sharing of experiences of the participants. Interactive methods such as group work, brain storming and games have been introduced at key places in the training package for better recall of core learning and to enliven the training process itself. This manual contains notes to help facilitators take the sessions.

## Before the Workshop

A training workshop needs extensive preparation and the facilitator should ensure that the same is done well in advance. The checklist below can help the facilitator to ensure the same:

Sr. No.	Particulars	Status (√ or ×)
1	Have read the manual and NACO Operational Guidelines	
2	Have thoroughly gone through the trainer's manual in preparation of the training	
3	Have ensured participation of PEs and ORWs (to especially support the PEs in understanding and completing planning, implementation and monitoring tools) by linking with TI projects	
4	Have prepared participants' take away package - Flipbooks (5)	
5	Have prepared all the materials (for games and exercises) required for the sessions	
6	Have linked with any local resource person required for the sessions (like PLHIV or doctor)	

## How to Facilitate

The workshop trainers or facilitators should be familiar with experiential and participatory forms of learning. They should have the ability to ask exploratory open-ended questions and should be sensitive towards involving all the participants especially given that the group is likely to be that of a varied profile.

The facilitators should be technically competent to answer various counseling related questions. Adaptations of the various topics may be made in order to suit local needs and priorities. While a range of devices such as brain storming games and such like have been provided in the manual itself. Facilitators could also go beyond these and include others such as debates and quizzes related to the session topics. It would be helpful to review the feedback forms on a daily basis so as to be able to respond to any significant issues such as lack of comprehension of important content or perceived lack of applicability, if any, on the topics and issues.

It will be important at all stages for participants to co-relate their classroom teachings with field level learning and vice versa.

## How to Use the Module

Each session provides the following information:

**Objective:** What the facilitator hopes to achieve by the end of the session.

**Expected Outcome:** The outcomes anticipated as a consequence of the session.

**Duration:** Approximate time each session will take.

**Methodology:** Teaching methodology and techniques that should be used.

**Materials/Preparation required:** Materials that are required to carry out the session, may include chart papers, marker pens, handouts, etc and any preparation that is required.

**Process:** The step-by-step instructions on how to implement the activities and run the sessions. This includes the detailed information, in the form of notes that the facilitator can use for the sessions.

In addition, daily feedback **forms** are provided at the end of each day. The facilitator should ensure that these are filled at the end of each day. If required, the facilitator should read out each session title in the feedback form to help illiterate PEs mark their feedback for the day appropriately.

A separate section on **Energizers** has been provided in the manual that the facilitator can use at her/his discretion.

## Workshop Take-aways

Participants will take away flip books that they can use as job-aids for one-one session at the field level with community members.

## Key things to remember as facilitator

### Dos

- Read the training module completely before the workshop.
- Be flexible. Scheduling may have to change depending on the need of the participants.
- Use different teaching methods to enhance participation and retain interest.
- Ensure all teaching materials like handouts, charts etc are available.
- Respect participants' local knowledge.

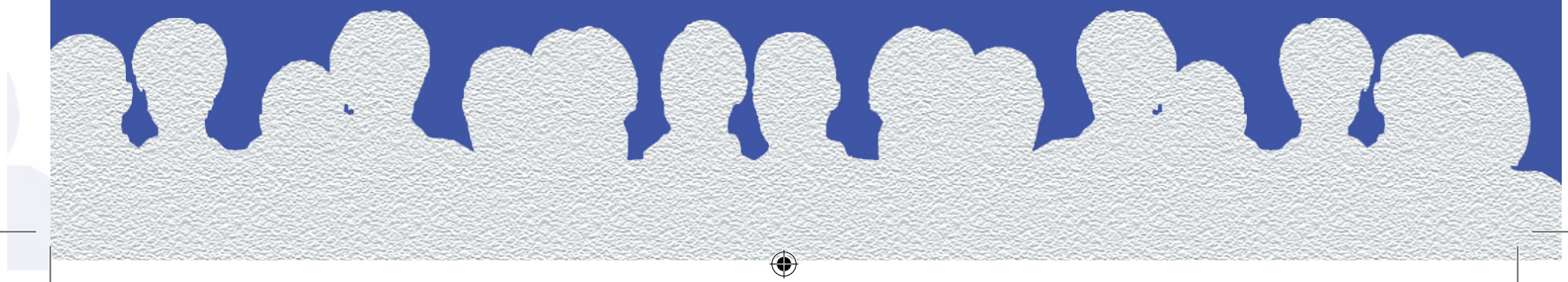


- Encourage peers to participate and make presentations.
- After the training, ensure that a follow-up plan is developed.
- Remember, this is a participatory workshop and your role is to FACILITATE!

### Don'ts

- Let any one person dominate the discussion.
- Speak more than the participants - let the participants brainstorm and discuss.
- Allow distractions like mobile phones and chatting between participants.
- Make the training a boring experience - intersperse the sessions with energizers.
- Read out from the Power Point Presentations-prepare yourself well and use the presentation slides as cue cards to elaborate on the relevant points.

# Day 1



## Day 1

Session Plan	Time	Duration
<b>Session 1: Starting Up (30 mins)</b>		
• 1a. Introduction	10:00 am – 10:10 am	10 mins
• 1b. Expectations and Sharing of Agenda	10:10 am – 10:20 am	10 mins
• 1c. Setting Ground Rules	10:20 am – 10:30 am	10 mins
<b>Session 2: Peer Education</b>		
<ul style="list-style-type: none"> <li>• 2a. Concept and Meaning of Peer Education</li> <li>- Presentation on Concept</li> <li>- Brainstorming –Advantages and Disadvantages of Peer Education</li> </ul>	10:30 am – 11:15 am	45 mins
<b>Tea/Coffee Break</b>	11:15 am – 11:30 am	15 mins
<b>Session 2 Contd.</b>		
<ul style="list-style-type: none"> <li>• 2b. Roles and Qualities of PEs</li> <li>- Case Study and Role Play</li> <li>- Brainstorming – Roles, Responsibilities and Qualities of PEs</li> </ul>	11:30 am – 12:00 pm	30 mins
<b>Session 3: Need and Importance of a PE</b>		
<ul style="list-style-type: none"> <li>- Film Screening</li> <li>- Discussion on issues Presented in Film</li> </ul>	12:00 pm – 1:00 pm	1 hr
Lunch break	1:00 pm - 1:45 pm	45 mins
<b>Session 4: Understanding the Community (2 hrs)</b>		
<ul style="list-style-type: none"> <li>• 4a. Understanding Risks and Vulnerabilities</li> <li>- Presentation – Risks and Vulnerability Factors</li> <li>- Group Work – Risk and Vulnerability Factor</li> <li>- Presentation by Groups</li> <li>- Group Work – Roles of PEs</li> <li>- Presentation by Groups</li> </ul>	1:45 pm – 2:45 pm	1 hr
<ul style="list-style-type: none"> <li>• 4b. Understanding Network</li> <li>- Contact Mapping – Explanation and Practice</li> <li>- Geographical and Social Networks – Concept</li> </ul>	2:45 pm – 3:45 pm	1 hr
<b>Evaluation of Day 1</b>	3:45 pm – 4:00 pm	15 mins

## Session 1: Starting Up

- a. Introduction
- b. Expectations and Sharing of Agenda
- c. Setting Ground Rules

<b>Session 1a</b>	Introduction
<b>Objective</b>	To help participants know each other and also the facilitator(s) and to create a comfortable ambience for learning
<b>Expected Outcome</b>	All the participants and facilitators will get introduced to each other
<b>Duration</b>	10 mins
<b>Methodology</b>	Game/Exercise
<b>Material/Preparation required</b>	As per the exercise mentioned below

## Process

- Welcome the participants to the 4-day training programme, thanking each participant for showing interest to participate in the training.
- Tell the participants that in the beginning they will try to know each other and then go ahead with the training programme. Explain that they will play a game and through that will get to know about each other.
- Choose an appropriate game/exercise given below and conduct it as per the instructions given.

### Game/Exercise Option 1 – Introduction in Pairs

**(Conduct if participants don't know each other or if the training is for mixed group from various organizations)**

- Make chits of paper with some symbols e.g. flowers, fruits, animals or some articles. There should be 2 chits of each symbol.
- Make enough number of chits considering the number of participants and put the chits in a bowl.
- Ask the participants to stand in a circle.
- Pass on the bowl of chits and ask each participant to pick up one chit.
- Give time for each participant to see the symbol on the chit and then identify the other person having a chit of the same symbol.
- Once the participants identify their partners, they should talk to the partner and get information about him or her. Information may include name the place from where they have come, the nature of work they are involved in, the number of years they are associated with the project, and hobby or expertise of the person.
- Give the pairs 2 minutes for this interaction.
- At the end of, 2 minutes, each pair comes in front and introduces each other to the group.



## Game/Exercise Option 2 – Family

(Conduct if the participants already know each other, or the participants are from the same organization who know each other for a long time)

- Make chits of paper with names of animal family e.g. if one of the animals is elephant, then there have to be 5-6 chits of elephants, one could be the mother elephant, one the father elephant, one the baby elephant, and so on, making up a family of elephants.
- Make enough chits considering the number of participants.
- Make the participants stand in a circle.
- Pass the bowl of chits and ask each participant to take one chit from the bowl.
- The participants should see the chit, and making the sound of the animal, then search for the other family members. All the participants of one family (e.g. elephant family) should come together.
- As the families come together, the facilitator may invite one family in front for introduction purposes.  
The head of the family will have to introduce herself/himself and the other members of the family by stating:
  - Who is that person in that particular animal family? (e.g. mother elephant)
  - What is his/her real name?
  - What type of work he/she is involved in, in the project?

Wind up the session by summarizing the game and its relevance to the current training:

- It is good to know each other before starting any work.
- This introduction will hopefully encourage all participants to interact more freely with each other both during sessions and after sessions.
- The group has become rich with the uniqueness of participating individuals. These qualities also help the project to move towards success.

<b>Session 1b</b>	Expectations and Sharing of agenda
<b>Objective</b>	To understand what the participants expect to get from this training workshop
<b>Expected Outcome</b>	List of expectations of participants
<b>Duration</b>	10 mins
<b>Methodology</b>	Discussion, sharing, listing
<b>Material/Preparation required</b>	2 chart papers, marker pens, agenda of the training programme



## Process

- Ask the participants: Why have they come here? What do they expect from coming here?
- Give an opportunity to each and every one to share their opinion.
- As they start sharing, jot down the expectations of the participants.
- While writing it on the chart paper, try to differentiate it between knowledge and skill.
- On one chart paper write about the knowledge-related expectations and on another the skill-related expectations.
- Read out all the expectations and inform the participants which expectations will be fulfilled in this training programme and which will be tackled later.
- Wind up the session by sharing the purpose of the training programme and reading out the agenda of the training programme.

Session 1c	Setting Ground Rules
<b>Objective</b>	To list down the rules to be followed during the training workshop. To help create a non-threatening atmosphere to stay and learn together
<b>Expected Outcome</b>	The list of ground rules to be followed by each and every one will be developed
<b>Duration</b>	10 mins
<b>Methodology</b>	Discussion, listing
<b>Material/Preparation required</b>	2 chart papers, marker pens

## Process

- By taking reference from the previous session, inform the participants that they are all going to stay and learn together the topics which have been shared in the previous session.
- For this it is important that they follow certain rules which will help make the learning process better for each one of them. These rules are to be decided by the participants themselves.
- Motivate the participants to share the rules which they should follow (e.g. no one should criticize another person, one is free to ask as many questions as one wants, mobiles should be kept on silent or switch off mode, all should follow time).
- Jot down the sharing by the participants.
- These will be rules to be followed during the training workshop.
- Take care that certain required rules are stated by the participants. If not, then put it forward first for discussion and if all agree, then make it a rule e.g. the sharing during the training workshop should be kept confidential.
- Sum up the session by reading out all the points and taking consensus of all the participants once again on the same.
- The chart paper on which the ground rules are written should be displayed on the soft board or the wall in the training hall. If required, the rules can be displayed visually too for the reference of illiterate PEs for e.g. no mobile usage maybe depicted as an image of a mobile with a cross on it.
- This display will remind the participants to follow the rules made by them.



## Session 2: Peer Education

- a. Concept and Meaning of Peer Education in TI
- b. Role and Qualities of PEs in TI

Session 2a	Concept and Meaning of Peer Education in TI
Objective	To help participants understand the meaning of peer education
Expected Outcome	Participants understand the terms 'Peer', 'Educator', 'Peer Educator' and 'Peer Education' and start thinking about themselves as peer educators
Duration	45 mins
Methodology	Discussion, explanation
Material/Preparation required	Chart paper, marker pens

## Process

- Ask the participants 'Who is a Peer Educator?' Encourage discussion.
- Share with the participants the meaning of peer, educator and peer educator.

### Peer

- A person from the same group e.g.
  - In a school set up - students may be the peers
  - In an industrial set up - workers may be peers
  - In a hospital set-up - doctors may be peers
- Similarly, MSM set-up-all men having sex with men are peers.
- Thus, a peer is a person who belongs to the same group and thus, understands the group and its issues better.

### Educator

- An educator is someone who provides education/information or raises awareness to bring about change.
- The education need not be formal education and can include one-to-one interactions too.

### Peer Educator

- PE is a person from the same group performing the role of educator for other members and working with her/his colleagues to influence attitude and behaviour change.
- A peer is someone who is similar to another person in a group to which he/she belongs. Peer educators share the characteristics of their peers.
- Thus, a MSM peer educator is someone who belongs to the MSM group and works with his group.

A PE in a Targeted Intervention (TI) project is responsible for providing information on STI, HIV/AIDS and harm reduction and promoting condom use and lubricants among peers, which ultimately results in building peer pressure for behaviour change.

- APE is also responsible for distributing condoms, lubricants.
- She/He provides basic data for monitoring the progress of the project.
- A PE is paid an honorarium as per NGO/CBO costing guidelines for her/his contributions to the TI project to reverse the epidemic in her/his community.
- A PE is responsible for understanding individual vulnerabilities and works with other members to address the vulnerabilities in order to ensure a healthy and productive life.

After the explanation put up 2 charts with the following headings:

- What are the advantages of peer education?
- What are the disadvantages of peer education?
- Let the participants freely express their thoughts and makes note on the chart papers.
- By the end of this exercise help the group to come to a consensus on the fact that peer education or community-led outreach is the best and most sustainable even though it has some drawbacks
- In Targeted Interventions peer educators play the most crucial role.
- Being community members they interact with their fellow colleagues and thus, due to their in-depth understanding of ground-realities they contribute to the programme.
- They act as a two-way link between the project staff and the community.
- They also develop life and job skills and thus attain self-esteem, self-respect and confidence.
- This enables them to reconstruct their identity, and the increased magnitude of self-esteem, self-respect and confidence of peer educators facilitates the process of community empowerment.
- Starting as a health educator, peer educators could gradually become a community mobilise, leader and thus the agents of social change.
- Wind up the session by revising all the important points of the concepts discussed and their relevance.

Session 2b	Roles and Qualities of Peer Educators
<b>Objective</b>	To help participants understand or perceive the role of peer educators
<b>Expected Outcome</b>	Clarity of participants on what they are supposed to do as a Peer Educator. This will ultimately help them to perform their role better
<b>Duration</b>	30 mins
<b>Methodology</b>	Role play, Listing <i>The trainer can decide to take this session separately or in conjunction with the previous session</i>
<b>Material/Preparation required</b>	Chart papers, marker pens



## Process

- By taking reference of a previous session (where the participants understood the meaning of peer education), inform the participants that in the next session they are going to think and discuss about the role of peer educator.
- Call 3 volunteers and share with them the following case study. Ask them to enact a role play on the case study.

### Case Study 1

A Peer Educator, who has been with the project for one year, and the concerned outreach worker meet a community member who has just been selected to be a peer educator. The new member wants to know the roles she/he has to perform that is explained by the older peer educator

*Give them 5 minutes for preparation.*

- At the time of role play, the co-facilitator will list the roles of a peer educator as reflected in the role play.
- After the role play gets over, read out the roles and responsibilities of peer educators which the co-facilitator has listed, and ask the participants to add any that they feel was not reflected in the role play.
- If any important point is missed out by the participants, put that up for discussion and include after acceptance by participants.
- Finalize the list of roles for peer educators and display it on the board. Use the list below for reference.

### Role of a Peer educator

- Peers are an interface between the MSM and the project team.
- Conducting outreach – As site managers, their main responsibilities are: To map MSM in their area of operation and regularly update this information.
- Maintain in regular contact with his/her own Network - 60 community members in case of MSM PEs (depending on the hotspot size +- 20).
- Contacting them on a weekly or bi-weekly basis within any given month.
- Able to meet all her/his contacts minimum once in 15 days and explain to them why is it important to contact them regularly.
- Providing dialogue-based IPC to community members—on STI, HIV/AIDS, condom.
- Usage & lubricant usage, etc. as and when required.

