Basics of HIV Prevention and Outreach Planning (Pre-TI)

Pehchan Training Curriculum
MSM, Transgender and Hijra Community Systems Strengthening

Facilitator Guide

Basics of HIV Prevention and Outreach Planning (Pre-TI)
Pehchan Consortium Partners

India HIV/AIDS Alliance (www.allianceindia.org)

Pehchan Focus: National coordination and grant oversight
Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations most vulnerable to HIV, including men who have sex with men (MSM), transgenders, hijras, people who use drugs (PWUD), sex workers, youth, and people living with HIV (PLHIV).

Alliance India Andhra Pradesh

Pehchan Focus: Andhra Pradesh
Alliance India supports a regional office in Hyderabad that leads implementation of Pehchan in Andhra Pradesh and serves as a State Lead Partner of the Bill & Melinda Gates Foundation.

The Humsafar Trust (www.humsafar.org)

Pehchan Focus: Maharashtra, Madhya Pradesh, Goa, Gujarat and Rajasthan
For nearly two decades, Humsafar Trust has worked with MSM and transgender communities in Mumbai, Maharashtra. It has successfully linked community advocacy and support activities to the development of effective HIV prevention and health services. It is one of the pioneers among MSM and transgender organisations in India and serves as the national secretariat of the Indian Network for Sexual Minorities (INFOSEM).

Pehchan North Region Office

Pehchan Focus: Punjab, Delhi, Uttar Pradesh and Bihar
Alliance India supports a regional implementing office based in Delhi that leads implementation of Pehchan in four states of North India.

Solidarity and Action Against The HIV Infection in India (SAATHII) (www.saathii.org)

Pehchan Focus: West Bengal, Manipur, Orissa and Jharkhand
With offices in five states and over 10 years of experience, SAATHII works with sexual minorities for HIV prevention. SAATHII works closely with the West Bengal’s State AIDS Control Society (SACS) and the State Technical Support Unit and is the SACS-designated State Training and Resource Centre for MSM, transgender and hijra.

South India AIDS Action Programme (SIAAP) (www.siaapindia.org)

Pehchan Focus: Tamil Nadu
SIAAP brings more than 22 years of experience with community-driven and community development focussed programmes, counselling, advocacy for progressive policies, and training to address HIV and wider vulnerability issues for MSM, transgender and hijra community.

Sangama (www.sangama.org)

Pehchan Focus: Karnataka and Kerala
For more than 20 years, Sangama has been assisting MSM, transgender and hijra communities to live their lives with self-acceptance, self-respect and dignity. Sangama lobbies for changes in existing laws that discriminate against sexual minorities and for changing public opinion in their favour.
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About this Module

This module was designed to help training participants: 1) learn basic facts about HIV/AIDS and STIs; 2) understand the roles and responsibilities of outreach workers and peer educators; and 3) appreciate the value of needs assessments, implementation planning, behaviour change communication, linkages and referrals, Drop-in-Centre management, condom promotion, and negotiation skills. In the Pehchan programme, this module orients participants on India’s National AIDS Control Programme and its Targeted Intervention prevention strategy and is used specifically with CBO Programme Managers, Programme Officers, Counsellors, and Outreach Workers.

About Pehchan

With financial support from the Global Fund, Pehchan is building the capacity of 200 community-based organisations (CBOs) for men who have sex with men (MSM), transgenders and hijras in 17 states in India to be more effective partners in the government’s HIV prevention programme. By supporting the development of strong CBOs, Pehchan addresses some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming. Named Pehchan, which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme will reach 453,750 MSM, transgenders and hijras by 2015. It is the Global Fund’s largest single-country grant to date, focused on the HIV response for vulnerable sexual minorities.

Training Curriculum Overview

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and to increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. To build CBO capacity, Pehchan developed a robust training programme through a process of engagement with community leaders, trainers, technical experts, and academicians in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Inputs from community consultations helped increase relevance and value of training modules. By engaging MSM, transgender and hijra (MTH) communities in the development process, there has been greater ownership of training and of the overall programme among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy. Thus, through a consultative, community-based process, Pehchan developed a training model responsive to the specific needs of the programme and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs in India.
Preface

As I put pen to paper, a shiver goes down my spine. It is hard to believe that this day has come after almost five long years! For many of us, Pehchan is not merely a programme; it is a way of life. Facing a growing HIV epidemic among men who have sex with men (MSM), transgender, and hijra communities in India, a group of development and health activists began to push for a large-scale project for these populations that would be responsive to their specific needs and would show this country and the world that these interventions are not only urgently needed but feasible.

Pehchan was finally launched in 2010 after more than two years of planning and negotiation. As the programme has evolved, it has never stepped back from its core principle: Pehchan is by, for and of India’s MSM, transgender and hijra communities. Leveraging rich community expertise, the Global Fund’s generous support and our government’s unwavering collaboration, Pehchan has been meticulously planned and passionately executed. More than just the sum of good intentions, it has thrived due to hard work, excellent stakeholder support, and creative execution.

At the heart of Pehchan are community systems strengthening. Our approach to capacity building has been engineered to maximise community leadership and expertise. The community drives and energises Pehchan. Our task was to develop 200 strong community-based organisations (CBOs) in a vast and complex country to partner with state governments and provide services to MSM, transgender and hijra communities to increase the effectiveness of the HIV response for these populations and improve their health and wellbeing. To achieve necessary scale and sustain social change, strong CBOs would require responsive development of human capital.

Over and above consistent services throughout Pehchan, we wanted to ensure quality. To achieve this, we proposed a standard training package for all CBO staff. When we looked around, we found there really wasn’t an existing curriculum that we could use. Consequently, we decided to develop one not only for Pehchan but also for future efforts to build the capacity of community systems for sexual minorities. So began our journey to create this curriculum.

Building on the experience of Sashakt, a pilot programme supported by UNDP that tested the model that we’re scaling up in Pehchan, an involved process of consultations and workshops was undertaken. Ideas for each module came from discussions with a range of stakeholders from across India, including community leaders, activists, academics and institutional representatives from government and donors. The list of modules grew with each consultation. For example in Sashakt, we had a single training module on family support and mental health; in Pehchan, we decided that it would be valuable to split these and have one on each.

Eventually, we agreed on the framework for the modules and the thematic components, finding a balance between individual and organisational capacity. Overall, there are two main areas of capacity building: one that is directly related to the services and the other that is focused on building capable service providers. Then we began the actual writing of the curriculum, a process of drafting, commenting, correcting, tweaking and finalising that took over eight months.
Once the curriculum was ready to use, trainings-of-trainers were organised to develop a cadre of master trainers who would work directly with CBO staff. Working through Pehchan’s four Regional Training Centers, these trainers, mostly members of MSM, transgender and hijra communities, provided further in-service revisions and suggestions to the modules to make them succinct, clear and user-friendly. Our consortium partner SAATHII contributed particularly to these efforts, and the current training curriculum reflects their hard work.

In fact, the contributors to this work are many, and in the Acknowledgements section following this Preface, we have done our best to name them. They include staff from all our consortium partners, technical experts, advocates, donor representatives and government colleagues. The staff at India HIV/AIDS Alliance, notably the Pehchan team, worked beautifully to develop both process and content. That we have come so far is also a tribute to vision and support of our leaders, at Alliance India and in our consortium partners, Humsafar Trust, SAATHII, Sangama, and SIAAP, as well as in India’s National AIDS Control Organisation and at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

We would like to think of the Pehchan Training Curriculum as a game changer. While the modules reflect the specific context of India, we are confident that they will be useful to governments, civil society organisations and individuals around the world interested in developing community systems to support improved HIV and other health programming for sexual minorities and other vulnerable communities as well.

After two years of trial and testing, we now share this curriculum with the world. Our team members and master trainers have helped us refine them, and seeing the growth of the staff in the CBOs we have trained has increased our confidence in the value of this curriculum. The impact of these efforts is becoming apparent. As CBOs have been strengthened through Pehchan, we are already seeing MSM, transgender and hijra communities more empowered to take charge, not only to improve HIV prevention but also to lead more productive and healthy lives.

Sonal Mehta
Director: Policy & Programmes
India HIV/AIDS Alliance
New Delhi
March 2013
General Acknowledgements

The Pehchan Training Curriculum is the work of many people, including community members, technical experts and programme implementers. When we were not able to find training materials necessary to establish, support and monitor strong community-based organisations for MSM, transgenders and hijras in India, the Pehchan consortium collectively developed a curriculum designed to address these challenges through a series of community consultations and development workshops. This process drew on the best ideas of the communities and helped develop a responsive curriculum that will help sustain strong CBOs as key element of Pehchan.

We would like to take this opportunity to acknowledge the contributions of those who helped in taking this process forward, including (in alphabetical order): Ajai, Praxis; Usha Andewar, The Humsafar Trust; Sarita Barapanda, IWW-UK; Jhuma Basak, Consultant; Dr. V. Chakrapani, C-Sharp; Umesh Chawla, UNDP; Alpana Dange, Consultant; Brinelle D’Sourza, TISS; Firoz, Love Life Society; Prashanth G, Maan AIDS Foundation; Urmiji Jadav, The Humsafar Trust; Jeeva, TRA; Harleen Kaur, Manas Foundation; Krishna, Suraksha; Monica Kumar, Manas Foundation; Muthu Kumar, Lotus Sangama; Sameer Kunta, Avahan; Aghina Lahiri, PLUS; Meera Limaya, Consultant; Veronica Magar, REACH; Magdalene, Center for Counselling; Sylvester Merchant, Lakshya; Amrita Nanda, Lawyers’ Collective; Nilanjan, SAFRG; Prabhakar, SIAAP; Priti Prabughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeeta Singh, Amalatas; Prabhakar Sinha, Heroes Project; Sreeram, Ashodaya Samithi; Suresh, KHPT; Sanjibnath Veul, JHU; and Roy Wadia, Heroes Project.

