



**The Peer Education
Training Module
for Armed Forces
Wives Welfare Associations**

**A Step-by-Step Training Module for
HIV/AIDS/STI Prevention, Care and Support**

The Module Structure

Profile of Peer educators: This peer education module is for the members of armed forces wives welfare associations. The wives of defence personnel at multiple levels will voluntarily associate in the PPE program for the HIV/AIDS initiatives in the concerned locality.

The purpose of the Module: The purpose of the module is to provide a guideline and process structure for developing and maintaining a peer education system at armed forces camps situated in different parts of the country. It is expected that this module will be used among the wives of defence personnel and will be monitored by key facilitators who attended the TOT held at Delhi.

Profile of expected participants and the numbers: The peer education training should be organised at different units and in batches. Approximately 20 participants are expected in each program. The participants should have proficiency in either English or Hindi and have minimum communication skills.

Organization of the module: The peer education module is framed to organize orientation program for the identified or potential peer educators among the wives of defence personnel. This module consists of various aspects/issues/challenges of HIV/AIDS responses. A detailed structure of the module is given below.

Section 1 Guidelines for Training of Trainers

- Introduction
- How to Use This Training Module?
- Key Components of a Training /Workshop
- Overall Objectives
- Expected Outcome
- Description of the Training Curriculum

Section 2 Basic Facts and Risk Perceptions on HIV/AIDS/STI

- What is HIV and AIDS?
- Risk Perception
- Difference between HIV and AIDS? Why is it important to know the difference?
- What is window period?
- What is an STI? Types and its Treatment
- Preventing HIV Infections & Other STIs: Recommended Prevention Strategies
- Care and support

Section 3 HIV/AIDS/STI and the Cross Cutting Issues

- Sex and sexuality
- Stigma and Discrimination
- Family and social disorganization
- Epidemic impacts on various groups

Section 4 Peer Education

- The Basics and Processes
- Peer education in the context of HIV/AIDS
- Selection of Peer educators
- Training of peer educators
- Roles and responsibilities
- Rewarding systems

Section 5 Effective Peer Education

- Adult learning methods
- Planning peer education
- Framing and prioritizing the messages
- Avoiding conflict situations
- Maintaining relations

Section 6: Communication

- Communicating in a better way
- Elements of communication
- Effective communication processes
- Verbal and Non verbal communication
- Peer counselling
- Sustaining relations

Section 7: Evaluation

- Introduction
- Sample of monitoring format
- Sample of a Session wise evaluation
- Sample of a Comprehensive training evaluation

Background

'Armed forces Wives' Welfare Associations, are associations of wives of army, air force and navy staff, and have been addressing various issues in order to enhance the overall well being of the forces and their families. There is a need to address HIV and AIDS related issues and offer the necessary preventive as well as care and support services. As such they propose to have a peer education system to promote and sustain behavioural change and to help those affected by and living with HIV. To develop a peer education system addressing the issues related to HIV and STI (sexually transmitted infections) SOMA has been contracted.

The Objectives

The main goal of this initiative will be to promote behaviour change in order to prevent STIs and HIV infection, and to provide the necessary care and support for those living with and affected by HIV. These goals will be met through the following main objectives:

1. To build the capacities of the members of armed forces wives associations to set up and manage a system of peer education for addressing issues related to HIV and AIDS sensitively, thereby mitigating the impact of HIV among the personnel and their families.
2. To develop a peer education module and handbook for trainers and
3. To organize a Training of trainers to set up the peer education system at multiple levels.

The Processes

The process of setting up an effective peer education system will mainly include, planning a peer education system, training of trainers, identifying and training peer educators, preparing a trainer handbook and peer education module, development of IEC material for peer educator on thematic issues, and monitoring peer education.

Although the exercise of incorporating HIV/AIDS prevention into armed forces 'structure' is crucial, it is not sufficient. Given the high risk of infection for active armed forces members, HIV/AIDS interventions cannot be a "one-shot deal". Programs need to address the factors aggravating the spread of the HIV virus and counter the long - term impact of the epidemic. Strategies for reducing infection rates in armed forces should be promoted, including education, condom promotion, voluntary testing, counselling, and medical care and should target all populations groups affected by the epidemic, including women and children. For the success of any HIV/AIDS program, a participatory approach in the planning and implementation of activities is of paramount importance.

SECTION 1 GUIDELINES FOR TRAINING OF TRAINERS

INTRODUCTION

HOW TO USE THIS TRAINING CURRICULUM?

KEY COMPONENTS OF A TRAINING OF TRAINERS WORKSHOP

OVERALL OBJECTIVES

EXPECTED OUTCOME

THE WORKSHOP AGENDA: AN OVERVIEW

DESCRIPTION OF THE TRAINING CURRICULUM DAY BY DAY

Learning objectives of this section are:

- To help the participants to know each other
- Establish the learning environment for the PE training
- Clarify the objectives and expectations of the participants
- Familiarization with the training curriculum

Time Frame	Materials needed
40 Minutes	Chart papers Permanent markers Clip board Small cut papers Cards

Introduction

Peer education modules; in general, aims to provide guidelines for the training of peer educators or to propose ideas for activities that could be carried out in peer education projects. This publication, however, focuses specifically on the training of trainers (TOT) of peer educators. This module is intended to be used by 'master' trainers in peer education while training the future trainers.

In the context of this module, peer education is the process whereby well-trained and motivated armed forces wives welfare association members would undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests).

These activities, occurring over an extended period of time, are aimed at developing their knowledge, attitudes, beliefs, and skills and at enabling them to be responsible for and to protect their own health.

How to Use this Training Module?

Most of the topics and techniques described in this program are accompanied by facilitator's notes. These provide information to help understand why a topic is important or how specific techniques will contribute to the objectives of peer education training. In addition to the more formal training curriculum, socializing with other trainees is an important part of the training experience. In the evenings, participants should have the opportunity to eat and enjoy themselves together, share their experience, their culture and their talents, play games, sing together, etc. This opportunity to network provides the trainees with an important bonding experience. In any 2 or 3 day training course, it is a good idea to leave a half-day free for a group excursion.

It should also be emphasized that this manual cannot replace in-person training course, but should primarily be seen as a support tool for a training workshop.

Key Components of a Training/Workshop

There is no ideal model of a training program, but it should include the following key components:

Exploration of the Rationale for Peer Education, Including its Benefits and Barriers

Although some of the future trainers of peer educators might be familiar with the practice of peer education, it is essential to ensure that at the start of the training, they not only understand the concept and benefits of this approach, but are also aware of its limitations or pitfalls.

Building Basic Knowledge of the Program's Content

A trainer of peer educators needs basic knowledge about the health issues that the program addresses. Whenever questions related to the program's content arise – whether during training or when supervising peer educators in their field work – the trainer should be capable of responding to them adequately.

Exploration of Personal Values Around the Health Issues being Addressed, Including Attitudes towards Gender-based Norms and Biases

Trainers of peer educators must recognize what their own values and biases are, so they can help the trainees begin to understand their own. It is difficult to lead a group in training through a process of self-awareness without having done some of this work on a personal level before.

Training in Communication and Group-work Skills

Facilitating a training course and working interactively with a group of trainees requires a good knowledge of communication techniques. Future trainers must be able to serve as a model for

communication techniques and group work, since the best training is conducted by example.

Basic Guidelines for Planning, Implementing, Monitoring and Evaluating Peer Education Program

Systems should be put in place for planning and implementing the peer education program. The indicators for monitoring and evaluation should be determined which should include quality, quantity and time dimensions. The number of PEs should be based on the population size and area. Guidelines for selection, monitoring and support for the PEs should be designed before starting the peer education component.

Referral to Health Services

Peer education programs do not occur in a vacuum, but are components within a larger framework of resources. Trainers need to be aware of the clinics, information sources, structure of supportive services, etc., that exist in their area and include this information as part of a comprehensive peer education program. They should instruct both peer educators and other members of the community on how to access them.

Overall Objectives

The overall objective of the training described here is to build the capacity of trainers of peer educators in designing and delivering a peer education-training program to prevent and control STI/HIV/AIDS.

The specific objectives are:

- Understand the need and purpose of the PE program on HIV/AIDS, its objectives and its outcomes. Be familiar with the basic facts and figures related to HIV/AIDS/STI so that the picture of the current epidemic scenario is clarified.
- Identify and focus on the attitudes and perceptions of the participants on HIV related issues and support them to reframe it to adopt a reality-oriented approach in responding to the issues.
- Be oriented about the relevance, need and scope of peer education in framing the HIV responses.
- Be aware of key methods and tips in PE processes. Peer education in armed forces setting needs to be practiced based on the adult learning principles.
- To sharpen their communication skills as a peer educator. This would enhance their capacity to convey the messages as the people expect and imbibe. The importance of interpersonal communication and its relevance to group communication in HIV related responses would also be covered.
- To workout their planning skills for the continuity of the peer education and message dissemination.
- To assess the output achievements of each program they undertake.

Expected Outcome

The expected outcome of this program is to evolve a cadre of armed forces wives welfare association members as confident, competent peer education trainers with the skills to design and implement a training program for peer educators in their local settings/situation.

Description of the Training Curriculum

Day One: Session Outline	Day Two: Session Outline
<p>Opening Session: Self Introduction of the Participants Drawing Exercise Purpose of the Workshop Specific Objectives Expected Outcomes Formation of Ground Rules Participant's Expectation</p> <p>What is HIV, AIDS Risk Perception Modes of transmission, prevention, difference between HIV/AIDS STIs, its types, the treatment Care and support: The services available</p> <p>Sex and sexuality: issues/concerns Stigma and Discrimination – general and gender Family and social disorganization Epidemic impacts on various groups</p> <p>Peer education in the context of HIV/AIDS Selection of Peer educators Training of peer educators Roles and responsibilities Rewarding systems Wrap-up after every session</p>	<p>Recap Stretching and Warm up Adult learning methods Planning peer education Framing and prioritizing the messages Avoiding conflict situations Maintaining relations Dos and Don'ts</p> <p>Elements of communication Effective communication processes Verbal and Non verbal communication</p> <p>Communication in HIV related responses Why one to one communication in HIV related responses How to make the situation for one to one communication How to prioritize and convey messages How to sustain the relations</p> <p>How to maintain peer links How to do group and individual planning for interactions How to update information level How to give confidence and win confidence Need of confidentiality Session wise evaluation Comprehensive Evaluation Wrap-up after every session</p>

Self Introduction of the Participants

- Arrival, Registration and Handing Out Name Tags

Pre-Workshop Questionnaires

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

Facilitator's Note

A pre-workshop questionnaire, aimed at assessing the initial knowledge, attitudes and skills of the trainees, is an evaluation tool similar to those used to evaluate the impact of an intervention within the participant's group of armed forces wives. Monitoring and evaluation is a significant aspect of quality control and sustainability of any program. This issue will be further explored in a session on evaluation on day 2.

Welcome Address

The organizers would welcome the participants to the workshop and would give a short introduction its genesis and importance of the TOT being organized with the peer educators.

Facilitator's Note

A welcome session can vary depending on the style of the host organization and on local traditions. Sometimes opening ceremonies are conducted along very traditional and formal lines. The trainees may have to sit quietly through several speeches, which sometimes are of little interest to them. The result may be that the participants become bored, wondering whether this is going to be the format for the rest of the training. Trainers should try to avoid this situation. For example, they should make sure that the trainees are given a voice during this important first meeting. At the very least, the trainees should each be invited to introduce themselves to the whole group, stating their name and the town and/or their background etc..

