NACO

AIDS Control Organisation

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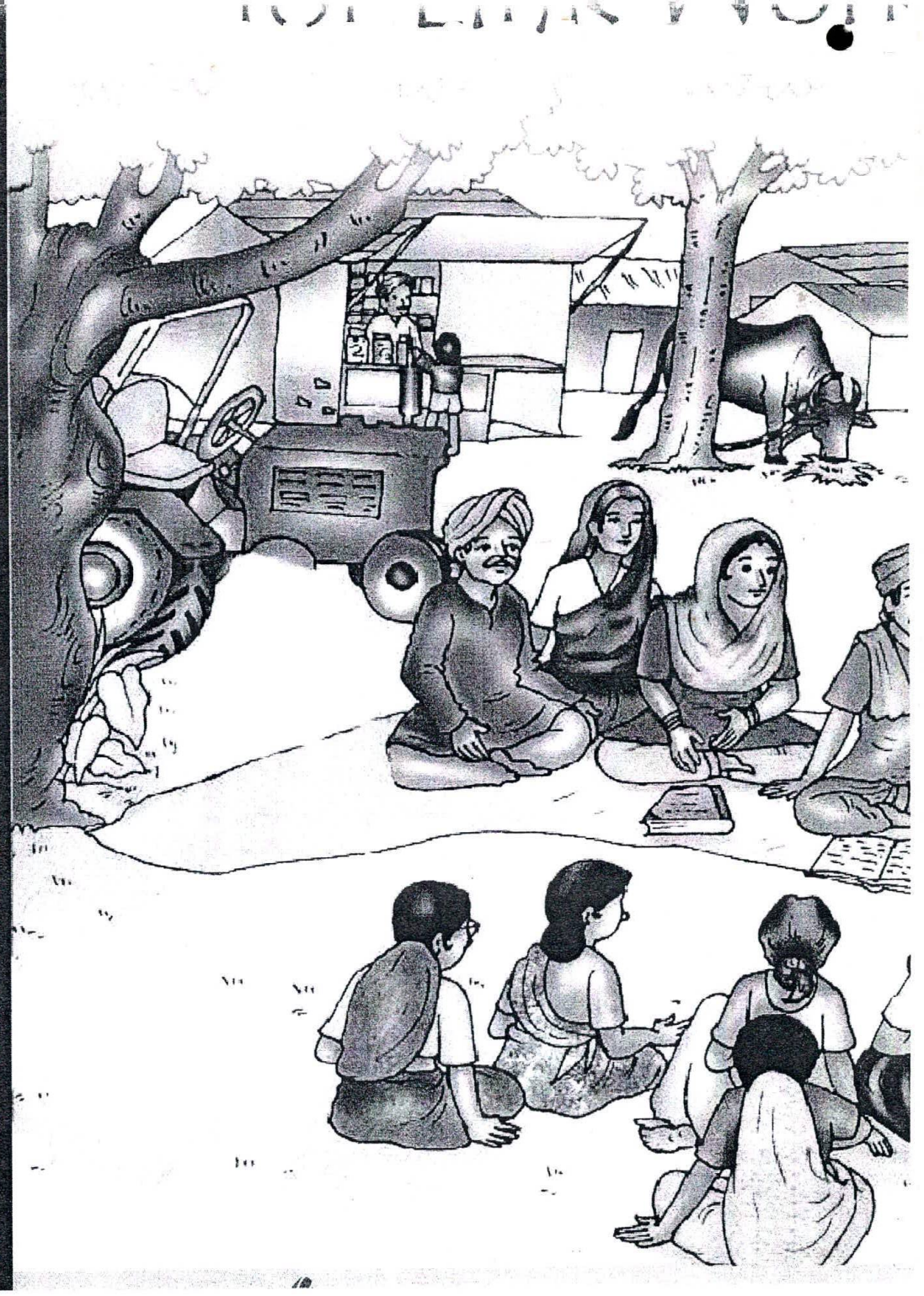


ABOUT THE HANDBOOK

This handbook has been developed for the Link Worker Scheme, under NCAP-III. The Link Workers are the target audience for this handbook though it is equally relevant and useful for the volunteers and other community based health workers.

This handbook summarizes the key discussion points from the Training Manual which will be used during two weeks training programme for Link Workers at the time of induction.

This handbook is meant to be used as ready reference material by the Link Workers while working in the community. At the same time, the handbook provides an outline of 'on the job' training to be provided to the volunteers under the Link Worker Scheme.

The use of the handbook by the Volunteers and Link Workers will depend on their level of literacy and ability to read it in the language in which this document is available. It is expected that the Handbook will be translated into the local languages by respective State AIDS Control Societies. The translated version will facilitate the use of the handbook by a larger number of Link Workers and Volunteers.

CONTENTS

CONTENTS

PART -1

Link Worker

1.1 ROLE OF LINK WORKER

Link Worker is the key personnel under the Link Worker Scheme under National AIDS Control Programme Phase-III. Their main responsibilities will be to enhance the access to HIV related information and services among the high risk groups and vulnerable young people and women in the rural community (for example, partners/spouses of migrants, mobile populations, IDUs, young girls/women in women headed households etc.).

It is expected that the Link Worker will spend at least two third of the time for reaching out to individuals with high risk behaviours who are part of the general population. The rest of one third time will be spent working with vulnerable young people and women in the community. While reaching out to high risk groups is the prime target, the Link Worker will establish rapport with the communities and understand the specific conditions in that particular location that makes certain people vulnerable. This approach will also help them identify these individuals as they are likely to be 'hidden'.

Some of the key roles identified for the Link Workers are:

- Conduct the village level mapping (vulnerability mapping, community resource mapping, health services/facility mapping, household mapping)
- Understand the migration patterns (both in and out migration) in the local community
- Work with the communities to create an enabling environment by establishing linkages with positive networks/CBOs and NGOs that have ongoing interventions for prevention, care and support

- Work towards reducing stigma and discrimination in the community by facilitating involvement of positive people, and addressing its gender dimensions
- Advocate with identified stakeholders (key persons in the community) for creating an enabling environment (see section on stigma and discrimination)
- Create awareness regarding the Rights of positive people and High Risk Individuals (HRIs)
- Facilitate formation of Red Ribbon clubs (RRC)
- Work towards reducing barriers to accessing services (STI management, utilization of VCTC/ICTC, PPTCT services) by HRGs and other highly vulnerable population
- Identify and train volunteers
- Facilitate formation of condom depots. Ensure timely supply of condom in intervention areas
- Supervise volunteers, Red Ribbon Clubs (RRC) and condom depots
- Collection of monthly data from RRC and condom depot holders
- Making monthly reports for the intervention area

1.2 ETHICS AND VALUES

The Link Worker is expected to be a role model for volunteers and society at large to catalyse the changes in individual and thus society for effective prevention and control of HIV & AIDS. It is also understood and respected that the Link Worker is a part of the community s/he is working for and also brings along certain family and societal values.

The Link Worker however needs to follow some values and ethics, while dealing with the members of the community, especially those are members of high risk/vulnerable groups and/or people living with HIV & AIDS. This is essential in order to enable the members of the high risk/vulnerable groups and/or people living with HIV & AIDS to access and utilise the available information and services to reduce their vulnerability and improve the quality of life for themselves.

The ethics and values that need to be followed by the Link Worker and Volunteers are:

- Maintain the **confidentiality** of the person in all circumstances. Ensure that no words or phrases are used in any situation that may lead to the identification of any member of high risk or vulnerable group or any PLWHA.
- Discuss the findings of the mapping exercise only with the supervisor and volunteers, especially regarding vulnerable and high risk groups.
- Do not blame or ridicule the person's practices, especially related to sexual matters. Rather, encourage them to talk about it and provide appropriate advises.
- When you are not sure of certain information or do not have knowledge on the subject under discussion, mention that you will return with more information on the subject. Discuss the matter with the supervisor if you don't find much about it in the handbook.
- Do not offer incomplete information or the information that you are not sure of.
- Always seek consent of the affected person before discussing his/her sexual identity/problems with others, even with the family member(s) of the concerned person.
- Collect all possible information about the services to which you refer to a person.

- Be **gender sensitive** and weigh possible implications while offering your suggestions/advises especially to women in different age groups and member of transgender community.
- Respect people's choices and their circumstances, while offering any suggestions/advises with regard to the control and prevention of HIV & AIDS.

There could be many issues and concerns that can be sensitive and difficult to talk about. So try to find out your comfort level for facilitating and guiding the discussions in the community. Nobody is perfect the first time. You need to practice and minimise the mistakes. There is always scope for improvement. Never hesitate to accept your mistake and correct yourself.