Once curricular framework was finalised, a group of technical and community experts was formed to develop manuscripts and solicit additional inputs from community leaders. The curriculum was then standardised with support from Dr. E.M. Sreejit and streamlined with support from a team at SAATHII, led by Pawan Dhall. This process included inputs from Sudha Jha, Anupam Hazra, Somen Acharya, Shantanu Pyne, Muyazzam Hossain, Amitava Sarkar, and Debjyoti Ghosh Dhall from SAATHII; Cairo Araijo, Vaibhav Saria, Dr. E.M. Sreejit, Jhuma Basak, and Vahista Dastoor, Consultants; Olga Aaron from SIAAP; and Hariyot Khosa and Chaitya Bhatt from India HIV/AIDS Alliance.

From the start, the Government of India’s National AIDS Control Organisation has been a key partner of Pehchan. In particular, Madam Aradhana Johri, Additional Secretary, NACO, has provided strong leadership and steady guidance to our work. The team from NACO’s Targeted Intervention (TI) Division has been a constant friend and resource to Pehchan, notably Dr. Neeraj Dhingra, Deputy Director General (TI); Manilal N. Raghvan, Programme Officer (TI); and Mridu, Technical Officer (TI). As the programme has moved from concept to scale-up, Pehchan has repeatedly benefitted from the encouragement and wisdom of NACO Directors General, past and present, including Madam Sujata Rao, Shri K. Chandramouli, Shri Sayan Chatterjee, and Shri Lov Verma.

Pehchan is implemented by a consortium of committed organisations that bring passion, experience, and vision to this work. The programme’s partners have been actively engaged in developing the training curriculum. We are grateful for the many contributions of Anupam Hazra and Pawan Dhall from SAATHII; Hemangi, Pallav Patnaik, Vivek Anand and Ashok Row Kavi from the Humsafar Trust; Olga Aaron and Indumati from SIAAP; Vijay Nair from Alliance India Andhra Pradesh; and Manohar from Sangama. Each contributed above and beyond the call of duty, helping to create a vibrant training programme while scaling up the programme across 17 states.
India HIV/AIDS Alliance’s Pehchan team has been untiring in its contributions to this curriculum, including Abhina Aher, Jonathan Ripley, Yadvendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nunthuk Vunghoihkim, Ramesh Tiwari, Sarbeshwar Patnaik, Ankita Bhalla, Dr. Ravi Kanth, Sophia Lonappan, Rajan Mani, Shaleen Rakesh, and James Robertson. A special thank-you to Sonal Mehta and Harjyot Khosa for their hard work, patience and persistence in bringing this curriculum to life.

Through it all, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided us both funding and guidance, setting clear standards and giving us enough flexibility to ensure the programme’s successful evolution and growth. We are deeply grateful for this support.

Pehchan’s Training Curriculum is the result of more than two years of work by many stakeholders. If any names have been omitted, please accept our apologies. We are grateful to all who have helped us reach this milestone.

The Pehchan Training Curriculum is dedicated to MSM, transgender and hijra communities in India who for years, have been true examples of strength and leadership by affirming their pehchan.
Module Acknowledgments: Basics of HIV Prevention and Outreach Planning (Pre-TI)

Each component of the Pehchan Training Curriculum has a number of contributors who have provided specific inputs. For this component, the following are acknowledged:

**Primary Authors**
Meera Limaya and Muthu Kumar, Consultants; and Yashwinder Singh and Chaitanya Bhatt, India HIV/AIDS Alliance

**Compilation**
Dr. E. M. Sreejit, Consultant

**Technical Input**
Olga Aaron, SIAAP; Souvik Ghosh, Sudip Chakraborty, Anupam Hazra and Debjyoti Ghosh, SAATHII

**Coordination and Development**
Vahista Dastoor, C4D Consultant
Pawan Dhall, SAATHII

**References**
- Targeting HIV Prevention, 2009, Animation, Boehringer, C., Sohn, A.G and Ko, Ingelheim, Germany.
About the Basics of HIV Prevention and Outreach Planning (Pre-TI) Module

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<tbody>
<tr>
<td>Name</td>
<td>Basics of HIV Prevention and Outreach Planning</td>
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</table>
| Pehchan Trainees | • Project Officer  
• Counsellor  
• Outreach Workers  
• Administrative and Finance Officer |
| Pehchan CBO Type | Pre-TI |
| Training Objectives | By the end of the training, the participants will:  
• Gain a basic understanding on HIV, AIDS and STIs and their prevention, care, support and treatment;  
• Learn about basics of behaviour change communication (BCC), peer education, outreach work; and  
• Learn the basics of Drop-in Centre (DIC) management, linkages and referrals, and crisis management. |
| Total Duration | Two days. A day's training typically covers 8 hours. |

Module Reference Materials

All the reference material required to facilitate this module has been provided in this document and in relevant digital files provided with the Pehchan Training Curriculum. Please familiarise yourself with the content before the training session.

**Attention:** Please do not change the names of file or folders, or move files from one folder to another, as some of the files are linked to each other. If you rename files or change their location on your computer, the hyperlinks to these documents in the Facilitator Guide will not work correctly.

If you are reading this module on a computer screen, you can click the hyperlinks to open files. If you are reading a printed copy of this module, the following list will help you locate the files you need.

**Audio-visual Support**

**Annexures**
1. Annexure 1 on ‘Points for Discussion’.
## Activity Index

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity Name</th>
<th>Time</th>
<th>Material</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Basics of HIV and STI Prevention, Care, Support</td>
<td>2 hours</td>
<td>N/A</td>
<td>Refer to the slides titled ‘HIV/AIDS and Modes of Transmission’, to ‘Positive Prevention’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’ Audio-video clip on ‘Targeting HIV Prevention’</td>
<td>N/A</td>
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<td></td>
<td>and Treatment</td>
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<tr>
<td>2</td>
<td>Programming Outreach and Preventions: The Pehchan</td>
<td>3 hours</td>
<td>Annexure</td>
<td>Refer to the slides titled ‘Roles and Responsibilities of ORWs and PEs’ to ‘Condom Availability and Accessibility’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
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</tr>
<tr>
<td></td>
<td>Approach</td>
<td></td>
<td>1 on ‘Points for Discussion’</td>
<td>Chart papers and markers</td>
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<td>3</td>
<td>Community Building and Communication</td>
<td>2 hours</td>
<td>Chart paper, sketch pens, markers</td>
<td>Refer to the slides titled ‘Behaviour Change Communication’ to ‘Dialogue-based Inter-personal Communication’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
<td>N/A</td>
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<td>30 minutes</td>
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<td>4</td>
<td>Referral and Linkages</td>
<td>2 hours</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Referrals and Linkages’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
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<tr>
<td>5</td>
<td>Drop-in-Centre Management</td>
<td>2 hours</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Drop-in Centre Management’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
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<td>6</td>
<td>Condom Promotion and Negotiation Skills</td>
<td>2 hours</td>
<td>N/A</td>
<td>Refer to the slides titled ‘Condom Promotion and Negotiation’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
<td>N/A</td>
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<tr>
<td>7</td>
<td>Overview of NACP III</td>
<td>2 hours</td>
<td>N/A</td>
<td>Refer to the slides titled ‘HIV/AIDS Overview &amp; Update on NACP III Interventions’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’</td>
<td>N/A</td>
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1 Overhead projector, laptop, sound system and whiteboard should be provided at every training.
Activity 1: Basics of HIV and STI Prevention, Care, Support and Treatment

<table>
<thead>
<tr>
<th>Time</th>
<th>2 hours</th>
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| Learning Outcomes | By the end of this activity, the participants will be able to articulate, using simple language, the following:  
• Basic concepts of HIV/AIDS;  
• Methods of HIV prevention;  
• Common symptoms of STIs; and  
• The link between STIs and HIV. |
| Materials | N/A |
| Take-home Material | N/A |

Methodology

Part I: HIV/AIDS and Modes of Transmission

Using the PowerPoint presentation ‘HIV/AIDS and Modes of Transmission’ ask the participants about the differences between acquiring the human immuno-deficiency virus (HIV) and acquired immuno-deficiency syndrome (AIDS) and what these terms are all about.

Screen the movie ‘Targeting HIV Replication’ to the participants. Before screening, brief the participants that this movie will give them an idea of how HIV replicates within the human system and how the body tries to battle the HIV virus with the aid of Antiretroviral Drugs. After that, using the slides titled ‘Basics of HIV/AIDS and Link between HIV and AIDS’, clarify to the participants the difference between the two terms.

Using the slide titled ‘Symptoms of HIV/AIDS’ briefly discuss the manifestations of HIV and AIDS.

Tell participants that the HIV infection has different stages: ask them what they know about these stages. After allowing a discussion for five minutes, use the slides titled ‘Stages of HIV Infection’ to talk about the different stages. Briefly mention the role of CD4 cells as ‘protectors of immunity’.

While discussing the fourth stage, start an interactive discussion on Opportunistic Infections (OIs). After a few minutes of interaction, display and elaborate on the information in the slide titled ‘Opportunistic Infections’.

Note to Facilitator

Try to familiarise yourself with local terminology and use them as far as possible.  
Do not use technical jargon. Use simple and local language; it will help the participants understand the subject better.
Proceed to the slide titled ‘How is HIV transmitted’.

- Ask participants what they think are the main modes of transmission and note them down on a flip-chart.
- Match what you have written down with the pictures that are shown in the presentation.
- Conduct an interactive session on the best ways to protect oneself from any STI transmission, including HIV.

**Part II: Sexually Transmitted Infections**

Start the session by asking the participants what they understand by ‘Sexually Transmitted Infections’ or STIs (‘Guptrog’ in Hindi). List down key responses related to STIs.

Using the slide titled ‘Sexually Transmitted Infections’, explain that:

- STIs are infections that are mainly passed from one person to another during vaginal, anal or oral sex;
- There are about 25 different STIs with different symptoms;
- The term STI is often preferred to the term sexually transmitted disease (STD) because there are a few STDs, such as chlamydia, that can infect a person without causing any obvious disease or symptoms (asymptomatic STI);
- STIs are commonly transmitted through vaginal, anal and oral sexual intercourse or other (non-penetrative) sexual contact. But some STIs like syphilis and hepatitis B may also be transmitted non-sexually through infected blood transfusion or by using infected needles and syringes, or from mother to child; and
- HIV is also a type of STI, but has many unique characteristics that set it apart from other STIs, particularly with regard to its symptoms and impact on health.