Introduction of Participants

Learning Objectives: To get acquainted with each other, to initiate the process of familiarization that will enable active participation and also build a platform for further training sessions/days

Drawing Exercise Process: This game is an energizer as well as an ice-breaking exercise which enables the participants to warm up and get to know each other.

Activity

Distribute A4 size blank sheet of paper along with sketch pen to each participants. Ask them to draw picture in five minutes with which they can identify themselves. Tell them that this is not any kind of drawing competition. The drawing should be big enough to relate or associate any one or two personality traits that they possess.

After five minutes, ask each one of them to show their drawings and share their expressions about it. Stick all the drawings on brown paper, make it a collage and paste it on the wall.

Purpose of the Workshop - General and Specific Objectives

Why Are We Here?

Participants should be able to discuss what they intend to achieve at the workshop and what might hinder the achievement. They should state their expectations about the workshop and how these expectations will be used as tools in HIV prevention. They may also share their fears, if any, about the workshop.

Methodology: Participatory discussion

Preparation/Material Required: Chart papers, markers

Activity: Introduce the session to participants. Go around the group asking each participant the question "Why are you here?" or "What are you expecting from this workshop? Note participants' responses. Skip whoever is not ready during the first round to give time for them to think it through. Revisit those who did not respond at first. Jot down responses. Do the third round in the opposite direction from the first round and ask participants to state clearly what they think can hinder their ability to function positively during the training. Again jot down their responses. The trainer should clarify issues by addressing any fears, providing information on areas of concern and noting areas of concern that require follow-up. Review the workshop goal and objectives with participants. Lead a discussion on what will indicate the attainment of these objectives by asking participants the question "How will we know that these objectives are being met?"

Participant's Expectation and Expected Outcomes

Activity: Participants are given an opportunity to speak about their expectations for the training session and to state any concerns regarding peer education that they would like to have addressed. Responses are recorded on a flip chart. Assess which expectations are likely to be met in the course of the training workshop, and which ones may go beyond its scope. At the end of the session, a review of these initial expectations could be part of the evaluation.

The facilitator provides a brief explanation of the expectations of the training team for a successful workshop incorporating participants' expectations. He or she explains what will happen during the training sessions in the next few days, so that participants are aware of what to expect

SECTION 2: BASIC FACTS AND RISK PERCEPTIONS ON HIV/AIDS/STI

WHAT IS HIV and AIDS?

RISK PRECEPTION

DIFFERENCE BETWEEN HIV AND AIDS? WHY IS IT IMPORTANT TO KNOW THE DIFFERENCE?

WHAT IS WINDOW PERIOD?

WHAT IS AN STI? IT'S TYPES AND THE TREATMENT

PREVENTING HIV INFECTION & OTHER STIs: RECOMMENDED PREVENTION STRATEGIES

CARE AND SUPPORT

Learning objectives of this section are:

- To make the participants aware about the basics of HIV / AIDS
- To clarify the modes of HIV transmission and how it is not transmitted
- Help each participant understand and be able to explain the significance of the window period
- Explain the meaning of STIs, describe the four common symptoms of STIs;
- Explain the relationship between STIs and HIV infection; list misconceptions about STIs and explain the consequences of STIs if they are not treated
- Explain methods of prevention of STIs, tell what a condom is, list the advantages/disadvantages of condom use; demonstrate the proper use of condoms
- Make aware about service structures available; enable each participant to consider reasons for and against recommending voluntary counselling and testing (VCT).

<i>Time Frame</i>	<i>Materials</i>
90 Minutes	Chart papers Permanent markers Clip board Small cut papers Cards Condoms

What is HIV and AIDS?

Activity:

1. Write the word "HIV" in English on the board and ask the participants to explain the full form and meaning. Write all responses on a chart paper and discuss them.
2. Post the chart paper with "HIV" (human immunodeficiency virus) in English and explain the full form and its meaning.
3. Write the word "AIDS" on the board and ask the participants to explain the full form and meaning. Write all responses on flip chart and discuss them.
4. Post chart paper with "AIDS" (acquired immune deficiency syndrome) and explain the full form and its meaning.
5. Ask the participants why it is necessary to learn about HIV

Methodology

Projection accompanied with narration:

Narration by Facilitator:

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

Modes of Transmission and How it does not Spread

Activity:

Divide the group into two equal halves and tell one group to list the modes of HIV transmission. The other group should write about the modes by which HIV is not spread.

Give them seven minutes.

Tell both the groups to present their findings.

Presentation

For the virus to be transmitted from one person to another:

infected body fluids must be passed on which contain

enough virus which is

still alive, and there must be

a direct way in for the virus to get into the other person's blood stream

HIV is mainly transmitted through:

- Unprotected sexual intercourse, both vaginal and anal;
- Infected blood or blood products given by transfusion or injection;
- Sharing or re-using injection drug equipment containing infected blood without cleaning it between uses;
- Pregnancy, childbirth and after delivery through breast-feeding.

There are no other routes of infection.

HIV cannot live on its own, in the air or water. People can get cold, the flu or pneumonia just being near someone who has them. But people do not get HIV in this way. People do not get HIV from living in the same house or room with someone who has HIV. People do not get it from being at school, at work or socializing with someone who has HIV. And no one has been known to get HIV from kissing.

HIV is not transmitted through:

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

What is AIDS then?

Activity:

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

Presentation

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

Facilitator's Note

At the end of the presentation highlight the following: HIV can be detected only through a blood test. Otherwise it is not possible to say if one is HIV positive or not from one's physical appearance. The test is available at most government hospitals (Voluntary, Confidential Counselling and Testing Centres - VCTC) The test is confidential and the results are not revealed to anyone but the person tested. The counsellors at the testing centres are available to answer any questions.

Risk Perception

What are High Risk Behaviours?

- High risk sexual behaviours are behaviours that put an individual at higher risk of either getting or transmitting a sexually transmitted infection or HIV.
- When a woman has vaginal or anal sex with a man without a condom and the man has some infection in the genitals, then the woman can also get infected.
- Similarly a man can get infected from a woman.
- When a woman has sexual relations and engages in unprotected (without a good quality condom) with many men, then the risk for getting infections increases many folds. The same is the case with men.
- When a man has anal sex with another man without a condom and he is having some infection in the genitals, then the other man can also get infected.
- When a man has sexual relations and engages in unprotected anal sex (without a good quality condom and water based lubricant) with many men, then the risk for getting infections increases many folds.

Levels of risk for getting HIV/AIDS infection

Level 1 : The following situations carry no-risk for getting HIV/AIDS infection:

- Drinking water or eating food from the same utensil used by an infected person.
- Using wells or bathing or washing places used by people with HIV/AIDS.
- Getting bitten by a person with HIV/AIDS.
- Socialising or living with people with HIV/AIDS.
- Hugging, kissing or shaking hands with a person with HIV/AIDS.
- Caring and looking after people with HIV/AIDS.
- Casual contact such as sitting next to an infected person, or by coughing or sneezing or from water, food, clothing, utensils, etc.
- Donating blood.
- Working with people who are infected with HIV.
- Sex between uninfected partners who have always been mutually faithful. This is safe sex practice.

Level 2: The following situations carry low-risk for getting HIV/AIDS infection. They are the safer sex practices.

- Deep kissing where no blood is exchanged.
- Mutual masturbation.
- Massaging each other's bodies.
- Oral sex by a woman with a man wearing a condom.
- Having vaginal or anal sex with a condom.

Level 3: The following situations carry high-risk for getting HIV/AIDS infection:

- Having vaginal or anal sex with a person without using condoms.

- Having sex with a person who has a sexually transmitted infection.
- Deep kissing where blood is exchanged.
- Wearing condoms after contact with the partner's sexual organs.
- Oral sex by either a man or a woman with a man who is not wearing condoms.
- Oral sex by either a man or woman with a woman.
- Infection of the unborn or newborn child of a pregnant woman with HIV infection.
- Sharing injection needles for injecting drugs.
- Getting a transfusion with blood or its products that is infected with HIV.

Level 4: The following situations increase the risk of indulging in high-risk behaviour:

- Having alcohol before having sex.
- Having drugs before having sex.
- Having sex when one is emotionally disturbed with feelings of insecurity, anger, frustration, etc.
- Spending time with a partner in privacy without buying condoms in advance.

Difference between HIV and AIDS and the Importance of Understanding the Difference

Activity

Form participants into three groups and ask one group each to come up with three things that make HIV different from AIDS when they consider:

Group 1: Things that are happening INSIDE the bodies of people with HIV and AIDS

Group 2: Things that are happening OUTSIDE the bodies of people with HIV and AIDS

Group 3: The different LIFESTYLES of a person with HIV and a person with AIDS

Report as before, with each group adding only new points. After the groups have reported, present the information below. The groups' three points on the differences between HIV and AIDS may have been organized in other ways. That is okay. The main point was to get every participant thinking about and discussing the differences.

Group 1: Various things are happening inside the bodies of people with HIV and AIDS

- HIV is the infection stage of the condition; AIDS is the disease phase.
- When the virus enters the body, it comes into contact with the frontline of the body's defence system. In the early stages of infection (during the first few days or week) the infected person might feel as though he/she is coming down with flu. HIV overpowers this frontline (made up of white blood cells called macrophages) and makes its way into other body cells, living in them, destroying them and multiplying at a rapid rate.
- Antibodies (chemical substances that a body produces to kill organisms attacking it) to the virus are produced. The body produces and releases antibodies into the bloodstream anywhere from six weeks to six months from the time of infection. This six-week to six-month period when antibodies to HIV are not detectable in the blood (shorter or longer depending on the particular body) is called the "window period."

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

- When the amount of viruses in the body reaches a high point and the amount of body cells that are supposed to fight off disease reaches a low point, the body becomes prone to various infections, called opportunistic infections. HIV and various opportunistic diseases then take over the body. This is when the person may be said to have AIDS.

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

- You can't tell when a person has HIV. A person who is HIV positive can look and feel as good as a person who does not have the virus. HIV-infected people can even look better, as many begin taking better care of their health and physical appearance.
- A person who is HIV positive can live for several years, looking just like a person who is not HIV positive. There are no signs on the person's body to show that he or she is carrying the virus.
- People who are HIV positive develop AIDS (or can be said to "live with" AIDS) when they have three or more signs of the syndrome (collection) of diseases listed earlier. Those with AIDS may have signs such as significant weight loss, thinning hair and skin diseases. Other signs that may not be as obvious to another person are the frequent bouts of diarrhoea, enlarged lymph glands under the jaw, neck, armpits and groin. Thrush, a white furry coating on the tongue, the roof of the mouth and sometimes the vagina, is another sign. Note: No one of these signs by itself means that a person is living with AIDS.
- People who live with AIDS may not only look sick, but they may also feel sick. Diseases take over the body because HIV has broken down the body's defence force or resistance (the immune system).
- These diseases are caused by "opportunistic infections." They are called so, because when the body's resistance is weak, infections of all types take the "opportunity" to invade and take over the body. Usually a normally healthy person can "resist" these infections. The body's immune system is designed to fight infections and disease.
- There is no cure for HIV. A vaccine against HIV is now being tested.
- A person living with AIDS can return to feeling well when diseases are treated and symptoms disappear.
- People don't actually die of AIDS. Death usually comes after a series of illnesses and when the body finally succumbs to (that is, is overpowered by) one or more of the diseases, which take over in the AIDS stage.

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

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

professionals are more likely to take risks with people who are HIV positive and don't have AIDS because they look good and their status may not be known.

What is "Window Period?"

The window period is the time from HIV infection to when the usual lab tests can detect the antibodies to the virus in an HIV-infected person.