- Understanding each individual's vulnerabilities and plan, with the ORW, to address them.
- Encouraging service and commodity uptake –
- Motivating community members to come to DIC and explain why they should come to the DIC.
- Distributing condoms.
- Making referrals for sick community members.
- Identifying power structures, along with ORW and community, which have either positive or negative influence on the life of the community members. Advocacy with known power structures.
- Training of new PEs within the project and outside.
- Maintaining the DIC.
- Generating demand for welfare programmes and facilitating identification of beneficiaries.
- Regularly visiting condom depots together information and to improve service.
- Building skills of priority groups in understanding and assessing high risk behaviour and in condom use, condom negotiation, and identification of STIs etc.
- Attending review meetings.
- Preparing and presenting the daily reports to ORWs.
- Preparing reports for activities implemented.
- Attending all trainings, workshops and seminars.

(From NACP-IV– Operational Guidelines for Targeted Interventions)

- Then, taking the reference of the role plays generate a discussion on what should be the qualities of a peer educator. Make note of these on a chart paper.
- Suggest additions to the list, if required. Use the qualities listed below as reference.

## Qualities of a Peer Educator

- Makes himself-available in terms of time
- Is committed to the goals and objectives of the project
- Is sensitive to the values of community
- Is well connected to key influential persons in the community and accepted by his peers.
- Is a good role model (practices safer sex)
- Is professional while working and does not come on to (making advances to) his peers, or accept advances from them
- Is well-mannered and easy-going
- Is able to communicate clearly and persuasively in front of a group or one-on-one
- Is non-judgmental and sensitive to gender issues (facilitator could use this opportunity to discuss gender and gender-based violence)
- Is open-minded, Is tolerant and has Patience



- Participates in planning special events for MSM
- Can be trusted (guards secrets)
- Is accountable towards the community
- Is tolerant and respectful of others' ideas and behaviours
- Is a good listener
- Has good communication and interpersonal skills
- Is self-confident
- Has leadership qualities
- Is willing to learn and experiment in the field
- Is committed to being accessible to community members at times of crisis
- Has the ability to create a new cadre of peers and delegate/hand over responsibilities
- Shares responsibilities
- Motivates community members to take up responsibilities beneficial to the project

(From NACP IV – Operational Guidelines for Targeted Interventions)

## Wind up the session

- In a TI, PEs have set roles that they need to play in order to make a difference and bring about change.
- But the most important role is for PEs to build trust and establish credibility with the high risk group members she/he represents.
- PEs should have some basic qualities that will help them in their work. Those who don't have these qualities but are peer educators, should strive hard to imbibe these qualities as that will help in performing their roles better.

## TOR of a Peer Educator

### Recruitment Criteria

Criteria	<ul style="list-style-type: none"><li>• Preferably should be literate with good knowledge of the local community. eg, MSM and TG/Hijra community.</li><li>• The peer educator selection should be done through a process of peer progression among the volunteers who are associated with the project by way of helping in community sensitisation, clinic services.</li><li>• The peer educators should be from the community in terms of their occupation, typology and age groups.</li><li>• Stakeholders, pressure groups or members of power structures, family members of the target population should preferably not be engaged as peer educators.</li></ul>
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Knowledge and Skills	<ul style="list-style-type: none"> <li>• Should have strong communication skills and knowledge about community structures, community dynamics, power structures within and outside the community which controls the community.</li> <li>• Ability to work in small teams, and flexible ways of working</li> <li>• Ability to maintain simple field records and have attitude to work in a team to complete pending works.</li> <li>• Should be identifying with the issues of community</li> <li>• Should be a good community motivator and should have rapport building skills.</li> </ul>
<b>Functions/Key Results Expected</b>	
<p><b>Summary of Key Functions:</b></p> <p>The peer educator will be responsible for supporting the outreach team in planning of service delivery by the project. The peer educator would be responsible to identify individual or groups who are at risk of HIV/AIDS and their partners who require services including the networks. The peer educator will make inroads to these networks and motivate them to use condoms, recognise the need for regular medical checkup and visit to preferred providers or clinics, recognise the need for HIV testing and safe disposal of used condoms/needles and syringes. Will motivate the individuals or groups to improve their self-esteem and communities to access services and other social development benefits.</p>	
<p><b>Duties and Responsibilities:</b> Will be responsible for performing the following functions:</p> <p><b>Planning and Management</b></p> <ol style="list-style-type: none"> <li>1. The peer educator along with other project staffs would be responsible for preparing micro-plans, calculate demand analysis of various commodities.</li> <li>2. Prepare weekly/monthly action plan for each hotspot, ensure supply of needles/syringes, condoms, lubes, BCC materials adequately for each hotspot.</li> <li>3. Should discuss with the community members and other stakeholders in preparing micro plan ensuring that field level support is ensured for smooth implementation of the project.</li> <li>4. Should ensure follow up of STI cases, HIV positive cases, home visit to HRGs who have not turned up for RMC or HIV testing.</li> </ol> <p><b>Advocacy and Networking</b></p> <ol style="list-style-type: none"> <li>1. Will discuss and rope in support of the stakeholders in smooth implementation of the programme in the area.</li> <li>2. Will be working with various power structures within and outside the community and would ensure their effective participation in the programme.</li> <li>3. Will identify and use preferred providers for delivering the project services after due training by SACS or DAPCU or TSU.</li> </ol> <p><b>Commodity Supplies and Management</b></p> <ol style="list-style-type: none"> <li>1. Will support the ORW will maintain records of free condoms or needles and syringes or lubes received from the project and distributed by self or peer educators.</li> </ol> <p><b>Reporting:</b></p> <ul style="list-style-type: none"> <li>• Provide data/information required for preparation of reports.</li> </ul>	
<p><b>Training Requirements:</b></p> <ul style="list-style-type: none"> <li>• Micro plan preparation and updating, Condom demo-re-demo, Basics of STI and HIV/AIDS, Basics of peer education, outreach planning tools, advocacy and networking, from the field.</li> </ul>	
<p><b>Norms:</b> For, FSW and MSM TIs = 1: 60 HRGs, For TG/Hijra Tis = 1: 40 HRGs</p>	





### Session 3: Need and Importance of a Peer Educator (Film Screening)

Session 3	Need and Importance of a Peer Educator (Film Screening)
<b>Objective</b>	To instill motivation that PEs can make a difference in the lives of their peers. To introduce the topic of peer education, including the job of a peer educator.
<b>Expected Outcome</b>	Participants are inspired towards passion and commitment to their work Participants reflect on the challenges faced by a peer educator and arrive at possible ways of dealing with them.
<b>Duration</b>	1 hr
<b>Methodology</b>	Screening of film, Discussion. <i>This film is set against a brothel setting and is most suitable for training <b>FSWPEs</b>.</i> <i>For training <b>MSM PEs</b>, the facilitator may choose to screen this film but needs to revolve the discussions around MSM issues. Alternatively, the facilitator may choose to screen any other film made specifically for MSM peer education.</i>
<b>Material/Preparation required</b>	Film 'Kamla Didi and the Making of a Peer Educator', projector and screen.

## Process

- The facilitator should screen the film that captures the role of PE and the challenges faced at the field level, inspiring PEs to work for their 'peers'.
- It should be screened in one stretch first. For the sake of discussion, the film can be screened again in parts where the facilitator can stop at crucial junctions to generate discussion, if required.
- Discussion to be generated around:
  - What are some of the issues portrayed in the film?(community members getting irritated about regular PE visits, need for repeating key messages on safer sex, selecting a good PE, roles and qualities of a PE, role of PE in addressing other issues faced by community members, collectivization, etc.)
  - Do these issues occur at the field level?
  - How do we face such challenges as PEs ? Did Kamla handle the situation appropriately? Could she have done something different to handle the situation?
  - What are some of the key qualities of a good PE reflected by Kamla?
  - What other issues, not covered in the film, can a PE face at the field level? What are some of the solutions to tackle these issues?
- The facilitator should end by emphasizing that the issues screened in the film can be discussed over the next four days across many sessions.



#### Session 4: Understanding the Community

- a. Understanding that MSM are not the same
- b. Understanding Risks and Vulnerabilities
- c. Understanding Networks

Session 4a	Understanding the Community
Objective	To gain a better understanding of the participants that MSM are not the same
Expected Outcome	Participants will have clarity on MSM Profiles
Duration	1 hour
Methodology	Group Discussion

### Process

- Pass out the eight MSM profiles to participants who you know are literate and will be able to read the profiles out loud. Give the participants you have chosen a minute to read the profiles to them, and then ask each of them to read them out loud. Do not allow discussion until all of the participants have read their profiles to the group.

### Questions

- What observations can you make from the profiles of MSM you have just heard?
- Would you consider all of these men MSM?
- Could we label any of them with another name? (Bi-sexual, transsexual, heterosexual)
- Why do some MSM also have sex with women?
- Do you think the majority of MSM in India are married?
- As a peer educator, would you be comfortable speaking with each of these MSM? Why or why not?
- Why do men have sex with men? (Desire, love, money, gifts, protection, unavailability of women, forced)

Next, ask if any participant would like to share his profile with the group. Ask the participants who shared their profiles how they felt. Were any of them hesitant to share their profiles based on how their peers might react or think of them? Close this activity by stressing the importance of peer educators accepting their peers for who they are, and not being judgmental if the peers are different from what they think a MSM should be. Who are MSM?



## Session 4b: Understanding Risks and Vulnerabilities

Session 4b	Understanding Risks and Vulnerabilities
<b>Objective</b>	To make participants understand the risk and vulnerability factors involved in MSM behaviour and the distinction between the two
<b>Expected Outcome</b>	Participants will have clarity on factors that lead to vulnerability towards STI and HIV/AIDS and will learn several risk and vulnerability reduction strategies
<b>Duration</b>	1 hr
<b>Methodology</b>	Discussion, Group Work, brainstorming
<b>Material/Preparation required:</b>	Chart papers and marker pens

### Process

- The facilitator should now generate a discussion among participants on what makes MSM more vulnerable to STI and HIV infection.
- Start by first explaining, with examples, what are risk factors and what are vulnerability factors

### HIV/AIDS

**a. How it spreads:** HIV spreads through the following routes:

- Blood—through infected blood given to an uninfected person. It also spreads through sharing of needles
- Through unprotected sex—where body fluids are exchanged. All sexual acts are not risky
- Through infected mother to child—at the time of delivery if some injury takes place, through umbilical chord, through breast milk (where risk is low). The risk of other infections for the body is much higher than the infection through breast milk

**b. How it doesn't spread:**

- If the needles are used once and disposed (new for each person, each time), or used after boiling for 20 minutes
- If proper precautions are taken before and at the time of delivery of HIV positive woman
- And by so many other things like eating with positive people, swimming with them, shaking hands, sneezing, sharing clothes, utensils etc. with them

**c. Prevention:**

We can prevent ourselves from getting infected by above mentioned ways (i.e. by using disposable or sterilized needles, by taking precautions during delivery to prevent the child from being HIV positive), but in addition to that 100% correct and consistent condom use is the best way to prevent HIV infection. Sex workers/MSM are prone to the infection because of the nature of their work.

Project can also help community members who are HIV+ to access care and support services provided by voluntary organizations.

**d. Complications:**

- Many times when a person is HIV positive, the immunity of the white blood cells, which are the protective cells of our body, goes down. Because of less immunity, there are many infections which the body catches fast. These infections are called as Opportunistic Infections or OIs.
- Because of HIV infection when the body's immunity reduces and a group of infections plague the body, then that situation is called AIDS. It is generally said that it takes 8-10 years from getting infected to reaching the stage of AIDS, but this period changes from person to person.

**e. ART:**

- i. ART is Anti Retroviral Therapy
- ii. This is a treatment given to HIV positive people to control the spread of infection
- iii. These medicines are not a cure from HIV but it restricts the replication of virus in the body
- iv. These medicines are to be taken regularly by the patients and are to be taken on doctors suggestions
- v. Once the medicines are started, a person has to take it lifelong
- vi. Generally these medicines are very costly, but in government hospitals these are given free of cost

## Risk Behavior

It is a particular behaviour that puts some one directly at risk of RTI/STI or HIV/AIDS infection. Main risk factors are:

- Unprotected anal, vaginal or oral sex

## Vulnerability Factors

Vulnerability factors are those that make risk behaviour more likely and which therefore put someone indirectly at risk of STI/HIV infection. Examples of vulnerability factors are:



- Having group sex
- Being poor (and so may have sex without condom for more money,)
- Being female (and so maybe prone to violence and forced sex without condom use)

The most important distinction between risk and vulnerability factors is that vulnerability factors in themselves do not lead to HIV infection. They may just lead to increased chances of risk behaviours. Some more examples of vulnerability factors for specific HRG.

### **Vulnerabilities of MSM**

- Goonda and other harassment
- Lack of financial resources
- Substance abuse
- Number of partners
- Dependence on Regular partner etc.

Then, divide the participants in to sub-groups. Give each group 1 typology of MSM. E.g. kothi, panthi, double decker etc.

- Each group has to note down all risk behavior and vulnerability factors specific to that HRG typology.
- Examples for Kothis is provided below for reference:

### **HRG and Typology: Kothi (MSM)**

#### **Risk behavior/s:**

- Unprotected anal and oral sex

#### **Vulnerability Factor/s:**

- Fear of exposure and so quick encounters that may be high risk
- Unavailability of condoms in urinals/bus stands etc. where these quick encounters take place
- Exposure to violence goons etc

Motivate the participants to brain storm and list as many points as possible. These factors may increase the risk of MSM towards STI or HIV/AIDS directly, or may increase vulnerability by indirect means. (Make sure one person who can write is present in each group).

- Ask one participant per sub-group to share the list with the larger group. Encourage larger group to add- on any risk behavior or vulnerability factors missed out.

- Now ask the participants, that after listing down the risks/vulnerability, what strategies according to them will reduce the risk/vulnerability and what should their role as PEs be towards it. This should be noted next to each risk behavior and vulnerability factor on the chart paper.

HRG and typology (Kothi)	
<b>Risk Behaviour/s:</b> <ul style="list-style-type: none"> <li>– Unprotected anal and oral sex</li> </ul> <b>Vulnerability Factor/s:</b> <ul style="list-style-type: none"> <li>– Fear of exposure and so quick encounters may be of high risk</li> <li>– Unavailability of condoms in urinals/bus</li> <li>– Exposure to violence goons etc</li> </ul>	<b>Role of PEs - Risk Reduction strategies</b> <ul style="list-style-type: none"> <li>– Encourage correct and consistent condom use for all types of sex</li> <li>– Provide adequate number of condoms and lubricants</li> <li>– Do condom demonstration and get re-demo done</li> <li>– Establish condom depots at crucial points stands etc. where these quick encounters like urinals, bus stands, etc. take place</li> <li>– Work with group to increase self-acceptance on their sexual identity</li> <li>– Encourage Kothis to look-out for each other when they solicit. Form small support groups for this if required</li> </ul>

Once the group work is done, invite one group to come up and share their discussion with all the participants. Encourage additions from other participants and address doubts, if any.

- Wind up the session by briefing that:
  - Without understanding and addressing risk behaviors and vulnerability factors, behavior change is not possible.
  - Only when vulnerabilities are addressed do people respond favourably to knowledge and information.
  - Thus, as PEs it is important to understand, accept and address vulnerability factors.



## Session 4c: Understanding Network

Session 4c	Understanding Network
<b>Objective</b>	To help peer educators understand types of network to reach out to HRGs To help peer educators plan by mapping their contacts
<b>Expected Outcome</b>	Clarity among PEs about types of network PEs map contacts and plan for outreach based on these contacts
<b>Duration</b>	1 hr
<b>Methodology</b>	Presentation of concept, Discussion, Practice of tool
<b>Material/Preparation required</b>	Chart papers and marker pens

## Process

- Inform the participants that now they are going to discuss the types of network that are important for both PE selection and for planning outreach.
- Give instructions for each PE to complete the Contact Mapping Exercise.

## Contact Mapping

**Aim:** Map contacts with MSM in each spot and plan for outreach based on these contacts.

**Frequency:** Every month to ensure both new and continuing MSMs in each spot are being reached.

### Guideline:

- Draw a map of the town and mark all the locations (including landmarks) and spots in the map. Write the number of MSM in each spot.
- Give a colour code to each of the ORWs and PEs.
- Using different colour codes, mark the number of MSM on each ORW and PE knows in the spot.  
For e.g. Assign the colour red to PE Raj and mark all his MSM contacts in each spot using red.
- Then for each spot list the names of contacts – PE and ORW wise.

If any PE is unable to write, ask an ORW to help her/him make note of all her/his contacts.

## Training Module for Peer Educators in MSM Interventions

District:		Targeted Intervention (TI) area:			
Name of Town:		Date:			
Estimated Number of MSMs in the town:		Contacted Number of MSMs in the town:			
Sl. No.	Name of Spot	PE1 Number of contacts	PE2 Number of contacts	PE3 Number of contacts	PE4 Number of contacts
1					
2					
3					
4					
5					
6					
7					
8					
Total					

District:		Targeted Intervention (TI) area:			
Location:		Spot:		Date:	
Estimated Number of MSMs in the town:		Contacted Number of MSMs in the town:			
Sl. No.	PE1 Name of contacts	PE2 Name of contacts	PE3 Name of contacts	ORW1 Name of contacts	ORW2 Name of contacts
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
No. of contacts that are known very well:					
No.					