Ask the participants what they perceive to be common STI symptoms. Take down their responses on a white board and discuss the following:

- How STI symptoms can vary: they may range from genital soreness and ulceration, unusual lumps, itching, pain when urinating, and/or an unusual discharge from the genitals – in both males and females, and also how symptoms among females maybe more complicated.
- How these symptoms help in diagnosis using syndromic management protocols in the resource-constrained settings of India (as a substitute for expensive laboratory test-based diagnoses).
- Common STIs among men who have sex with men (MSM), male-to-female transgendered persons (TGs) and hijras (all grouped together as MTH), are syphilis, gonorrhoea, hepatitis B. Ask the participants to add to the list.

Discuss the following:

- Most STIs are completely curable (except hepatitis B and C).
- Why STIs must be treated as early as possible because they cause complications, including increased risk for HIV transmission.
- Why it is important to go to a qualified doctor for early and complete treatment as soon as one suspects symptoms suggestive of STI or possibility of having been exposed to an STI. Point out the importance of going to the doctor and that too frequently (e.g., every three months) for check-ups.

**Note to Facilitator**

If one of the partners in a sexual relationship is infected by an STI, then both need to undergo a check-up, as per doctors’ advice, to avoid transmission and re-infection. This should be done even if the sexual partner does not have any symptoms of STI. Thus it is imperative to point out the importance of getting the client’s sexual partners checked for STIs and treated for the same, if necessary (including their female sexual partners).
Bring to attention the necessity for the MTH clients to take the full dose/course of the treatment medicine to prevent complications and re-infection and why it is important to avoid sexual activity till the STI is cured, or at least use condoms wherever it is not possible to abstain from sexual activity.

Discuss the complications of untreated STIs:

- They can cause serious illness;
- Chance of contracting HIV is enhanced (ulcerative STIs);
- Some STIs can be passed from infected mother to foetus during pregnancy; and
- Long-standing STIs like gonorrhoea can cause blocks in the urinary tract.

Briefly summarise STI prevention measures: condom and lubricant usage for penetrative sex; non-penetrative sex and abstinence if visible sores and ulcers are present; and vaccination for hepatitis B as per the doctor’s advice.

Questions on vaccination for HIV may be anticipated and participants should be informed that research on vaccines is underway with no conclusive results are there so far.

Ask participants why they think STIs are within the ambit of Pehchan Programme. After they give their opinion, corroborate their statements (or refute if necessary) by mentioning that the prevalence of STIs amongst female sex workers (FSWs)/MSM/TG/Hijra/Injecting drug users (IDUs) is high, and the factors responsible for the high rate of STIs include low literacy levels, social taboos, stigma and low level of knowledge and information about STIs, which is where the project steps in.

**Part III: Avoiding HIV and STI**

**Tests for HIV and Pre- and Post-test Counselling for HIV Testing**

Display the slide titled ‘How to avoid HIV and STI Transmission’ at the start of the discussion. Write the answers on the whiteboard and then brainstorm with the participants about methods of avoidance other than those stated earlier either on the list or in the presentation.

Ask participants to make a note of all the methods which come up during this session. Also, remind them that this shall be further elaborated during the session on ‘Positive Prevention’. Also clarify ways in which HIV is NOT transmitted. Use the slide titled ‘You cannot get HIV from’.

Ask participants what they know about the various types of HIV testing. After about five minutes of interaction, use the slide titled ‘Tests for HIV’ to discuss the different types of HIV detection tests used in India.

Ask participants about the importance of counselling in HIV testing. Use the slides from ‘Goals of Pre and post Counselling’ till ‘Post Test Counselling for a Positive Test Result’ to elaborate on the different issues covered in pre- and post-test counselling.

Ask the participants if they are aware of the treatments available to persons infected with HIV (people living with HIV or PLHIV). Using the slide ‘What are antiretroviral drugs?’ explain what Antiretroviral Therapy (ART) is and tell them that ART starts only with a CD4 count of ≤350 cells/mm (this is current Indian standard, every country can have different standards) *(WHO, 2010)*.

Continue on the next slide, ‘How ART works in the body’. If possible, summarise briefly the information provided in the film screened at the start of the module. Discuss the issues mentioned in the slide notes at some length.
Part IV: Positive Prevention

Using the slides titled ‘Positive Prevention’ open the session by asking the participants to define what they understand by Positive Prevention. After about 10-15 minutes of discussion, explain how the National AIDS Control Programme (NACP) looks on HIV prevention as a core component, and what the goals and objectives are of prevention.

After explaining these goals, discuss the different types of behaviours which are considered to be high-risk. Then ask the participants who they think prevention programmes target.

Explain the basis of carrying out positive prevention programs and the understanding of susceptibility and risk. Explain to participants why understanding the basic facts of HIV and STI transmission is a key to positive prevention, and discuss at what levels interventions can be carried out.

In this segment, explain the idea of self-discipline. Have an open discussion with the group as to why an individual needs to take control of oneself and one’s conduct; for positive prevention.
Activity 2: Programming Outreach and Preventions: The Pehchan Approach

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<tr>
<th>Time</th>
<th>3 hours</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
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<td>• Be able to list the roles and responsibilities of Outreach Workers (ORWs) and Peer Educators (PEs);</td>
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<td></td>
<td>• Be able to explain the importance of conducting needs-assessment in the project, and the process involved in conducting a needs assessment;</td>
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<td>• Understand the need for and importance of using different tools to plan outreach, and receive hands-on training on using specific tools;</td>
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<td>• Understand how outreach activities are implemented at the field level; and</td>
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<td></td>
<td>• Be able to prepare the first draft of hotspot maps.</td>
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<tr>
<td>Materials</td>
<td>Chart papers and markers.</td>
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<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘Roles and Responsibilities of ORWs and PEs’ to ‘Condom Availability and Accessibility’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Hotspot maps created by the participants.</td>
</tr>
</tbody>
</table>

Methodology

Part I: Roles and Responsibilities of ORWs and PEs

Divide the participants into groups of six or seven participants each, and give each group chart papers and markers. Ask them to draw a line down the middle of the chart paper, dividing the paper into two columns. The first column should be titled Peer Educators (PE) and the second Outreach Workers (ORW).

Ask the groups to list the roles and responsibilities of each. Provide 10 minutes for this task. Ensure that the group has equal numbers of both ORWs and PEs in order to facilitate mutual learning. To save time, only one or two groups may be allowed to present their points.

Randomly select a group to present, and encourage other participants to provide feedback and add points from their lists (if not included). Display all the points on a chart paper so that they can be referred back to by the participants later on.

Using the slides titled ‘Roles and Responsibilities of ORWs and PEs’, explain the role of a PE – who is a PE is, why a PE’s role is important, especially when it comes to the programme and what are the duties of a PE. Explain the role of an ORW, and his/her importance in this project as well as his/her duties.

Wrap up this session by saying that the entire project depends on how well the PEs and ORWs do their jobs, and how well they coordinate with each other.
Part II: Needs-assessment Study

Start this session by dividing the participants in three groups. Tell the groups to deliberate on the following questions for ten minutes, listing their responses on a chart paper:

- Group 1: How do you think one can assess needs of the community?
- Group 2: What do you think are the needs of the community?
- Group 3: Who will be your key informants? How will you gather information from them?

Invite each group to present their responses to the larger group. Orient the participants on:

- What a needs-assessment is;
- Why needs-assessment is important for programmes like Pehchan;
- Who can conduct a needs-assessment;
- How it is conducted; and
- What are the various terminologies connected with it, such as ‘stakeholders’, ‘key informants’, ‘focus group discussions’ (FGDs) and ‘in-depth interviews’.

Point out to the participants that needs-assessment:

- Generates quantitative information as well as qualitative data;
- Involves establishing contact with MTH community members (it can help the programme to meet up to 50% of the estimated population in a given location on a one-to-one or group basis);
- Meeting the community helps in generating interest and curiosity about the Programme; and
- Helps in mobilising the community and in the process helps in understanding the community and its needs better.

Ask the participants to brainstorm on the process of conducting a needs-assessment exercise: how is data collected as a part of the needs-assessment exercise? Note their responses on a flip-chart and discuss the process adopted in an assessment. Explain to the group through the slides titled ‘Needs-assessment and Advanced Needs-assessment’ that data will be gathered from the field in three ways (in Pehchan Programme):

- From FGDs with the community (10-12 members in each FGD);
- In-depth interviews with 8-10 stakeholders and key informants, who are senior members in the community and who can give the required information on the overall community scenario; and
- Around 50-60 interviews with the MTH community members.

Explain that this exercise in Pehchan shall be carried out by external consultants. Also mention that the information gathered will be analysed and used for developing strategies and making decision and that this exercise provides first-hand information about the community: the lifestyle of its members, its vulnerability factors and risk-behaviours prevalent, its culture and many more community-related details.

In this context, mention the various themes which are included in needs-assessment of new CBOs in Pehchan [those implementing the Pre-targeted intervention (TI) package], and existing CBOs (those implementing the TI Plus package).

Explain how consultant support shall be given at various stages. Explain the steps that are needed for completing quarterly reports of the needs assessment.
Part III: Planning and Implementation

Start with a game. Ask one of the participants to stretch both arms as far as possible and then describe it as the ‘outreach’ of a person. Ask each participant to do the same, with all of the participants standing in a circle and touching each other with the tips of their fingers. At this point, explain how important it is to ‘reach out’ to the last person in the community and form a ‘protective circle’ around all the community members and provide them the benefits of an HIV intervention or other health projects.

Using the slides titled ‘Planning and Implementation’ discuss how:

- Outreach, broadly is an activity with an overall objective of raising awareness on HIV/AIDS and STIs, commodity distribution (condoms and lubricants) and promoting health-seeking behaviour; and
- It is important to study and understand the situation and work plan accordingly for an effective outreach programme as outreach is the backbone of any HIV intervention, particularly HIV prevention programmes (like the NACP-III, HIV TI programmes or Pehchan Pre-TI package).