The window period can last from six weeks to six months. Different bodies take different lengths of time to produce and release the antibodies in response to the infection with HIV.

During the window period, the commonly used tests cannot detect the antibodies to the virus. Therefore, if someone is tested during that period, the test result will be negative even though they are infected. Some labs describe the findings as "non-reactive."

Why is it important to know about the window period?

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

What is an STI? It's Types and the Treatment

Activity

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

Group A

1. What are sexually transmitted infections?
2. What is meant by sexually transmitted infections?

3. What happens when one gets a sexually transmitted infection?

Group B

1. What are the common symptoms of STIs?

Group C

1. What do people think about sexually transmitted infections?

2. What are your beliefs about the transmission and treatment of sexually transmitted infections?

Group D

1. Where do people generally go when they have STI?

2. How should sexually transmitted infections be treated?

3. How can sexually transmitted infections be prevented?

Group E

1. What do you know about safe sex?

2. What do you know about unsafe sex?

Facilitator's Note

- Visit each group to help them. Do not give answers directly. You can give clues.
- Encourage the participants from other groups to ask questions and encourage the spokesperson or his/her group members to answer, If they can not answer properly, discuss and explain the answer (see the fact sheet).
- Compliment the participants for their work and tell them that these issues will be taken up in detail in the subsequent sessions.
- At the end, make a brief presentation based on the handouts provided (30minutes).

What are STIs?

- Sexually transmitted infections are the infections that are transmitted through sexual contacts. There are two categories of STIs - symptomatic and asymptomatic STIs. Symptomatic infections can be detected through specific symptoms, while asymptomatic STIs have no symptoms and can be detected only through lab tests.

Symptoms in Men

- Discharge from penis
- Pain during urination
- Sores or blisters around genital area
- Swelling
- Genital ulcers
- Warts

Symptoms in women

- Sores, lumps, blisters or rashes in or near the genitals
- Purulent, curdy, yellowish, foul smelling vaginal discharge

- Burning pain while passing urine
- Lower abdominal pain
- Unusual swelling and itching around the pubic area

Preventing HIV Infections & Other STIs: Recommended Prevention Strategies:

Abstaining from sexual intercourse is the most effective HIV prevention strategy. For individuals who are sexually active, the following are highly effective:

1. Engaging in sexual activities that do not involve vaginal, anal or oral intercourse
2. Having sexual intercourse only with one uninfected partner
3. Using latex condoms correctly from start to finish with each act of intercourse.

STI/HIV Transmission can be prevented!

STI/HIV transmission can be prevented by:

1. Practicing safer sex (ABC strategy)

* Abstain from intercourse

* Be mutually faithful to one uninfected partner

* Use a Condom for every act of intercourse if there is more than one sexual partner

2. Receiving a blood transfusion only if necessary and with properly screened blood

Presentation

- Sex does not only mean vaginal and anal sex which if had without a condom, carries the highest risk of STI / HIV transmission.
- Some of the safer sex practices include oral sex, mutual masturbation, thigh sex, breast sex, rubbing, kissing, etc.
- When it is not possible to abstain from sex or be faithful to one single sexual partner, the best option is to use a good quality condom every time one has vaginal or anal sex.
- Condoms, if used correctly, are the safest means for protecting oneself from STIs and HIV infection.

Activity

1. Show a condom to the participants and ask, "What is this?"
2. Distribute condoms to all participants and ask them to touch it, blow them up.
3. In a flip chart write down points to be considered while/before using condoms. Allow 10 minutes for discussion.
4. Divide the participants into groups of three.
5. Distribute condoms and penis models to each group.
6. Explain the proper procedure for using condoms and ask one participant to volunteer to demonstrate how to properly put on a condom (use the visual to depict all steps for correct condom use).
7. Observe the demonstration and correct if necessary.
8. Have the participants practice putting on condoms in role plays. Explain the roles to the groups: one person will act as a peer educator, another as the friend and the third person as an observer.
9. Explain that the PE will demonstrate how to use a condom to his/her peer, the observer will observe and provide feedback after the demonstration and the PE's friend will learn from the demonstration. Have them rotate so everyone gets a chance to play all three roles.

10. At the end of the session, make a brief presentation on the benefits of using condom:

- Prevents STIs, including HIV/AIDS
- Prevents unwanted pregnancies.
- It is manly to use condoms - it can slow down ejaculation and enhance male performance.
- Condoms are sexy - it can prolong pleasure for both partners.
- Feels cleaner.
- Feels more secure.
- Shows you care about your partner.
- No need to spend money on medications to treat STIs.
- Saves you the cost and embarrassment of an STI.
- Requires no medical screening advice - can use on your own.
- They are often free or not very inexpensive.

Condoms for Women: The female condom is now available, though more expensive than a male condom. Research and studies are in progress to determine its effectiveness in preventing transmission of HIV and its use. If a male condom cannot be used, consider using a female condom.

The Value of Condoms

- The condom, when used properly, greatly reduces the risk of STI and HIV transmission between partners.
- It is also the ONLY contraceptive method that offers this protection. All peer educators must become skilled at handling, talking about and explaining the use of condoms. Since condoms are associated with sex, people often get tensed up and feel shy when talking about or handling them.

Proper Use of Condoms: How to use a condom?

Visual: Pictorial demonstration of condom use: different step

Proper use of condom

1. Open the package carefully so the condom does not tear. Do not use your teeth as this may tear the condom. DO NOT unroll the condom before putting it on.
2. Squeeze the tip of the condom, and put it on the erect (hard) penis. Continue squeezing the tip of the condom (this prevents air from becoming trapped in the end of the condom) while unrolling it until the condom covers the entire penis.
3. Always put the condom on before entering or coming in contact with your partner's genitals, anus or mouth.
4. Do not use vaseline, grease, oil or lotions for lubrication as they can weaken the condom.
5. After ejaculation (coming), hold the base of the condom and pull the penis out before the penis becomes soft. Tie the end of the condom and wrap it in a paper.
6. Burn or bury the condom with other garbage.

Making Responsible Choices

In summary, sexually transmitted infections, including HIV infection, are preventable. The effectiveness of responsible prevention strategies depends largely on the individual. Whatever strategy one chooses, its effectiveness will depend primarily on consistent adherence to those choices.)

Condom Care

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

Condom Availability

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

Condom is the only contraceptive tool that provides protection from unwanted pregnancies and Sexually Transmitted Infections and HIV/AIDS.

Care and Support

People living with HIV/AIDS can live healthy and productive lives when they have access to information, treatment, care and support.

Information includes knowing what your rights are in terms of employment, welfare, education and family life, and having clear information about treatment and how to get treatment. It also means knowing about property rights, personal laws related to divorce, alimony and custody of children. Personal laws gain importance in the context of women, as they are likely to face more discrimination and harassment on being diagnosed with HIV/AIDS.

Support means acceptance, affection, respect and love from friends and family and from the community. It also means supportive laws to protect against discrimination and stigmatization.

Care includes moral support and access to necessary medical treatments, a healthy diet, clean water and accommodation. Although key human rights, such as the right to information, the right to life and the right to health create entitlement to care and support, most young people (especially young women) living with HIV/AIDS do not have full access to these services. The situation is worse for young people belonging to marginalized groups, such as sex workers, homosexuals and injecting drug users. The realization of human rights and other constitutional rights is not simply a matter of state action to develop laws and policies that protect against discrimination and stigma. Advocacy for public policies and legal action is also very important.

However, this is not enough to transform the reality at the grassroots. When it comes to improving the daily lives of people living with HIV/AIDS, the community, family and friends have to play an important and

dynamic role.

Treatment and care consists of number of different elements including:

1. Voluntary Counselling and Testing Centers (VCTCs): The voluntary counselling and testing center (VCTC) has the potential to be a powerful tool for reducing risky behaviours. It also serves as a key entry point to care and support services, making it an important complement to other HIV and AIDS prevention and care strategies. VCTCs are managed by NACO/State AIDS Control Societies. Now there are VCTCs at many places.
2. Food and Nutrition: Nutrition is an essential part of any HIV care package. Good nutrition may help prolong the period of time between HIV infection and the onset of Opportunistic Infection.
3. Prevention of Parent to Child Transmission of HIV (PPTCT): Parent to child transmission of HIV can occur during pregnancy, at the time of delivery, and after birth through breastfeeding. At PPTCT centers the mother-to-be are counseled. An important part of the prevention of further transmission of HIV is the education of a mother to be, about the different options she has, and what implications the options have for her health and her baby's health.
4. Drugs: for treatment of opportunistic infections and anti-retroviral therapy (ART).

HIV positive people have differing needs according to the stage of their infection

- The **first stage** is when people are **asymptomatic**, that is when they have no signs/symptoms of their infection
- The **second stage** is **symptomatic** - when people have symptoms of HIV infection.
- The **third stage** relates to support and care of people who are **terminally ill and nearing the end of their life**.

Treatment Issues in HIV/ AIDS

- Some drugs are available which act against HIV
- These are called Anti retroviral drugs (ARVs)
- Anti retroviral drugs (ARVs) help a person to keep the immune system strong
- ARVs are not a cure for AIDS. However, by controlling the virus they help to improve the quality of life of people living with HIV/AIDS
- These drugs are to be taken under medical supervision
- Once started, ARVs are to be taken for the whole life
- ARVs delay the onset of AIDS. If not taken, more than 80% patients with AIDS die within 1-2 years of developing symptoms
- Can prevent the transmission of HIV in baby from infected pregnant mother

SECTION 3 - HIV/AIDS/STI AND THE CROSS CUTTING ISSUES

SEX AND SEXUALITY

STIGMA AND DISCRIMINATION

FAMILY AND SOCIAL DISORGANIZATION

EPIDEMIC IMPACTS ON VARIOUS GROUPS

Learning objectives for this section:

- To develop non judgmental attitudes by increased knowledge on different sexual orientation
- Identify reasons why people are not comfortable talking about sex and learn that the people have inaccurate and incomplete information about sex and related issues
- Clarify the myths and misconception related to sex and sexual orientation
- Explore feelings associated with sexual issues and talk about sex and sexual issues comfortably with oneself and their peers
- To remove inhibitions in openly discussing and encouraging peers to discuss about sexual issues.

<i>Time Frame</i>	<i>Materials</i>
90 Minutes	Chart papers Permanent markers Clip board Small cut papers Cards

SEX AND SEXUALITY

Activity

Write the following questions on three different pieces of chart paper and paste them on the wall.

- Recall the first time you heard the word sex.
- How old were you and what did you feel?
- Recall the first time you asked someone about sex and under what circumstances.

Divide the participants into groups. Ask each group to sit in circle. Ask the participant in each group to turn to the person on her/his right and discuss with each other the above questions for ten minutes.

Ask the volunteers to share their experience with the group. If none is willing, ask each one to talk briefly about their own or their partner's experiences.

Emphasize that:

- Sex is natural and can be a pleasurable activity.
- It is not for procreation alone.
- Women should recognize and respect themselves as sexual beings and not feel ashamed to talk about their sexuality.

Encourage the participants to share and express their views. Make them feel that it's very natural for us to feel shy or to have apprehension to talk on sexual issues but it is very important for us to know to talk about sex.

Facilitate a discussion around the following issues:

- What sexual information do you feel you lacked as a child and today as an adult?
 - Why is it important to know that information?
 - Would you have felt differently about sex and about yourself if you had the information?
 - What might you have done differently had you known before?
- Note down responses on flip chart

Encourage participants to summarize learning from this exercise. Emphasize that:

All of us have got the information about sex through some sources at different levels. Feelings associated with sex are influenced by gender, culture, religion and life circumstances. If such feelings and emotions happen to be negative, they can have negative implications on the personality of the individuals.