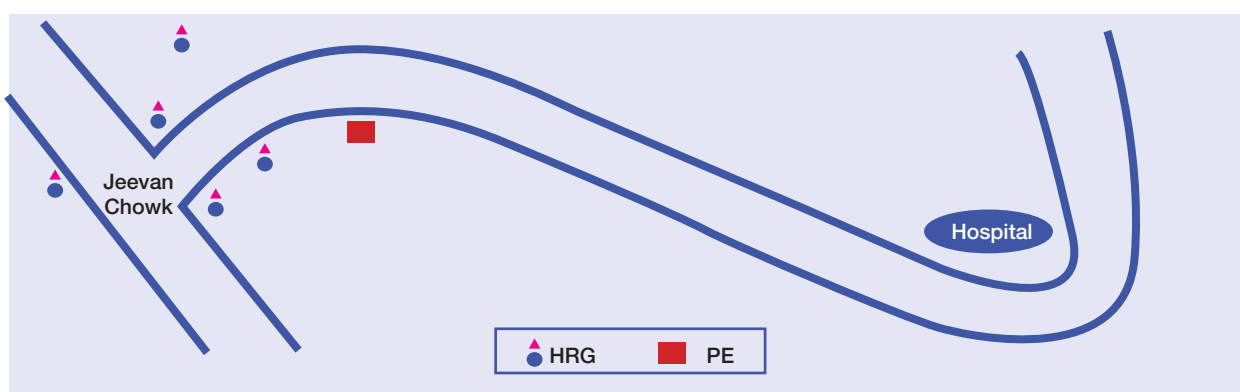


As one discusses the reasons for low outreach contact, introduce the topic of geographical and social Networks.

**Geographical networking** is defined as networking/reaching HRGs within a fixed geography. Using this concept, a PE is given the responsibility of reaching all the HRG members that are operating in a particular geography irrespective of his rapport or relationship with them. This in practical terms means that the peer has to go and make friends with all the HRG members in the particular spot (geography) irrespective of age, time of operation, etc. For this he may have to work beyond his normal sex work times, make an effort to meet the women/men or get introduced another way.

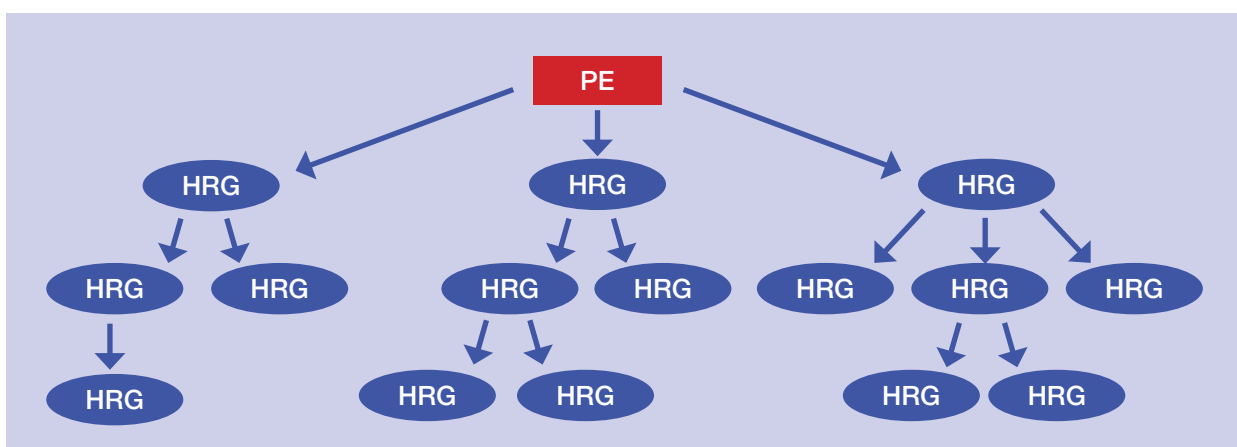
Colour code the contacts that are common in more than one list.

- Discuss the following:
  - In which spot are the contacts limited?
  - Where is outreach not happening? How do we increase outreach?
  - Who are the contacts in each spot? Whom is the project not reaching?
- Remember: Contacts may not be mutually exclusive—the same community member maybe counted twice



**Social networking** is defined as networking/reaching HRGs within a social circuit. Using this concept, the PE is given the responsibility of reaching out to his friends irrespective of a defined geographical area. This in practical terms may mean that the peer may have to travel to several spots, do his work and also work for the project. The project may have to appoint more than one peer in one spot/ geography.





Encourage the participants to discuss advantages and disadvantages of both networks.

\* Summarize the discussion as under:

- Both networks are important to consider in selecting peers as well as in planning outreach.
- Peer selection depends on the situation and either combination of both strategies may need to be used. In the early stage of the project social network may be more efficient even though it is time consuming.
- Once all the social contacts of each peer/volunteer are introduced to the project and the rapport is built by each peer with others in her group, the project should move to geographic networks.
- The project should decide which one to adapt and determine this based on the project needs and reach at that time.

## Evaluation of Day 1

Date:

Participant's Name (Optional):

Session	Particulars	Feedback			Remarks*
		Good	OK	Poor	
	Overall response to today's session				
1a	Introduction				
1b	Expectations and Sharing of Agenda				
1c	Setting Ground Rules				
2a	Concept and Meaning of Peer Education in TI				
2b	Role and Qualities of PEs in TI				



3	Need and Importance of a Peer Educator (Film Screening)				
4a	Understanding MSM community				
4b	Understanding Risks and Vulnerabilities				
4c	Understanding Networks				

Any other comments

\*Please comment on duration, content, methodology and visual aids



# Day 2



## Day 2

Session Plan	Time	Duration
<b>Recap of day 1</b>	10:00 am – 10:15 am	15 mins
<b>Session 1: Outreach and Outreach Planning (2 hrs)</b>	10:15 am – 11:15 am	1 hr
• Introduction on Outreach and Outreach Planning		
• Broad Mapping		
<b>Tea/Coffee Break</b>	11:15 am – 11:30 am	15 mins
Session 1 Contd.	11:30 am – 12:30 pm	1 hr
• Spot Analysis – Explanation and Practice		
• Hotspot Load Mapping – Explanation and Practice		
<b>Session 2: Sexually Transmitted Infections (1 hr 30 mins)</b>	12:30 pm – 1:30 pm	1 hr
2a. Body mapping		
2 b. Understanding Sexually Transmitted Infections		
• Presentation on Concepts		
• Discussion		
<b>Lunch Break</b>	1:30 pm – 2:15 pm	45 mins
<b>Session 2 Contd.</b>		
2c. Role of PEs in Prevention and Control of STI	2:15 pm – 2:45 pm	30 mins
• Discussion – Reasons for Untreated STI		
• Group Work – Role of PEs		
Presentation of Group Work		
<b>Session 3: Positive Prevention and Referral to ICTC and ART</b>	2:45 pm – 3:45 pm	1 hr
Introduction to Concept		
Brainstorming – Need for Positive Prevention and Issues therein		
Brainstorming – Services for PLHIV		
Discussion – Referral to ICTC and ART		
<b>Evaluation of Day 2</b>	3:45 pm – 4:00 pm	15 mins

## Session 1: Outreach and Outreach Planning (Spot Analysis, Hotspot Load Mapping)

<b>Session 1</b>	Outreach and outreach Planning
<b>Objective</b>	To help the participants appreciate the importance of understanding the situation in the field and planning their work accordingly
<b>Expected Outcome</b>	The participants will have clear understanding of mapping of various field situations for planning their work
<b>Duration</b>	2 hrs
<b>Methodology</b>	Discussion, Mapping, Presentation, Explanation
<b>Material/Preparation required</b>	Chart papers, markers, bind is of various colours and various shapes For this exercise the presence of ORWs is essential. The facilitator should ensure that 1ORW is present to work with a group of 6-8 PEs during group work exercises

## Process

- In the beginning tell the participants that it is important to study and understand the field situation and how to plan work accordingly if outreach has to be successful.
- Discuss the need for outreach and outreach planning.

**Outreach:** It is a systematic approach of delivering STI and HIV/AIDS prevention services to High Risk Groups. The overall objective of outreach is preventing transmission of STI/RTI, HIV/AIDS and other blood borne viruses (specifically among IDU populations) among HRGs.

### Outreach includes:

- Contacting HRG community members
- Building rapport with them
- Providing them with information and services/materials that could prevent the spread of STI and HIV/AIDS among them
- Linking them with health and other services

### Outreach Planning

It is a process using various tools that facilitate individual level planning and follow up of service uptake, based on individual risk and vulnerability profiles of HRG community members.



### Benefits of Outreach Planning include:

1. Defined area of operation for PE – duplication of effort and diffusion of responsibility is avoided when a site is demarcated and responsibility for that site rests with an individual PE.
2. Repeat visits for monthly screening – The PE is able to monitor clinic visits for monthly screening in the given site.
3. Individual tracking – The PE can track how many HRG members are being reached during a given month for various services (clinic/camp attendance, one to one sessions, contacts, group sessions, and condom distribution).
4. Collecting, analyzing and acting upon data – Using the PE daily activity report, the PE is able to generate data and use it to provide minimum services to all HRGs in her/his site.
5. PE becomes the site manager – PEs decide and budget for activities to be conducted in their sites and take responsibility to ensure service provision to all HRGs in their site.

Divide the participants into groups of 3 or 4. You may continue to use these same sub-group divisions for all exercises or re-do group divisions for each exercise.

- Ask participants to prepare a map of the area where they work. Provide chart papers and coloured markers and various types of bindis to each group.
- Ask the participants to draw on the chart paper the area where they work and include in it roads and important places nearby like school, hospital, tree, some shops, beer bars etc.
- After they complete this drawing ask them to mark the areas where the HRGs are located (MSM) and also make note of how many are located in each spot. For e.g. If it is a site for MSM, like a public urinal, then they will have to make note of how many MSM are there.
- Along with making note of the areas and the number of HRGs, ask the participants to also note the timings when the HRGs are found in that area.
- This is a broad mapping of the area that each PE works in. Tell the participants that this is just one of the tools they can use for their work.
- Next, one by one discuss the various tools that can be used by the PEs to understand the field and plan their work.
- First explain spot analysis - the objective and the process to be followed in using the tool.

### Spot analysis

**Aim:** Compile information collected during urban situation and needs assessment related to each high- risk spot/site in project areas to facilitate planning.

**Frequency:** Every six months since ground realities may change.

**Guideline:**

The following spot-specific information should be available to develop a plan for the spot:

- Volume of client–high volume (more than 10 clients/week), medium volume (5-9 clients/week), low volume (less than 4 clients/week)
- Typology of MSM – Kothi, double deckers, etc.
- Age of MSM – below 20 years, 20-40 years, above 40 years
- Time of operation–morning (6am–10am), afternoon (10am–2pm), evening (2pm–8pm) and night (8pm – 6am)
- Frequency of operation – daily, weekly, monthly

The following should be kept in mind:

- Volume of client–Planning should ensure that MSM with higher volume of clients are reached as a priority.
- Typology– Planning should include typology of MSM and needs to be specific to each type.
- Age–MSM needs differ with respect to age therefore planning should address that.
- Time/day of operation–Understanding the time and day of operation will help plan outreach with respect to those times. For example, there are certain days in a month when more MSM come to a particular spot such as a market. During those days of the month, the outreach needs to be strengthened.

Similarly, evenings and nights may be very busy in certain spots. Hence, the project needs to ensure that outreach is planned during those times of the day.

After the brief, encourage the groups to practice using the tool. The participants can use flipcharts, marker pens and bindi for the same.

- After completing the tool, one of the groups is encouraged to make a presentation to the larger group.
- Encourage discussions on:
  - What was the process followed by the group?
  - What is the outcome of the exercise?
  - How does this exercise help in planning outreach?
  - What are the common mistakes while completing this tool?
  - What consequences do these mistakes have?
- Then discuss the next tool – Hotspot Load Mapping.

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## Hotspot Load Mapping

### Aim

- Understand the gap between estimates of MSM, the number of unique contacts and the number of regular contacts by studying the MSM load in a day, a week and a month in different hotspots.
- Also get information on the potential regular contacts: the potential number of MSM a TI team can contact in a month.

### Guideline

- Draw a map of the TI area clearly depicting the MSM (the hotspots at which MSM pick up/solicit their clients) in the area.
- Colour code the hotspots based on MSM typology such as Kothi, double deckers., etc.
- Write down besides each hotspot, the number of MSM who are always available on a normal day.
- Next write the number of MSM available at these hotspots in a week.
- Make note of any specific days in a week when the number of MSM available peaks and reasons for the same e.g. More MSM available on a market day.
- Once the above exercise is done, mark the number of MSM available in these hotspots on a monthly basis and specific days in a month where the turnover is high and the reasons for the same e.g. More MSM are available on pay day.
- Add the daily, weekly and monthly turn over in all the hotspots and draw up a picture of MSM turnover in a TI area.
- Compare these figures with their estimate, unique contact and regular contact figures for these sites and analyse the following:

Hotspot: .....  
 Town: .....  
 Date: .....

● Hotspot
D-Daily
W-Weekly
M-Monthly
# No. of Sex Workers



- Are the total MSM available in these hotspots/TI area more or less than the unique contact and regular contact? Why?
- Is there a link between the MSM not contacted and the typology ? Which typology is left out of outreach most often?
- Is high weekly and monthly turn over linked with any specific typology of MSM e.g. is there a high turnover seen in mostly Kothi? Why?
- Are the MSM from outside the area?
- Are there specific sites where unique contact and regular contact is less than monthly turnover? Why?
- Which are the hotspots (and typology of MSM) that need focused outreach in the TI area? Who (outreach team) is responsible for these specific hotspots? What should they do to improve outreach to ensure higher contacts?

After the brief, encourage the groups to practice using the tool. The participants can use flipcharts, marker pens and bindi for the same.

- After completing each tool, one of the group is encouraged to make a presentation to the larger group.
- Encourage discussions on:
  - What was the process followed by the group?
  - What is the outcome of the exercise?
  - How does this exercise help in planning outreach?
  - What are the common mistakes while completing this tool?
  - What consequences do these mistakes have?

## Session 2: Sexually Transmitted Infections (STI)

- a. Body Mapping Exercise
- b. Understanding about Sexually Transmitted Infections
- c. Role of PEs in Prevention and Control of STI

<b>Session 2a</b>	Body Mapping Exercise
<b>Objective</b>	Enable HRGs to explore STI and HIV vulnerability factors relating to the body. To increase awareness of one's body and its erotic zones, and to increase comfort with speaking about different parts of the body related to sex
<b>Expected Outcome</b>	The participants will be able to understand the level of HIV transmission risk for different sexual activities
<b>Duration</b>	1 hour and 30 minutes
<b>Methodology</b>	Group work, Group discussion and brainstorming
<b>Material/Preparation required</b>	Flipcharts, tape and markers
<b>Preparation</b>	Make copies of the Anatomy "Male and Female Sex Organs" – to be used as handouts

## Process

Divide the participants into two groups. Give each group several pieces of flipchart paper, some tape and markers. Explain to each group that you want them to draw a picture outline of a man and a picture outline of a woman. The groups may find it easier to ask someone to lie down and then trace their outline. Now ask the participants to label all possible parts of the body that can be used for sex between a man and a woman and between a man and a man. Ask them to either draw these directly onto the drawings or to draw them on pieces of paper and then stick them on. When the groups have completed this task, ask each group to explain what they have drawn on the bodies and why. Encourage others to ask questions about the drawings and to make any comments. Explain or clarify any body part listed and its function. Refer to the Trainer's Notes at the end of this activity and make sure the participants have included the parts listed.

Next ask and discuss the following questions:

## Discussion Questions

1. Why do you think we are discussing women as well as men in this activity? (Note: it is important for participants to be aware that many MSM will also have sex with women and are married or will get married. For this reason, peer educators will also need a clear understanding of a woman's body and sexuality in order to answer questions that may arise.)



2. How is a man sexually stimulated? How is a woman sexually stimulated? (Note: write the answers on a flipchart which will also be used in the next activity, and make sure the participants understand each one. Make sure the acts listed in the Trainer's notes at the end of this activity are included in the list.)
3. Are there other words that you use or have heard that describe these acts? (Note: write these words on the flipchart next to the appropriate act.)
4. Address the importance of having choices about sexual practices and erotic stimulation, particularly related to HIV/AIDS prevention. Pass out the "Anatomy of Male and Female Sex Organs" information sheet at the end of this session.
5. Ask which sexual practices can cause STI/HIV risk? The degree of risk against each. (High, Low or No risk)?
6. Following this, the community members need to discuss options for safer sex that are available, particularly non-penetrative sex.