Discuss with the participants that outreach is a systematic approach of delivering STI/HIV prevention services to high-risk groups (HRG) and that it includes:

- Contacting HRG (MTH) community members and building rapport with them; and
- Providing them information and services/material (condoms and lubricants) to prevent the spread of STI/HIV, and linking MTH community members to health and other services.

Explain the following:

- The objective of outreach planning is to enable outreach activities to reach 80-100 per cent of the available MTH population on a regular basis, in order to achieve maximum coverage and impact on HIV prevention;
- Outreach planning led by PEs is a process that empowers them and helps increase the ownership of the programme by the community and peers;
- How outreach planning as a process uses various tools to facilitate individual-level planning and follow-up of service uptake, based on individual risk and vulnerability profiles of HRG community members; and
- Benefits of outreach planning include:
  - Avoidance of duplication and diffusion of efforts and responsibility;
  - Clear demarcation of outreach sites (or hotspots) for better accountability of an individual PE;
  - Individual tracking of HRG members reached;
  - Help in planning outreach at the hotspots; and
  - Generating data for use in making decision.

Introduce a group activity regarding Outreach Area Mapping in the following manner:

- Divide the participants in three to four groups, and give them chart papers and markers. Also provide them with bindis or post-it notes in various colours.
- Ask each group to prepare a map for the area where they work. The map should include all the important roads and important places like schools, banks, hospitals, some shops, bars, and parks.
- After they finish drawing a map of their area, ask them to mark where the MTH community members are located and make note of how many are located at each hotspot. For instance, if it is a cruising site for MSM, like a public urinal, then make note of how many MSM cruise the place at any given time or how many are regular visitors to that site.
While the participants work on the numbers, ask them to provide the timings when these MTH community members are found in that area.

After the maps are prepared, explain that the map outlines the area of jurisdiction for each PE in the project area, and that hotspot mapping is one of the tools that can be used during their work in the area.

Explain the availability of various tools for outreach planning.

Using the slides titled ‘Hotspot Analysis Tool’ explain:

- How this tool helps:
  - To compile information in an urban situation; and
  - Also to undertake a needs-assessment related to each hotspot in this project area to facilitate planning;
- Why it is important to repeat the tool every six months as ground realities may change from time to time;
- How spot-specific information should be available to develop a plan for the spot, such as volume of MTH clients, typology, age groups, time of operation of the spot and frequency of operation; and
- Remind the participants of the following, to be kept in mind at all times when planning outreach:
  - Volume of clients: planning should ensure that the hotspots with higher client load need to be reached as a priority.
  - Typology: planning should be specific to each type of client (MSM/TG/Hijras).
  - All solicitation and service points need to be reached. ORW/PEs can directly reach the points or reach these through other community members. The ORWs need to advocate with concerned stakeholders there, such as person in-charge of a public urinal, guard of a park, local shopkeeper etc., so that a supportive environment for outreach is developed.
  - Age: MTH needs differ with respect to age, therefore planning needs to address this.
  - Time/day of operation: understanding the busy hours and days of operation will help plan outreach with respect to those times. Example: certain days in a month when more sexual activities or sex work takes place in a hotspot or more MTH people come to a particular spot such as a market during specific hours of a day. Outreach needs to be strengthened in those hours or on those days.
  - Evenings and nights may be busy at certain spots and hence the project needs to ensure the outreach is planned during those times of the day.

Introduce a group activity at this point. Divide the participants into smaller groups. Encourage the group to practice the Hotspot Analysis Tool in the group. The participants may use the flip-charts and marker pens for this purpose.

Call upon the group to make presentation to the remaining audience. Encourage a discussion on the following questions.

- What was the process followed by the group?
- What is the outcome of the exercise?
- How do you think this exercise will help in planning?
- What are the common mistakes made while using this tool?
- What are the consequences of such mistakes?
Use the slides titled ‘Contact Mapping’.

- Describe it as a tool to map contacts with MTH community members in each hotspot and to plan the outreach accordingly so that duplication of contacts can be avoided by the PEs.
- As a tool it needs to be used every six months to ensure all new MTH members at any given hotspot can be reached.
- Ask the participants to draw a map of a town or other working area and mark all the locations (including landmarks) and hotspots in the map and do the following:
  - Write the number of MTH in each spot.
  - Assign an easily recognisable label (like alphabets A, B, C or numbers 1, 2,3) to each ORW and PE.
  - Use colour codes to mark the MTH members who are associated with a particular ORW and PE. For example, assign colour to all the first PE’s MTH contacts in each hotspot. Repeat this activity for all PEs.
  - For each hotspot, list the names of contacts based on PE and ORW. Provide outreach site-wise/ hotspot-wise line listing.
  - The contacts which appear as common across the lists should be given a separate colour code.

Discuss the following:

- Which are the hotspots that have limited contacts?
- Where is outreach not happening? How do we increase outreach?
- Who are the contacts in each hotspot?
- Who is the project not reaching to?

Remind the participants that:

- This tool is for monitoring the work done by each PE at each hotspot;
- Contacts may not be mutually exclusive – the same community member may be counted twice by more than one PE; and
- Both geographic and social networks of PEs can play an important role in planning outreach.

Describe ‘Contact Mapping’ as a way to help participants understand who the contacts are after mapping them in each hotspot. To explain this better, carry out a group exercise in the following manner:

- Ask the original groups to get together and look at their map again.
- Ask each group to select three hotspots on the map that have the maximum number of contacts.
- Give the groups 30 minutes and ask them to list names of the contacts in each of the hotspots.
- Ask each group to answer the following questions and record their answers:
  - Which of the contacts does each ORW know very well?
  - What are the numbers and identities of the contacts that are known by more than one ORW?
After 30 minutes, ask each of the groups to present their group work. Again encourage the PEs to make the presentations. Ask participants what they learned and how it will help them in planning outreach. Conclude this part of the session by informing the group that:

- Both geographic networks and social networks of peers play an important role in planning outreach to the MTH community; and
- Mobility is a critical factor among MTH and hence the need to use the tool every six months as described in these group exercises.

Remind the participants that it is important to know:

- The number of contacts in each hotspot and whether we can increase that number in order to maximise the benefits to as many MTH members as possible;
- The contacts which may be missing from the list;
- That ORWs and PEs have contacts in more than one hotspot; and
- That peers have their own social networks, certain MTH members who they are friends with and have influence over.

Using the PowerPoint slides titled ‘Participatory Site Load Mapping’; explain to the participants that this tool is meant to:

- Help programme implementers understand the gap between estimates of MTH populations, the number of unique contacts and the number of regular contacts by studying the MTH load in a day, a week and a month in different outreach sites or hotspots;
- Give information on potential regular contacts: the potential number of MTH people the team based at the SSR level can contact in a month;
- Help understand the turnover of MTH people at a given outreach site in a day, a week and a month and compare the same with the number of unique contacts and the number of regular contacts at these sites; and
- In order to make the participants understand better, discuss with them that in order to reach out to MTH people it is important to know where and how many are available on a given day, a week and a month.

Divide the participants based on the organisation they belong to, and ask them to draw a map of the SSR’s working area, clearly depicting the sites at which MTH people pick up/solicit their clients/sex partners.

Ask the participants to colour-code outreach sites based on MTH sub-typology. Check that the participants have marked all the outreach sites based on MTH sub-typology. Once all the sites are marked, ask the participants to write down beside the site the number of MTH people who are always available on a normal day.

Next ask the participants to write the number of MTH people available at these outreach sites in a week. Check with the participants if there are any specific days in a week when the number of MTH people peaks and ask reasons for the same.

Once the above exercise is done, ask participants to mark the number of MTH people available in these outreach sites on a monthly basis and also ask if there are specific days in a month when the turnover is high and the reasons for the same. Then ask the participants to add the daily, weekly and monthly turnover in all the sites and draw up a picture of MTH turnover for their SSR.

Now again ask the participants to compare these figures with their estimate, unique contact figures and regular contact figures for these outreach sites and analyse in the following way:
• Is the total number of MTH people available in these sites more or less than the unique contact and regular contact number? Why?
• Is weekly and monthly high turnover linked with any specific typology of MTH people or sex work?
• Are there specific sites where number of unique contact and regular contact is less than monthly turnover? Why?
• Which are the sites and typology of MTH that need focused outreach in the SSR? Who (in the outreach team) is responsible for these specific sites? What should they do to improve outreach to ensure higher contacts?

Using the slides titled ‘Opportunity Gap Analysis’ define ‘Opportunity Gaps’ as obstacles that impede an individual/community from moving from one level to the next in the behaviour change processes. After that, describe how it is important for the programme to analyse site-wise opportunity gaps in outreach. Explain the guidelines for this purpose as described below.

• Various outreach processes (contacts, registrations, condoms) take place in the field. However during these processes, there are dropouts and that is what is called ‘Opportunity Gaps’.
• Analysis should be done for the outreach sites, where HIV prevention programme are implemented.
• Make note of the status of each indicator in an opportunity-gap analysis framework.
• For each indicator, identify the gap and reasons for those gaps, making a note of the next steps to address the gap.

Gaps may be due to either internal or external factors.
• Internal factors: where project has direct control, as in work of ORWs and PEs.
• External factors: not under the project’s control; like the high mobility of MTH people on a daily basis.

Other indicators that can be included are: number of community members that have
• Faced crises;
• Received support from the project for these crises; and
• Received entitlements and have had their non-HIV needs addressed.

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<tr>
<th>Activities</th>
<th>Status</th>
<th>Opportunity gaps</th>
<th>Reasons</th>
<th>What should we do?</th>
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<td>Internal</td>
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<tr>
<td>Estimate</td>
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<td>Contacts</td>
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<td>Registration</td>
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<td>Regular contacts</td>
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<td>STI treatment</td>
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<td>Follow-up</td>
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<tr>
<td>Regular check-ups</td>
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<tr>
<td>ICTC* referrals</td>
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*Government-run Integrated Counselling and Testing Centres
After the brief, encourage the group to complete the task-tool. The participants can use the flip-charts and marker pens for the same. After completing the task-tool, encourage one of the groups to present their work to the larger group. Encourage a discussion on the following topics.