Incomplete and inaccurate information about sex leads to curiosity that in turn can compel people to indulge in risky sexual behaviour. Concerns about sexuality arise early in lives. Sexuality education enhances the quality of people's lives by clarifying misconceptions and helping young people make informed and healthy choices. These include protection from unwanted pregnancies, infection and abuse.

Providing information on sexuality is not encouraging someone to have sex. It is about educating the people about body and body parts including sexual anatomy and physiology. It is also about helping people to understand how sexuality is related to the overall well being of the individual, family, community and society at large.

Purpose of sex

Activity

- Linking up with the previous activity, encourage participants to express the reason why people have sex.
- Note down their responses on the chart paper or flip chart
- Encourage participants to interpret the learning from this exercise. Summarize with the following key messages:
 - We cannot assume that all people are motivated by the same reasons to have sex. Some people have sex for various reasons, while some are forced or abused or may not have a choice..
 - We should not be judgmental whether a certain purpose of having sex is immoral or abnormal. However, it is important to ensure that any purpose of sex should not inflict harm to others physically, emotionally and spiritually.

Word Sense

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

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

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

Sexual identity indicates maleness and femaleness.

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

Sexual orientation

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

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

Acknowledge that some of the participants might have strong values about a person's sexual orientation. Tell the participants that you will respect every individual's right to his or her opinion.

Activity

Draw a line across the top of a sheet of flipchart paper. Label one side of the continuum "Heterosexual" and the opposite end "Homosexual." Label the middle of the continuum "Bisexual." Use this diagram to explain that the range of sexual orientation, from heterosexuality to homosexuality, is a continuum.

Most individuals' sexual orientation falls somewhere along this continuum. While scientific studies

have shown that an individual cannot change his or her sexual orientation at will, sexual orientation might change throughout a person's lifetime. So an individual's orientation can move along the continuum as time passes. Explain that a person's sexual orientation is often confused with other aspects of his or her sexuality. For example, people often mistake sexual orientation with gender roles.

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

Another distinction to make is that a person's sexual behaviour does not always indicate his or her sexual orientation. To make this point, draw a third line below the other two. Label one side "Sex with men" and the other "Sex with women."

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

Indeed, some married persons engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.

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

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

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

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

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

Myths and Misconception of Sexuality

Activity

The cards are distributed to each participant. In turn, each participant reads her/his card aloud and says whether the statement is a myth or a fact. Alternately, the group can be requested to share their opinions about each statement. The facilitator provides the explanation why the belief is a fact or fallacy

Alternative activity:

An alternative approach is to make it like a game. First break the group into teams of about 10. The teams compete with each other for points against correct answers.

The VIPP cards would be all jumbled in a box. Either the facilitator or a member of each team would draw out their question. The facilitator would read it for all to hear. One team would be allowed to confer and come up with the answer. If the team answers correctly, they would be awarded 100 points for getting the myth/fact part correct and 400 points for being able to explain why (total points for a correct answer: 500).

Statements for Visual Impressive Participatory Presentation (VIPP) Cards

1. Once a girl has had her first period, She can become pregnant	FACT When a girl starts having her menstrual periods it means that her reproductive organs have begun working and that she can become pregnant. It does not mean, however, that her physical organs, body and mental condition are necessarily prepared for the birth of a child.
2. During unprotected intercourse a girl can become pregnant even if she has not had her first period	FACT Because women's ovaries release an egg around 14 days before the onset of her menstrual period, it is possible for a girl to get pregnant even before her first period.
3. It is unhealthy for a girl to bathe or swim during her period.	MYTH There is no reason why a woman should not do any specific activity because of her period, unless she has cramps or discomfort. She only has to maintain genital hygiene to avoid reproductive tract infections (RTIs).
4. Abstinence is the only method of birth control that is 100% effective.	FACT The only way to be absolutely sure of avoiding pregnancy is not to have sex.
5. Girls and boys can have STIs without showing any symptoms	FACT While some STIs may have quite recognizable symptoms, others may not. Gonorrhoea, for

	example, typically displays no symptoms in women and often is undetectable in men. It is important to be examined by a doctor if you think you may have an STI.
6. A girl cannot get pregnant if she has sex only once or a few times.	MYTH A girl can get pregnant even with a single intercourse including her first one.
7. A girl can get pregnant if she has sex during her period.	FACT It is possible for a girl to get pregnant at any time during her menstrual cycle.
8. Once you have had gonorrhoea and have been cured, you cannot get it again.	MYTH A person can get gonorrhoea as many times as she or he has unprotected sex with an infected person. It is important, therefore, that anyone who is treated for gonorrhoea (or any other STI) makes sure that his or her sexual partners are treated as well or condom is used for each act of intercourse
9. Condoms help prevent the spread of STIs	FACT Not only are they an effective method of birth control but are also effective in preventing STIs.
10. The size of the penis is equivalent to masculinity or virility.	MYTH The size of the penis (either flaccid or erect) is no indication of a man's masculinity or sexual ability
11. A girl can get pregnant even if a boy does not ejaculate or come inside her.	FACT Even if a boy does not ejaculate inside a girl's vagina it is still possible for a girl to get pregnant because the pre-seminal fluids contain sperms.
12. STIs can be cured if the infected man has sex with a virgin.	MYTH STIs require regular medical treatment. Having sex with a virgin or anyone else one will only pass on the infection to him/her
13. Menstruation is unclean	MYTH Menstruation is related to the cycle of life. The uterus prepares itself for growth of the baby, if and when conception takes place. When this does not occur, the soft, temporary lining of the uterus sheds resulting in results in menstruation.

14. The female determines the sex of a baby.	MYTH The male genetic material (XY) determines the sex of a baby through either the X (girl) or Y (boy) chromosome. Female genetic material is only XX.
15. Nocturnal emissions (Night fall) make boys weak.	MYTH Loss of semen through a wet dream, masturbation or sexual intercourse is a perfectly normal and harmless thing. It does not make you weak.
16. Masturbation is normal.	FACT It is a normal sexual activity practiced by both males and females.
17. Homosexuality is abnormal.	MYTH A homosexual is a person who is attracted to people of the same sex and derives sexual pleasure from them. Both men and women can have such an attraction towards the people of same or different sex at different times in their lives. It is common and should be considered normal.
18 Circumcision increases the sexual power of a man.	MYTH Circumcision is a procedure by which the loose fold of the foreskin of the penis is cut off. It is also easier to keep the penis clean. However it makes no difference in the sexual pleasure or powers of the man.
19. A drop of semen is equal to 20 drops of blood. Hence the loss of semen weakens the body and should be avoided.	MYTH Semen has no relationship to blood and its loss causes no weakness to the body .Semen is meant to be released from the body during sexual excitation.
20. The vast majority of homosexuals are men.	MYTH Both men and women can be and are homosexuals. Male homosexuals are more visible simply because society allows men in general to be more open about sex.
21. Most of the women infected with HIV are prostitutes.	MYTH Most women infected with HIV are housewives. The rate of HIV infection in ante-natal clinics in Delhi increased by 100% in 1994 and 400% in 1995. Around 70 - 80% of all women are infected by their husbands.

<p>22. Most men who enjoy sex with men are married and have children.</p>	<p>FACT Over 90% of male clients who regularly visit male sex workers do not consider themselves to be homosexual or even bi-sexual. The fact that they are married and have children confirms their "normalcy". Likewise, if the client takes the role of active partner during anal sex, he may consider the male sex worker to be a woman. They follow the logic that a woman takes the receptive role in sex. Thus anyone who takes the receptive role is a woman.</p>
<p>23. In India homosexuality came into practice with the coming of the British.</p>	<p>MYTH Homosexuality is a human phenomenon that has nothing to do with nationality One could say that homosexual behaviours have been practiced in India since time immemorial. Homosexual behaviours are explicitly described in many ancient texts including the Kama Sutra and are depicted in the sculptures of Khajuraho and others. Traditions of keeping eunuchs, mistresses or harems of young boys have been documented since the last 1,500 years.</p>
<p>24. You cannot get infected with HIV from a mosquito.</p>	<p>FACT 1) HIV is the HUMAN Immuno-deficiency Virus. It Lives within human white blood cells. It cannot Survive outside its host. Thus, as soon as the White blood cells die, HIV dies. 2) White blood cells and HIV are destroyed in the highly acidic environment of the mosquito's Stomach. 3) Mosquitoes suck in blood for food. They do not inject blood. There is no way that they can inject HIV back into another person. A syringe is used to inject medicine; in the process it could inject droplets of infected blood. Any tiny droplet of blood left on the outside of the mosquito's stinger would be unable to infect. Such a small amount would probably dry very quickly. When blood dries and HIV is exposed to air, the virus dies within a few seconds. Thus even infected blood would become harmless. If, somehow, the blood does not dry it is unlikely that the blood could enter the body. When the mosquito inserts its stinger, the</p>

	<p>tension of the skin around the stinger would squeeze the blood back off the stinger and the blood would remain outside the body 4) Mosquitoes do inject their saliva into their victims. Malaria is carried in the saliva and spreads in this way. HIV cannot exist in mosquito's saliva and thus cannot spread through mosquito bites.</p>
<p>25. A man can only become infected with HIV from an infected woman, not if he has unprotected sex with an infected man or hijra.</p>	<p>MYTH The gender of the sexual partner is absolutely Irrelevant. HIV transmission can happen whenever the virus from an infected person is able to access the white blood cells of an uninfected person. Both unprotected vaginal and anal sex is highly dangerous.</p>
<p>26. If you have an STI, having sex with a hijra will cure it.</p>	<p>MYTH Only proper medical treatment can cure an STD.</p>
<p>27. The risk of infection through a needle stick injury from a syringe used on an HIV infected person is 1 in 5 lakhs.</p>	<p>FACT HIV must enter your body in sufficient quantity for you to get infected. This is also one of the reasons why it is almost impossible to get infected from a barber's razor. There has been no known cases of transmission in this way</p>
<p>28. In India 85% of people having HIV have been infected through sexual transmission.</p>	<p>FACT Although India portrays itself as a moral country which does not indulge in premarital and extra marital sex, the statistics for HIV transmission and STI prevalence do not back that up. Of the total number of reported AIDS cases, in more than 85% of cases the infection was attributed to sexual transmission.</p>
<p>29. Anal sex has a higher chance of HIV transmission than vaginal sex.</p>	<p>FACT Both anal and vaginal sex are unsafe. Both the vagina and the rectum are lined with a mucus membrane through which the virus can pass directly into the blood stream. Anal sex has a higher chance of transmission because the chances of minor abrasions or tearing are higher</p>
<p>30. 1 out of every 4 people in the world who have an STI is an Indian.</p>	<p>FACT 4 crore Indians seek treatment at government STI clinics each year and this is just the tip of the iceberg. There are many people who</p>

	choose to seek treatment from private clinics, quacks, or do not seek treatment at all. It is estimated that only 30% of women with STIs seek medical treatment
31. Presence of an STI in an individual increases the chances of acquiring transmitting HIV by 10 times	FACT The same behaviours which can lead to an STI can lead to HIV transmission. Furthermore, the existence of an STI increases the chances of acquiring and transmitting HIV infection by 10 times.
32. 50% of all HIV infections happen between the age of 15 and 25.	FACT Young people are constantly experimenting with sex and drugs but they may not understand the risks of experimentation. The infectivity of STIs and HIV among young people is particularly high because of physiological reasons, the inability to take informed decisions and make sound judgements regarding sexual matters. Among youth, girls are more vulnerable because of their greater biological and social vulnerability
33. Using a Copper T for birth control also protects you from HIV.	MYTH Condoms are the only form of birth control which also offer protection from the sexual transmission of HIV Use of Copper T actually increases the rate of transmission.
34. 7 or 8 out of every 10 women who will be infected with HIV will be infected by their husbands.	FACT The only risk behaviour that the majority of women Who are HIV infected is "having sex with their husbands" — their "marital duty".
35. One way of knowing you are HIV positive is if you loose more than 10% of your body weight over a period of less than one month for no apparent reason.	MYTH Although rapid weight loss can be an indication of a weakening immune system and, thus, the presence of HIV, there are many other reasons for unexplained weight loss. The only way you can be sure whether you have the virus is to take an HIV test.
36. Direct stimulation of the prostrate gland during anal sex can result in orgasm.	FACT Not only is this one source of sexual pleasure during anal sex, but the same nerve which carries pleasurable sensations from the penis (or clitoris) reaches the anus.