**TRAINER'S NOTE:** Parts of the Body that can be used for enetrative and non-penetrative sex: penis, mouth, urethral opening (man and woman), testicles, scrotum, vagina, labia, vulva, clitoris, buttocks, anus, breasts, nipples, thighs. Examples of acts that sexually stimulate men and/or women: kissing, hugging, oral sex, rimming, touching/caressing, nipple stimulation, masturbation and mutual masturbation, rubbing and pressing bodies together, massage, fingering, fisting, thigh sex, breast sex, foot sex, anal sex, sex toys, watching videos, internet sex.

## Session 2b: Understanding about Sexually Transmitted Infections (STI)

<b>Objective</b>	To give basic information on STI to the participants. To overcome myths and misunderstandings related to STI.
<b>Expected Outcome</b>	The participants will get information on types of STI, signs and symptoms of STI, transmission and treatment of STI and relation between STI and HIV.
<b>Duration</b>	1 hr
<b>Methodology</b>	Discussion, Presentation, Explanation
<b>Material/Preparation required</b>	Picture cards–STI (back to back printing), chart papers and marker pens. As this is a technical session, if required, the facilitator can arrange for a doctor as a resource person.

## Process

**Note:** Use local terminologies as much as possible which will help participants understand or learn the content.

- In the beginning ask the participants if they have any questions in mind about STI or any experience related to it which they would like to share.
- After collecting the questions or listening to the situations, share with the participants, the important points related to STI which will be covered in this session. Discuss in detail each of the topics.
- Ask the participants if they have any doubts. Try to address all doubts.

The prevalence of STI amongst MSM is high. The factors responsible for the high rate of STI are low level of knowledge and information about STI among MSM. In addition to this problem, there are a lot of myths and misconceptions about STI in these communities. Moreover many of MSMs being illiterate are not able to understand scientific and technical information, therefore are uninterested to know about STI. Considering the above issues, it is very vital to disseminate proper information on STI and its symptoms amongst male and females.

## Meaning of STI

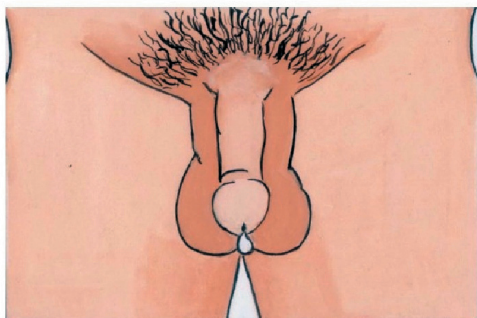
STI means sexually transmitted infections. These are caused by virus, bacteria, or fungal micro organisms, which are passed through unprotected sexual intercourse with an infected partner.



## Symptoms of STI (use Picture cards)

### STI in Males

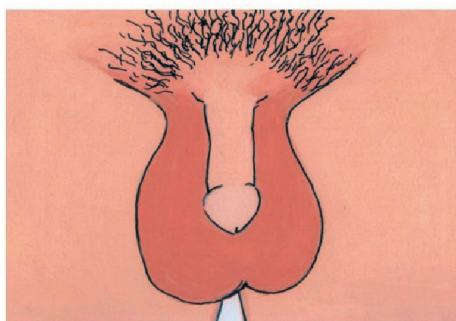
#### URETHRAL DISCHARGE



#### URETHRAL DISCHARGE

- Pain or burning while passing urine
- Increased frequency of urination
- May be cream or yellow coloured discharge coming from urine passing hole
- Discharge may be thick or thin like mucus

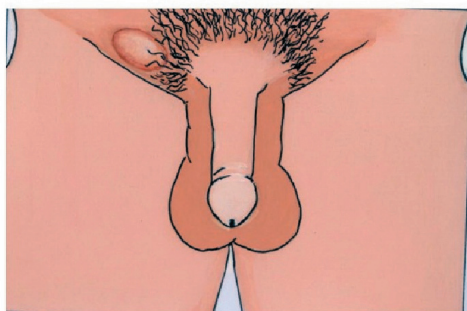
#### PAINFUL SCROTAL SWELLING



#### PAINFUL SCROTAL SWELLING

- Swelling and pain in the scrotal region
- Pain or burning while passing urine
- Systemic symptoms like malaise, fever
- History of urethral discharge

#### INGUINAL BUBO

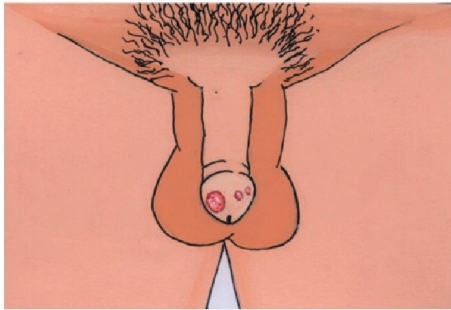


#### INGUINAL BUBO

- Swelling in inguinal region which may be painful
- Preceding history of genital ulcer or discharge
- Systemic symptoms like malaise, fever



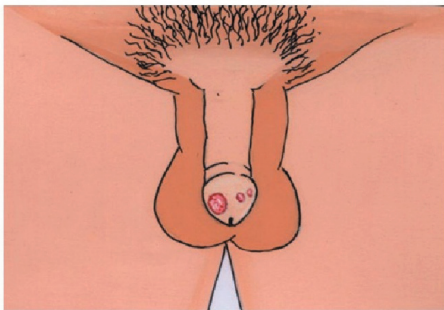
### GENITAL ULCER – NON-HERPETIC



### GENITAL ULCER – NON-HERPETIC

- Genital ulcer; single or multiple, painful or painless
- Burning sensation in the genital area
- Enlarged lymph nodes

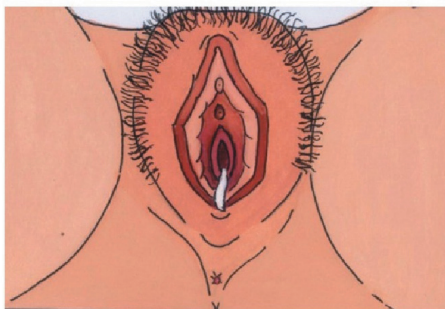
### GENITAL ULCER – HERPETIC



### GENITAL ULCER – HERPETIC

- Eruption of vesicles, painful, multiple genital ulcer
- Burning sensation in the genital area
- Recurrence

### VAGINAL DISCHARGE



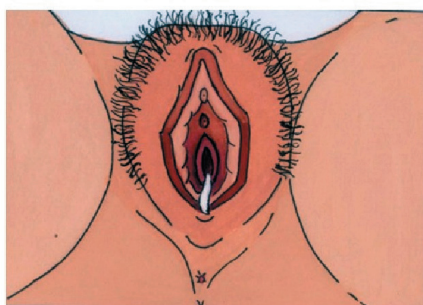
### VAGINAL DISCHARGE

- Vaginal discharge (cheese, white)
- Nature and type of discharge – quantity, colour and odour
- Itching around genitalia



## Female STIs

### CERVICAL DISCHARGE



### CERVICAL DISCHARGE

- Yellowish discharge with bad odour
- Nature and type of discharge – quantity, colour and odour
- Burning while passing urine, increased frequency

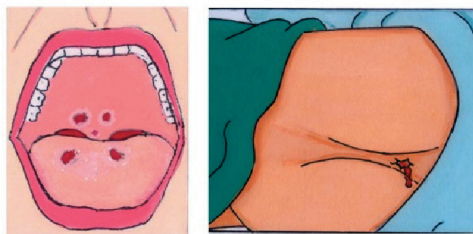
### LOWER ABDOMINAL PAIN (LAP)



### LOWER ABDOMINAL PAIN (LAP)

- Lower abdominal pain
- Fever
- Vaginal discharge
- Menstrual irregularities like heavy, irregular vaginal bleeding
- Pain during bleeding
- Lower backache
- Cervical motion tenderness

### ORAL AND ANAL STI



### ORAL AND ANAL STI

- Ulcers, sores, blisters, discharge, growth at oral and/or anal regions



### OTHER STI

- Warts (single or multiple, soft painless growths which look like a cauliflower)
- Molluscum Contagiosum (multiple, soft, painless smooth, pearl like swellings)
- Genital Louse Infestation (itching, leading and scratching which may be limited to genital area all over the body)
- Genital Scabies (itching of genitals, especially at night)

## Transmission and prevention

Most of the time STIs are commonly transmitted through sexual intercourse. Diseases like syphilis, Hepatitis B, HIV etc. may be transmitted through infected blood transfusion or by using infected needles and syringes. However, most of these can be easily prevented by taking appropriate measures. Screening the blood for these diseases is one of the important steps.

## Treatment

STI must be treated as early as possible. Most STI are completely curable (except HIV and Hepatitis). It is important to go to a qualified doctor for treatment, as soon as any signs are seen. But the safest (especially in case of MSM) is to go to a doctor regularly, every month, for a check-up. When the doctor gives you medicine for STI, it is important to take the full course of medicine. Discontinuation in the middle may lead to re-infection. Till the STI is cured, try not to have sex. If it is not possible to avoid having sex, one must be sure to use a condom.

## Untreated STI

- These can cause serious illness.
- They enhance the chance of contracting HIV (ulcerative STI).
- Untreated syphilis can lead to mental inertia.
- Some of the STI can be passed through next generation if the pregnant mother is infected (Syphilis/Gonorrhea).



- Longstanding gonorrhea can constrict urinary tract even can block it.
- Chronic cervicitis can cause infertility.

## Symptomatic and asymptomatic STI

Some STI do not show any signs and symptoms on the outside, but the signs may be inside and that is why an internal examination by a doctor is essential, so protcopic examination of anal area is crucial among MSM interventions. Also, symptoms for Syphilis disappear in sometime and only a blood test can confirm its presence.

## Women are more prone to infection 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 factors:

- The family ignores or over looks 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 disease.
- Women have less control over their reproductive health.
- STI have linkage with sexual behaviour and thus it is not socially accepted that a woman disclose her disease.

Importance of partner treatment: If any one partner has an STI, then both should take medication, as per doctor's suggestions, to avoid re-infection. This should be done even if the partner does not have symptoms of the STI.

If it is a MSM group of participants, also discuss the need and importance for internal examination.

- Explain that STI can sometimes be a symptom aticsoa monthly health check-up is very important. To emphasise this point conduct a small game.

End the session by stressing the following:

- PEs need to provide all this information on STI to community members.
- In a later session, PEs will learn how to use a visual aid (flipbook) on STI during the interaction with community members.

## Session 2c: Role of Peer Educators in Prevention and Control of STI

<b>Objective</b>	To help participants think and get clarity on their role in controlling STI among the community members
<b>Expected Outcome</b>	The participants will be able to list their role in preventing and controlling STI
<b>Duration</b>	30 mins
<b>Methodology</b>	Group Work, Discussion
<b>Material/Preparation required</b>	Chart papers, marker pens

### Process

- Many MSM have untreated STI, so ask the participants for reasons behind the same.
- List the reasons as stated by the participants.
- Considering the importance of treating STI early (reference of previous session) and the reasons listed by the participants, tell the participants that in the group work they will discuss what PEs can do to change the situation.
- Divide participants into 4 groups and let each group brainstorm on the role of PEs.
- Let each group present their discussion in front of the larger group.
- Add any roles, after discussing the same with the participants, thus making a comprehensive list of the roles of PEs in STI management.

### Role of PE in STI management

- Identify and network with preferred providers of the community.
- Disseminate information to MSM and their clients regarding STI.
- Motivate them to visit the clinic for health check-up.
- Accompany them to the clinic (if they are willing) so that they can get confidence.
- Motivate community members for syphilis testing (twice a year).
- Enquire and counsel them on compliance of treatment.
- Put efforts to bring the partners to the clinic.
- Provide information and counseling on consistent condom use.
- Monitor quality of services - maintenance of confidentiality, privacy, pay attention to whether non-judgmental attitude and friendly behaviour is extended by the project staff.
- Be active member of clinic management team.
- Participate actively in the clinic meetings and provide feedback that will help in triangulating data gathered by the clinic team and outreach team as well.
- Be a link between clinic team/STI care providers and community members.
- Develop an outreach plan along with the ORW for community members/hotspots from where the STI clinic turnover is low.
- Encourage and involve new community members to seek services.



### Session 3: Positive Prevention and Referral to ICTC and ART

<b>Objective</b>	To help participants understand the importance of positive prevention, risk reduction counselling for PLHIV and respect for PLHIVs' sexual rights. To help them identify issues related with sero-discordant couples and address them in the local care settings.
<b>Expected Outcome</b>	The participants will understand the various aspects of positive prevention and be able to counsel their peers in positive prevention
<b>Duration</b>	1 hr
<b>Methodology</b>	Experience sharing by PLHIV, discussion, presentation, group work, role play, brainstorming
<b>Material/Preparation required</b>	Information on local services readily available for PLHIV

### Process

- Arrange for a HIV positive community member to come in and share with the participants about his/her experiences:
  - Situation at the time when a person understood positive status.
  - Situation in which the person is in today.
  - What experiences she/he has gone through?
  - How the person has handled the challenges faced?
  - Where or from whom has she/he received support?
- If the above is not possible, then ask the participants, if they know any HIV positive person around them, their friend or anyone else. Also ask them what problems do they face—social, psychological, financial, care related etc.
- Introduce the topic of 'Positive Prevention'.

### What is Positive Prevention?

Meeting the prevention needs of people infected with HIV is termed as 'Positive Prevention'. It aims to increase the self-esteem, confidence and ability of HIV positive people to protect their own health and to avoid passing on the infection to others.

Brainstorm on the following questions with the group:

- Why should a PLHIV know about prevention of HIV transmission?
- What are the important messages of positive prevention?
- What are some of the issues of sero-discordant couples (i.e. in a couple one person is positive and the other is not?)
- Summarize the discussions.

## Why should a PLHIV know about prevention of HIV transmission?

People living with HIV need to be provided with information and support on safe sex and safe injecting practices. Their partners also need to be informed about the same. PLHIV have personal sexual health rights to choose:

- To have or not to have sex
- Methods of enjoying sexual pleasure and satisfaction
- To ensure safety for them and their sexual partners

People's perceptions of risk may change when their health situation improves. Reinforcement of prevention messages is necessary.

## What are the important messages of 'Positive Prevention'?

PLHIV should be provided information on:

- Risk of sexual transmission
- Appropriate methods
- Available services

## What are some issues for sero-discordant couples?

These are couples without same status of HIV (one is HIV positive and the other is not). They need to consider reducing risk and parental options. Some issues to be considered:

- Reluctance to attend counselling together
- Barriers to consistent condom use
- Health care providers' role in discussing and encouraging support from non-positive partner



\* Encourage the PLHIV speaker to now talk about very specific issues:

- Experience at ICTC, process followed
- Experience at ART centre, process followed
- Other services available for PLHIV

\* If a speaker is not available, let the group brain storm on services that are presently available for HIV positive people, including ICTC and ART services and the role of PEs in helping PLHIV access these services.

\* List these services. While listing, differentiate the services into two sections, those which are provided or made available by the project and other services.

## Referral Services for PLHIV

HIV/AIDS has emerged as a major social problem as well as an acute 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 employment, housing and basic social amenities, PLHIV are often ostracized by their families and society. Even the health care providers are known to often discriminate against them. All this creates tremendous psychological pressure on the persons and their families leading to severe depression and even suicidal attempts. Moreover, opportunistic infections (OIs) like TB add to the disease burden. Care and support for the persons living with HIV/AIDS has become a significant concern in HIV/AIDS intervention programmes.

The available services for HIV positive people:

- At project level
  - Counselling
  - Support from PEs and staff
  - Membership of groups like PLHIV support group
- At other health centers
  - ICTC and ART centers – testing and treatment
  - Counselling services
  - DOTS services – for TB treatment
- At government scheme level
  - Sanjay Gandhi Niradhar Yojana
  - Insurance scheme

### Role of Peer Educators:

- Spread awareness about HIV among HRGs and also PLHIV
- Inform HRGs about the need for HIV testing and where it is available
- Encourage HRGs to go for HIV testing at ICTC (bi-annual testing)
- Accompany HRG to ICTC, if required
- Ensure confidentiality of HIV status
- Ensure pre- and post-test counselling for every HRG tested at ICTC
- Stand by the HIV positive person and his family
- Ensure pre-ART registration at government ART centers
- Liaise with health care services providers to get proper treatment for PLHIV
- Motivate STI patients and wives of HIV patients for regular testing
- Help to cope with HIV status
- Refer to doctors and counselors
- Counsel families of PLHIV with the permission

### Summarize the session

- PEs need to refer HRGs to ICTCs for HIV testing.
- PEs have an important role of linking with all services, including ART services, so as to support PLHIVs effectively.