- What was the process followed by the group?
- What was the outcome of the exercise?
- How did/can the exercise help in planning outreach?
- What were the common mistakes made while completing the task-tool?
- What consequences could these mistakes have?

Using the slides titled ‘Peer Maps’ explain how it is important to understand and analyse the outreach done by PEs with MTH community members. Then present the guidelines to map the peers as described below:

- PEs should map the hotspots in town or other working area, and meet their community members in these hotspots.
- PEs should map MTH populations that they are accountable for, depicting high, medium and low volumes in these hotspots using different colour codes.

The PEs are to indicate the following:

- Number of times each of them met clients that they are working with in the last month; and
- How many condoms were distributed to each of the clients contacted?

Let the participants analyse the map in the manner given below:

- In the previous month did the PE meet with all the MTH clients he/she is working with? If not, why?
- Based on the volume of sexual activity, including sex work, was there any difference in the kind of outreach done by the PE? Did he/she meet with high-volume MTH clients more often than low-volume MTH clients?
- Were the condoms distributed on the basis of volume of sexual activity? Were enough condoms distributed to cover all sexual acts of MTH clients? Was there a shortfall? How is this shortfall in condom distribution being filled? Is it through condom outlets?

Conclude the session by saying that it is important to understand the need of each of the clients that a PE is accountable for planning regular contacts and condom distribution accordingly. This will ensure that the condoms are available to MTH members whenever they are in need, and at the same time will avoid dumping of condoms where no need exists.

Using the slides titled ‘Condom Availability and Accessibility’, describe the tool which (i) helps in mapping condom-availability points and (ii) helps to understand if they are easily accessible to MTH clients.

Begin by discussing with the participants the importance of condoms to prevent HIV. Discuss that in condom programming the first priority is to make condoms accessible and available. Remind them how condom availability is a key component under the Pre-TI activities of Pehchan.

Ask the participants to work in groups and draw a map of their town or other working area or use an existing map. Ask them to mark all the places where MTH individuals solicit sexual partners or clients for sex work (hotspots). Also ask participants where sexual activity normally takes place.
Mark all these places on the map using bindis of two different colours: one to indicate sites where solicitation takes place and the other to indicate sites where the actual sexual act takes place. Then ask the participants to check when a site is active (for soliciting and sex work) and at what time of the day. Mark with colours depicting the site as active either only in the day or at night or both times.

Next ask the participants to mark the condom depots in the map symbolically to indicate whether the depots are functional during the day or at night or round the clock. Once the map is complete ask the following questions:

- Are there condom depots in all the sites where soliciting or sex work takes place? If not, what are the reasons? Do the sites, e.g. Hijra dera-based sites which do not have depots, prefer direct distribution?
- Do all the sites 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 MTH clients?

Conclude by stating the importance of access to condoms at the right time and place. Ask participants to draw up a plan to fill the gaps in condom accessibility and availability, if any.
Activity 3: Community Building and Communication

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<tr>
<th>Time</th>
<th>2 hours 30 minutes</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
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<td></td>
<td>• Understand the Behaviour Change Communication concept and how it is useful for developing positive behaviours;</td>
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<td></td>
<td>• Promote and sustain individual, community and societal behaviour change among MTH members; and</td>
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<tr>
<td></td>
<td>• Understand dialogue-based inter-personal communication (IPC).</td>
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<tr>
<td>Materials</td>
<td>Annexure 1 on ‘Points for Discussion’ Chart paper, sketch pens, markers.</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘Behaviour Change Communication’ to ‘Dialogue-based Inter-personal Communication’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.</td>
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<tr>
<td>Take-home Material</td>
<td>N/A</td>
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</tbody>
</table>

Methodology

Part I: Behaviour Change Communication (BCC)

Using the slide titled ‘Behaviour Change Communication’; tell the participants that BCC is an interactive process with communities to impart tailored messages. It uses approaches that adopt a variety of communication channels to develop a positive change in behaviour. BCC helps promote and sustain individual, community and societal behaviour change and maintain appropriate behaviours. Explain how:

• Providing correct information to relevant populations is a key strategy in all HIV interventions.
• It is important for HRGs like MTH people to have correct information on general and sexual health-related subjects to reduce the vulnerability to STI/HIV infection.
• The information can be imparted through peers (PEs) to MTH community members.

Divide the participants into three to four small groups. Provide each participant in a group with Annexure 1 on ‘Points for Discussion’. Let each group memorise the ‘Points for Discussion’ and practice the same within the group. After the participants have discussed the annexure within their groups, ask them to enact a mock session on how they will talk to a community member on a particular subject.

Generate a discussion on the topics that are important for the PEs to talk about in the field with community members. Identify the topics and encourage the participants to list them.
Part II: Dialogue-based Inter-personal Communication (IPC)

Use the slide titled ‘Dialogue-based Inter-personal Communication’, to emphasise the importance of communication, especially ‘communicating right’, and discuss:

- How IPC 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 the barriers, and plan ways to address them;
- How IPC can be used as a key Pre-TI component, that is, to talk about outreach, drop-in centres (DICs), ICTC referrals, advocacy initiatives and CBO formation; and
- That IPC comprises the following components:
  - Content: this can be on STI or HIV/AIDS.
  - Methods: processes used to stimulate dialogue. In this session participants will learn about two 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 attitudes: PEs need to have an appropriate attitude while working with MTH clients and should be non-judgmental and un-biased.

Tell participants that they will now learn about two IPC tools that can be used during outreach work: ‘Body Mapping’ and ‘Why Is It So?’ Brief the participants on the objectives and processes for the first tool ‘Body Mapping’. Remind them of the purpose of this exercise, which is to:

- Enable HRG members to explore STI/HIV vulnerability factors relating to one’s body; and
- Understand more about non-penetrative sexual activities.

**Body Mapping:** Ask for a volunteer in each group to lie on the ground and have someone trace the outline of his/her body on the ground or on a chart paper. Ask participants to treat the outline as a naked body and to draw in the details. Now ask participants to brainstorm on the following questions:

- What are the erogenous spots in the body?
- What are the ports of entry of HIV virus?
- How does the HIV virus enter the body? What makes it easier for the virus to enter the body? (Clear any misconceptions).
- What options are there for safer sex, particularly non-penetrative sex?

Relate this discussion to the participants’ knowledge about erogenous spots and explain that there are a vast number of options for safer sex which do not allow STI or HIV infections to spread. Conclude the session by asking the group to reflect on the following:

- What are the advantages of this tool?
- What are the difficulties that you are likely to face while conducting such a session with MTH clients?
- What is their learning’s from this session?

‘Why Is It So?’ Brief the participants on the objectives and processes for the second tool. Remind the participants that the purpose behind this tool is to help HRG members understand why risk behaviours occur and what can be done to reduce them.
Encourage the group to start a dialogue by naming the different kinds of behaviours that put people at risk of HIV/STI infection. Correct any misconceptions. Pick any one risk behaviour and ask them to draw a symbol of this risk behaviour in the centre of a flip-chart inside a circle.

Ask, ‘Why is it so?’ and ask them to draw and/or write the reasons for the risk behaviour in question, inside blurbs connected to the circle. Keep asking ‘Why is it so?’ adding further reasons in connecting blurbs until the participants are exhausted with reasons.

Now ask the participants what the diagram says about the following:

- What are the most important reasons (vulnerability factors) for the risk behaviour in question?
- What are the ways that HRG members already try and reduce the risk behaviour?
- What would further help them avoid the risk behaviour represented in the diagram?
- If time permits, practice this tool with more risk behaviours identified by the participants.
Activity 4: Referrals and Linkages

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<th>Time</th>
<th>2 hours</th>
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**Learning Outcomes**

By the end of this activity, the participants will:

- Understand the necessity and importance of linkages with government agencies and NGOs;
- Understand the different terminologies like referral, accompanied referral, referral slips, linkages, etc.; and
- Understand the relevance of a contacts database.

**Materials**

N/A

**Audio-visual Support**

Refer to the slides titled ‘Referrals and Linkages’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.

**Take-home Material**

N/A

**Methodology**

Divide the participants into three to four groups and ask each group to discuss amongst themselves and collate information about:

- The needs of the community they work with;
- The services available in their working area, with contact details and services provided; and
- The service providers (individuals) with their contact details, timings for services, special services provided.

Through the slides titled ‘Referrals and Linkages’ introduce participants to the following terms:

- Referrals: services that are not available with you, but are demanded by the community. In order to provide these services, you must take help from other government agencies or NGOs. For e.g. for HIV testing, clients are referred to government ICTCs.
- Accompanied referrals: referrals in which ORW/PE accompany the client to the various services. This helps to improve the relationship and trust between the client and the ORW/PE.
- Referral slips: a small slip which is required when the client is referred to another facility or service. The slip has details such as name of the client, age, sex, and reason for the referral. The slip is issued to the client, who has to produce it at the service referred to. Usually the service provider, after noting details of services provided to the client, keeps one copy of the referral slip for reference and returns the other to the client. The copy with the client helps in follow-up by the ORW/PE, and the one with the service provider helps you confirm if the client did visit the service provider and received the services needed.
- Linkage: To provide services that the community needs, which are not currently met by the programme, through a chain of other established facilities that provide those services. This may mean locating your agency close to or in the same premises as another key service (for example, establishing a DIC close to a health clinic). It could also mean facilitating the provision of different but related services from the same service provider (example: the government ICTCs, which
provide not only HIV counselling and testing services, but also information on STIs and prevention of parent-to-child transmission of HIV. Such linkages help in saving time and money for the clients, who can benefit from availability of different services close to each other or under the same roof.