37. It is possible for a woman to get pregnant through anal sex.	MYTH There is no connection between the digestive tract and the reproductive tract.
38. Having sex with someone of the same sex means you are a homosexual.	MYTH Homosexuality is a very personal issue. One's self identity is completely a personal choice which has very little to do with sexual behaviours. A male sex worker may have 10 male clients a day but he may only be turned on by women. He may not consider himself a homosexual. On the other hand, a virgin may feel attracted to other women very strongly and know she is a homosexual. In India it is most common for men who enjoy sex with other men to not identify with the term homosexual. Human sexual response does not neatly fit into a set of prescribed terms. Each person falls somewhere along a spectrum of sexual attraction. It is estimated that only 10% of the population is solely attracted to people of the opposite sex. It is estimated that another 10% is solely attracted to people of the same sex. All the other 80% fall somewhere in between. Because of the powerful pressures of society, expectations of parents and peers, most of the 80% (and many of the 10% homosexuals) choose to live a predominantly heterosexual lifestyle.
39. The vagina is the primary sexual organ of a woman.	MYTH The vagina is primarily a reproductive organ. Because of its function as the birth-channel, the vagina has a very low concentration of nerves. Fewer than 30% of women are ever able to achieve orgasm through vaginal penetration. The clitoris is the primary sexual organ of a woman. It has no other function than to provide sexual pleasure.
40. STIs can only be transmitted via the genitals.	MYTH STIs can also be transmitted through anal and oral sex. It possible to have a STI infection in the mouth and anus.

Difference between Sex, Sexuality and Gender

Activity

Write the word SEXUALITY in the middle of a chart paper or white board.

Encourage participants to come up with a list of words that they think are associated with sexuality. Note down their responses with different colours around the word sexuality.

After the brainstorming session, ask participants to define what sexuality is. Highlight the definition of sexuality:

"Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are experienced and expressed." (WHO draft working definition 2002)

Sum up the session with the following key messages:

Sexuality is influenced by interaction of biological, psychological, social, economical, political, cultural, ethical, legal, historical and religious and spiritual factors.

Sexuality is more than acts of sex, it is also different from gender, which refers to how societies view women and men, the differences between them and to the roles assigned to them.

Every one does not experience sexuality in the same way. Being aware of these differences helps to inculcate the values of respecting others sexuality and provides space to communicate about each other's views and opinions. It helps people to be sensitive to the needs of others.

Stigma and Discrimination

The following process has multiple objectives. It aims at understanding the risk factors and vulnerability, and the consequences of problems that people face in today's society. There is an inbuilt opportunity that during the process it enables to create awareness of how stigma and discrimination may increase people's vulnerability and to share experience and good practice in working with especially vulnerable people.

One Day in my Life

Keep four sheets of paper ready with each labeled with one of the following characters: HIV-positive young woman; homosexual young man; street kid; and young sex worker

Activity

Four volunteers are asked to wear one of the above 'labels' and play that character. Acting the part of, for example, the street kid, they tell the group briefly what their day has been like since they woke up in the morning.

The audience is then invited to ask each of the 'actors' additional questions about their life, which they

answer as if they were a street kid or a young sex worker, or whatever character they have been playing. To conclude, the group discusses the experience and the actors can, if they wish, describe what it felt like to portray their character.

Family and Social Disorganization

Both conflicts and complex emergencies in the armed forces setup provoke (both directly and indirectly) a type of social and demographic disruption that places people in situations where the risk of HIV/AIDS (as well as other health problems) is heightened. The violence, family disorganization and uprooting caused by conflicts and complex emergencies often require that survivors develop new coping strategies that can at times involve high-risk sexual relationships. People find themselves alone, insecure and in need of emotional support, conditions that often lead to development of sexual relationships.

Activity

Divide the participants into three groups and ask them list down the different types of discrimination when a person tested positive for HIV experiences from home and from society. Ask the respective group to present what they have listed out. Make the participants discuss on types of discrimination and the probable reasons for that.

Discussion

Denial involves a refusal to see reality, i.e. the very existence of the problem, the risks involved, the possibility that one may be at risk, the likelihood that people are taking risks in one's community and finally the fact that some of the people in the community are infected with HIV. Denial breeds irresponsible behaviour, which compounds the risks.

Discrimination flows from the belief that one only gets AIDS because of one's depraved activities or lifestyle. It is based on ignorance about the nature of the disease, perpetuates false concepts about it and causes more pain to those who have it. It is useful to analyze the roots of such beliefs because they are linked to prejudice against the behaviour of the affected. Eg often high risk groups like sex workers and MSM are often victimised for having brought this disease on themselves due their own behaviour.

Facilitator's Note

Stigma and discrimination associated with HIV and AIDS are one of the greatest barriers to preventing further infections, providing adequate care, support and treatment and alleviating the impact of HIV and AIDS. Stigma and discrimination are triggered by many factors, including lack of understanding of the disease, myths about how HIV is transmitted, prejudice, lack of treatment and social fears. Stigma and discrimination can deter people from getting tested, lead to others being infected and prevent people who are infected from receiving adequate care and treatment.

Epidemic Impact on Various Groups

Impact of the HIV epidemic varies among different behavioural groups in the society. The society could be broadly divided into low risk group, medium risk groups and high-risk group.

Activity

1. Divide the participants into three groups.
2. Distribute chart papers to each group and assign each group with one of the risk category
3. Ask them to list out the features of the three categories of the risk groups, populations belonging to these groups and the factors leading to risk.
4. After the exercise put up the chart papers in the board and facilitate open discussion.

Discussion

Low risk group: Groups in the society who are at lower risk to acquire or spread HIV. Married women, men, youth, babies and children are the population who are at low risk

Medium risk: Groups who have chances to acquire or spread HIV. They are more vulnerable to HIV than the low risk groups. Migrants, clients of sex workers, truck drivers, families of high risk behaviour people, street children are a few examples

High risk: The marginalised groups in the society who have greater risk to acquire or spread HIV in the society. Injecting drug users (IDUs), sex workers, men who have sex with men (MSM) are the most vulnerable groups.

Injecting Drug Users (IDUs)

Sharing of needles is the major risk factor for HIV among the IDUs. In most Asian countries, IDUs are the first community to be affected by HIV. The IDUs are threatened not only by their behavioural risks but also by a societal response, which ostracises drug use and uses a predominantly punitive model, coupled with limited drug treatment facilities.

Sex Workers

Both types of sex workers- male and female operate in the society. They practice high risk behaviour for their day to day sustenance, which makes them the most vulnerable group. Due to their highly marginalised status in society, sex workers have little access to accurate information about reproductive health and STI. Cultural, economic and social constraints limit their access to legal protection and to medical services.

Most sex workers experience increased vulnerability to HIV/AIDS due to a low level of education, which restricts access to information and health care services. They have little control over the risk in sexual encounters because the client often determines whether or not to use a condom. Moreover, violence against sex workers is common.

MSM

Male having sex with male group are very common in any society though they are hidden in nature. There are different categories of MSM and different terminologies are used to designate them. This varies with the places and culture. Mostly there are two groups ie receivers and providers.

Multiple sex partners, unprotected anal sex and the hidden nature of MSM sexual relations in many communities all contribute to the prevalence of risk among MSM. The societal norms against homosexuality make the group more vulnerable and marginalized. Hence the risk linked with their sexual behaviour is also affected.

Migrants

Migrants have complex causes, ranging from economic and/or political reasons to "forced" displacement (e.g. conflict, trafficking). The mobile groups and their respective families are vulnerable to HIV/AIDS/STI in different ways. Although information is limited about the behaviour of labour migrants in their respective host countries, the assumption is that during their long absence from their families a considerable number of them become clients of sex workers.

SECTION 4 - PEER EDUCATION

THE BASICS AND PROCESSES

PEER EDUCATION IN THE CONTEXT OF HIV/AIDS

SELECTION OF PEER EDUCATORS

TRAINING OF PEER EDUCATORS

ROLES AND RESPONSIBILITIES

REWARDING SYSTEMS

Learning Objectives:

- To introduce participants to the idea/concept of peer education.
- To establish the importance of peer education in HIV/AIDS prevention
- To arrive at a consensus on the selection criteria and qualities of a peer educator
- Describe at least five duties and responsibilities of peer educators and demonstrate at least four qualities required of peer educators.
- To come to an agreement about the rewards/incentive system for peer educators

Time Frame	Materials
90 Minutes	Chart papers Permanent markers Clip board Small cut papers Cards

Peer Education - The Basics and the process

Activity

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

Introduce the following definitions:

- **Peer** is a friend who has a similar background such as profession (or linked to the profession), age and language, lives in the same geographical area, has similar social status, etc.
- **Peer education** is a process of carrying out informal or organized educational activities with individuals or small groups of peers over a period of time.

A peer is a person who belongs to the same social group as another person or group. The social group may be based on age, sex, sexual orientation, occupation, socio-economic and/or health status, etc.

Education refers to the development of a person's knowledge, attitudes, beliefs or behaviour resulting from the learning process.

Explain the following basics about what is peer education:

Peer education is a process of carrying out informal or organized educational activities with individuals or small groups of peers, over a period of time. Peer education occurs in a variety of settings and includes many different activities. The following forms of interaction between individuals and groups can be termed as peer education:

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

In all the above cases, peer educators are non-professional teachers talking to, working with and motivating their peers. Regardless of where they take place and who is targeted, all peer education projects use trained people to assist others in their peer group to make 'informed' decisions about STI/HIV/AIDS through activities undertaken in one-to-one or small group settings.

Who Are Peer Educators?

A peer educator is a person who, in order to provide knowledge and bring positive behaviour

change(s) related to STI/HIV, educates his/her friends individually or in a group by using different educational activities. For example, a peer educator can educate his/her friends by telling a story, playing a game, showing a picture, etc.

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

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

A person should receive peer educator training in order to be an effective peer educator.