While in the community and participating/facilitating any discussion or counselling anyone, you <u>SHOULD NOT DO</u> the following:

- Behave in a manner that is unfriendly.
- Appear embarrassed.
- Appear not to care.
- Be inflexible.
- Act witty.
- Speak too fast.
- Tell people they are wrong.
- Give information and instructions that are confusing.
- Discuss issues, events inappropriate in the given situation.
- Make feel participants self-conscious.
- Not allow opportunity for participants to share their own knowledge and experiences.
- Usage of terms and language that are difficult to understand or may be confused for different meaning.

1.3 DIRECTORY OF SERVICES AND IMPORTANT CONTACTS

The Link Worker and other users of the Handbook (Volunteers) are expected to explore and fill up the relevant services' and persons' contact details and addresses in the table given below.

Name of the Service/Person	Contact Address	Contact Number	To be Contacted for
Community Health Centre			
Primary Health Centre			
Sub Centre			
Integrated Counselling and Testing Centre			
Aanganwadi Centre			
ART Centre			
Skin & Venereal Diseases Clinic			

Name of the Service/Person	Contact Address	Contact Number	To be Contacted for
District AIDS Prevention and Control Unit			
Link Worker Supervisor			
District Resource Person			
Youth Friendly Clinic			
Network of PLWHA/Support Group			
NGO/CBO Implementing Targeted Intervention in the District			

Name of the Service/Person	Contact Address	Contact Number	To be Contacted for
NGO/CBO Working on HIV & AIDS related Issues			
NGO/CBO Working for Vulnerable/High-risk Groups			
MSM Support Group			
Community Care Centre			
NGO/CBO working on Care and Support Issues			

1.4 ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Clinic
ANM	Auxiliary Nurse Midwife
APAC	AIDS Prevention Control Project
ART	Antiretroviral Therapy
ARV	Anti Retro Viral
ASHA	Accredited Social Health Activities
AWW	Aanganwadi Worker
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CAU	Communication and Advocacy Unit
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CCC	Community Care Centres
CGHS	Central Government Health Services
CHC	Community Health Centres
CMIS	Computerized Management Information System
CSM	Condom Social Marketing
CST	Care, Support and Treatment
CSW	Commercial Sex Worker
DAPCU	District AIDS Prevention and Control Unit
DMU	District Management Unit
DOTS	Directly observed Treatment
DSA	District Strategic Assessment
FSW	Female Sex Worker
GFATM	Global Fund for AIDS, TB & Malaria
GIPA	Greater Involvement of People living with AIDS
HAART	Highly Active Anti Retroviral Therapy
HIV	Human Immuno-deficiency Virus
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HRD	Human Resources Development
HRG	High Risk Group
HRI	High Risk Individual
ICDS	Integrated Child Development Services
ICHAP	India Canada HIV/AIDS Prevention
ICMR	Indian Council of Medical Research
ICT	Integrated Counseling & Testing
ICTC	Integrated Counseling & Testing Centre
IDSP	Integrated Disease Surveillance Programme
IDU	Intravenous Drug User
INP+	Indian Network of Positive People
IEC	Information, Education and Communication
IPC	Inter Personal Communication
ITPA	Immoral Trafficking Prevention Act
KP	Key Population
LHV	Lady Health Visitor
LWS	Link Worker Scheme
MCI	Medical Council of India
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MEA	Ministry of External Affairs
MHRD	Ministry of Human Resource Development
MOYA	Ministry of Youth Affairs
MPW	Multi Purpose Worker
MSJE	Ministry of Social Justice & Empowerment
MSM	Men having Sex with Men
MSW	Male Sex Worker
MTP	Medium Term Plan
NAC	National AIDS Committee
NACB	National AIDS Control Board
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme

NARI	National AIDS Research Institute
NCA	National Council on AIDS
NE	North East
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NHA	National Highway Authority of India
NHP	National Health Policy
NRHM	National Rural Health Mission
NYKS	Nehru Yuva Kendra Sangathan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PD	Project Director
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PIU	Project Implementation Units
PLWHA	People Living with HIV/AIDS
PMU	Project Management Unit
PNC	Post Natal Care
PPTCT	Prevention of Parent to Child Transmission
PRA	Participatory Rural Appraisal
PRI	Panchayati Raj Institutions
PSV	Participatory Site Visits
PWN	Positive Women's Network
RACU	Regional AIDS Control Unit
RBA	Right-Based Approach
RCH	Reproductive & Child Health
RCSHA	Resource Centre for Sexual Health and HIV & AIDS
RIMP	Rural Indigenous Medical Practitioner
RMP	Registered Medical Practitioner
RNTCP	Revised National TB Control Programme
RRC	Red Ribbon Club
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SHG	Self Help Group
SIMS	Strategic Information Management Systems
SIMU	Strategic Information Management Unit
SM	Social Marketing
SMO	Social Marketing Organisation
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TAC	Technical Advisory Committee
TBA	Traditional Birth Attendant
TG	Trans-Gender
TI	Targeted Intervention
TOR	Terms of Reference
TRC	Tuberculosis Research Centre
TRG	Technical Resource Group
TSG	Technical Support Group
TSU	Technical Support Unit
USAID	United States Agency for International Development
UT	Union Territories
VCT	Voluntary Counseling & Testing
VCTC	Voluntary Counseling & Testing Centre
WB	World Bank
WBC	White Blood Cells
W&CD	Women & Child Development
WHR	World Health Report
YFIC	Youth Friendly Information Centre

1.5 GLOSSARY

Abstinence	Not engaging in any sexual behaviour with another person. Some individuals define abstinence in terms of refraining from penile-vaginal intercourse; others define the word to exclude a wider range of sexual activities.
AIDS (Acquired Immuno Deficiency Syndrome)	A disease caused by a retrovirus, HIV (human immuno deficiency virus), and characterized by failure of the immune system to protect against infections and certain cancers.
Anal intercourse	A sexual act involving the insertion of a penis in, or external stimulation of, another person's anus.
Anaemia	A deficiency of functional red blood cells or a low haemoglobin level, which reduces the bloods ability to carry oxygen. Symptoms may include fatigue, weakness, shortness of breath, and heart rhythm abnormalities.
Antenatal	Before birth.
Antibody	A substance in the blood formed in response to invading disease agents such as viruses, fungi, bacteria, and parasites. Usually antibodies defend the body against invading disease agents, however, the HIV antibody does not give such protection.
Antiretroviral	A treatment that may prevent HIV from damaging the immune system.
ART	Antiretroviral therapy is the course of medications or drugs you take to fight HIV. Other terms that mean the same thing are HAART (Highly Active Antiretroviral Therapy), antiretroviral drugs', 'HIV treatment', 'medications', 'drug regimen' and 'HIV drugs'.
ARV	Antiretroviral - Antiretroviral therapy is the course of medications or drugs you take to fight HIV. Other terms that mean the same thing are HAART (Highly Active Antiretroviral Therapy), 'anti-retroviral drugs', 'HIV treatment', 'medications', 'drug regimen' and 'HIV drugs'.
Asymptomatic	Having no signs or symptoms of a disease, yet able to transmit the causative agent.
Behaviour Change	There are a number of theories and models of human behaviour that guide health promotion and education efforts to encourage behaviour change, i.e, the adoption and maintenance of healthy behaviours.
Blood transfusion	The infusion of donated blood or blood components for the treatment of a medical condition (e.g., anaemia, loss of blood due to injury or surgery).
Commercial Sex Work	The work which involves the exchange or selling of sex (anal/or/vaginal) for money.
Commercial Sex Worker	The person who engages in commercial sex work. A person could engage in commercial sex work by force and/or by choice.
Condom	A sheath made of latex or polyurethane that is worn over the penis to prevent pregnancy and/or the spread of HIV and other sexually transmitted infections; the female condom is an internal pouch worn inside the vagina or anus.