## Evaluation of Day 2

Date:

Participant's Name (Optional):

Session	Particulars	Feedback			Remarks*
		Good	OK	Poor	
Overall response to today's session					
1	Outreach and Outreach Planning (Spot Analysis, Hotspot Load Mapping)				
2a	Body Mapping				
2b	Understanding Sexually Transmitted Infections				
2c	Role of PEs in Prevention and Control of STI				
3	Positive Prevention and Referral to ICTC and ART				

Any other comments

\*Please comment on duration, content, methodology and visual aids



# Day 3



## Day 3

Session Plan	Time	Duration
<b>Recap of day 2</b>	10:00 am – 10:15 am	15 mins
<b>Session 1: Condom Promotion (2 hrs 30 mins)</b>	10:15 am – 11:15 am	1 hr
• Male and Female Condoms – Presentation		
• Dispelling myths about condoms – Discussion and Game		
• Condom Demonstration		
<b>Tea/Coffee Break</b>	11:15 am – 11:30 am	15 mins
<b>Session 1 Contd.</b>		
1b. Condom Demand and Supply	11:30 am – 1:00 pm	1 hr 30 mins
• Presentation and Practice – Condom Accessibility and Availability Mapping		
• Presentation and Practice – Condom Estimation		
• Presentation and Practice – Condom Gap Analysis		
<b>Lunch Break</b>	1:00 pm – 1:45 pm	45 mins
<b>Session 2: Communication to address Vulnerability</b>		
• 2a. Dialogue-Based Inter-Personal Communication by PEs	1:45 pm – 2:45 pm	1 hr
• Presentation – Dialogue-Based Communication		
• Group Work – Practising Tools (Body Mapping, Why is it so?)		
2b. one-one Communication by PEs	2:45 pm – 4:15 pm	1 hr 30 mins
• Discussion – Topics of Communication		
• Group Work – Practising Talking Points (using flipbook)		
- Presentation on Talking Points		
<b>Evaluation of Day 3</b>	4:15 pm – 4:30 pm	15 mins

**Session 1: Condom Promotion**  
**a. Male and Female Condoms**  
**b. Condom Demand and Supply**

<b>Session 1a</b>	Male and Female Condoms
<b>Objective</b>	To help participants get complete information about condom usage and practice steps of demonstration
<b>Expected Outcome</b>	Participants will know the steps of male and female condom demonstration Participants will have clarity about what information they are expected to communicate at the field level
<b>Duration</b>	1 hr
<b>Methodology</b>	Discussion, Demonstration, Presentation, Explanation
<b>Material/Preparation required</b>	Chart papers, marker pens, male and female condoms, penis models, vagina models (if available)

## Process

- Start the session by talking about condoms. One can choose to talk about either male condoms or both male and female condoms, depending upon the group and their interest.

Male Condoms	Female Condoms
Made from latex	Made from Polyurethane
Cannot be used with oil based lubricants	Can be used with both water and oil based lubricants
Has to be rolled on erect penis	Use not dependent on erection
Covers penis, internal female genitalia	Covers penis (also base), internal and part of external female genitalia
Has to be removed immediately after ejaculation	Does not have to be removed immediately after ejaculation
Latex can decay under hot and humid conditions	Polyurethane is not susceptible to deterioration from heat and humidity



## Important points to be considered about male condoms

1. While putting the condom if one realises that the side is wrong, one should not use the same condom by changing the side. As it has already touched the body, some body fluids might be attached to it and it could carry the risk of infection. In such cases, one should use another condom.
2. In oral sex, the chances of infection are low. However, the use of a condom is still essential.
3. Using a condom is a skill, and one should develop comfort in putting it on.
4. Condoms should be kept in a cool and dry place away from sunlight and water.
5. There is no need to use extra lubricant as condoms are already lubricated, but if required one can use water based lubricants (not oil).
6. There are various types of condom like flavoured (e.g. Chocolate/strawberry etc), and textured (dotted/ribbed etc).
7. The government and various companies manufacture condoms. Government condoms are available free of cost for distribution. They are also of the same quality (quality checked at equally reputed laboratories).
8. Some condoms are socially marketed also. These are cheaper than market cost.
9. Condoms provide dual protection (from infections and from unwanted pregnancy).
10. Now days female condoms are also available in the market but they are very expensive. Some projects provide the same through social marketing.

### Characteristics of female condoms

- Additional choice, additional protection from STI/HIV/AIDS and unwanted pregnancies
- Acceptable to women and men
- Sense of security and control for women
- Expanding choices increases protection

### Advantages

- Used when it is difficult to negotiate use of male condoms
- Effective protection against STI/HIV/AIDS and unwanted pregnancies
- Uninterrupted sex
- Long shelf life
- Increased comfort during sex
- Increased earnings
- Used without partner's knowledge if required
- Used during menstruation
- Empowers women to take their health into their own hands
- Can also be used by those with latex allergy

After providing this background on condoms ask participants to list the major myths and misconceptions with regards to condoms and condom usage. Ask them: Why do clients not use condoms?

- List the same and add some common misconceptions you have heard about. Use the reference list below.

### Common Myths and Misconceptions about Condoms

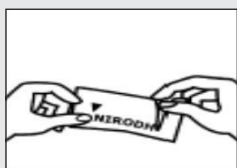
- Using condom during sex is irritating.
- Condom will tear during intercourse.
- Condom reduces sexual pleasure.
- Condom is sticky and oily.
- Erection goes before using condom.
- Double condoms will provide better protection.
- Use of condom implies lack of emotional feeling of love for the partner.
- Condom is barrier of “mistrust” between two partners.

Clarify these myths by stating that:

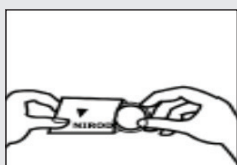
- Condoms are soft and lubricated and proper use of condom does not cause irritation.
- Two condoms should not be put at a time because the chance of tearing both increases.
- Condom does not create any barrier for feeling.
- The process of wearing a condom is also pleasurable.
- If a client uses a condom he will enjoy himself more without any tension or apprehension about getting infected by STI or HIV/AIDS.
- To further reduce these myths, distribute condoms and encourage the participants to handle them. Ask them to blow it up, put it on the hand, and fill up some water in it. While doing so, explain about the length and width of the condom, how much it can be expanded, how much water can be filled up in it etc.
- Next call upon any 2 participants to do a male condom demonstration. The other participants need to observe the demonstration carefully.
- After the demonstration, ask the participants if it was done correctly. If yes, appreciate the efforts of the volunteer, if not, then ask the other participants to give suggestions for improvement.
- Also remind participants about the condom demonstration done in the film ‘**Kamla Didi and the Making of a New PE**’. Discuss what steps were missed in that.
- Explain the steps of male condom demonstration in detail.



## Male condom demonstration



**Step 1:** Check the expiry date (those who can read and write can see the expiry date on the wrapper). For those who can't read and write, see if the condom moves easily inside the packet when you squeeze one end of the packet. If it does not, then such a condom is not to be used.



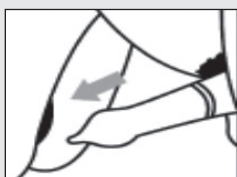
**Step 2:** Tear the packet carefully from one side, so as not to damage the condom, and gently squeeze the condom out of the packet.



**Step 3:** Check the correct side of the condom and then hold the condom by the tip between thumb and forefinger, so that the air from the nipple of the condom is expelled. Ensure that the rolled edge of the condom is rolled outward towards the tip.



**Step 4:** Continuing to hold the tip of the condom, place the condom on the head of the erect penis, and gently unroll the condom all the way to the base of the penis. A condom should be worn before the penis comes into contact with the partner's oral, anal or vaginal opening.



**Step 5:** Sex!



**Step 6:** After ejaculation withdraw the penis from the vagina while the penis is still erect. While withdrawing the penis from the body of the partner, take care not to let the condom slip off. Hold the rim of the condom to the base of penis.



**Step 7:** Take the condom off the penis without allowing the semen inside to spill anywhere near the vaginal, oral or anal opening of the partner.



**Step 8:** Knot the open end of the condom to avoid semen spilling on the floor and causing a mess. Wrap the tied condom in a piece of paper and dispose in garbage.

(\*Adapted from Poster by Pathfinder International Mukta Project)

Next, divide the participants into pairs and ask each pair to practice the demonstration keeping in mind the steps already discussed.

- Stress that as the participants will be teaching this to the community members at the field level, they should learn to do this without any mistake.
- As the participants are now comfortable with condom demonstration, encourage them to try out other practical things like putting the condom on a penis model in the dark by closing one's eyes (as many times the rooms or wherever the clients are entertained, is very dark and it is important that the condom be put correctly even then.)

After the demonstration of the male condom, if the facilitator finds it appropriate and if the group is eager, demonstrate how to use a female condom. Since many MSMs have female partners too, its important for MSM Peer as well as HRGs to know about the female condom demonstration.

**Note:** For the demonstration and practice of female condom, everyone may not get a separate condom, but for learning purposes, a female condom can be reused.

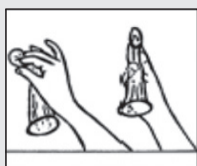
## Female condom demonstration



**Step 1:** Check the expiry date. At arrow tear downwards.



**Step 2:** Remove condom from the pack.



**Step 3:** Hold the inner ring between thumb and forefinger. Form a figure of eight with the inner ring or squeeze the sides of the inner ring together and grasp it firmly.

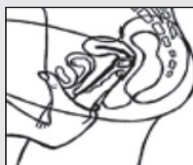


**Step 4:** Decide on a comfortable position to insert the female condom. This can be done in three positions: sitting, squatting or lying down.



**Step 5:** Locate the opening of the vagina and separate the outer lips. Now push the inner ring up into the vagina as far as possible.





**Step 6:** Insert index or middle finger into the female condom to fit it properly. This will become easier with practice.



**Step 7:** About 1 inch of the sheath including the outer ring will remain outside your body.



**Step 8:** Hold the outer ring of the female condom with one or two hands and if you are comfortable guide the penis inside the sheath into the vagina. (Otherwise there is a possibility that on entering the vagina the penis will push the outer ring into the vagina or the penis will enter to the side between the sheath and the vaginal wall.)



**Step 9:** To take out the female condom, grasp the outer ring, twist it to seal in the fluid and gently remove.



**Step 10:** Place the condom in a tissue or in the empty package and throw it into the garbage. Do not put it into the toilet.

(\*Adapted from [www.condomdepot.com](http://www.condomdepot.com))

## Wind up the session by

- Reminding the participants that they need to impart this knowledge to the community members at the field level.
- Informing the participants that the information or messages about condoms and condom usage, which they are supposed to communicate at the field level, will be discussed in detail in the next session on communication.



## Session 1b: Condom Demand and Supply

<b>Objective</b>	To help participants map condom availability and plan for the same. To help participants get hands-on training on calculating condom supply (no. of condoms required to be distributed). To help participants analyse and reduce the condom gap (difference between demand and supply).
<b>Expected Outcome</b>	Participants learn to use the 'Condom Accessibility and Availability Mapping tool to map condom depots in a hotspot. Participants use simple formula and tool to calculate condom supply requirement and do a condom gap analysis.
<b>Duration</b>	1 hr 30 mins
<b>Methodology</b>	Discussion, Exercise
<b>Material/Preparation required</b>	Chart papers, marker pens As condom requirement estimation and condom gap analysis is done by the PE with the help of the outreach worker (ORW) at the TI level, for this session, the facilitator should ensure that the ORW is present. The ORWs should be asked to get field data on condom supply and estimation of HRGs for this session.

## Process

- The facilitator starts the session by emphasizing that as one of the key tasks of PEs is condom distribution.
- In the beginning, the facilitator introduces the 'Condom Accessibility and Availability Mapping tool

### Condom Accessibility and Availability Mapping Aim

Map condom availability points and analyse their accessibility to MSM.

#### Guideline:

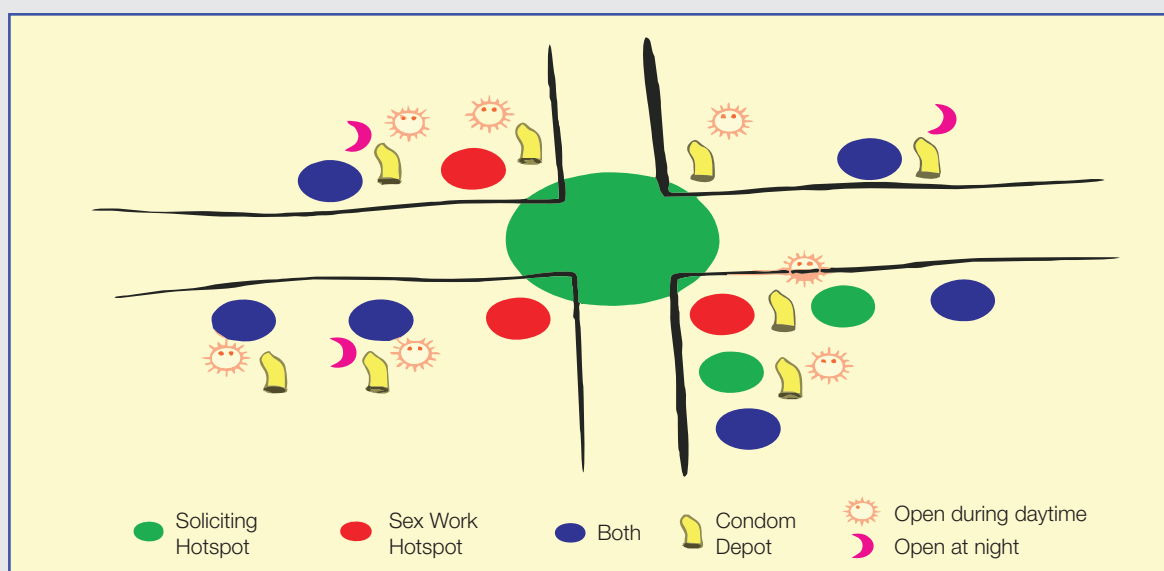
- Draw a map of the town or use an existing map of the town.
- Mark all the places where MSMs solicit clients and where the sexual act takes place using bindis of two different colours: one to indicate hotspots where solicitation takes place and the other to indicate hotspots where the actual sexual act takes place.



- Discuss and understand to see when each hotspot is active (soliciting and sex work) and at what time of the day. Mark with color depicting the hotspot as active either only in the day or at night or both the times.
- Then mark the condom depots in the map also symbolically indicating whether the depots are function during the day or at night or round the clock.

**Discuss the following:**

- Are there condom depots in all the hotspots where soliciting or sex work takes place? If not what are the reasons? Do the hotspots, e.g. home-based hotspots, which do not have depots, prefer direct distribution?
- Do all the hot spots that are active during the day or night or round the clock, have condom depots that are open at the same time as the sites are active?
- Are condom depots accessible to the key population?



After practicing the tool, the facilitator emphasises that it is important for the PEs to understand the methodology of calculating condoms to be distributed to each community member (MSM).

- The facilitator then shares the 'Condom Demand Estimation' with the participants.

## Condom Demand Estimation

At the national level NACO estimates the demand for condoms for the MSM (HRGs) populations on the basis of CMIS information, condom consumption by TIs for last 2 years.

- But at the TI/NGO level the most important thing to consider is the categorisation of the HRGs on the basis of the number of encounters/partners per day:
  - High Volume (>10 sex acts per week)
  - Medium Volume (5-9 sex acts per week)
  - Low Volume (< 4 sex acts per week)
- It is also important to consider the risk category i.e. age group of the MSM, type of sex activities preferred, type of sex work settings.
- The HRG master register collects data on the average sexual acts per week. Moreover, subjectively, each PE can do an analysis of the client load for her site.
- Condom demand for different sub-categories is based on the simple formula:

$$D = (S \times I \times N) - C$$

D = the condom requirement

S = the number of MSMs (of that sub-category i.e. high, medium, low) operating in that area

I = the number of sexual acts per week

N = the number of weeks a MSM is 'active' in a given month

C = the number of condoms from other sources including clients

- The above formula can be used for individual sex workers also, by putting 'S' as 1.
- Based on this, the facilitator asks the PEs to calculate condom requirement for the community members they work for, and if possible dividing it up for each community member. The ORWs are encouraged to assist their PEs and provide input while this exercise is being undertaken.
- This exercise can be taken up for the whole group by asking some PEs to come up and work on this formula in front of everybody. Or it can be done by individual PEs.
- The facilitator then moves on to discuss 'Condom Gap Analysis'.

## Condom Gap Analysis

- At the TI/NGO level, a condom gap analysis is important as part of micro-planning so as to analyse and reduce the condom gap (difference between demand and supply). The main considerations are:
  - Actual requirement of condoms by each HRG may differ widely with the condoms distributed and the cruising/sex work settings of the project.
  - Condom distribution by staff of the TI as a part of outreach contacts needs to be accounted for.
  - Condom uptake by the HRGs and their clients from various sources—which may be the opportunity gap analysis for strengthening the condom programme.