Peer education is effective because it is:

- Culturally appropriate - from "within".
- Community-based.
- Accepted by the target audience / community.
- Economically effective.
- Enabling for the marginalized community

Qualities of a Peer Educator

Activity

1. Invite the participants to sit in a circle. Explain that a peer educator must have or develop qualities that allow him/her to work with people. This exercise will enable the group to discuss and list the essential qualities for a good peer educator.
2. Ask each participant to take a flash card and a marker, and ask them to close their eyes. You might want to play some soft music on a tape recorder. Explain that everyone should think of a person they love and can talk with.
3. After five minutes, ask them to open their eyes, and write the one quality they like the most in the person they just thought of.
4. Ask them to place their respective cards on the floor after they finish writing. Invite the participants to read the cards and group the cards that are similar.
5. Ask them to arrange the cards in a vertical line on the floor.
6. Ask each participant to take as many stones/seeds/leaves (marker) as there are cards. For example, there may be six cards on the floor so every participant must have six markers.
7. Start at the top of the vertical line. Ask the participant to think for a moment and place one marker in front of the card if they feel that they possess that quality. If someone feels that s/he does not possess that quality, they should not place their marker against it. Finish marking all the qualities in this manner.
8. Invite the participants to sit in a circle around the display, and facilitate a discussion based on what you observe. For example, Card #1 may have as many stones as there are participants. This means that every one thinks they have the quality written on that card. Ask how this quality can help them in their own lives and when helping their friends. Cover all the cards in this manner.
9. Sum up the discussion and the results of the exercise, by emphasizing the importance of those qualities for a peer educator.

Facilitator's Note

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

Some qualities that need to be developed by a peer educator in order to be effective in his/her work

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

Peer Education can Help in HIV / AIDS Prevention and Care

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

Selection of Peer Educators

- They should have the ability to communicate clearly and persuasively with their peers. They should have good interpersonal skills, including listening skills.
- They should be strongly motivated to work towards HIV risk reduction.
- They should have a socio-cultural background similar to that of the target audience (this may include age, sex, profession).
- They should be accepted and respected by the target group (their peers).

- They should have a non-judgmental attitude and should demonstrate sensitivity, care, compassion and respect for people affected by STI/HIV/AIDS.
- They should be self-confident and show potential for leadership. They should have the potential to be a "safer sex" role model for their peers.
- They should be able to get to the location of the target audience. They should be able to work irregular hours.
- They should be able to pass a practical, knowledge-based exam at the end of the training. If possible, they should have some minimum functional literacy

Training of Peer Educators

There are many different designs for peer educator's training programs, all with their own advantages and disadvantages. Some programs use an intensive training schedule over several full days; others extend over a period of weeks or months, with briefer sessions. A successful design of a peer educator's training program requires a consistent commitment by the trainees to one evening of training per week throughout the (academic) calendar. In such a training format, the peer educators can, for example, meet once a week for two to three hours.

What should go into Peer Education Training?

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

Tips for a basic training course for peer educators

Personal development

Communication, Empathy and non-judgmental attitude, Assertiveness, Self-confidence and self worth, Group dynamics, Sensitivity, Gender issues, Socio-cultural and economic dynamics

Knowledge

HIV/AIDS, Routes of transmission, prevention, Fears about HIV/AIDS, prejudice, stigma and discrimination, Risk behaviours/practices, Safe/safer behaviours, Drugs, Drug use Condoms, Rights and responsibilities, STIs - symptoms and treatment, Contraception, Physical anatomy of a man and woman

Skills

Group Work, Facilitation, Communication, Basic counselling, Methods of delivering, Information, Presentation

Balancing Act: Keeping the Energy Level Up

The experience of training peer educators can sometimes feel like walking a tight rope. If you tip too much in either direction, things get wobbly and you might lose your 'balance' during the

training session. You must use all of your senses to observe the group's energy level. Sometimes the trainees will give you feedback. For example, if you are talking too much about a particular subject or taking too long to process an exercise rather than moving on to something new, you might hear about it from the trainees. The feedback may be direct or indirect. Sometimes peer educators will ask to move on to something else. At other times, they may become restless, start to fidget, begin to focus their attention elsewhere and perhaps even begin to disrupt the training segment.

One of the challenges you will face as the trainer is to ensure that new facts are learned, without making the program seem too much like being in traditional school. The idea is to watch, listen and see when the group is finding it difficult to follow what you are saying or doing. If you see this happening, it is probably worth taking a break and doing something else. It is important, however, to keep track of what information has been covered and to re-visit it, to ensure that the team is absorbing and retaining the information.

Roles and Responsibilities

Activity

1. Divide the group into two small groups.
2. Ask one group to list the qualities of peer educators.
3. Ask another group to list the roles and responsibilities of peer educators.
4. Provide flip charts and markers and give each group 10 minutes
5. Discuss the responses

Discussion

1. Educating peers on STIs and HIV in one-on-one and small group sessions.
2. Assisting peers to access condoms, STIs and Voluntary Counselling and Testing Centers (VCTC) services.
3. Distributing condoms / lubricants and demonstrating correct condom use
4. Participating in HIV outreach awareness and other public events
5. Distributing educational material
6. Training other peers
7. Holding regular meetings
8. Teaching peers to negotiate safer sex.
9. Promoting condoms
10. Teaching peers how to do a personal risk assessment.
11. Teach peers about home care for PLHA
12. Supporting PLHA's efforts in living positively
13. Providing referrals to health care facilities
14. Functioning as leaders, change agents, role models and innovators in the community
15. Facilitating and catalysing the development of positive self image and self esteem within the key populations
16. Facilitating community mobilization and the process of individual and community empowerment

Rewarding Systems: Factors that Motivate a Peer Educator

- Concern for other members of their own peer community,
- Desire to help other members to adopt safe sex practices,

- Appropriate understanding of STI/ HIV/ AIDS prevention and control
- Desire to acquire more knowledge/skill about STI/HIV/AIDS and their prevention and control,
- Recognition by their peers as an educator.

There are two schools of thoughts regarding rewarding peer education

1. Peer educators are doing work in the community as health workers and are keeping aside a definite quota of their time for the work. Hence they should be given a monthly remuneration, whether it is called salary or incentive.
2. Peer educators should be seen as community volunteers and the work they do is for their communities' benefit. Hence they should not be remunerated. They could be rewarded by public recognition or token presents. However, compensation needs to be provided for time spent. They will need to be compensated for loss of wages when they participate in training, periodic review meetings with the service providers and/or the NGOs, and reimbursement of actual expenses such as for accompanying peers for STI treatment, counselling at VCTC, etc.

SECTION 5 - EFFECTIVE PEER EDUCATION

ADULT LEARNING METHODS

PLANNING PEER EDUCATION

FRAMING AND PRIORITIZING THE MESSAGES

AVOIDING CONFLICT SITUATIONS

MAINTAINING RELATIONS

Learning Objectives:

- Identified at least six principles of adult learning based on their personal experience
- Described at least three ways in which they will apply adult learning principles in their work
- Able to set a objective for their work
- Make a work plan for their interventions

<i>Time Frame</i>	<i>Materials needed</i>
<i>60 Minutes</i>	<i>Chart papers Permanent markers Clip board Small cut papers Cards</i>

Adult Learning Methods

- The key principle behind successful peer education is the application of the adult learning methods in the interaction of the peer educators

Activity

Ask the participants to review past year's experience and recall about:

What has been the most important learning?

Why you learn it?

How did they learn it?

From whom did you learn?

You wanted to learn, but you could not. Why were you not able to learn?

Give them 15 to 30 minutes and then discuss their responses.

Explain How Adults Learn

1. Adults have a lot of experience and knowledge that influences their learning. Hence, learning should be based on their previous experience.
2. Adults have set habits and strong beliefs and liking. Any direct contradiction to these beliefs or habits will evoke resistance and prevent new learning.
3. Adults have some amount of pride and the learning environment should allow the pride in their responsibilities to grow.
4. Adults have a lot to gain or lose through their activities and actions and the focus should therefore be on the gain.
5. Adults react instantly towards authority. This reaction is not uniform. Some respect authority, some resent it, and some others react on the way the authority is used. It is therefore important to use it appropriately in the learning environment.
6. Adults have decisions to make and problems to solve and therefore learn whatever helps them make decisions or solve problems. In other words, they learn what is relevant to their immediate needs.
7. Adults have many responsibilities outside of a particular learning situation and they are often preoccupied with these responsibilities. If the learning environment clashes with these responsibilities, the learning will be adversely affected.
8. Adults develop group behaviour consistent with their needs and are receptive to learning that reflects the group needs.
9. Adults have established emotional frameworks consisting of values, attitudes and tendencies and would like to retain them.
10. Adults respond to reinforcement relevant to their perceived needs.
11. Adults are sensitive to mutual trust and respect. They will not learn if they feel that they and their beliefs are not respected or trusted.
12. Adults respond to people who are interested in their learning and/or welfare.
13. Adults learn from people who are willing to share the risk of failure with them.
14. Adults like to do things they have volunteered to do or if they feel that they have the freedom to choose what to do from among several options.
15. Adults can change and therefore learn.

Planning Peer Education

Every activity that you undertake requires adequate planning for implementation of the program. The peer education program is no exception. Detailed below are the essential steps in planning a peer education program. It is not necessary that the activities within a step follow the same sequence. You may have to sequence activities within a step depending on the field-situations.

Activity: Theme for a Dream

1. Invite the participants to sit in a circle.
2. Explain that planning is an important element of this training and of life. In order to plan, one must have a dream. One must have a vision of where one wants to be. This vision may be of an individual for himself/herself, or it may be the vision of a group for the group.
3. Ask the participants to work individually and arrive at a vision for themselves.
4. Explain that they should each draw a picture of, or create in words, a dream that they would like to realize for themselves. Something that represents the life they want to have for themselves. Allow the participants 20 minutes for this exercise.
5. Invite them to share their vision with each other through a presentation.
6. Ask them to put their "vision" up on a wall so that everyone can see it. After everyone has heard and seen all of the visions, facilitate a short discussion using the following questions:
 - How did it feel to dream and share the dream? Why?
 - Can dreams come true? Why/why not?
 - How can you make your dream come true?

Facilitator's Note

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

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

Learning to Set Objectives

Activity

Invite the participants to place their goals before them and think about SMART objectives.

Explain that objectives need to be:

S - Specific

M - Measurable

A - Achievable

R - Relevant

T - Time-bound

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

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

Facilitator's Note

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

Breaking down the Objectives into Activities

Activity

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

Facilitator's Note

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

Framing and Prioritizing the Messages

Activity:

1. Divide the participants into two or three groups
2. Present different case studies to the group
3. Ask them to analyze the situation and list out appropriate messages to be delivered
4. Ask them to prioritize the messages so as it could be delivered appropriately
5. Invite them to present the same and facilitate open discussion on this

Cross-Cutting Messages on Empowerment and Community Mobilization

1. We need to empower ourselves in order to assert ourselves and refuse sex when we don't want it.
2. We need to counter violence, individually as well as collectively.
3. We will form support groups and networks in order to derive strength from and support each other when in need.
4. We need to increase our awareness levels
5. We need to build skills in communication, negotiation, collective bargaining
6. We ask for social and economic security, including access to credit, health care and all other services that are available to others.
7. We ask for recognition and the opportunity to participate in decisions that affect us
8. Above all we seek our right to self determination and to conduct our work safely. This will help not only in fighting HIV/AIDS but will also in asserting ourselves as individuals in the society.

Dosage of health education message for the first encounter

In the first contact, particularly if the peer educator and the peer have never seen each other before, it is important to begin with rapport building, exchanging pleasantries, enquiring about their welfare, and then start with a discussion of general problems and gradually introduce health issues, including reproductive health and finally narrow down on STI / HIV /AIDS. Once initial rapport is built up, the following messages have to be given out.