Contraception	The use of mechanical devices, foams, medication and/or creams to prevent pregnancy.
Cunnilingus	Oral sex on a woman; sexual contact between one person's tongue or mouth and a woman's vulva, clitoris, or vagina.
Deficiency	Not up to normal levels or not working as well as it should be
ELISA (Enzyme-Linked Immunosorbent)	A blood test used to detect the presence of antibodies to HIV; results that show the presence of HIV antibodies must be confirmed by the Western Blot test before a person is considered to be HIV-infected. Has high degree of sensitivity (accurate for detecting true positive samples).
Fellatio	Oral sex on a man; sexual contact between one person's tongue or mouth and a man's penis or scrotum.
Gender	Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female in a particular point in time. (World Health Organization definition).
Genital	Refers to the reproductive or sexual organs.
HIV Positive	The presence of antibodies against HIV in the blood. If antibodies are present (indicating exposure to or infection with HIV), an individual is HIV positive; if not, the individual is HIV negative.
Human Immuno Deficiency Virus (HIV)	HIV is the virus that causes the Acquired Immuno Deficiency Syndrome (AIDS). HIV attacks and slowly destroys the immune system by entering and destroying the cells that control and support the immune response system. After a long period of infection, usually 3-7 years, enough of the immune system cells have been destroyed to lead to immune deficiency. The virus can therefore be present in the body for several years before symptoms appear. When a person is immuno deficient, the body has difficulty defending itself against many infections and certain cancers, known as "opportunistic infections".
Immune Deficiency (immuno deficiency)	Inability of the immune system to function properly, resulting in increased susceptibility to opportunistic illnesses and cancers; immunodeficiency may be either congenital (present from birth) or acquired, as with HIV & AIDS.
Immune System	A system of the body that recognizes germs that cause infection and tries to eliminate or fight against them.
Immunity	Resistance to disease; the body's ability to recognize and defend against pathogenic organisms and cancerous cells.
Immuno Deficiency	A deficiency or weakness of the immune system's response that prevents it from working, doing its job well.
Infection	A condition in which the body is invaded by an infectious microorganism (e.g., bacteria, virus, fungus).
Informed consent	A mechanism designed to protect subjects in clinical trials. Before entering a trial, participants must sign a form stating that they have been given and understand important information about the trial and voluntarily agree to take part.

IUD	Intra-uterine device–A long-term, reversible method of contraception, involving the insertion into the uterus of a small flexible device of metal/plastic/hormonal materials. IUDs are effective for at least four years, and many for much longer.
Monitoring	The continuous follow-up of activities to ensure that they are proceeding according to plan and are on schedule and/or to signal the need for adjustment.
Monogamy	The practice of having one mate (sexual partner in the context of HIV and STD transmission) at a time.
MSM	Men who have sex with men.
Opportunistic illnesses/infections	People with HIV infection have a high risk for a wide range of illnesses due to HIV risk factors and HIV itself. Among the most severe illnesses are the 26 AIDS-defining opportunistic illnesses (OIs) that occur as a result of HIV disease progression, and generally occur only after substantial damage to the immune system.
Oral	Refers to the mouth; taken by mouth.
Policy	A set of decisions to pursue courses of action for achieving goals.
Postpartum	The period following childbirth.
Primary Health Care	Package of basic health services provided at the lowest level of a health system.
Safer sex	Sexual activities that reduce or eliminate the exchange of body fluids that can transmit HIV by means of barriers such as latex condoms, gloves, and dental dams.
Sexual Intercourse	Penetrative sexual behaviours, including oral sex, anal sex and penile-vaginal sex.
Sexuality	The sexual knowledge, beliefs, attitudes, values, and behaviours of individuals. Its dimensions include the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings, and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural, and moral concerns.
Sexually Transmitted Disease/Sexually Transmitted Infection	Disease resulting from bacteria or viruses and often acquired through sexual contact. Some STIs can also be acquired in other ways (i.e. blood transfusions, intravenous drug use, mother-to-child transmission). The term 'STI' is slowly replacing 'STD' (sexually transmitted disease) in order to include HIV infection. Most STIs, like HIV, are not acquired from partners who are obviously ill, but rather through exposure to infections that are asymptomatic or unnoticeable at the time of transmission.
Symptom (adjective symptomatic)	A subjectively perceptible sensation or change that signals the presence of a disease or condition.

Syndrome	A set of symptoms or disease manifestations that occur together and characterise a specific condition.
Traditional Birth Attendant	This comprises women who provide delivery services in the community. This includes traditional birth attendants who initially acquired their skills by delivering babies themselves or through apprenticeship. (WHO does not include them in the category of 'skilled attendants' who are allowed to provide/manage deliveries).
Virus	One of a group of minute organisms that cannot grow or reproduce outside a host cell; various families of viruses infect humans, animals, plants, and bacteria. During replication, a virus integrates its genetic material (DNA or RNA) into a host cell and takes over the cell's biological machinery to reproduce new virus particles.
Voluntary Counselling and Testing	VCT is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential.
Western Blot	A confirmation test for the presence of specific antibodies that is more accurate than the ELISA test for detecting true negatives.
White Blood Cells	In human body WBC are the basis of immune defences against infections and cancer.
Withdrawal	One of the oldest known methods of contraception in which the man withdraws his penis from the vagina before ejaculation. Also known as coitus interruptus. Not an effective method of preventing pregnancy and HIV Transmission.

PART -2

HIV & AIDS

2.1 HIV EPIDEMIC IN INDIA

The first case of HIV infection in India was reported in 1986 in Chennai, Tamilnadu.
Today the number of people living with HIV & AIDS in India is estimated to be between 2 and 3.1 million[1]. This accounts for 0.24% to 0.29% of the total population. Over 99% of the population is still HIV negative and this emphasizes the need for HIV prevention. By August 2006, 124,995 cases of HIV & AIDS were reported. Of these, over 88% cases are in the age group of 15-49 years[2]. Women constitute close to 30% of the reported cases.

Over the years the HIV has moved from urban to rural and from high risk to general population. 57% of the total HIV positive persons are at present in rural areas. Also increased number of women are now contracting the infection.

In India, HIV transmission is mainly taking place through sexual route (86%). In North Eastern part of the country, especially in Nagaland and Manipur, the transmission is mainly through injecting drugs use. This route is however becoming more common in other parts of the country as well. The third most common way of transmission is from HIV 'positive' mothers to their babies - 4% of the total cases have contracted the infection through peri-natal route[3].

The lower status on women in the society and less access to resources prevents them from protecting themselves. Many women are getting the HIV infection from their husbands or partners who have high risk behaviours (for example they may be having sex with other men or women or sharing injections and syringes with others)

Certain populations are categorised as key or high-risk population since they have high risk behaviours. Their high risk behaviour is characterized by unprotected multi-partner (often paid) sex - vaginal and/or anal sex; and/or injecting drug use with shared injecting equipment. Thus commercial sex workers (male, female and transgender); their partners and clients; the injecting drug

[1] *http://www.avert.org/indiaaids.htm accessed on September 25, 2007*
[2] *http://www.nacoonline.org/ accessed on September 25, 2007*
[3] *http://www.nacoonline.org/ accessed on September 25, 2007*

users (IDUs) and their partners; and Men having sex with Men (MSM), including transgender are at the highest risk.

Truckers and migrants are also at risk subseaquent to the high risk groups described above. Many of the truckers and migrants have unprotected sexual contact with sex workers (male, female and transgender) as well as with partners from the general population (wives or regular partners) and so have a potential to spread HIV infection from the high risk groups to general population.

Six states in India have high prevalence of HIV. This means that more than 1% of Prevalence among anatehatal women and more than 5% among high risk groups. These states are Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra and two North Eastern states - Nagaland and Manipur. Three states have moderate prevalence, namely, Gujarat, Goa and Pondicherry.

Other states are also highly vulnerable. This means that if we do not take steps to prevent HIV in these States, they may also have a huge number of HIV positive persons in near future.

2.2 NATIONAL AIDS CONTROL PROGRAMME - III

The primary goal of NACP-III is to halt and reverse the epidemic in India over the next 5 years(2007-2012) by integrating programmes for prevention, care, support and treatment. This will be achieved through four pronged strategy namely:

1. Saturation of coverage of high risk groups with targeted interventions (TIs), Scaled up interventions in the general population
2. Providing greater care, support and treatment to a larger number of people living with HIV & AIDS.
3. Strengthening the infrastructure systems and human resources in prevention, care, support and treatment programmes at the district, state and national levels.
4. Strengthening a nation-wide Strategic Information Management System.

Priorities and thrust areas of NACP-III include the following:

Prevention

The mainstay of the programme will continue to be prevention since more than 99% of the people are HIV negative. The programme will focus on saturating the estimated 4 million people in the high risk groups (commercial sex workers, IDUs and MSM); an estimated 12 million highly vulnerable populations, namely migrants and truckers; and the large number of young women and men in the general community who constitute almost 40% of the country's population, with prevention messages.

To create a non stigmatizing environment and enhance access of key populations and people living with HIV & AIDS to services, a well coordinated communication strategy is being put in place. NACP-III will also seek convergence with the Reproductive and Child Health (RCH)and NRHM Programme particularly in the areas of access to safe blood, treatment for sexually transmitted diseases, ante-natal care for all pregnant women living with HIV & AIDS and screening of all pregnant women attending ANC clinic.