- The acceptability of the condom strategy adopted by the TI in terms of price, brand, quality, adequacy, sources of distribution, distribution channels used, IEC/messages used by the TI for condom programming, the demonstration skills of the staff in different negotiable/non-negotiable conditions, negotiation skills of the HRGs with their clients.
- The **process followed for condom gap analysis** is that each PE captures information on demand at the site level (with the help of the ORW) using a simple format like the one below:

## PE Data Collection Tool

(to be used once in 6 months and used as baseline)

Type of HRG:				Name of Site:			
ID/Name	Sub- Type **	No. encounter- red/week (recall)	No. of condoms used last week	No. of free condoms received from TI project	No. of free condoms received from (other than TI)	No. of condoms purchased through social marketing (by client or by HRG)	Condom need/gap to be met by project [C-(E+F+G)]
A	B	C	D	E	F	G	H

\*Type –MSM

\*\* Sub-type –Kothis, Panthis, TGs for MSM

- Data is compiled at TI/NGO level using the following format:

## Condom Demand and Supply assessment

(to be used by ORW with support from PE)

Demand			
MSM	Kothi	Double decker	Total
Number of MSM			
Average no. of clients (encounters) per week – <i>column D</i>			
Average no. of clients in a month (no. of encounters in a week X4) based on last week's recall			
Condom requirement/month			
Free Distribution – column F			
Through Social Marketing – column G			
Through other sources – column H			

- Average condom demand along with the subsequent gap is calculated for every sub-group categorized under HRGs
  - Such analysis then feed into the **re-assessment of condom demand/supply**.
- Again, the facilitator encourages the participants (both PEs and ORWS) to practice using this tool.
- During the exercises the PEs and ORWs should use data from the field level.

## Session 2: Communication to Address Vulnerability

### a. Dialogue-Based Inter-Personal Communication by PEs

### b. One-One Communication by PEs

<b>Session 2a</b>	Dialogue-Based Inter-Personal Communication by PEs
<b>Objective</b>	To help participants understand the need for dialogue-based communication and get hands-on training for the same
<b>Expected Outcome</b>	Participants get trained in tools for dialogue-based communication
<b>Duration</b>	1 hr
<b>Methodology</b>	Discussion, Group work
<b>Material/Preparation required</b>	Chart papers, marker pens

## Process

- Remind all participants about the importance of communication, and especially ‘communicating right’.
- Move on to talking about dialogue-based Inter-Personal Communication (IPC).

## Dialogue-based IPC

Dialogue-based IPC or simply IPC that moves beyond messages and through face to face interaction, dialogue and critical reflection, helps vulnerable and high risk behaviour populations to:

- Identify barriers to STI/HIV risk reduction
- Analyse these barriers and
- Plan ways to address them

### When can one use IPC?

IPC can be used for all TI components i.e. to talk about outreach, clinical services, drop-in-centers, ICTC referral, advocacy initiatives, CBO formation, etc.

### Components of IPC

In dialogue-based IPC there are certain essential components:

- **Content** – This can be on STI or HIV/AIDS.



- **Method**– These are processes used to stimulate dialogue. These methods have been elaborated in the NACO Operational Guidelines, and in this session participants will learn about two of these methods.
- **Facilitation Skills**– PEs need to ensure that they encourage dialogue and discussion on key issues rather than just providing messages. Thus, IPC is an important tool for initiating dialogue.
- **Values and Attitude**– PEs need to have appropriate attitude while working with HRGs and be non-judgmental and un-biased.

After the brief introduction, inform the participants that for group work practice they will look at IPC tools that can be used for outreach – ‘Why is it so?’

### IPC Tool: Why is it so? aim

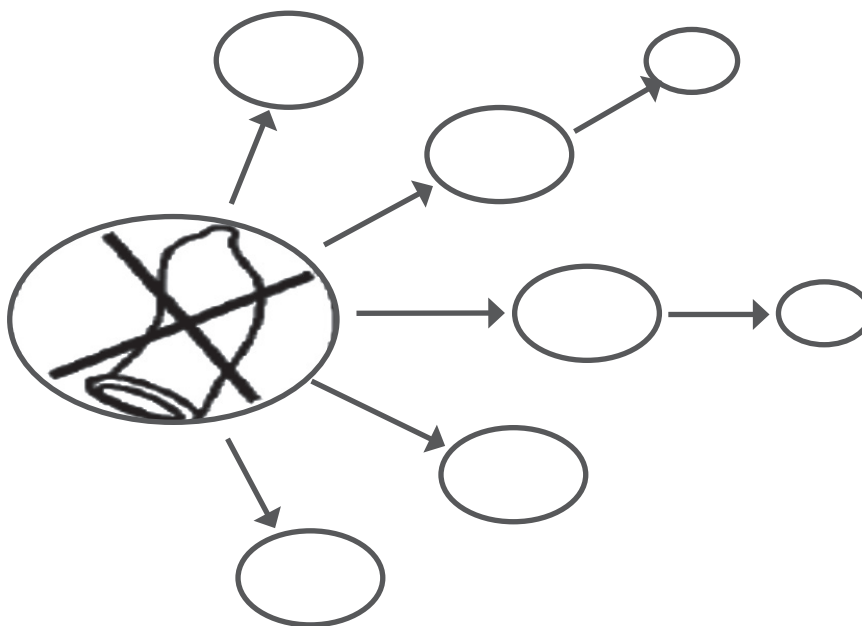
Help HRGs analyse why risk behaviours occur and what can be done to reduce them.

#### Materials Required:

Chart paper, coloured marker pens.

#### Guideline:

- Identify risky behaviour for HIV (like unprotected sex, etc.) and draw a symbol of one of the risky behaviour (based on the group’s preference for discussion) in the middle of a circle in the center of a flipchart.
- Ask ‘Why is it so?’ and let community members draw or write the reasons for risky behaviour in balloons around the central circle.
- Continue this till the community members cannot think of any more reasons.
- Select one of the reasons/factors and ask ‘Why is it so?’ Let community members identify issues that make them more vulnerable to taking that risk.
- Continue this till the community members cannot think of any more vulnerability factors.
- Repeat this process for all reasons/factors for risk behaviour.
- Discuss the following:
  - What are the most important reasons (vulnerability factors) for risk behaviour?
  - What are the ways in which HRGs can try and reduce risk behaviour?
- Example of non-condom usage as a risky behavior is provided below. But the inner circle may have other issues like ‘needle/syringe sharing’ or specific ones like ‘unprotected anal sex’, etc.



Now divide the participants into smaller groups and give them time to practice ‘Why is it so?’

- After completing the exercise, encourage the participants to discuss the following for each tool:
  - What are the advantages of using this tool?
  - What are the constraints in using the tool?—e.g. takes too much time, cannot be used in street based settings etc.



## Session 2b: One-One Communication by PEs

<b>Session 2b</b>	One-One Communication by PEs
<b>Objective</b>	To discuss with participants the topics on which they need to give information to community members
<b>Expected Outcome</b>	The participants will understand the topics on which they need to impart information and the details of each of the topics
<b>Duration</b>	1 hour 30 minutes
<b>Methodology</b>	Discussion, Group work, Presentation, Explanation
<b>Material/Preparation required</b>	Chart papers, marker pens, Talking Points Visual Aid (3 flipbooks)

## Process

- By referring to the session on risk and vulnerability, remind the participants that one of the ways to reduce vulnerability is by imparting information and knowledge. In case of MSM, information about various health related aspects helps to reduce the vulnerability to STI and HIV/AIDS. One of the strategies for this is the use of peer educators to impart that knowledge to community members.
- Generate a discussion on the topics on which the PEs need to talk to other MSMs in the field and lists these on the board. She/he reviews the list for completeness.
- Then introduce the Talking Points Visual Aid to the participants.
- Divide the participants in 3-4 small groups and provide each participant with the visual aid (available with the training package).
- Together, each group memorizes the talking points and practices the same within the group.
- After the group work, ask participants to come forward at random and enact how they will talk about a particular issue with a community member (the participant is asked to use the learnings from the visual aid).

### 1. STI

#### a. Prevention

- i. Most STIs occur due to unprotected sex
- ii. STIs can be prevented if we ensure that we use condoms with our customers as well our regular partner, each and every time we have sex





**b. Signs and symptoms:**

- i. The most common symptoms are:
  - 1. Unusual white discharge from the vagina–pus-like this discharge may smell foul
  - 2. Pain in the lower abdomen or pelvic region
  - 3. Sores over the genital area or in the anus or mouth
- ii. Other symptoms that can be seen include:
  - 1. Swelling in the groin
  - 2. Burning sensation or pain during urination
  - 3. Small growths in and around the genital area
  - 4. Itching in or around the genital area
  - 5. Pain during sexual intercourse

**c. Treatment:**

- i. Most STIs are completely curable
- ii. Visit the doctor and get oneself checked
- iii. As per doctor's suggestion, get tests done
- iv. Continue treatment till the time the infection is fully cured
- v. If possible, avoid sexual relations till the time the infection gets fully cured
- vi. Use condoms during every sexual encounter

**d. Importance of partner treatment:**

If any one partner has an STI, then both should take medication, as per doctor's suggestions, to avoid re-infection

**e. Regular health check-ups:**

STIs in men can sometimes be asymptomatic so a monthly health check-up is very important

- f. In addition to the services offered by the doctor and the nurse at project clinic, they can also refer you to various organizations for specialist check-up/treatment/services at lower cost. For example, if one of the community children etc. Member wishes to be tested for HIV, the doctor at the project clinic can explain how the test is done, where the test can be done, how much it will cost, etc. Similarly, the TI project helps community members to access free medical services provided by the Government, such as treatment for tuberculosis, immunization for children.

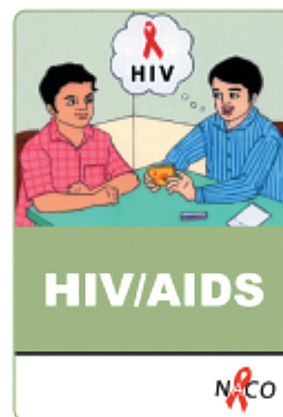


## HIV/AIDS

### a. How it spreads

HIV spreads through the following routes:

- i. Blood—through infected blood given to an uninfected person. It also spreads through sharing of needles.
- ii. Through unprotected sex—where body fluids are exchanged. All sexual acts are not risky.
- iii. Through infected mother to child—at the time of delivery if some injury takes place, through umbilical chord, through breast milk (where risk is low). The risk of other infections for the body is much higher than the infection through breast milk.



### b. How it doesn't spread

- i. If the needles are used once and disposed (new for each person, each time), or used after boiling for 20 minutes.
- ii. If proper precautions are taken before and at the time of delivery of HIV positive woman.
- iii. And by so many other things like eating with positive people, swimming with them, shaking hands, sneezing, sharing clothes, utensils etc. with them.

### c. Prevention

We can prevent ourselves from getting infected by above mentioned ways (i.e. by using disposable or sterilized needles, by taking precautions during delivery to prevent the child from being HIV (positive), but in addition to that 100% correct and consistent condom use is the best way to prevent HIV infection. Sex workers/MSM are prone to the infection because of the nature of their work.

d. Project can also help community members who are HIV+ to access care and support services provided by voluntary organizations.

### e. Testing

There are two types of tests:

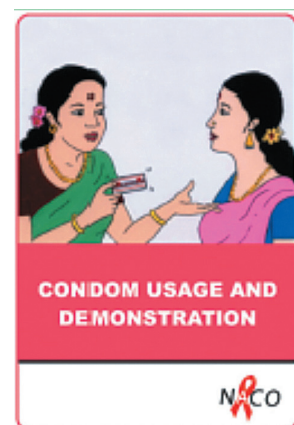
- i. In one type antibodies are tested—our body makes antibodies as a reaction to the virus which enters the body. It takes 12 weeks to make antibodies. These types of tests check whether antibodies are there in the blood. If antibodies are there that means virus is there for which antibodies are made.
- ii. Another type of test checks the actual virus.

## f. Complications

- i. Many times when a person is HIV positive, the immunity of the white blood cells, which are the protective cells of our body, goes down. Because of less immunity, there are many infections which the body catches fast. These infections are called as Opportunistic Infections or OIs.
- ii. Because of HIV infection when the body's immunity reduces and a group of infections plague the body, then that situation is called AIDS. It is generally said that it takes 8-10 years from getting infected to reaching the stage of AIDS, but this period changes from person to person.

## g. ART

- i. ART is Anti Retroviral Therapy.
- ii. This is a treatment given to HIV positive people to control the spread of infection.
- iii. These medicines are not a cure from HIV but it restricts the replication of virus in the body.
- iv. These medicines are to be taken regularly by the patients and are to be taken on doctors suggestions.
- v. Once the medicines are started, a person has to take it lifelong.
- i. Generally these medicines are very costly, but in government hospitals these are given free of cost.



## Condom Usage and Demonstration

Please refer to 'Notes for facilitator' is session on Condom Usage.

## Activity 2: Peer Education One-on-One and Group Settings

Every peer educator needs to develop personal skills that help him to best communicate with his peers both in one-on-one and group settings. Tell the group that we are now going to look at peer education in these two settings and examine how a peer educator can effectively communicate. With the group, decide on a topic that everyone is comfortable facilitating. It could be how to put on a condom or how to recognize STIs, or another topic that the group comes up with.

Ask for two volunteers to participate in a role play. One volunteer will be the peer educator and the other volunteer will be his peer. Read the following out loud and ask the volunteers to take a few minutes to act out the roles: One-on-One role play:

**Case Study:** Dinesh, a peer educator, is on a field visit in Andheri area where he has previously held discussions with some peers he met with awhile ago. Raj, a MSM community member, lives in this area. Dinesh calls him on his cell phone to arrange a meeting. Dinesh arrives at the agreed venue 15 minutes later and meets Raj ...



**As a group, discuss the following questions:**

1. How effective was the peer education session?
2. What techniques were used to get and hold the peer's attention?
3. How effective were the communication techniques?
4. What types of nonverbal communication did the PE use?
5. Ask the volunteers how it felt.

**Review the following points with the group:**

One-on-one peer education sessions are most effective when the peer educator:

- Understands the beliefs, concerns and needs of the listening peer
- Makes the listener feel comfortable
- Shows understanding (empathy) and concern
- Asks the listener questions and allows him to make his own informed decisions
- Points the listener to other information and services
- Demonstrates patience when the listener has difficulty understanding what the peer educator is saying
- Encourages the listener
- Tries to get his peer to talk about "someone just like him" or "someone he knows very well" if he is too shy to talk about personal experiences (Note: this technique sometimes allows people to speak more freely.) Peer educators will also have the opportunity to work in group settings. Explain that we will now do another role play, but this time with the peer educator working in a small group setting. Ask for four people to volunteer to be one peer educator and three peers. Read the following role play out loud:

Small group role play: Sandeep, a peer educator, has met several times with two peers who are dating each other. They were able to discuss freely how to practice safer sex, and now Sandeep is returning to meet with them for a second time. They have agreed to meet at the house of the peer's friend who is also interested in meeting with Sandeep. Sandeep has now arrived, and after greeting, the group warmly begins to chat. As a group, discuss the following questions:

1. How effective was the peer education session?
2. How was the communication style different from the one-on-one session?
3. How effective were the communication techniques?
4. What types of non verbal communication did the peer educator use?
5. Did all the peers get involved in the session?
6. Which do you think is easier – presenting in a small group or one-on-one? Why?

Review the following points with the group either through presentation or brainstorming: Small group peer education (facilitation) is most effective when the peer educator:

- Presents materials at a good pace
- Presents accurate information
- Presents information that will be of interest to everyone
- Presents well-organized information in a simple, easy-to-understand manner
- Shows confidence
- Makes good use of communication materials
- Holds the group's attention
- Makes the peers feel comfortable
- Clarifies difficult information
- Talks less, asks more questions
- Acknowledges good responses
- Reflects and repeats messages
- Encourages everyone in the group to actively participate



### Evaluation of Day 3

Date: Participant's Name (Optional):

Session	Particulars	Feedback			Remarks*
		Good	OK	Poor	
Overall response to today's session					
1a	Male and Female Condoms				
1b	Condom Demand and Supply (Condom Accessibility and Availability Mapping, Condom Gap Analysis)				
2a	Dialogue-Based Inter-Personal Communication by PEs				
2b	One-One Communication by PEs				

Any other comments

\*Please comment on duration, content, methodology and visual aids

# Day 4



## Day 4

Session Plan	Time	Duration
<b>Recap of day 3</b>	10:00 am – 10:15 am	15 mins
<b>Session 1: Monitoring and Documentation (2 hrs 30 mins)</b>		
• Tool 1:	10:15 am – 11:00 am	45 mins
<b>Tea/Coffee Break</b>	11:00 am – 11:15 am	15 mins
<b>Session 1 Contd.</b>		
• Tool 2:	11:15 am – 11:45 am	30 mins
• Tool 3: Peer Maps	11:45 am – 12:15 pm	30 mins
- Presentation of tool		
- Group Work – Practising the tool		
- Presentation by Group		
• Tool 4: PE Weekly Planning and activity Sheet	12:15 pm – 1:00 pm	45 mins
- Presentation of tool		
- Group Work – Practising the tool		
- Group Presentation		
<b>Lunch Break</b>	1:00 pm – 1:45 pm	45 mins
<b>Session 2: Crisis Management</b>	1:45 pm – 2:30 pm	45 mins
- Discussion –Types of Crisis		
- Group Work – Case Study		
- Presentation and Discussion		
- Discussion – Crisis Management Systems		
<b>Session 3: Going Beyond HIV (General Health Social Entitlements)</b>	2:30 pm – 3:15 pm	45 mins
- Group Work – Practising Talking Points (using flipbooks)		
- Presentation on Talking Points		
- Discussion – Social Entitlements		
<b>Evaluation of Day 4</b>	3:15 pm - 3:30 pm	15 mins



## Session 1: Monitoring and Documentation (Peer Map, PE Weekly Planning and Activity Sheet)

<b>Session 1</b>	Monitoring and Documentation
<b>Objective</b>	To help the participants understand the importance of documentation of their work. To train participants on the formats to be used for documentation.
<b>Expected Outcome</b>	The participants learn to use the formats for documentation.
<b>Duration</b>	2 hrs 30 mins
<b>Methodology</b>	Discussion, Mapping, Presentation, Explanation
<b>Material/Preparation required</b>	Chart papers, markers, bindis of various colours and various shapes, handouts of the formats for participants ORWs to be encouraged to bring required field-level data to fill up Opportunity Gap Analysis and PE Daily Diary cum Tracking Tool.