Sum up by emphasising the need to establish linkages and networking because they:

- Help in linking CBO’s services to the needs and demands of the community being served;
- Assist a CBO to network with other support groups and CBOs of the same community (at district, state, regional, national and international levels), key NGOs and even self-help groups (SHGs);
- Connect you to rights-based organisations engaged in the development field;
- Connect you with professional institutions and legal-aid organisations;
- Help engage with other civil rights movements in the country;
- Connect you with health services closely linked to HIV, such as:
  - TB referrals to DOTS centres;
  - ICTC linkages;
  - STI clinics;
  - Treatment for opportunistic infections or OIs; and
  - ART centres
- Connect you with other key health and emergency services such as:
  - Reproductive health services for female sexual partners of MTH clients; and
  - Psycho-social support and counselling for dealing with issues around gender and sexual identity, violence, trauma, family support and information on legal rights
- Connect you with government bodies/departments and civil society agencies for MTH community development and overall well-being. Linkages could include the following:
  - Vocational training/income-generation programmes, SHGs;
  - Social support services for nutrition, education, banking, insurance and acquiring citizenship identity documents like passports, PAN cards, BPL cards and Aadhar cards; and
  - Legal support services like NGOs providing legal-aid and government-run State and District Legal Services Authorities that provide free legal aid to those in need.

Make the participants sit in the organisations they come from and ask them to prepare points on how to establish a crisis intervention team in their area or organisation. Ask them to ponder the following questions.

- What should be the objectives of crisis intervention?
- What should be the constitution of the team?
- What is the rationale behind the interventions thought of by your team?
- How will you make the services accessible and available to the community when they are in need?
- How will you document different aspects of these processes?

Point out that they could start by mapping all the resources in their area which they feel can make for a good resource in crisis response. Explain that:

- Addressing any crisis at hand should involve concrete, easy-to-implement, effective crisis management techniques, in combination with local advocacy programmes.
• Creating an enabling environment for effective MTH prevention programmes will build self-esteem, which in turn will help MTH focus more on their physical and mental health and well-being, specifically in relation to STIs and HIV.

• Crisis management responses rely on creating Community Action Groups to assist victims in seeking medical care and legal recourse and to train community-friendly lawyers, beat-level police, and SSR staff to provide support for filing first information reports (FIRs).

• On the whiteboard/chart paper draw three concentric circles. The smallest and innermost circle represents the primary support circle of crisis management consisting of the immediate resources (the Counsellor, and those ORWs and PEs who are in the immediate vicinity of the client). The second circle or middle circle represents second-line support consisting of the Project Manager, the Administrative and Finance Officer, the ORW and PEs not in the immediate vicinity of the client. The third and outer circle, represents tertiary support, i.e. referrals and linkages to be built-up with services in order for the client to receive help from the right quarters.

On the basis of the above, ask the group whether they have any new strategies to address and/or prevent any kind of crisis.
Activity 5: Drop-in Centre (DIC) Management

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Understand the importance of a DIC in Pre-TI interventions for MTH community members under Pehchan Programme.</td>
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<tr>
<td>Materials</td>
<td>N/A</td>
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<tr>
<td>Audio-visual Support</td>
<td>Refer to the slides titled ‘Drop-in Centre Management’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
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</table>

Methodology

Using the PowerPoint slides titled ‘Drop-in Centre Management’, describe how:

• DICs act as ‘safe spaces’ critical in the early phase of delivery of health services linked to HIV or even other health and development services, especially for street-based populations;
• A DIC is vital, given the limited interaction that can be possible between the outreach staff of a CBO and MTH community members at places like streets and parks;
• At DICs, MTH people can interact with each other, rest, seek advice, share information, approach someone in case of a crisis, or pick up condoms;
• DICs can serve as centres for some popular activities like self-defence classes, literacy classes, and other skill-building activities;
• DICs serve as centres for HIV-related and other counselling and/or for STI services. DICs also facilitate ICTC referrals;
• DICs can also provide referrals to satellite services such as TB treatment, de-addiction, legal aid, crisis response, social welfare schemes and services; and
• A DIC should ideally be located close to where MTH community members live or operate, or can access easily with minimal travel.

Emphasise that the location and functioning of the DIC should be dictated by availability and the preference of the MTH community members. Explain how it is important for:

• The DIC to be located within easy access to MTH community members;
• The CBO running the DIC to have information about the services available in the surrounding areas, and extensive social mapping of the area should be done to identify community resources to which the DIC can make referrals to; and
• The CBO to keep in mind the ‘Three A’s’:
  • Availability (menu of services under one roof);
  • Accessibility (in terms of location and timings); and
  • Affordability (cost to reach the DIC).

Explain how the DIC infrastructure should have:

• Sufficient space, that is, at least three or four rooms, one large one for group meetings, while the others can be for services such as counselling;
• Clean, well-ventilated spaces;
• A toilet;
• Running water/soap;
• Basic furniture; and
• If possible, a TV and some light recreational reading materials.

List the services that can be provided by the DIC.

• Outreach services where ORWs and PEs reach out to MTH community members in their own environment, on a daily basis, to build rapport and refer them back to the DIC.
• IEC dissemination where continued education is provided through leaflets/games/demonstrations/group discussions on STI/HIV issues.
• Psychosocial support where the counsellor is made available to address issues on behavioural change and issues around HIV-testing.
• Condom programming to promote correct use of condoms and lubricants, and access to free condoms and lubricants.
• ICTC, OI treatment, ART, STI treatment, TB treatment and other health, legal and social support referrals.

Tell the participants about commonly asked questions by MTH community members about a DIC, and how they should answer these questions:

• Will anyone take our photographs in the DIC?
  State that confidentiality about the individual and his/her gender and sexuality will be strictly maintained and no one will take photographs without an MTH individual’s consent.

• Will we get loans/money for visiting the DIC or attending meetings at the DIC?
  Explain that a DIC provides a safe space to discuss and address health and other rights-based issues of the community, for counselling and as a place to celebrate community events. No money will be provided for visiting a DIC but community members should be assured that they will be respected and treated in a nice manner and be told that they will enjoy the community gatherings and events.

• What are the services I will get when I come to the DIC?
  List the services usually provided by a DIC such as health-related services, counselling services, a safe space for community members to interact, and community events.

• What else we will get from a DIC?
  Say that there are possibilities of a cultural team being formed in future where people with dance, theatre, make-up and singing skills can be provided an opportunity to showcase their talents. They could practice in the DIC, enhancing their skills and give performances during community events.

• If I bring my partner, can I do dhandha (sex work) in the DIC?
  Use this as an opportunity to talk about the rules and regulations of a DIC. You could answer in two ways: (i) ‘Sex is not allowed in a DIC and there are also some other regulations which you will understand when you come to the DIC.’; or, (ii) simply say that ‘You will get the answer once you visit the DIC’. This is because sometimes simply saying ‘No’ might hurt the person who has questioned.
# Activity 6: Condom Promotion and Negotiation Skills

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<th>Time</th>
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<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
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<td>• Understand the importance of condom-usage; and</td>
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<td></td>
<td>• Know the myths and misconceptions about condom-usage.</td>
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<td>Refer to the slides titled ‘Condom Promotion and Negotiation’ in the PowerPoint presentation from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.</td>
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<tr>
<td>Take-home Material</td>
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## Methodology

Using the slides titled ‘Condom Promotion and Negotiation’ introduce the participants to the learning objectives of this session on Condom Promotion and Negotiation Skills. Ask the participants what they already know about condoms. Allow and encourage all the trainees to participate in the discussion. Emphasise the following points during the discussion:

- While putting on 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.
- In oral sex, the chances of HIV infection are low. However, the use of a condom is still essential as oral sex can lead to STIs.
- Using a condom is a skill, and one should develop comfort in putting it on.
- Condoms should be kept in a cool and a dry place away from sunlight and water.
- There is no need to use extra lubricant as condoms are already lubricated, but if required, say for anal sex, one can use water-based lubricants like KY Jelly (not oil).
- There are various types of condoms, such as flavoured (chocolate/strawberry) and textured (dotted/ribbed). These can enhance sexual pleasure.
- 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).
- Some condoms are also socially marketed. These are cheaper than those available at market cost.
- Condoms provide dual protection from infections and from unwanted pregnancy.
- Female condoms are also available in the market but they are still very expensive. But some HIV intervention projects provide them through social marketing.

Discuss some of the common myths and misconceptions about condoms, such as:

- Using condom during sex is irritating.
- Condoms reduce sexual pleasure.
- Condoms are sticky and oily.
• Erection fails before slipping the condom on to the penis.
• Double condoms provide better protection.
• Use of condom implies lack of emotional feeling or love for the partner.
• Condom is a barrier of ‘mistrust’ between two partners.

Address these myths by clarifying that:
• Condoms are soft and lubricated and proper use of condom does not cause irritation;
• Two condoms should not be put on at a time because the chance of both tearing increases;
• Condoms need not create any barrier of feelings, loss of erection or mistrust. Rather, using a condom shows that you care for yourself and your sexual partner. Learning how to use a condom properly and with comfort will prevent loss of erection and any negative feelings. It is important for you to talk about these issues with your sexual partner. Not using condoms is an option only if both you and your sexual partner are in a sexually monogamous relationship, know for sure that you do not have any STI or HIV, and are able to maintain this status in future;
• The process of wearing a condom is also pleasurable and can add to the sexual pleasure; and
• Using a condom allows enjoyment of sexual pleasure without any tension or apprehension about getting infected by an STI or HIV.

Call upon the participants to handle a condom available during the session. Ask them to blow it, put it on the hand, and fill it up with some water. While doing so, explain that the condom is long and wide enough to accommodate an erect penis without the risk of rupturing (demonstrate by filling it with water or blowing it into a big size).

Next, call upon any two 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 volunteers. If not, ask the other participants to give suggestions for improvement. Quickly summarise the main steps in condom-usage, including the use of water-based lubricants.

With two participants, enact a role play in the following manner:

_Dilnaar is a kothi who likes going to a truck stop to have sex. He meets a handsome truck driver, Jassi, who takes an instant liking to him. They decide to have sex with each other, but in bed, Jassi refuses to use a condom. Dilnaar refuses to have sex till Jassi uses a condom._

At this stage, ask the participants what Dilnaar should do to encourage Jassi to use a condom.