Care, support and treatment

Under NACP-III, prevention will go hand in hand with access to prophylaxis, management of opportunistic infections and ART. Focus will also be on assuring universal access to first line ARV drugs. To ensure drug adherence, the Community Care Centres will be planned as a bridge between the patient and the ART centres and provide psycho-social support, counselling through strong outreach services, referrals and

palliative care. Home based care will be an integral part of this strategy.

Care, support and treatment services will include management of opportunistic infections including control of TB in PLWHA, anti-retroviral treatment (ART), safety measures, positive prevention and impact mitigation.

Impact mitigation

NACP-III will make efforts to address the needs of persons living with and affected by HIV, especially children. This will be done through the sectors and agencies involved in child protection and welfare. Impact of HIV on others will be mitigated through other welfare agencies providing nutritional support, opportunities for income generation and other welfare services.

NACP-III will promote Greater Involvement of People living with HIV & AIDS (GIPA) and facilitate establishment of PLWHA networks and civil society forums in each district by 2010. Attempt to bring in non-stigmatizing legislation will be made and capacity developed at all levels for effective advocacy against discrimination and a rights based approach to the HIV mitigation programme.

Decentralization of implementation

Given the spread of HIV infection into rural areas, NACP-III will further decentralize its organizational structure to implement programmes at the district level. The basic unit of implementation will now be the district. The categorization of districts based on vulnerability will be useful in preparing plans that are need based. Accordingly, differential packages of services have been developed for each category of districts. Institutional arrangements and capacities of the SACS as well as the proposed District AIDS Prevention and Control Units (DAPCUs) will be strengthened. To address special vulnerabilities of the North-Eastern States, a Regional AIDS Control Unit (RACU) will be established as a sub-office of NACO.

Monitoring & evaluation

A Strategic Information Management Systems (SIMS) unit will be set up at national and state levels to address issues relating to planning, monitoring, evaluation, surveillance and research. The proposed surveillance system will focus on tracking the epidemic, identifying pockets of infection and estimating the burden of infection.

2.3 HIV & AIDS: UNDERSTANDING THE TERMS

HIV:

HIV (Human Immuno Deficiency Virus) is a virus that causes AIDS.
AIDS (Acquired Immuno-Deficiency Syndrome) is a health condition in which the person develops infections and diseases because of poor immunity.

A person who has HIV virus present in the body is called HIV 'Positive'.

AIDS:

When a person gets infected with HIV, the virus enters the white blood cells (WBCs) and begins to multiply there. In the process white cells are destroyed. The virus is released into the blood stream and attacks more WBCs and the process continues. The number of WBCs in the body starts to fall. The WBCs can no longer do their job of protecting the body from various germs. The immune system (defence system) gradually breaks down.

Depending on the person's behaviour and nutritional status the period for complete break down of immune system may vary. When the immune system is severely compromised and WBCs are present in very low numbers, the person is said to have developed AIDS.

In the absence of an adequate defence system the body is attacked by different kinds of germs which would not have affected a normal person. Thus the person develops illness not because of the HIV but because of many other infections that a person catches because the defence system is not functioning.

"A"-Acquired means that the disease is not hereditary (cannot be passed on in the genes) but develops after birth from contact with a disease causing agent (in this case HIV).

"I"-Immune - It affects the system of the body that protects us from infections- the immune system.

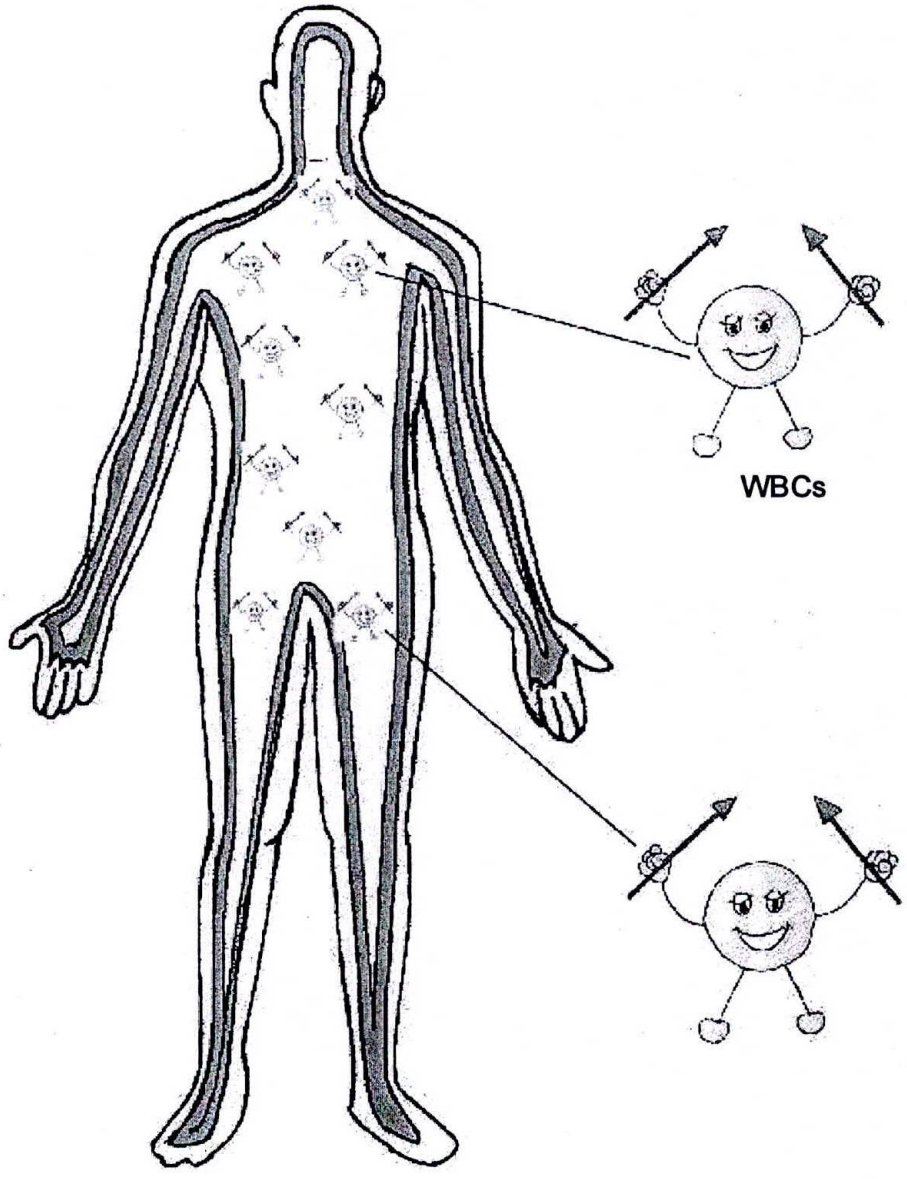
"D"-Deficiency - The immune system is not functioning adequately or is weakened.

"S"-Syndrome - A set or a group of symptoms that characterize a disease.