## Process

- Start the session by providing some background information on monitoring and areas of monitoring.

### Necessity and usefulness of monitoring

- Gives clear idea about day today performance.
- Helps in understanding how much have been achieved.
- Helps in understanding how services can be improved.
- Helps in identifying problems in day-to-day processes and performance.
- Helps in developing strategies to overcome the problems.
- Helps to plan follow-up activities.

### Areas of monitoring

#### Qualitative (mainly for PE performance)

- Rapport and friendship with other community members.
- Dissemination of information about different aspects of STI and HIV/AIDS.



- Motivation to community members for regular health check-ups.
- Motivation to community members to use condoms.
- Distribution and social marketing of condoms.
- Communication/messaging with community members.
- Communication with stake holders.
- Support to community members to access services like ICTC.
- Support to HIV infected community members.
- Support to community members to address harassment issues.

### Quantitative

- Number of STI patients.
- Number of patients who have completed the treatment.
- Number of patients followed up.
- Number of persons who are provided information/messages.
- Number of condoms distributed.
- Number of persons referred to the ICTC.
- Number of community members showing interest in forming their own banking system.
- Number of incidences of violence.
- Number of community members arrested.
- Number of incidences addressed by community members.

Next, tell the participants that this session will include two parts:

- Part 1 will focus on the various participatory tools that can be used for monitoring a project.
- Part 2 will focus on the monitoring format to be used by the PEs.
  - Divide the participants into smaller groups so that they can complete the group practice exercises for each tool.
  - Start with 'Opportunity Gap Analysis' tool. Explain the objective, frequency and the process to be followed in using the tool.

### Tool 3: Peer Map aim

Understand and analyse outreach done by PEs with MSM she/he is working with.

#### Guideline

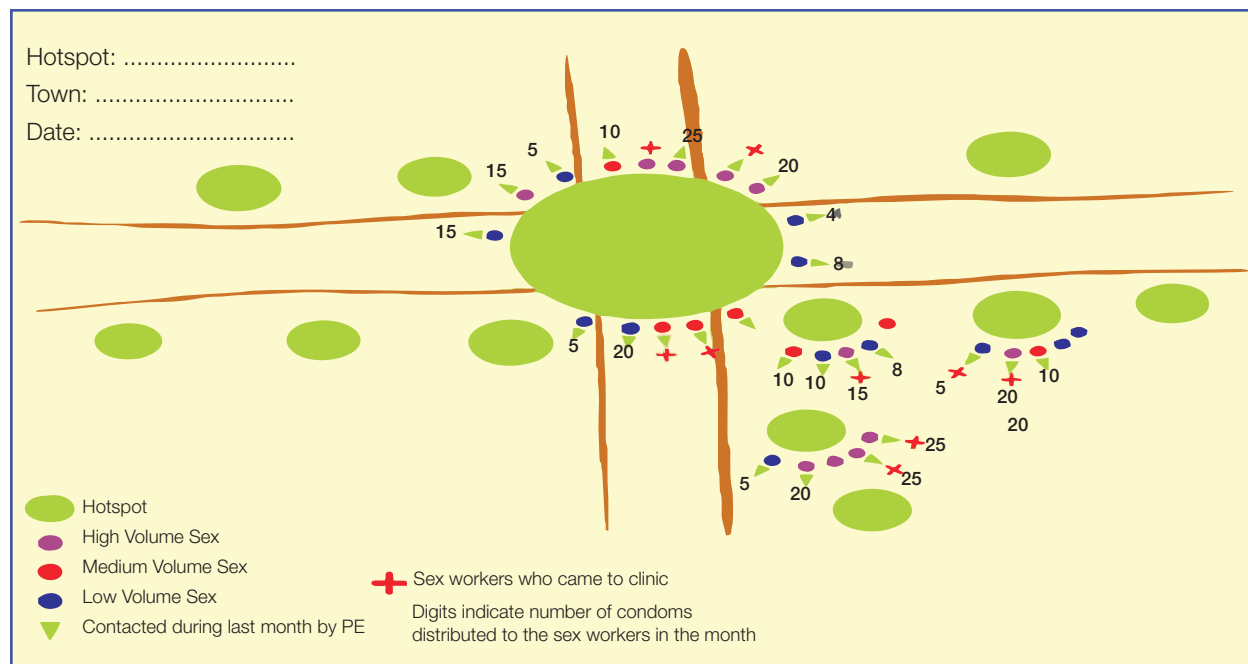
- PEs to map the hotspots in the town where they work and meet their community members.
- In these hotspots the PEs to map the MSM that they are accountable for, depicting high volume, medium volume and low volume in these hotspots using different colour codes.
- PEs to then indicate the following:

- Number of times each of them met the MSM they are working with, in the last month?
- How many condoms were distributed to each of the MSM contacted?
- Condom outlet boxes in these sites?
- Analyse the map as under:
  - In the previous month, did the PE meet all MSM that he is working with? If not, why?
  - Based on the volume of sex work, was there any difference in kind of outreach done by the PE?

Did he meet high volume MSM more often and the low volume MSM less often?

- Were the condoms distributed based on the volume of sexual encounters? Were enough condoms distributed to cover all the sexual acts of each of the MSM? Is there a shortfall? How is this shortfall in condom distribution, being filled? Is it through the depots? Are the clients bringing condoms?

*These maps can be adapted to include other indicators like clinic attendance, access to crisis support, access to entitlements, etc.*



After the brief, encourage the groups to complete that tool and present the same.

- Encourage discussions on:
  - What was the process followed by the group?
  - What is the outcome of the exercise?
  - How does this exercise help in planning outreach?



- What are the common mistakes while completing this tool?
- What consequences do these mistakes have?
- Then move on to Part 2 of this session. Go through the PE Daily Diary cum Tracking Tool explaining in detail:
  - What is the frequency of using this format?
  - Why is the format used? (data captured by the format)
  - Guidelines/Steps in filling the format
- Discussions are encouraged on:
  - Whether all required data can be captured using this format
  - The common mistakes in filling this format

## Tool 4: PE Weekly Planning and Activity Sheet for MSM PEs

### Aim

- To track type of services given by the PE on day to day basis.
- To know the number of community members planned for outreach and the number actually reached.
- To know if condoms were used during last sex act.
- To know about community members not contacted.

### Guideline

- Who and When:
  - This format will be used by the PE for every contact made during a given week with the HRGs in his/her designated hotspot/site.
  - The format will be pre-listed/printed with HRG members' names and UID numbers by the TIMIS/Accountant from the line list/master register available at the project office.
  - The expectation from the PE is to cover all HRGs listed in a given hotspot/site with project services minimum once in two weeks and identify all new HRGs in the site.
  - The name of the new HRG member will be entered in the last row of the format.
  - The filled in format is to be shared on a weekly basis with the respective ORW-in-charge for performance tracking and planning for the coming week.

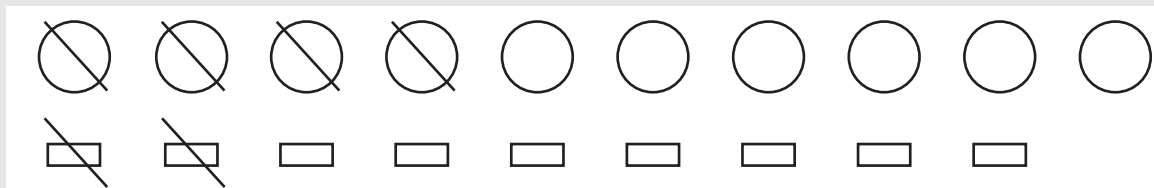
How: Each row represents information to be filled up for listed HRGs contacted. The details as below:

**Sl. no:** The serial number will also be used for prioritising the HRG members by the risk factors and vulnerability. PE and ORW will do this prioritising in consultation with each other every week. The prioritised serial number will be highlighted by colour to help the PE plan his outreach.

**Name of the HRG:** This column will be pre-listed/printed by the TI officer with the names of HRG Members registered and outreached by the respective peer educator in a given hotspot/site.

**UID numbers:** The first set of circles in the box indicates tens and second set of rectangles indicates Units.

For example 42 can be represented as



**Referral Due/Overdue–STI: /ICTC** If a HRG member is due/overdue for STI follow-up (as per ANM/ Counsellor), then with the support of ORW, the PE will tick mark. The number of tick mark will indicate the increased emphasis for the HRGs to be brought to the clinic:

√ = one tick if HRG member is scheduled to visit the clinic during the current month.

√√ = two ticks if HRG member is scheduled for a clinic visit since last month and has not visited the clinic as per schedule.

√√√=three ticks if HRG member is scheduled for a clinic visit since last two months (three including current month) and has not visited the clinic as per schedule.

**Risk assessment (risk and vulnerability):** Each week, the PE assesses the risk of the HRG members based on seven parameters. The information will help the PE and ORW to focus on the most at risk HRG member and provide services based on the needs. A brief description on each risk parameter is given below:

The risk factors are:

- High number of clients (>15 per week) – If the HRG member's client load is above 15 sex acts in a week, then he is at high risk.
- Low condom use (not used condoms in more 2 sex acts out of last 10 sex acts) – If the HRG member states that she/he has not used condom in more than 20% of the acts (more than 2 out of a scale of 10) then she/he is at risk.
- First year in sex work – If the HRG member informs that she/he is in sex work from last one year only, then she/he at high risk.
- STI last three months – If the HRG member reports of an STI in the last 3 months, then the HRG member is at risk.

The vulnerability factors are:

- **Alcohol:** If the HRG member takes alcohol, then as she/he is vulnerable.



- **Unsafe sex(more money):** If the HRG member is doing sex acts mainly for money (economic reasons), then she/he is vulnerable.
- **Violence:** if the HRG member has been victim of violence or harassment, then he is vulnerable.

**Condom requirement as per Condom Gap analysis:** The information on the number of condoms required for each HRG member is calculated based on their sex acts. This information will be periodically (quarterly once) updated by the ORW in consultation with the respective peer educator.

**Services:** In each interaction with the HRG member, the PE will be giving services as listed below (8typeofservices). The PE can give one or more than one service in each contact made with the HRG member depending on the need and requirement of the HRG member.

- **Condom distributed:** During each contact made with the HRG member, the condoms are distributed as per requirement. The PE has to ensure that the number of condoms distributed to each HRG member are recorded in the format are in “pieces” and not in “packets”.

- **Condoms old (male):** The PE has to record the number of condoms sold to each HRG member in “pieces” and not in “packets”.

The PE will mark (√) when a HRG member is provided 1:1, 1: group or is referred.

- **1:1:** When the PE meets the HRG member in one contact and talks about the project services

- Provides information on STI, HIV, importance of regular medical check-up, referrals to ICTC, condom usage, conducts condom demonstration.

- **1: Group:** When the PE meets more than one HRG member in one contact and talks about the project services- Provides information on STI, HIV, importance of regular medical check-up, referrals to ICTC, condom usage, conducts condom demonstration.

**Referrals (general and STI):** Each HRG member has to be referred to STI clinic (project clinic or preferred providers) and various other project services (ICTC,ART,TB etc.).

**STI referrals:** The PE has to ensure that all the HRG members covered are referred to STI clinics/ preferred provider for Regular Medical Checkups (RMC) once in a quarter. Further, a HRG member has to be referred to STI clinics/Preferred Provider for symptomatic and asymptomatic STI treatment.

**ICTC referrals:** All the HRG members need to be tested for the HIV twice in a year at the designated ICTC. The PE has to motivate the HRG members for getting tested at the ICTC. PE will also ensure that a referral slip is given to the HRG member through the ORW/ANM.

**ART:** The PE will list positive HRG members in his hotspots. The PE will ensure that all the positive HRG members are registered with the ART. The PE will motivate the HRG members on the importance of drug adherence on ART.

**Condom use during last sex:** During every interaction with the HRG members, the PE must probe if HRG member has used condom during the last sex act. If the HRG member informs that:

- Condom was used during last sex act – tick (√)
- Condom not used during last sex act – mark (x)

**Violence identification/reported:** During contact by the PE, the HRG member informs that he was victim of violence or harassment during the week, then PE will tick(√),(The ORW will address the issue with the help of PE) else she will mark (x).

On weekly basis, the site review will be jointly done with the ORW in which the form will be handed over to the ORW who in turn will check the format for its completeness. The information from the filled in form at will be used for the performance tracking, prioritizing and planning for the next week.

Usefulness of the information in the peer format:

- Helps in knowing the number of HRG members who meet every week in a given hotspot.
- Helps in identifying the new HRG members in the given hotspot.
- Helps in knowing the type of services provided to each HRG member in a given hotspot by the PE.
- Helps in knowing the number of condoms been distributed to each HRG member as well as the total number of condoms distributed and in a given hotspot.
- Helps in knowing the number of listed HRG members who are not contacted and shall be the priority for the next week.
- Help in knowing risk profile of each HRG member in which she/he is in.
- Help in knowing number of violence and harassment incidence occurred in a given site/hotspot.



## For FSW and MSM PEs

PE Weekly Planning & Activity Sheet (PSW, MSM)																			
Name of the PE		District		Name of the hot spots		Week		1		2		3		4					
Name of the Supervising ORW		For the Month						Date: (End of the week)											
Sl No.	Name of the HRB Groups	000000 000	PE's Symbol for identifying HRB Groups	Referral due Over due				Risk Assessment				Services							
				STI	ICTC	High no. of drug using clients (>15 per week)	Low condom use (not used) condoms in more 2 sex acts out of last 10 sex acts)	First year in sex work	STI reported in last three months	Alcohol	Unsafe sex (more non-mon-ey)	Violence	Condom requirement per week	# of condom distributed (Male)	# of condom sold (Female)	# of contacts	# of referrals (STI & others centers) Reported access by HRB Groups	Condoms use during last sex	Violence identification / reported
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
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21																			
22																			
23																			
24																			
25																			
Total																			



## Session 2: Crisis Management

<b>Session 2</b>	Crisis Management
<b>Objective</b>	To help participants understand their role in solving crisis faced by the community and to gain the trust of the community
<b>Expected Outcome</b>	The participants will be become aware about community needs and how to help community during crisis
<b>Duration</b>	45 mins
<b>Methodology</b>	Brainstorming, Discussion, Explanation
<b>Material/Preparation required</b>	Chart papers and marker pens

## Process

- Start the session by asking participants to list crisis faced by the community—at individual level by community members and as a community at large.
- Make note of the crisis stated by the participants. If possible, divide the same in to two—Individual crisis and Group crisis.
- Divide the group into two. Give each group one situation card.

## Case Study

During the interaction with a community member, a P E realises that the community member is tense as last night a local goonda of the area force fully had sex with him without using a condom. This goonda has been doing this with many other community members in the area.

- Encourage the groups to discuss the following:
  - Is this a common situation faced by community members?
  - How is this currently handled at the field level?
- Let each group present their discussions to the large group.
- After the presentation, initiate a discussion on the current methods of dealing with other crisis stated earlier.  
Encourage participants to share their experiences.
- Refer to the two situation cards discussed earlier and ask the group the following:
  - Could there be a mechanism to handle this and other crisis at the field level?





- Would the community feel secure and trust PEs more if such a system is developed?
- What would such a crisis management system include?
- Discuss need to develop an effective crisis management system including the need to document cases. Share existing crisis management systems in different projects across the country.

## Rationale for Crisis Management

Harassment and violence towards sexual minorities is common and is a significant barrier to targeted interventions towards key HIV affected populations. Harassment may include arrest on false charges (e.g. of solicitation or for carrying condoms), beatings and even sexual assault. Harassment and abuse may come from the general public, police, goondas, local leaders, clients or from within the HRG itself. Then the obstacle of violence and harassment is removed through timely and proper crisis response and regular sensitization and advocacy programs; an environment is thus created that helps members of the HRG in building up their self esteem. This in turn helps them to focus more on their health and specifically issues relating to STI, including HIV/AIDS. As part of a TI, crisis response interventions increase outreach to members of the HRG, thereby strengthening the NGO's or CBO's relationship with them and gaining their trust. Crisis response also facilitates the establishment of a good rapport between field workers and members of the HRG, which helps communication about prevention and treatments of STI.