1. AIDS is a disease that is caused by a virus called HIV.
2. There is no cure for AIDS and when one has AIDS, one's body is unable to fight diseases.
3. As a result, one gets various infections and diseases (diarrhoea, TB, pneumonia, cancer) and eventually dies in a very slow and painful way.
4. In the early stages of infection, a person is healthy and it is not possible to tell if a person is infected (carrying the disease) or not.
5. HIV is spread from one person to other person through:
 - o Unprotected (without a condom) sexual intercourse with an infected person
 - o Transfusion of infected blood, i.e. blood unknowingly collected from a person who is carrying the disease.
 - o Sharing used needles potentially having residual infected blood from a previous infected person on whom the needle was used.
 - o From mother to unborn child
6. A person is highly vulnerable to getting HIV when:
 - o One has vaginal and / or anal sex with more than one regular partner or with strangers and one doesn't know if the stranger is having any diseases, particularly STIs or HIV.
 - o When one has an STI (symptoms such as discharge, ulcers, boils, blisters in the genitalia) while having sex.
 - o When one has sex without using a condom
7. One can protect oneself from getting infected with HIV by:
 - o Using condoms in every sexual encounter
 - o Detecting and treating any STIs early and being in good health through regular health check-ups.
 - o Getting one's partner detected and treated for STIs early.

Dosage of Message for Repeat Encounter - Second Encounter

Reinforce the messages given in the first encounter.

Enquire if that person has visited the clinic and/or drop-in centre.

Additional messages/inputs in the second encounter would be:

In case the person is currently having any of the symptoms associated with different STIs, the peer educator should encourage the person to come along with him/her to the clinic for a free check-up and treatment.

Asking the person to encourage his/her client / sexual partner to avail free health check-up services from the project-run clinic.

Dosage of Message in the Third Encounter

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

In the third and subsequent encounters the peer educators should enquire about general welfare and health status of the person and his/her sexual partner.

Enquire if the person has visited the clinic and/or drop-in centre and repeatedly encourage the person to go for periodic general health care check-up even if the person is feeling perfectly healthy.

Take feedback on the quality of services available at the clinic and drop-in centre, particularly if the person is satisfied with the health care provider, clinic timings and other access issues and discuss any barriers he/she is facing in accessing services either from the clinic or the drop-in centre.

Avoiding Conflict Situations

Conflict is when two or more values, perspectives and opinions are contradictory in nature and haven't been aligned or agreed upon.

- The following process will give the participants an idea of how to avoid conflicts and enable them to answer difficult questions in difficult situations.

Activity

1. Present a case study on a conflict situation in the work area to the group
2. Ask the participants to divide into groups and to list out strategies how to manage the situation
3. Present and facilitate discussion

Discussion

People have differing styles of communication, ambitions, political or religious views and different cultural backgrounds. These differences lead to conflict between individuals and we must be alert to preventing and resolving situations where conflict arises.

Maintaining Relations

- Broadly the conflicts are of two types - within one self and with others

To Manage a Conflict Within Oneself

1. Name the conflict, or identify the issue
2. Get perspective by discussing the issue with your friend
3. Pick at least one thing you can do about the conflict.
4. Then do something. Wait at least a day before you do anything about the conflict. This gives you a cooling off period. Then take an action.

To Manage a Conflict With Another

1. Know what you don't like about yourself. We often don't like in others what we don't want to see in ourselves.
2. Manage yourself. If you and/or the other person are getting heated up, then manage yourself to stay calm by
 - a. Speaking to the person as if the other person is not heated up - this can be very effective!
 - b. Avoid use of the word "you" - this avoids blaming.
 - c. Nod your head to assure them you heard them.
 - d. Maintain eye contact with them.
3. Move the discussion to a private area, if possible.
4. Give the other person time to vent. Don't interrupt them or judge what they are saying.
5. Verify that you are accurately hearing each other. When they are done speaking:
 - a. Ask the other person to let you rephrase (uninterrupted) what you are hearing from them to ensure you are hearing them.
 - b. To understand them more, ask open-ended questions. Avoid "why" questions - those questions often make people feel defensive.
6. Repeat the above step, this time for them to verify that they are hearing you. When you present your position
7. Acknowledge where you disagree and where you agree.
8. Work the issue, not the person. When they are convinced that you understand them: Ask "What can we do fix the problem?"
9. If possible, identify at least one action that can be done by one or both of you.
 - a. Ask the other person if they will support the action.
 - b. If they will not, then ask for a "cooling off period".
10. Thank the person for working with you.

Ways to deal with conflict

1. **Avoid it.** Pretend it is not there or ignore it. Use it when it simply is not worth the effort to argue.

Usually this approach tends to worsen the conflict over time.

2. **Accommodate it.** Give in to others, sometimes to the extent that you compromise yourself. Usually this approach tends to worsen the conflict over time, and causes conflicts within yourself.
3. **Competing.** Work to get your way, rather than clarifying and addressing the issue. This is used only when you have a very strong conviction about your position.
4. **Compromising.** Mutual give-and-take. This is used in order to get past the issue and move on.
5. **Collaborating.** Focus on working together. This is applicable when the goal is to meet as many current needs as possible by using mutual resources. This approach sometimes raises new mutual needs.

Section 6 - Communication

Communicating in a better way

Elements of communication

Effective communication processes

Verbal and Non verbal communication

Peer counselling

Sustaining relations

Learning objectives

- Identified the need and ways of communication
- Described at least three ways in which they will apply communication principles in their work
- Able to frame the messages which may reduce the risk of HIV/AIDS

<i>Time Frame</i>	<i>Materials needed</i>
<i>90 Minutes</i>	<i>Chart papers Permanent markers Clip board Small cut papers Cards</i>

Communicating in a Better Way

Communication is part of every social exchange, from interpersonal dialogue to global mass media, from music, theatre or local radio to conversations in the local market, cafe or household. What works in communicating about health depends on the context, and the way different communication processes and approaches are linked together, or remain separate. It's important to understand how communication can build momentum around some issues, but can also isolate some social groups and conversations.

Communication is a learned skill. Most people are born with the physical ability to talk, but we must learn to speak well and communicate effectively. Speaking, listening, and our ability to understand verbal and nonverbal meanings are skills we develop in various ways.

The field of communication focuses on how people use messages to generate meanings within and across various contexts, cultures, channels, and media. The field promotes the effective and ethical practice of human communication.

Elements of communication

Here are the various components of the communication process in detail.

- Source - Originator of a process of exchange of information
- Receiver - Receiver of the information
- Content/Message - The information which is being communicated
- Medium - Channel through which information is given
- Distortion - which may occur between the source content and received content, this may be caused due to various factors.
- Feedback - Where information and understanding is passed-on from the receiver to source person.

If we put it in other words:

- Input. The sender has an intention to communicate with another person. This intention makes up the content of the message.
- Sender. The sender encodes the message, e.g. the idea of "piece of furniture to sit on". Thus he gives expression to the content.
- Channel. The message is sent via a channel, which can be made of a variety of materials. In acoustic communication it consists of air, in written communication of paper or other writing materials.
- Noise. The channel is subjected to various sources of noise. One example is telephone communication, where numerous secondary sounds are audible. Even a solid channel such as paper can be crushed or stained. Such phenomena are also noise in the communicative sense.
- Receiver. The receiver decodes the incoming message, or expression. He "translates" it and thus receives the
- Output. This is the content decoded by the receiver.
- Code. In the process, the relevance of a code becomes obvious: The codes of the sender and receiver must have at least a certain set in common in order to make communication work

Effective Communication Processes

Activity: Chinese Whisper

- Ask participants to stand in a circle.
- Inform the rule of the game ie, Not to ask questions or reconfirm what is said when someone passes an information
- Give a message to one of them.
- Ask him to pass it on the neighbor.
- This person will whisper this message to the person on his right.
- Next person will again whisper it to the person on his right, and so on.

Message to first person: "Jaswant's mole is truly a hole in his story which is only a figment of his imagination in his version of the history" OR It could be anything, but slightly complex.

- Once all the participants in the circle are covered ask the last person to repeat the message loudly. Now ask the first person to say the original message load.
- Highlight the differences and distortions.
- Ask why did the message get changed.
- Record on board/chart - likely reasons to be given by the participants "lack of attention", "could not hear properly", "could not reconfirm".
- Relate these responses with distortion due to perceptions, and with absence of feedback.

Also prepare a chart paper with the following points and explain the group about the concept and other aspects of communication.

Reducing distortion

Distortions can ruin a communication, especially if you are communicating with people on an issue as sensitive as HIV/AIDS. Communication on HIV/AIDS usually involves dealing with young people or groups that are marginalized. It also involves serious issues of trust and confidentiality, as it relates to peoples personal and intimate behaviours.

You could reduce these distortions and increase the effectiveness of your communication by:

- Communicating with small groups and being direct.
- Using language easily understood and spoken by the target group.
- Increasing the similarities between the sender and the receiver.
- Keeping the message short and clear.
- Putting yourself in the receiver's shoes.
- Using multiple ways of communicating - verbal, written, audio or visual.
- Keeping confidences and listening

Communication can be categorized into four different types, depending on the nature of the interaction.

1. Intrapersonal communication is a type of communication whereby a person interacts with himself/herself. This types of communication is intrinsic or reflective.
2. Interpersonal communication is a type of communication where there is one-to-one interaction among small group. This is the most effective and commonly used form of communication.
3. Intergroup communication is a type of communication where interaction between different

groups takes place.

4. Mass communication is a type of communication where a large body (millions of people) of people are addressed.

Interpersonal Communication in Peer education

Interpersonal communication is a one to one, dynamic, purposive and participative process between a source and a receiver in a desire to arrive at a meaningful exchange of experiences and mutual understanding

Activity

Prepare a 3 chart papers with the following points and hide it with another blank chart paper.

Ask the group to divide into two and give a situation or scenario where the two groups have to interact using various communication methods.

Facilitator note down the points

After 10 minutes of interaction, ask one group on methods used by other groups and list it down

Repeat the same with the other group and list it down.

Compare it with the presentation prepared in the chart paper and explain about the importance.

Presentation

Why Interpersonal Communication?

- Backbone of good interpersonal relations
- Required for intersectoral coordination
- Image building
- Behaviour change of self /clients
- Helps in correct diagnosis , better prognosis (correct information, compliance, follow up)
- Helps to avoid conflicts
- Helps the clients make critical decisions
- Motivation
- Counselling
- Guidance
- Advice
- Beliefs
- Rumours
- Misconceptions

Verbal and Non verbal communication

Communication can be verbal and non-verbal. In verbal communication, we use words/language in written or spoken form. Non-verbal communication is often given secondary

importance, but it is much more important than verbal communication. It includes a series of gestures such as facial expressions, signs, body movements, eye contact, tone of voice and sounds.

- Obviously, adequate knowledge of the subject matter is crucial to your success as a peer educator; however, it's not the only crucial element. Of course to create a climate that facilitates learning and retention demands good nonverbal and verbal skills. It is not only what you say but, it's how you say it that can make the difference. Nonverbal messages are an essential component of communication process.
 - An awareness of nonverbal behaviour will allow you to become better receivers of your peers' messages.
 - You will become a better sender of signals that reinforce learning.
 - This mode of communication increases the degree of the perceived psychological closeness between you and your peers. Certain nonverbal behaviours
 - **Eye Contact:** Eye contact, an important channel of interpersonal communication, helps regulate the flow of communication. And it signals interest in others. Furthermore, eye contact with audiences increases the speaker's credibility. People who make eye contact open the flow of communication and convey interest, concern, warmth and credibility.
 - **Facial expressions:** Smiling is a powerful cue that transmits:
 - Happiness
 - Friendliness
 - Warmth
 - Liking
 - Affiliation
 - Thus, if you smile frequently you will be perceived as more likable, friendly, warm and approachable.
 - **Gestures:** If you fail to gesture while speaking, you may be perceived as boring, stiff and unanimated. A lively and animated talking style captures audience's attention, makes the subject more interesting, facilitates learning and provides a bit of entertainment. Nodding your head- a form of gesture indicates that you are listening.
 - **Posture and Body Orientation:** You communicate numerous messages by the way you walk, talk, stand and sit. Standing erect, but not rigid, and leaning slightly forward communicates that you are approachable, receptive and friendly. Furthermore, interpersonal closeness results when the people involved face each other. Speaking with your back turned or looking at the floor or ceiling should be avoided; it communicates your disinterest.
- Proximity:** Cultural norms dictate a comfortable distance for interaction with your target audience. You should look for signals of discomfort caused by invading their space.
- **Para-linguistics:** This facet of nonverbal communication includes such vocal elements as: tone, pitch, rhythm, timbre, loudness, and inflection. For maximum effectiveness, learn to vary these six elements of your voice.
 - **Humour:** Laughter releases stress and tension for both participants and facilitator. You should develop the ability to laugh at yourself and encourage others to do the same. It fosters a friendly environment that facilitates learning.