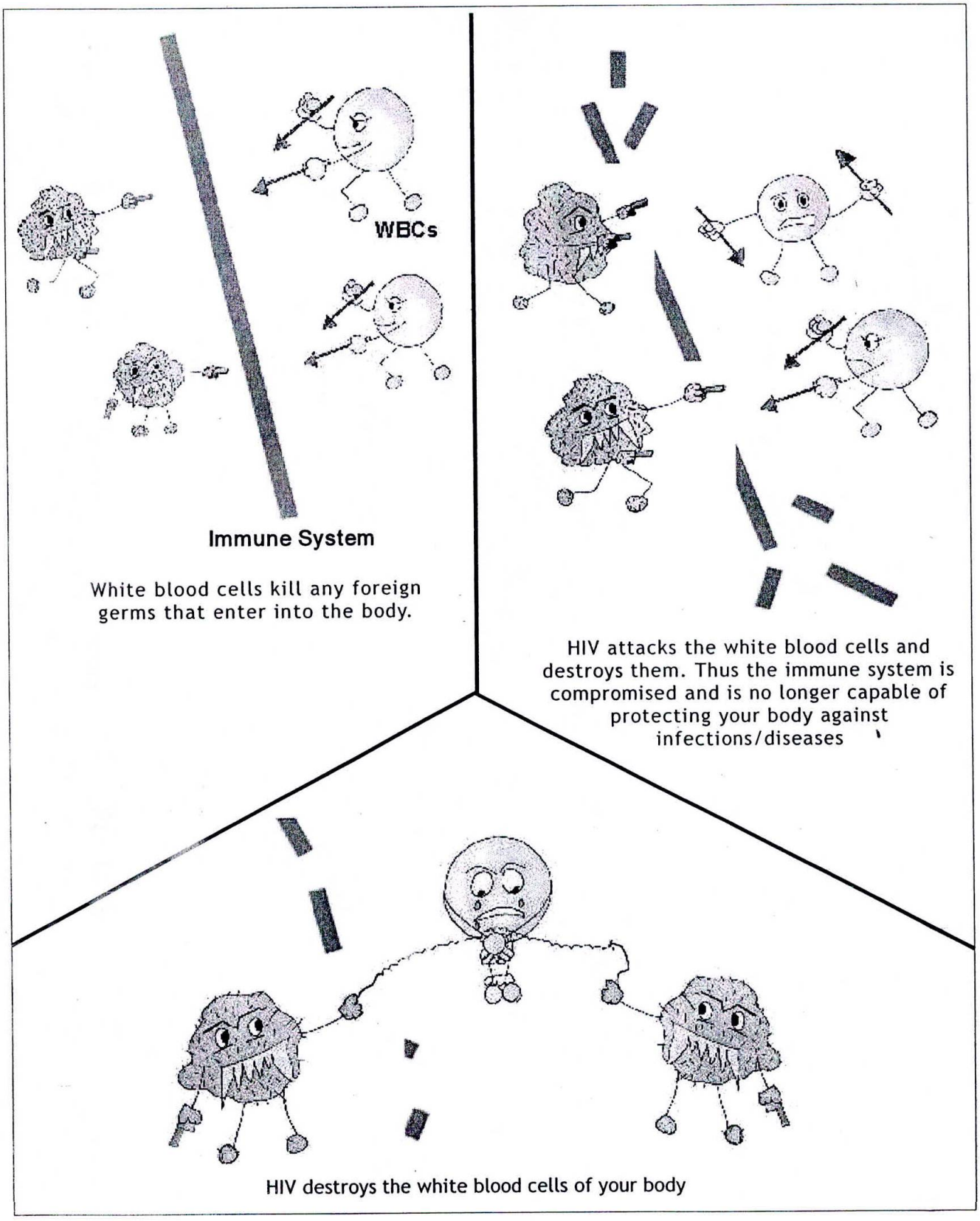
Summing up, HIV is a virus and AIDS is a disease condition in which the person becomes susceptible to many infections and diseases because of less number of white blood cells in the body.

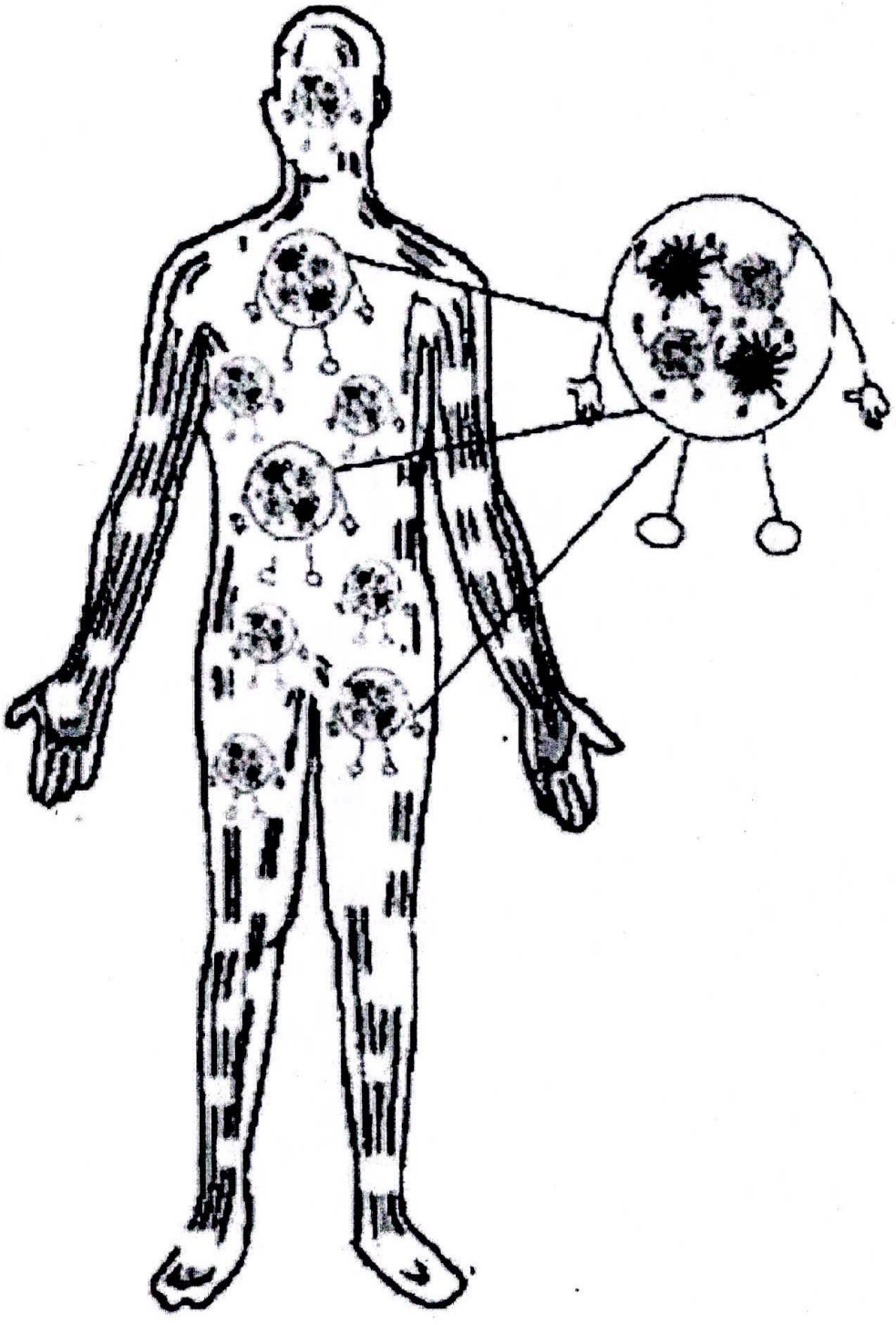
Immune system

A healthy person's body is protected from infections by White Blood Cells (WBCs), which make up the immune system. The immune system is the normal defence of the body against harmful germs.



Your immune system is your guard against diseases. The immune system mainly consists of the white blood cells and can be considered as body's first line of defence.


WBCs
Immune System
White blood cells kill any foreign germs that enter into the body.
HIV attacks the white blood cells and destroys them. Thus the immune system is compromised and is no longer capable of protecting your body against infections/diseases
HIV destroys the white blood cells of your body



Once HIV has weakened your immune system,germs can easily invade the body and make you sick.

2.4 MODES OF HIV TRANSMISSION

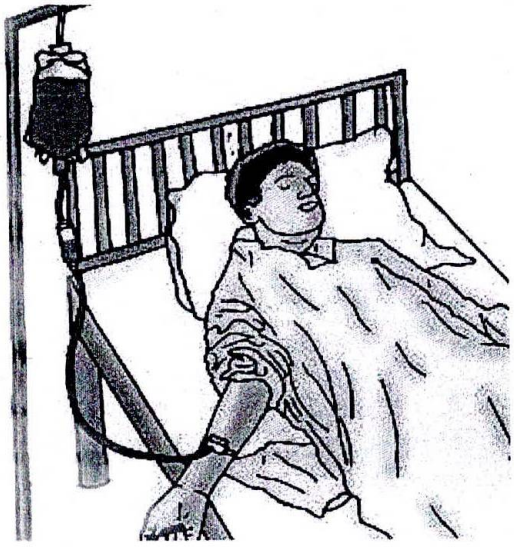
HIV spreads from one person to another through specific body fluids, which include blood, semen, vaginal fluids, and mother's milk.

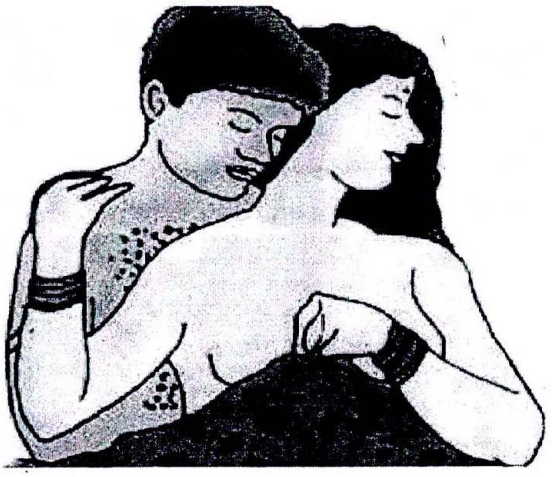
There are 4 modes of transmission of HIV:

- Unprotected sexual contact (sex without condom)
- Transfusion of infected blood
- Use of infected/unsterilised needles and syringe
- From HIV 'positive' parents to newborn

1. Unprotected sexual contact (sex without condom)

Unprotected sexual contact with a person, who has HIV, is the most common way of transmission of HIV infection from one person to another. HIV can be passed on by vaginal, oral or anal sex. Around 86 % of people in India are infected by sexual route.