• Should he talk about Jassi being safe from anything Dilnaar has?
• Should he talk about hygiene?
• Should he try and take an emotional angle, and tell Jassi that if he really likes him, he ought to wear a condom?

After taking the opinions of the participants, let the actors demonstrate what they feel would be the best way to negotiate condom-usage in this situation. Allow brief discussion on the role play and the issue of condom negotiation. Remind the participants that no two situations are the same – various ruses might need to be used in order to ensure condom usage.
Activity 7: Overview of NACP III

Time  | 2 hours
---|---

Learning Outcomes  
By the end of this activity, the participants will:
- Learn about NACP III and India’s response to the HIV/AIDS challenge; and
- Understand the concept of Targeted Intervention.

Materials  
N/A

Audio-visual Support  
Refer to the slides titled ‘HIV/AIDS Overview & Update on NACP III Interventions’ from the PowerPoint presentation ‘Basics of HIV Prevention and Outreach Planning’.

Take-home Material  
N/A

Methodology

Note to Facilitator
Please explain that the Pre-TI package of Project Pehchan is a precursor to a TI project. Depending on the success of Project Pehchan and NACO/SACS annual plans, a Pre-TI CBO may be implementable in one to two years time.

Also, describe how:
- though NACP III is coming to an end soon; and
- NACP III is still relevant to the project despite NACP IV coming into force by the end of this year (2012).

Part I: Overview of NACP III
Tell the participants that the session is intended to introduce the participants to India’s response to the HIV/AIDS challenge and the rationale for starting the National AIDS Control Programme (NACP).

Using the slides ‘HIV/AIDS Overview & Update on NACP III Interventions’, explain the following:

- In 1992, the Government of India launched the first National AIDS Control Programme (NACP I, 1992-1999) with the objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of the HIV epidemic in the country.
- To strengthen the management capacity for oversight and better implementation of the NACP, an autonomous National AIDS Control Organisation (NACO) was set up.
- The main objective of NACP I (1992-1999) was to develop facilities to provide treatment for STIs in district hospitals and medical colleges, expand the network of blood banks, initiate an HIV surveillance system, and set up SACS/DACS in all states and in some districts of the country.
- NACP II (1999-2006) was launched in 1999 with the focus shifting from raising awareness to changing behaviour, decentralisation of programme implementation at the state-level and greater involvement of NGOs. NACP II, among other things, launched the strategy ‘Greater Involvement of People Living with HIV/AIDS’ (GIPA). It also marked the launch of the National Rural Health Mission (NRHM) and the provision of ART.
- NACP II paved way for NACP III which aimed at halting and reversing the epidemic in India over a five year period (2007-2012). NACP III aimed to achieve its goal through:
  - Saturation of coverage of HRGs with STI/HIV TI programmes (TIs) and a scaled-up intervention for the general population;
  - Provision of greater care, support and treatment to a larger number of PLHIV;
  - Addressing human rights and ethical issues, with a focus on fundamental rights of PLHIV and their active involvement;
• Strengthening the capacity (e.g. infrastructure, human resources) in prevention, care, support and treatment at the district, state and national levels; and
• Strengthening the nationwide Strategic Information Management System (SIMS) to help track the HIV epidemic.

Current HIV/AIDS Scenario in India

• There were an estimated 23.9 lakh PLHIV by the end of 2009, with an estimated adult HIV prevalence of 0.32 per cent.
• Nearly 87 per cent of HIV infections occur through the heterosexual route of transmission.
• While the overall HIV prevalence in India is low, there is a concentrated epidemic, contributed by a very high prevalence among HRGs, with the highest among IDUs followed by MTH people, FSWs and STI clinic attendees respectively.
• A few states, and a few districts in those states, saw more impact of the epidemic. A few states, where HIV prevalence is particularly high either in general or in specific districts and among specific populations, are Andhra Pradesh, Delhi, Gujarat, Karnataka, Maharashtra, Manipur, Tamil Nadu, and West Bengal.
• Some gains have been made during NACP III in tackling the HIV epidemic, particularly in reducing HIV prevalence among pregnant women (antenatal clients or ANCs) and prevention of parent-to-child transmission in some states. But these gains are yet to be replicated on a larger scale, particularly among MTH populations.

Part II: What is a Targeted Intervention (TI)?

Introduce the concept of TI to the participants by explaining how:

• The primary drivers of the HIV epidemic in India are unprotected paid sex/commercial female sex work, unprotected sex between men, and people those inject drugs;
• TIs are a resource-effective (value for money) way to implement HIV prevention and care programmes in resource-poor settings like India;
• TIs are a cost-effective method aimed at offering HIV prevention and care services to high-risk populations (FSWs, MTH, and IDUs) by providing them with the information, means and skills they need to minimise HIV transmission and to deal better with its impact; and
• A TI-approach recognises that people who are at risk of HIV infection are often marginalised from the broader community and are stigmatised and discriminated.

Components of a TI

• BCC which involves understanding and assessment of individual and group practices/behaviours which can pose risk of HIV infection.
• Access to STI services: improving access to STI services as STIs (both symptomatic and asymptomatic) increase the risk of HIV transmission.
• Provision of commodities to ensure safer practices like condoms, water-based lubricants and fresh syringes and needles (in exchange of used ones).
• Enabling environment that focuses on reducing stigma and discrimination and creation of an environment that helps in accessing information, services and commodities by the HRGs.
• Community organising and ownership building by engaging CBOs in program-management through developing their capacity and ownership.
• Linkages to HIV care, support and treatment programmes, including PLHIV networks, ICTCs, ART centres, Community Care Centres, DOTS centres for TB treatment, detoxification centres and other harm-reduction initiatives.

Part III: Brainstorming and Summarising

Encourage a discussion and gather feedback from participants on the topics covered in this session. This activity is an opportunity to reinforce the importance of a TI and of working with populations most at risk for HIV, like MTH community members. Brainstorming will also help in identifying the possible challenges and bottlenecks perceived by the participants during the course of their work.

Engage the participants in an exchange of ideas about the topics and also enable them to question the facilitator, which provides the latter with an opportunity to review the session. At this point the facilitator should encourage the participants to seek answers to questions such as:

• Why was NACO instituted?
• What do you understand by the term ‘concentrated epidemic’ and ‘HRG’, and how are they important for our response to the HIV epidemic? and
• What do you think was the rationale for NACP and for TI in particular?

Finally, conclude the discussion by summarising key points discussed throughout this module.
Annexure 1: Points for Discussion

Sexually-Transmitted Infection (STI)

Prevention
- Most STIs occur due to unprotected sex.
- STIs can be prevented if we ensure that we use condoms during each sexual act.

Signs and Symptoms
Most common systems are:
- Discharge from the genitals – pus like discharge, whether foul smelling or not.
- Pain in groin.
- Soreness in the genitals.
- Itching.
- Burning sensation while passing urine.

Treatment
- Most STIs are curable.
- Refer to the doctor for further care and treatment.
- Complete the drug treatment.
- Use condoms during every sexual relation.

Importance of Partner Treatment
- If a sexual partner has STI, then both you and the partner should take treatment to avoid re-infection.

Referrals
- Whenever a potential client is identified with symptoms suggestive of STI, provide all the information and knowledge about STI.
- Refer to the doctor for further treatment.
- Regular follow-up at the clinic is important after the initial visit.

HIV/AIDS
- How does HIV spread?
- How does HIV not spread? (Kissing, touching, sharing utensils etc.)
- What are the ways of preventing HIV transmission? (Use of sterile needle, condoms etc.)
Testing for HIV

Preparing for HIV testing
(CDC, 2001)
Even if a client declines to undergo HIV testing, counsellors must ensure that the following information is provided to all people visiting the testing center:

- Information, benefits and consequences of HIV testing.
- Risks for transmission and prevention of HIV.
- The importance of getting an HIV test.
- Meaning of the test
- Obtaining further information or, HIV prevention counselling.
- Orienting about other referral services.

There are two types of tests
(NACO, 2007)

- **ELISA:** Enzyme-linked immunosorbent assay (ELISA) is the most commonly performed screening test at blood banks and tertiary care sites testing large number of specimens in a day. It is easy to perform, adaptable to large number of samples, is sensitive and specific and cost effective.
- **Rapid Testing:** Rapid tests are in vitro qualitative tests for the detection of antibodies to HIV type 1 and 2 in human serum, plasma whole blood saliva and urine. Currently HIV testing in India is performed on serum/whole blood, and plasma. This is because the HIV testing on urine and saliva samples has not been evaluated and validated in India.

ART

- ART stands for Anti Retroviral Therapy.
- This is a treatment given to HIV positive people, and it restricts the replication of virus in the body.
- These medicines are taken regularly and lifelong, under a doctor’s advice.
- These medicines are available free of cost at all government hospitals.
Annexure 2: PowerPoint Presentation – Basics of HIV Prevention and Outreach Planning

Training on Basics of HIV Prevention and Outreach Planning (Pre-TI)

Basics of HIV Prevention and Outreach Planning (Pre-TI)

HIV/AIDS and Modes of Transmission
Basics of HIV and AIDS

H**uman**

Immunodeficiency

V**irus**

Acquired Immunodeficiency Syndrome

Link Between HIV and AIDS

HIV → AIDS

Stages of HIV Infection

5–10 years

- **Beginning:**
  - No symptoms
  - Mild weight loss
  - Mouth ulcers
  - Acting and skin disease

- **After a few years:**
  - Significant weight loss
  - Throat, TB and fever

- **After several years:**
  - Weakening systems
  - Chronic herpes
  - Ulcerations and extra-pulmonary TB

- **After 10 years:**
  - The CD4 count (hearts) progressively decreases and the HIV (circles) increases.

When the hearts go down and the circles go up, more problems arise. They are more serious, last longer and weight loss is more significant.
Opportunistic Infection

How HIV is Transmitted
- Direct contact with infected blood or bodily fluids
- Injecting infected needles
- From infected mother to child
- Unprotected sexual intercourse

Basics of HIV Prevention and Outreach Planning (Pre-TI)
Sexually Transmitted Infections
Sexually Transmitted Infections

What do you mean by STI?
Does it mean I have HIV?