Communicating with Visual Aids:

Value of using visuals

- You remember 10 percent of what you hear
- You remember 50 percent of what you hear and see
- You remember 90 percent of what you hear, see and do
- Visuals are used effectively to strengthen communication.
- Visuals help people remember what they hear.
- The trick is in relating what you hear to a picture.

Activity :

Suppose we are talking of how HIV is transmitted. Imagine that as a communicator, you have just given a talk on this. What do you feel will be the reaction to:

- Only a talk
- Talk with the help of posters showing of what the virus is and how it attacks the human body
- A talk and video or magnet board demonstration of how the virus infects the human body.

Discussion : Which of the above situation will be ideal and why?

Peer counselling

Activity

Invite 4 volunteers from the group and divide them into two. Brief them that one person is going to represent a HIV infected person and another one a friend.

With the other two volunteers also do the same but in the place of the friend, the person will act as counsellor.

Let each process go on for 5 minutes.

After the completion of the exercise ask the group about their impressions on both friendly discussion and counselling

List it down and ask them whether merging of some of the processes taken place will enhance the effectiveness.... answer might be yes.

Do a presentation in chart paper and conclude that the peer counselling should be more friendly and non judgemental.

Presentation

Counselling is a non-directive, non-judgemental form of help. It is a process whereby a person (client) is empowered to gain new awareness of himself/herself through the support and challenge offered by another person (counselor) through their relationship. People are said to be peers when they share a common identity or experience. The commonality may be age, gender, education, career, sexual orientation or other self-defined common experience.

Peer counselling is less formal and long-term than professional counselling. Peer counselors provide short-term, non-professional support to help other PLHA resolve difficulties and make decisions in relation to their treatment options, including physical, mental, emotional, spiritual and sexual aspects of their health.

Peer Counselling is Characterized by:

- Providing help and support and an understanding listener for someone who is concerned or confused;
- Creating a climate in which the client feels accepted, non-defensive and able to talk freely;
- Helping the client to gain a clearer insight into herself and her situation so that she is better able to help herself and draw on her own experiences.
- Disclosing personal experience of the peer counsellor, when the disclosure is relevant to the client. Counselling is different from other ways of helping such as advice-giving, giving practical help, nursing and sympathizing because it:
- Helps the client talk about, explore and understand her thoughts and feelings, and to work out what she might do before taking action;
- Encourages the client to decide on her own solutions.

Peer counselling is not necessarily a better way of helping people. It is different. Other models of support, such as advice-giving, medical care, etc., are seen as complementary to peer counselling.

Sustaining relations

It is important that the HIV related prevention work that you have started maintains its desired pace continuously for it to be effective. There are no specific ways that could be recommended and it is important to pursue maintenance of the response according to decisions taken in consultation with all the participants in the response. However some points that could be of use are listed below.

- Conduct at least quarterly reviews in a participatory way
- Recognition for good work must be given in whatever way is appropriate
- Invite people from other spheres to look at the work that is happening at your level and ask for their feedback
- Invite State AIDS Control Society to visit your field area and interact with the key people and get their feedback
- Create more leaders
- Organize events like essay writing, public speaking with local sponsorship for prizes
- Bring up HIV/AIDS response and the need for it in public gatherings and other important events

Wrap-up:

Be Focused on what to communicate

- Be clear.
- Be Concise
- To the point. Don't fudge, qualify, or dodge.

Be Active while communicating

- Positive. No whining, go for it
- Doing. Active verb words
- Achieving. It will be done

More Objectives could include:

- Make the content interesting.
- Show methods to clarify thinking
- Be entertaining
- Make it easy to take in
- Keep it simple

Section 7 - Evaluation

Introduction

Sample of Monitoring Format

Sample of a Session wise evaluation

Sample of a Comprehensive evaluation

<i>Time Frame</i>	<i>Materials needed</i>
<i>30 Minutes</i>	<i>Chart papers Permanent markers Evaluation formats</i>

Evaluation

Many people believe evaluation is a useless activity that generates lots of boring data with useless conclusions.

Some people believe that evaluation is about proving the success or failure of a project.

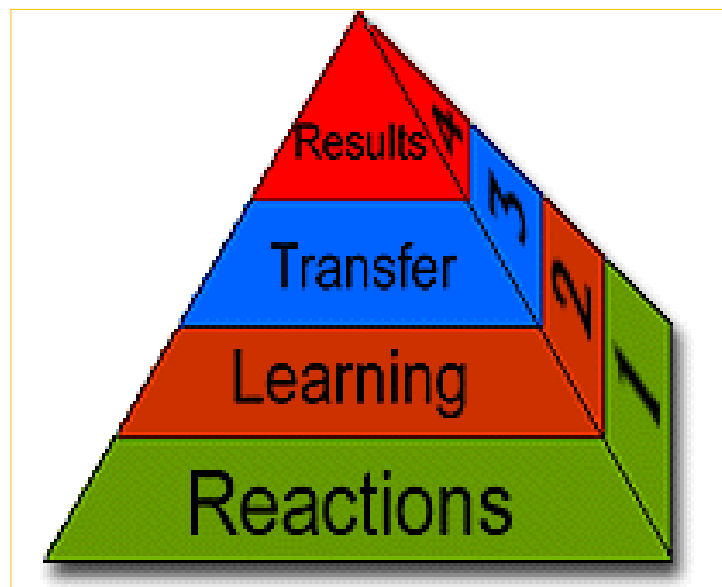
More recently evaluation has focused on utility, relevance and practicality at least as much as scientific validity.

Many believe that evaluation is a highly unique and complex process that occurs at a certain time in a certain way, and almost always includes the use of outside experts.

But it is none of these mentioned above.

Evaluation can help understand, verify or increase the impact of training or any services on the participants. It will also help to improve delivery systems to be more efficient and less costly. It can verify that you're doing what you think you're doing - Typically, plans about how to deliver trainings, end up changing substantially as those plans are put into place. Evaluations can verify if the training objectives are really running as originally planned.

Kirkpatrick's Four Levels of Evaluation



In Kirkpatrick's four-level model, each successive evaluation level is built on information provided by the lower level.

Level 1 Evaluation - Reactions

- Just as the word implies, evaluation at this level measures how participants in a training program react to it. It attempts to answer questions regarding the participants' perceptions - Did they like it? Was the material relevant to their work? This type of evaluation is often called a "smilesheet."

- According to Kirkpatrick, every program should at least be evaluated at this level to provide for the improvement of a training program. In addition, the participants' reactions have important consequences for learning (level two). Although a positive reaction does not guarantee learning, a negative reaction almost certainly reduces its possibility.

Level 2 Evaluation - Learning

- To assess the amount of learning that has occurred due to a training program, level two evaluations often use tests conducted before training (pretest) and after training (post test).
- Assessing at this level moves the evaluation beyond learner satisfaction and attempts to assess the extent the trainees have advanced in skills, knowledge, or attitude. Methods for this level of evaluation range from formal to informal testing to team assessment and self-assessment. If possible, participants take the test or assessment before the training (pretest) and after training (post test) to determine the amount of learning that has occurred.

Level 3 Evaluation - Transfer

- This level measures the transfer that has occurred in learners' behaviour due to the training program. Evaluating at this level attempts to answer the question - Are the newly acquired skills, knowledge, or attitude being used in the everyday environment of the learner? For many trainers this level represents the truest assessment of a training's effectiveness. However, measuring at this level is difficult as it is often impossible to predict when the change in behaviour will occur, and thus requires important decisions in terms of when to evaluate, how often to evaluate, and how to evaluate.

Level 4 Evaluation- Results

- Level four evaluation attempts to assess training in terms of effectiveness or the results in their work. It would be a measurement of the change in the results of the work as a result of the training given.

Methods for Long-Term Evaluation

- Send post-training surveys
- Offer ongoing, sequenced training and coaching over a period of time
- Conduct follow-up needs assessment
- Check metrics to measure if participants achieved training objectives
- Interview trainees

Sample of Monitoring format

Instructions to the participants:

We have committed to working together as a team during this training program. It is therefore important to evaluate both our relationships with one another and progress on our objectives on a daily basis so that we can take corrective actions. Circle the number on each scale that identifies how well you think our team has been working together. Feel free to add any comments.

How were the objectives of the day?				
1	2	3	4	5
None set or Irrelevant				Well defined and clear objectives
What was the level of commitment of the participants?				
1	2	3	4	5
Individuals protect their own self-interest				Individuals support each other and group's goals
What was the outcome of the procedures & guidelines given by the facilitator for each activity?				
1	2	3	4	5
Unclear or not followed				Clearly agreed upon and followed
How were the roles and responsibilities of the group?				
1	2	3	4	5
Roles were rigid				We rotated roles and responsibilities
What was the level of participation among the group?				
1	2	3	4	5
Few people were involved throughout the day				Everyone was involved and eager to participate
How as the trust among the participants as evidenced by the quality of experience sharing?				
1	2	3	4	5
Very low level of trust because participants did not express their opinions freely				High level of trust because everyone expressed their opinions, doubts, etc. without any hesitation

How were the conflicts/differences of opinion in the group resolved?				
1	2	3	4	5
High level of conflicts persisted even after the session concluded				Little evidence of unresolved conflicts by the end of the session
Was the training content relevant to your job responsibilities?				
1	2	3	4	5
No, it was not relevant. The content was also not complete to meet session objectives.				Yes, it was totally relevant, and content was complete to meet session objectives
Was the time used effectively during the program?				
1	2	3	4	5
Much time was wasted on unnecessary discussion that was not relevant to the session objectives				Time was well spent on clarifying doubts and the entire focus was on session objectives
How was the direction and control provided by the facilitator?				
1	2	3	4	5
Inappropriate (either too little or too much) amount of direction control wherein the and control				Just the right amount of direction and participants felt able to learn on their own

Session wise Evaluation

For each content of the course listed below, indicate how important were each topic or activity to you which were covered during the training sessions.

Content	Very Important	Important	Somewhat Important	Not Important

Please comment on specific actions or items that helped or hindered your learning with regard to the following:

Item	Helped or assisted	Hindered or caused problems
The course content		
The course process		
Language		
The Facilitator		
Other participants		
The workshop venue		
Food		
Living arrangements		
Any other aspect of workshop (specify)		

In view of the above, I recommend that:

Sample of a Comprehensive Training Evaluation

Name: (optional) _____ Date: _____

Kindly mark "✓" in the relevant column/row

1. Your personal objectives for this training program were met:

Completely _____

Partially _____

Not met _____

2. Your professional objectives for this training program were met:

Completely _____

Partially _____

Not met _____

3. What were the strong points of this training program?

A. _____

B. _____

C. _____

4. What were the weak points of this training program?

A. _____

B. _____

C. _____