A woman has a greater chance of being infected by HIV as compared to a man. This is because the contact period between the semen and the female body (vagina) is longer than the contact period between the vaginal secretions and the male organ (penis). Also the surface area of a woman's genital (vagina) is more as compared to those of males (penis).

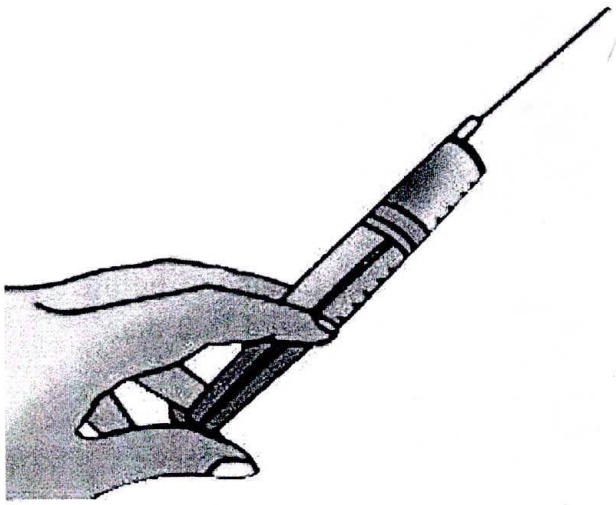
2. Transfusion of infected blood

Transfusion of infected blood (that has HIV) can directly transmit HIV infection into the blood stream of the person. This can happen when the blood for transfusion is not tested for HIV. The

chances of passing on the HIV infection through this route are around 90%.

It is now mandatory for all blood banks in India to screen all donated blood for HIV before the blood bag is cleared for transfusion to a patient.

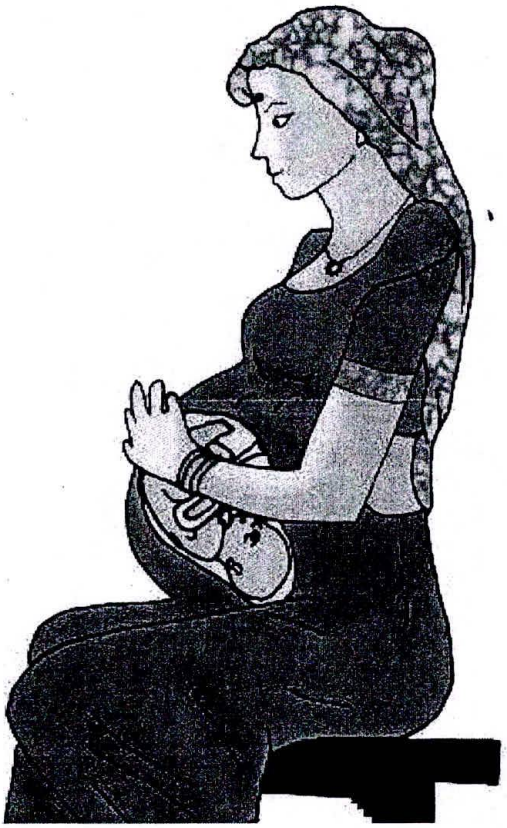
3. Use of infected/unsterilised needles and syringes



Using needles and syringes, which have already been used by another person will have small amounts of left over blood in the needle which can have HIV virus present in it. This infected blood will directly transfer HIV into the blood stream, if the needle and syringe is reused without being properly sterilized.

4. From HIV 'positive' parents to newborn

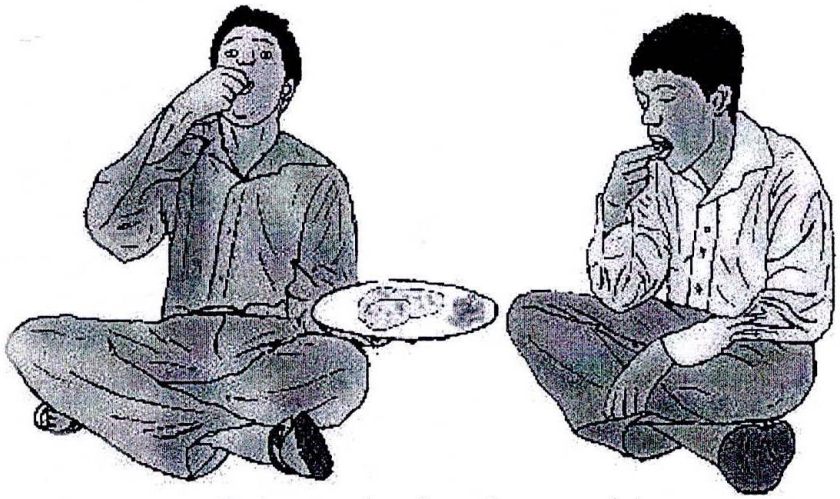
There are 30% chances of HIV being transmitted from a HIV positive mother to the child. HIV can be passed on during pregnancy, childbirth or breastfeeding. The transmission during birth is the most common way. It happens through HIV present in vaginal secretions and blood (in the birth canal) at the time of delivery. After birth, it can transmit through breast milk.



More information about this mode of transmission is provided in subsequent sections of this handbook.

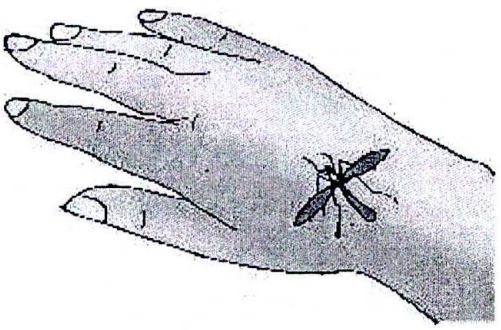
HIV does not spread by:

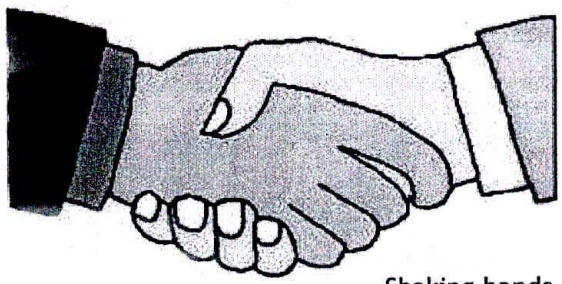
- Casual contacts such as touching, holding hands, shaking hands, embracing, socializing or living with people with HIV & AIDS.
- Mosquito bites
- Working or playing together
- Sharing food, utensils, or clothes
- Body contact in public places
- Hugging, touching or masturbation
- Caring and looking after people with HIV & AIDS
- Use of public toilets, swimming pools, community showers
- Contact with objects in phone booths, public transport, doorknobs, money etc.
- Sharing telephone or computers
- Sneezing and coughing



Eating together from the same plate.
Sharing utenesils, clothes, money etc.