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Tests for HIV pre- and post-test counselling

How to Prevent HIV and STI Transmission
You Cannot Get HIV From...

- Kissing;
- Injecting drugs with new or sterile needles;
- Sneezing, coughing, sharing glasses or cups;
- Insects; and
- Protected sexual intercourse.

Tests for HIV

- ELISA
- Rapid test
- Western blot assay
- Second ELISA

Goals of Pre- and Post-Test Counselling

- Help the client cope with information related to the disease and the test;
- Get informed consent before the test;
- Help them understand what the test results mean;
- If the test result is positive, the client is guided to understand their social responsibilities, and to develop skills to cope with the infection; and
- If the test result is negative, the client is guided to increase their level of information and understanding the consequences of HIV infection, and to motivate a change in behaviour that reduces risk of getting infected in future.
Pre-Test Counselling

Let me tell you what this test is about.

I don’t allow him to use condoms—we are faithful to each other.

Post-Test Counselling – Results Negative

Now that we know you are not infected, let us talk about how you can stay safe from HIV always.

Oh, I am so relieved.

Why should we have a retest—was there a mistake?

Post-Test Counselling – Results Positive

First of all, I want to assure you that you can live a long and productive life, even if you have tested positive...

My life is ruined—I will lose everything.

It’s his fault—he must have had sex with somebody else!
What are Anti-Retroviral Drugs?

- Medications for the treatment of infection by retroviruses, primarily HIV.
- Typically three or four are taken in combination. The approach is known as Highly Active Anti-Retroviral Therapy (HAART) or ART in short.
- Different classes of anti-retroviral drugs act on different stages of the HIV life-cycle to slow down or prevent its replication.

How ART Works in the Body

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Positive Prevention
Positive Prevention

Challenges in Positive Prevention

Positive prevention needs to be scaled up and integrated into all interventions that bring PLHIV into contact with service providers.

Positive prevention could include:

- Risk reduction;
- Negotiation for safer sex – condom use, contextual abstinence;
- Building self-efficacy; and
- Creating supportive environment.

Risk Reduction

Let's see what risks you face and how you can reduce them.

Yes, that will help us feel more comfortable and less fearful.
Positive Prevention Works at Three Levels

Individual level

Group level

Environmental level

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Roles and Responsibilities of ORWs and Peer Educators
Basics of HIV Prevention and Outreach Planning (Pre-TI)

Needs Assessment and Advanced Needs Assessment

- Focus group discussions (FGDs)
- In-depth interviews
- Key informant interviews
**FGD Tools**

- FGD tool for MSM (for both Pre-TI and TI plus CBOs under Pehchan)
- FGD tool for TG/Man (for both Pre-TI and TI plus CBOs under Pehchan)
- FGD tool for Married MSM (for TI plus CBOs under Pehchan)
- FGD tool for PLHIV (for TI plus CBOs under Pehchan)

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**Need Assessment Themes: New CBOs**

- Description of sex sites;
- Health needs;
- HIV/AIDS and STI knowledge of the community;
- Barriers to accessing health services;
- Community-friendly health services;
- Drop-in centres; and
- Advocacy issues.

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**Need Assessment Themes: Existing CBOs**

- Health needs of the community;
- Referral services;
- Mental health;
- Violence and trauma;
- Family counselling and support issues;
- Advocacy issues; and
- Others.

**Married MSM**

- Reasons for getting married;
- Sexual health problems;
- Social problem;
- Reaching wives of married MSM; and
- Service needs.

**PLHIV**

- General health issues;
- Sexual health issues;
- Mental health issues;
- Awareness and availability of healthcare;
- Access to healthcare; and
- Issues around positive living.
What Should Happen Every Quarter in Pehchan

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Planning and Implementation

What is Outreach?
Basics of HIV Prevention and Outreach Planning (Pre-TI)

Outreach Planning Tools

Hotspot Analysis Tool

Factors for the tool
- Volume of clients
- Typology
- Age
- Time/day of operation

Contact Mapping Tool

It is important to know:
- The number of contacts in each spot and whether we can increase that number in order to maximise the benefits to as many MTH members as possible;
- The contacts which may be missing from the list;
- That ORWs and PEs have contacts in more than one hotspot; and
- That PEs have their own social network, certain MTH community members who they are friends with and have influence over.
Contact Database

District:

Pre-TI name:

Name of town / other working area:

Date:

Estimated nos. of MHT in town:

Contacted nos. of MHT in the town:

<table>
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<tr>
<th>No.</th>
<th>Name of hotspot</th>
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<td>4</td>
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<tr>
<td>Total</td>
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No. of contacts that are known very well:

No.

Participatory Site Load Mapping

Example 1.2: Participatory Site Load Mapping

Opportunity Gap Analysis

<table>
<thead>
<tr>
<th>Activities</th>
<th>Status</th>
<th>Opportunity gaps</th>
<th>Reasons</th>
<th>What should we do?</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>Estimate</td>
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<tr>
<td>Contacts</td>
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<td>Registration</td>
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<tr>
<td>Regular contacts</td>
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<tr>
<td>STI treatment</td>
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<td></td>
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<tr>
<td>Follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular check-ups</td>
<td></td>
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<tr>
<td>ICTC referrals</td>
<td></td>
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</table>

Opportunity gap: obstacles that impede an individual / community from moving from one level to the next level in the behaviour change process.
Peer Maps

Example 1.7: Peer Maps

Condom Availability and Accessibility Map

Example 1.6: Condom Accessibility and Availability Map

Basics of HIV Prevention and Outreach Planning (Pre-Ti)

Behaviour Change and Communication
Behaviour Change Communication

An interactive process with communities to impart tailored messages and adopt approaches using a variety of communication channels to develop positive behaviours, promote and sustain individual, community and societal behaviour change and maintain appropriate behaviours.

Dialogue-based Interpersonal Communication

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Referrals and Linkages
What are Referrals and Linkages?

Some terms to remember:
- Referrals
- Accompanied referrals
- Referral slips
- Linkages

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Drop-in Centre (DIC) Management

Need for DICs

Photo by Peter Caton for India HIV/AIDS Alliance
Basics of HIV Prevention and Outreach Planning (Pre-TI)

Condom Promotion & Negotiation Skills

Things to Remember During Condom-use

- Condoms should be used for any kind of penetrative sex—anal, vaginal, or oral. In oral sex, even if chances of HIV infection are low, condoms prevent STIs.
- Use a condom to avoid unwanted infections and pregnancy— they are available free or at low cost through social marketing.
- Condoms are usually pre-lubricated— for extra lubrication for anal sex, use water-based lube.
- Practice using a condom — it requires a bit of patience for a lot of pleasure!
- Don’t try to reverse a condom and use it in case you have rolled it on wrong, your body fluids may have already touched the walls of the condom, and can cause infection — use a fresh condom!
- Condoms are available for both men and women.
- Condoms are distributed by both government and private companies.
- Condoms can come in various flavours and textures.
- Condoms need to be stored in a cool and dry piece Always check their expiry date before use.

Basics of HIV Prevention and Outreach Planning (Pre-TI)

HIV/AIDS Overview and Update on NACP III Interventions
Lessons from NACP II

- Greater focus on care groups or high-risk groups (HRGs)
- Programmatic link between TI and continuum of HIV care
- Strengthen supportive supervision; support to SAGOs and NGOs
- Strategic shift from support to empowerment

NACP III

NACP III – 2007-2012

Basics of HIV Prevention and Outreach Planning (Pre-TI)

Targeted Intervention under NACP III (2007-2012)
Components of TI Projects

Status of TIs Under NACP III (January 2010)

Existence of TIs

Source: UNAIDS Country Progress Report India, March 2010

Estimated HRG Populations and Coverage (End 2009)

<table>
<thead>
<tr>
<th>HRG</th>
<th>Estimated population</th>
<th>Ti coverage (%)</th>
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<tr>
<td>FSWs</td>
<td>1.26 million</td>
<td>0.57 million (57%)</td>
</tr>
<tr>
<td>MSM (MTH combined)</td>
<td>0.35 million</td>
<td>0.28 million (80%)</td>
</tr>
<tr>
<td>IDUs</td>
<td>0.18 million</td>
<td>0.14 million (78%)</td>
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MSM (MTH Combined) Interventions in NACP III and Pehchan Programme

- Relatively low number of TIs for MTH people compared to FSWs, though HIV prevalence is higher.
- 50% of TIs to be transitioned from NGO to CBO ownership and leadership.
- TG and hijras conflated with MSM.
- Lack of separate TG/hijra TIs mostly because of absence of relevant population-mapping.
- Pehchan aims to address gaps in NACP III of low number of CBO lead TI projects for MTH populations. Pre-TI package of Pehchan meant to prepare CBOs take up TI projects in underserved districts/areas, with greater emphasis on TG/hijra coverage.

Saturation of HRG Coverage in NACP III

- District level mapping and planning.
- Coverage partners of FSWs, MSM (MTH), ETUs.
- Linkages between TI projects and continuum of HIV care.
- Focus on enabling environment.
- Community ownership.
- Setting of TUs to enhance capacity of partners and quality of interventions.

Key Guiding Principles

Key partners: DADS, NGOs, CBOs, Ministry of Women and Child Development and Ministry of Social Justice and Empowerment and UN agencies.

Expanding Coverage of Bridge Populations in NACP III

- Mapping of hot spots and hot spots.
- Focus on labour needs of people involved in sex work and destination.
- Greater investments and coverage of labour unions and related corporate companies.
- Improved access to services.
- Special focus on gender dimension in the agriculture and construction sector.
- Focus on socio-economic vulnerability.

Key Guiding Principles

Key Partners: NHAI, DADS, CBO, Ministry of Surface Transportation, T
tTruckers Associations and Companies and Tyn Manufactures.
References


Notes
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# Pehchan Training Curriculum

**MSM, Trangender and Hijra Community Systems Strengthening**

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<tr>
<td><strong>module B</strong></td>
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