## Essential Ingredients of Effective Crisis Management

- Trained and committed members who are willing to be “on call” 24 hours a day and to respond immediately when a crisis happens.
- Effective communication mechanisms (i.e. crisis phones) that the community can contact.
- Availability of information about crisis response to community members.
- Experienced and committed lawyers who are willing to provide assistance 24 hours a day.
- Networking, alliance building, and sensitisation work with local stakeholders (especially the HRG) through regular meetings and education as appropriate. This includes community level legal literacy sessions.
- Close alliances with other civil society organisations, activists and local media contacts who can advocate on behalf of the community when necessary.
- Reflections on crisis management cases to improve and build internal capacities.

## Establishing a Crisis Response System

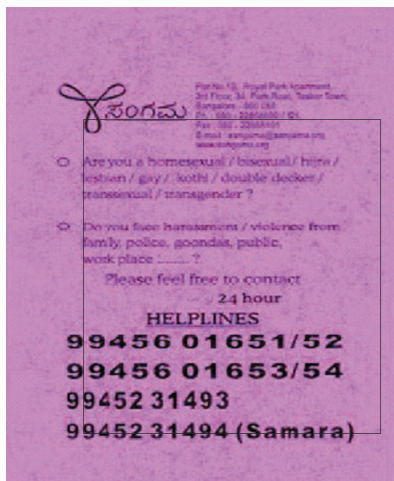
The following steps can be taken to establish a crisis response system:

- A crisis management team is established. This should consist of Peer Educators, Outreach Workers, senior project staff, and legal resource persons familiar with the legal issues surrounding harassment of MSM. The team establishes detailed protocols for staffing and procedures of the crisis response system, and is responsible for implementing these.

- Mobile phones are obtained to be used exclusively for community members to call in case of a crisis.
- Nominated community members volunteer to manage these phones for crisis management. These members may change every month so that a pool of crisis managers develops and no volunteers are overburdened.
- Crisis mobiles are never switched off. Volunteers undertake to be available 24 hours a day to respond to a crisis. Many crises happen at night, and the crisis team and project staff should be ready to respond even at odd hours.
- All crisis mobile numbers are widely circulated within the community through practical, pocket-sized crisis cards printed in the local language as well as English. The card lists the mobile phone numbers and describes the kind of crisis management that the NGO/CBO offers to the community.

## Examples of Crisis Intervention Materials

Below is an information card for a crisis intervention programme targeting MSM and TGs.



## Summarise the session:

- Crisis response interventions increase outreach to members of the HRG, thereby strengthening the NGO's or CBO's relationship with them and gaining their trust.
- There can be many ways to establish a crisis response system and it depends upon the availability of resources and requirement of community members.
- PEs should discuss formation of crisis management systems at project levels and with community members and come up with appropriate systems.



### Session 3: Going Beyond HIV (General Health, Self Help Groups and Social Entitlements)

<b>Session 3</b>	Going Beyond HIV (General Health, Self Help Groups and Social Entitlements)
<b>Objective</b>	To help participants understand their role in helping community members beyond HIV
<b>Expected Outcome</b>	The participants will be able to identify and help community members during other health, social and economical needs. The participants will include issues like general health, self help group (SHG) formation and collectivisation in their one-to-one communication with the community members
<b>Duration</b>	45 mins
<b>Methodology</b>	Group work, Discussion, Presentation, Explanation
<b>Material/Preparation required</b>	Chart papers, marker pens, Talking Points Visual Aid (2 flipbooks) For the last part of session a resource person can be invited who knows about the various social entitlements and how to avail the same. This could be someone from the government department or someone from the NGO who has experience working on this issue

## Process

- As this the last main session before the end of the workshop, encourage the PEs to recap the role of PEs discussed so far.
- Introduce two important components of work beyond HIV that need to be part of the PE's tasks:
  - Talking about general health
  - Talking about SHGs and collectivization
- Introduce the Talking Points Visual Aid on general health and SHGs to the participants.

## Talking Points

### 1. General Health

- a. Health and hygiene:
  - i. Collect your drinking water from a safe source
  - ii. If you doubt the safety of water, boil the water for 20 minutes before use

- iii. Eat home-cooked food as far as possible. Outside food is not always prepared in hygienic conditions. Eating unhygienic food can make us sick. One can get stomach infection and vomiting which can sometimes be serious.
- iv. Stay away from alcohol and tobacco. Using these can cause diseases such as cancer, insomnia, jaundice etc. Besides, if we are intoxicated before attending to a customer, we may not always be able to insist the customer to wear a condom. This can put our lives in danger.



- b. Individual cleanliness:  
A person can maintain personal hygiene by:
  - i. Taking bath every day
  - ii. Changing clothes and undergarments every day. Using freshly washed clothes everyday
  - iii. Washing hands with soap before and after a meal
  - iv. Washing private parts after every sexual intercourse
  - v. Keeping the nails cut and clean
- c. Cleanliness of surroundings:
  - i. Keep your surroundings clean by disposing household waste and garbage in bins
  - ii. Avoid having pools of stagnant water collected in your area. This can lead to breeding of mosquitoes and as a result diseases like malaria can spread
  - iii. Do not spit in open and public places. Use spittoons
  - iv. Always dispose used condoms in garbage after wrapping it in a piece of paper

## 2. Getting Social Entitlements

Besides the above, PEs with help of TI can help the community members in meeting other needs like –

- Getting ration card.
- Getting children of HRGs admitted to school.
- Opening bank accounts.
- Any other applicable benefit from state or central government.
- Divide the participants in 3-4 small groups and provide each participant with the visual aid (available with the training package).
- Together, each group memorizes the talking points and practices the same within the group.
- After the group work, ask participants to come forward at random and enact how they will talk about a particular issue with a community member (the participant is asked to use the learnings from the visual aid).
- At the end introduce the resource person and inform the participants that they would now discuss about social entitlements.
- Ensure the resource person covers the following:
  - Various social entitlements that can be accessed by HRGs.
  - Support required by PEs from the NGO and other support structures like DAPCU and SACS to meet these needs.



- Wrap up the session and training programme by stating the following points:
  - A PE is the backbone of the TI project.  
He has many roles to play as has been discussed over the past 4 days.
  - As a PE is part of the community it is important that he acts as a link between the community members and the project.
  - Apart from providing useful information on STI and HIV/AIDS, including information on condom usage, the PE has to provide information on other issues like general health and hygiene, government services available, etc.
  - A PE has to ensure that she/he documents her work as that has a dual purpose:
    - It helps her/him keep track of work she/he has done and plan accordingly.
    - It helps the project plan and strategize to reach out to maximum community members.
  - A PE should not only provide information on key issues (using the flipbooks she/he has learnt about during this training) but also encourage discussions and participation using IPC tools.

## Evaluation of Day 4

Date:

Participant's Name (Optional):

Session	Particulars	Feedback			Remarks*
		Good	Ok	Poor	
	Overall response to today's session				
1	Monitoring and Documentation (Peer Map, PE Weekly Planning and Activity Sheet)				
2	Crisis Management				
3	Going Beyond HIV (General Health, And Social Entitlements)				

Any other comments

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\*Please comment on duration, content, methodology and visual aids



## Session 4: Training Evaluation

<b>Session 4</b>	Training Evaluation
<b>Objective</b>	To understand the response of participants to the training workshop
<b>Expected Outcome</b>	Participants share their opinion about the training workshop and provide feedback to the trainer
<b>Duration</b>	30 mins
<b>Methodology</b>	Exercise
<b>Material/Preparation required</b>	A setoff 18 tokens (6 red,6 green,6 yellow)for each participant, list of questions, 6 boxes If tokens are not available, the facilitator can use locally available materials like gram, peas or stones

## Process

- Request the participants to give their honest feedback about what they felt about the training workshop.
- Handout a set of 18 tokens to each participant. Each participant will get 6 red,6 yellow and 6 green tokens. In the mean while, the facilitator will keep 6 boxes ready (these boxes should have a slit so that the tokens can be put in).
- The facilitator will then explain to the participants that she/he will read out a question. The participant should decide which token is the appropriate answer for that question and put that token in the box for that question. So, if the answer is:
  - ‘Very Good ’or ‘very useful ’then a green token is to be put in.
  - ‘Ok ’then a yellow token is to be put in.
  - ‘Not So Good’ or ‘not so useful ’then a red token is to be put in.
- For each question, the facilitator will use a different box.

## Questions for feedback

1. Whether the content covered in the training workshop would be useful for the participants in the work which they are doing?
2. How were the methodologies used in the training workshop?
3. How was the time management?
4. How were the accommodation arrangements?
5. How were the food arrangements?
6. How will they rate the overall training?



Collect the remaining tokens from the participants and later analyse the responses of the participants.

- It would also be useful to generate a discussion around suggestions that participants have for further enhancement of such training and areas on which they feel they would need refresher training.
- The facilitator will now close the workshop by thanking all the members for their participation.



# Annexure: Energizers





# Energizers

1. Divide participants into small groups of five or six. Group members have to hold hands, but with the following conditions: No one can hold the hand of the person next to her ;no one must hold both the hands of the same person. The group will thus be linked together in a 'knot'. The aim of the game is to unravel the knot without letting go of the hands at any point, and form a circle again. Ask participants to try different ways to remove the knot—passing under the hands, turning around, and soon. Most groups are able to succeed in this task within a few minutes, so do encourage them to keep trying.

In the next round, you could get all the smaller groups to join together so that one large circle is formed. The game is then played in the same way. In this case, un-raveling the knot is much more difficult, but do let participants try for as long as they would like to.

Have a brief discussion at the end, to make the point that while there may be some problems that are too big and complex for a PE to resolve (just as the second knot was difficult to unravel), there are several others that he can overcome with the support of her colleagues and his own determination. Also, it is important for PEs to remember that the community can solve its own problems so a PE should just act as a catalyst and help the community unravel the 'knot'.

2. Divide participants into pairs. In each pair, one participant is 'A' and another 'B '.The 'A's have to mime some action and the 'B's have to copy them exactly, as if they were mirror images of 'A'. After a few minutes, 'B' could mime the actions and 'A' could become the mirror image.
3. Ask participants to sit in a circle. One person should volunteer to leave the room. The participants then select a ' leader' who has to perform some action such as clapping, tapping her foot, or waving her hands. The group has to follow the leader's actions. The person sent outside then comes back to the room; she has to guess who the leader is. The leader has to change her actions every few minutes and the rest of the group must follow the sections. But the group has to be careful to do so without looking at the leader, so they don't give her away. If the leader is 'caught', then she leaves the room, another leader is selected and the game continues.
4. Divide participants into pairs and ask everyone to observe their partners closely. Then one person in each pair has to go out of the room, while her partner makes some small change to her appearance (for example, she could remove her bangle, or wear her dupatta differently, or even exchange her shoes with someone else). The first person is then called back ;she has to say what is different about her partner. If she guesses correctly, it is her turn to change her appearance while her partner goes out.
5. Ask participants to stand up, and tell them that they must follow what you say. Now give instructions while also performing some action (for example, raise your hands and say, "Raise

your hands”; then close your eyes and say, “Close your eyes”). After the first few times, say something and do something quite different from what you are saying (for example, raise your right leg while saying “Raise your right arm”); it is likely that the group will follow your actions rather than your words. Point this out; then play a few more rounds of the game, occasionally miming an action that is completely different from your instruction.

6. Ask participants to stand in a circle, while you stand in the middle. The aim of the game is to create a story, with everyone contributing one sentence. You could begin by describing an action in a couple of sentences (for example, “The boy realized that it was going to rain. He was not sure if he would be able to catch the bus.”) and then ask a participant to add a sentence to take the story forward (for example, she could say, “Suddenly he saw someone crossing the road.”); the next participant adds another sentence, and so on, until everyone has contributed to the story. Make sure participants understand that their sentence should add something so the story moves forward; if anyone has any difficulty, you could step in with another sentence and then help participants to continue. The game ends either when everyone has had her say or when there is a clear end to the story they have created.



# Assessment Tool (Can be used for Pre-Training and Post-Training assessment)

Assessment of HIV and AIDS-Related Knowledge It is very important that the trainer ensure that the peer educators have a solid understanding of HIV and AIDS-related information to expel any myths or misconceptions that they may have.

## The assessment is divided into 4 parts

1. HIV and AIDS
2. STIs
3. Condom Use
4. Testing and Counseling

There are various ways a trainer can present the assessment. If the group is literate, they may be given the assessment individually. At the end of the training, the same assessment could be given to see what they learned and retained. If the group has low-literate participants, the questions may be read out loud. The trainer could designate a hand or body signal for statements that are true and another signal for statements that are false. For example, if a statement is true, a participant could raise one hand; if a statement is false, a participant could stand up.

Alternately, the assessment may be presented in a game format. The trainer reads a question to one group and they must decide on an answer. If they get it right, they get one point; if they get it wrong, they don't get any points. The trainer can also provide extra points if a group provides an explanation. The trainer should also make recommendations to the peer educators' organizations so that specific topics can be reviewed or presented in more detail during their monthly organizational meetings. Remember, learning should be an on-going process!

## HIV and AIDS True or False

1. HIV is the virus that causes AIDS. **True**

2. When having anal sex, the man on the top (insertive or active) is not at risk of contracting HIV. **False**
3. HIV is spread by kissing. **False**
4. You can get HIV by giving blood. **False**
5. Someone who has HIV but looks and feels healthy can still infect other people. **True**
6. Drinking alcohol can increase the risk of getting HIV. **True**
7. Mosquitoes can spread HIV. **False**
8. Sharing needles to inject drugs can spread HIV. **True**
9. Using a latex condom during sex can reduce the risk of getting HIV. **True**
10. You can get HIV from a toilet seat. **False**
11. Most people who get infected with HIV become seriously ill within three years. **False**
12. Vaccination can protect people from HIV infection. **False**
13. AIDS is a syndrome that has no cure. **True**
14. Anal sex is safer than vaginal sex. **False**
15. There is no risk of HIV transmission during oral sex. **False**

## STIs True or False

1. A person can always tell if he or she has an STI. (**False**; people can have STIs without having any symptoms.)
2. It is impossible for STIs to enter through a condom if it is properly used and doesn't break. (**True**; the small particles that cause STIs cannot penetrate latex [male condoms] or polyurethane [female condoms].)
3. With proper medical treatment, all STIs except HIV can be cured. (**False**; Genital Herpes and Genital Warts, which are caused by viruses, cannot be cured, although their symptoms can be treated.)
4. You cannot contract STIs by holding hands, talking, walking or dancing with a man. (**True**; most STIs are spread by close sexual contact with an infected person.)
5. The organisms that cause STIs can only enter the body through either a man's penis or a woman's vagina. (**False**; STI bacteria and viruses can enter the body through any mucus membranes — including the penis, anus, vagina, mouth, and in some cases the eyes — or through shared needles.)
6. Many curable STIs, if left untreated, can cause severe complications. (**True**; some complications can lead to death from liver disease; other complications can lead to heart failure or damage to the brain.)
7. People who have an STI should not have unprotected sex, because they are more likely to contract or transmit the HIV infection. (**True**; this is because infection with STIs makes a person more likely to contract or transmit HIV, especially when the other STIs have caused open sores. The inflamed areas act like an open window, allowing the HIV to enter.)
8. Abstinence or having only one faithful sexual partner who is not affected is the only 100% way to avoid getting an STI. **True**
9. You can get Hepatitis from fingering and rimming. **True**



## Condom Use True or False

1. Condoms prevent STIs and HIV. **True**
2. Putting male condoms on can be sensual. **True**
3. Wearing two male condoms provides more protection than one condom. **False**
4. Condoms always cause irritation and pain. **False**
5. Condoms show you care for your regular partner. **True**
6. Male condoms are made out of latex rubber. **True**
7. One size of male condoms fits all. **True**
8. Using a male and female condom at the same time offers you greater protection against HIV and other STIs. **False**
9. Condoms prevent pregnancy. **True**
10. Condoms break a lot. **False**

## Testing and Counselling True or False

1. A positive test means that a person has AIDS (**False**; a positive test means a person has HIV.)
2. An MSM who has several partners and always uses a condom with his casual partners but sometimes does not with his regular partner goes for ICICTC and tests negative. He must go back for another test in 1 month. (**False**; he should test again, but after three months.)
3. ICTC can tell a person when he was infected with HIV. (**False**; testing can only tell a person whether or not they have HIV.)
4. ICTC tests for the HIV in the body. (**False**; the test looks for HIV antibodies in the body.)
5. If a person tests positive for HIV, he will be given drugs to kill the HIV virus. (**False**; antiretroviral drugs (ARV) are available to boost a person's immune system but do not kill the virus.)
6. People living with HIV can be cured with some herbal preparations. (**False**; Bedridden people must be taken to clinics/hospitals PE.)