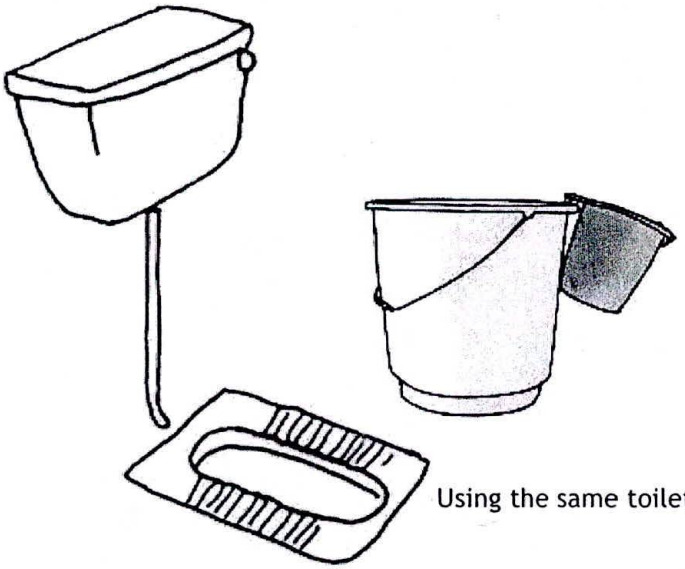
Mosquito bite



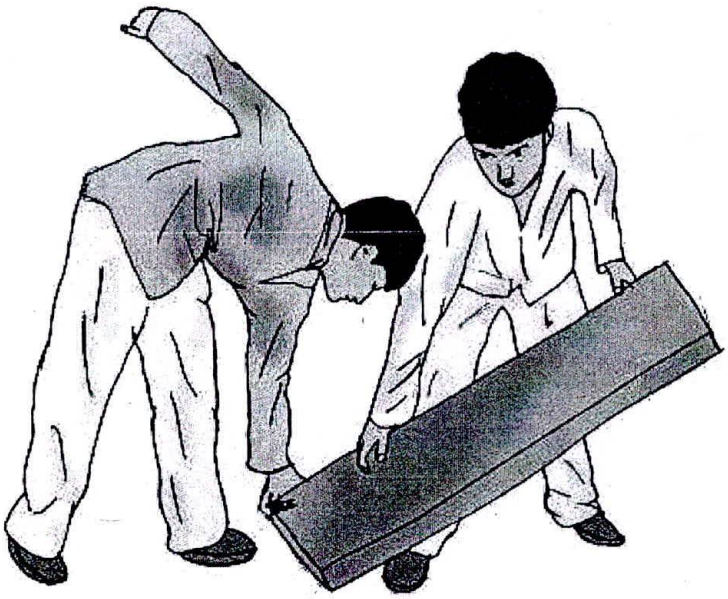


Shaking hands, hugging, kissing or masturbating

Sharing phones and computers



Using the same toilet



Working together in the same work place

Caring and looking after people with HIV

PART -3

Understanding the context

3.1 WOMEN AND HIV & AIDS

Women are much more vulnerable to HIV than men and also face greater risk of HIV transmission because of various other reasons

Physiologically, the differences in the genital tract directly contribute to adolescent and young women running a higher risk of acquiring HIV infections. These differences include immature cells in the genital tract and inadequate local immunity, which makes the genital tract more susceptible to infections. Besides the vaginal lining is thin and is more likely to be injured or damaged during the sexual act.

Biologically, the risk for transmission from male to female is greater than from female to male for several reasons.

- There is a greater exposed surface area in the female genital tract than in the male genital tract.
- There is a higher concentration of HIV in semen than in vaginal fluids.
- Coercive or forced sex might lead to micro-lesions in the genital tract that facilitate entry of the virus.
- Women often have asymptomatic STIs that are left untreated, which increases vulnerability to HIV.

Socially, factors stemming from gender inequalities also make women particularly vulnerable to HIV infection caused not by their own behaviour, but by that of their partner. These factors include:

- Cultural norms often deny women the knowledge of sexual health; or when women possess such knowledge regarding sexual health, it is often considered inappropriate for them to reveal this, making partner communication about risk and safety impossible.

- Women are often expected to remain monogamous; yet being married often places them at high risk for infection (because men are not often expected to be monogamous,

and women may not be able to refuse sex with their husbands in a marital relationship).

- The threat of physical violence, the fear of abandonment, or the loss of economic support can act as significant barriers for women to negotiate condom use, discuss fidelity with their partners, or leave relationships they perceive to be risky.

- Women often have little control over their bodies and little decision making power; men make most decisions about when, where, and how to have sex.

- Social pressure to bear children may also affect women's choice concerning the relative importance of pregnancy versus protection from infections.

- Young women are at greater risk than men for rape, sexual coercion, or being forced into sex work.

Economically, lack of control over resources can also lead to vulnerability for several reasons:

- Young women are often forced to enter into sex work and/or multiple or temporary partnerships in the hope of bartering sex for economic gain or survival, including food, shelter, and safety.

- Many young women are at risk simply because they are economically dependent on their husbands for survival and support, which limits their decision-making and negotiating power.

- Sex workers in general are at an extremely high risk for infection, particularly when they do not have the ability to negotiate with clients who refuse to wear a condom or when they are working in settings where commercial sex work is not tolerated by society and law.

3.2 YOUTH AND HIV & AIDS

Of the over 1 billion youth (ages 15-24) worldwide, some 10 million are living with HIV. Every day, an estimated 6,000 youth are infected with the virus. More than 70 percent of India's population is under the age of 35. Out of this 33.8 percent come under 15-34 age group. The number of adolescents alone (10-19) has crossed 230 million. Thus, now every second Indian is a young Indian. Yet young women and men are steadily emerging as the epicentre of the HIV & AIDS epidemic.

A substantial segment of this critical sub population is out of school, sexually active, marry early, migrate for work in vulnerable situations and are exposed to negative peer pressure and risk environment. The curiosity, risk-taking behaviour and peer pressure to prove oneself are major factors that force an adolescent and youth to take on drugs and sexual experimentation. This is further fuelled by exposure to media and confusing information sources. With little or no information and knowledge on implications of their behaviour many of the youth contract STIs and HIV infection. Lack of youth friendly services and fear of social exposure of their behavioural practices significantly reduces their access to information and services.

In India about 86% HIV infection is through heterosexual mode. Yet young people's knowledge of reproductive health, sexual hygiene and modes of HIV and STI transmission continues to be low particularly in rural areas. The median age at first sex in the country is about 21 years for males and 18 years for females although there are wide inter-state variations. It ranges from as low as 16 years in Andhra Pradesh, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh to as high as 20 years in Kerala and Goa (rural female) and a low of 18 years in Madhya Pradesh to a high of 25 years in Kerala (rural males).

Thus, the risk perception and behaviour of the young people (13 - 35) are going to determine the future direction of HIV & AIDS in the country. Nearly 33 percent of reported AIDS cases in India are in the age group of 15-29 years. Many of them are also IDUs who started substance abuse between 16 & 20 years.

Young women are another highly vulnerable category. Currently women account for 37 percent of HIV infected adults in India. Nationally only 48

percent of women are aware of the HIV protective value of a condom (NACO, BSS, 2001). Because of stigma and discrimination a majority of young women are not able to access STI and HIV & AIDS service facilities. In view of this reducing growth of infection among women and girls has emerged as a challenging task. Thus, in many ways HIV & AIDS is primarily a youth issue.

Young women face the highest risks

The higher biological vulnerability of females to infection accounts, in part, for the growing number of young women infected with HIV. Socio-cultural norms that reinforce gender inequalities, such as patterns of sexual networking and age-mixing, are also important factors that leave girls and young women more vulnerable to HIV than their male peers.

One-third of all women living with HIV are between the ages of 15 and 24. **Worldwide, young women (15-24 years) are 1.6 times as likely as young men to be HIV positive.** Many young women are reported to have experienced coerced and unprotected sex from an early age. Forced sex and consequent abrasions facilitate entry of the virus.

Abstinence before marriage may not be a successful prevention strategy for girls who marry early if their older husbands already carry the virus. Marriage can actually increase the risk of HIV for young girls. In various instances, married girls between the ages of 15 and 19 have higher HIV infection levels than non-married sexually active females of the same age. The big age difference between girls (15 to 19) and their sexual partners also limit their ability and power to resist unsafe sexual practices.

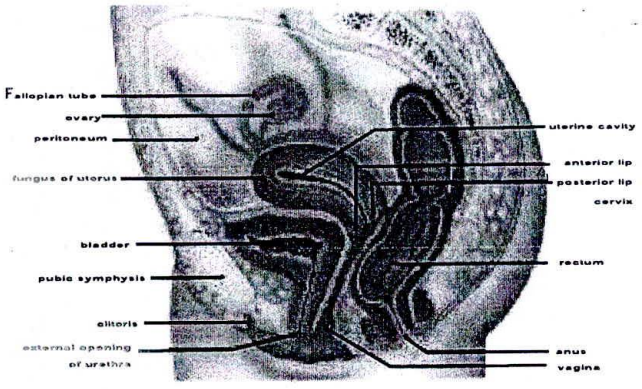
The Link Worker can facilitate the formation of the group of youth and adolescents in the villages. The groups should be encouraged to learn and discuss matters related to sex, sexuality, STIs, HIV & AIDS, prevention methods and access to services. The Link Worker can also invite the ANM, ASHA, AWW and NGO working in the area to share information and knowledge about the health issues and access to the services.

3.3 SEX AND SEXUALITY

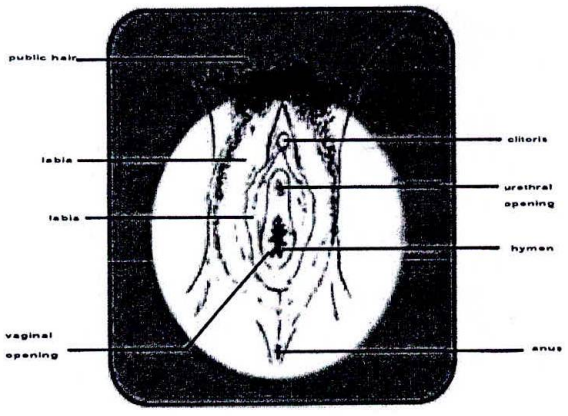
*The terms of **'sex'** and **'sexuality'** are often confused. One use of the term sex is to refer to the state of being male or female based on the biological characteristics. At other times, people refer to this term while implying physical activity involving sex organs for the purpose of pleasure or reproduction. Others use the word 'Sex' to refer to erotic feelings or desires such as sexual fantasies and thoughts or sexual urges.*

Sex is the biological differences between women and men that refer to visible difference in genitals and the related difference in anatomy and procreative function. The sex difference between men and women are universal, obvious, and generally permanent. Sex describes the biological, physical, and genetic composition with which we are born.

Female sex organ



Female Sex Organ (Anatomy)

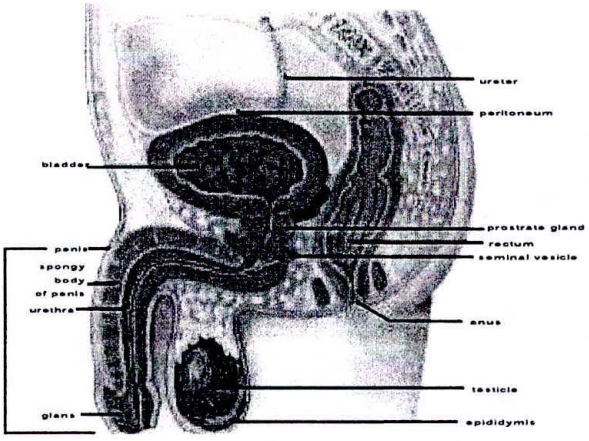


Female Sex Organ (Outside)

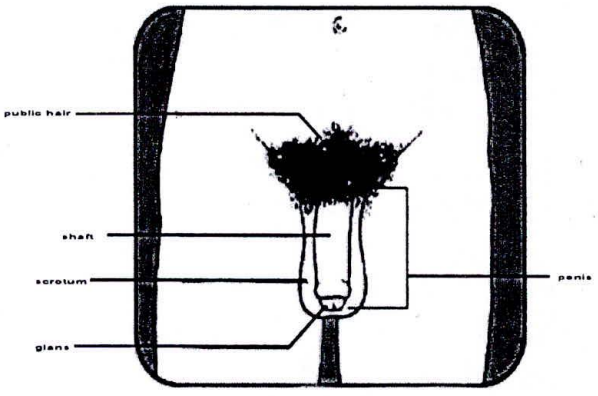
Sexuality is a broader concept than sex. Sexuality is distinct from sex and gender yet intimately linked to it. It is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour; it is a multidimensional and dynamic concept. Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality

Sexuality is the expression of who we are as human beings. It involves a person's thoughts, feelings, and sexual expression and relationships, as well as the biology of the sexual response

Male sex organ



Male Sex Organ (Anatomy)



Male Sex Organ (Outside)

system. **Sexuality is a total sensory experience, involving the mind and body- not just the genitals.**

Sexual health is the ability to express one's sexuality free from the risk of sexually transmitted infections (STIs), unwanted pregnancy, coercion, violence, and discrimination. It means being able to have an informed, enjoyable, and safe sex life, based on a positive approach to sexual expression and mutual respect in sexual relations.

Sexual norms and values

Every culture has norms related to sex and sexuality. These norms are reflected in gender roles, relationships, marriage, friendships, and family. Societal norms often determine sexual practices, marriage customs and what unapproved sexual behaviours are. For example, the norms in most cultures recognize marriage between a man and a woman but not between two men or two women as partners.

All societies have values that guide private and public behaviour. However, an individual's values those reflecting a person's day-to-day behaviour may not be consistent with the culture's formal values. For example, the expectation from a young unmarried girl in India is that she should be a virgin, however many young girls may not personally endorse the same value.

Understanding the influence of norms and values on sexual behaviour

Our society encompasses a wide range of sexual norms and values. People's sexual attitudes, experiences and behaviours are shaped to a large extent by their cultural traditions and beliefs. For

example, in many cultures, women are perceived to be the passive and submissive sexual partner. Right from birth, a girl is taught to suppress her sexual instincts. Among females, pre-marital and extramarital sex is a taboo and virginity among unmarried girls is highly valued. On the other hand, sexual activity among boys and young men is condoned.

Most cultures also have social norms regarding sexuality. For example, many cultures define normal sexuality to consist only of heterosexual sex acts between married couples. Other cultures and groups go further, to regard only sexual acts that have a reproductive purpose as acceptable.

But at the same time studies have shown that human sexual behaviour does not generally fit neatly within structures imposed by societies or religions, with masturbation and pre-marital sex, adultery and homosexual and bisexual behaviour being far more common that most societies are willing to acknowledge.

Links between gender and sexuality

Gender norms within different cultural contexts help define male and female sexual and reproductive health (SRH) behaviour. They determine the power dynamics that influence the way girls and boys experience intimacy, sexuality, and reproduction. As adolescents come of age, gender norms give them clues about what they should know or not know about sexuality, how they should interact with the opposite sex or same sex partners, and whether or not they should have access to sexual and reproductive health information and services.

Gender-related expectations compromise girls' knowledge and ability to protect themselves. Their communication and negotiation skills are restricted by the lead role taken by males in decision-making. Their health risks are increased by norms that teach them to take a subservient role in decision-making; not to question the fidelity of their partners and to tolerate violent sexual behaviour. On the other hand, masculine ideals of the strong, silent male can promote violent behaviour and limit boys' receptiveness to information, ability to communicate, and openness in intimate and sexual relationships.

PART -4

Prevention and Control of HIV & AIDS

4.1 HIGH RISK BEHAVIOURS AND REDUCING RISK

Any act of unprotected sex (sex without a condom) with a person who has HIV could result in the partner becoming infected. This is because HIV is present in high concentration in semen and in cervical and vaginal fluids. All forms of unprotected penetrative sexual intercourse (anal, vaginal, and oral) with a HIV 'positive' person carry a risk of transmission.

1. Unprotected sexual contact

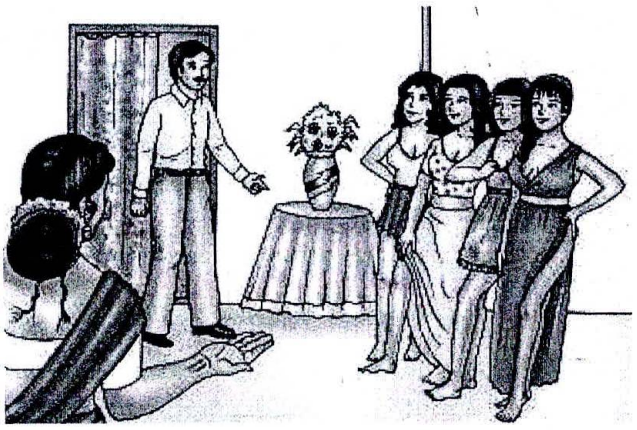
High Risk Behaviour

Infection with HIV through sexual intercourse is possible by the following direct contacts:

1. Contact between the penis and vagina in heterosexual intercourse.
2. Contact between penis and the rectum in anal intercourse between man and woman or man and man
3. Contact between seminal fluid (possibly also vaginal secretions including menstrual blood) and the mucous membranes of the mouth during oral sex (mouth to genital organs)

If one engages in unprotected sex with several partners, the risk of becoming infected with HIV increases with each sexual partner.

A woman has a greater chance of being infected by a HIV positive male than a man being infected by an HIV positive female. This is because the contact period between the seminal secretions



and the female's body is longer than the contact between the vaginal secretions and the male organ. Vaginal surface area of women exposed to secretions is also larger compared to the males.

HIV is more likely to be transmitted during anal sex than during vaginal sex. This is because anus is more likely to develop small tears and injuries during sex act. The anus is not naturally lubricated and is also difficult to penetrate. The tears and injuries in the rectum during sex act allow HIV to pass easily into the body. Since semen has high concentration of HIV, the receptive partner (or the one who is penetrated during anal sex) is at higher risk as semen stays in the anus.

The risk involved in oral sex is much less than that in vaginal or anal sex.

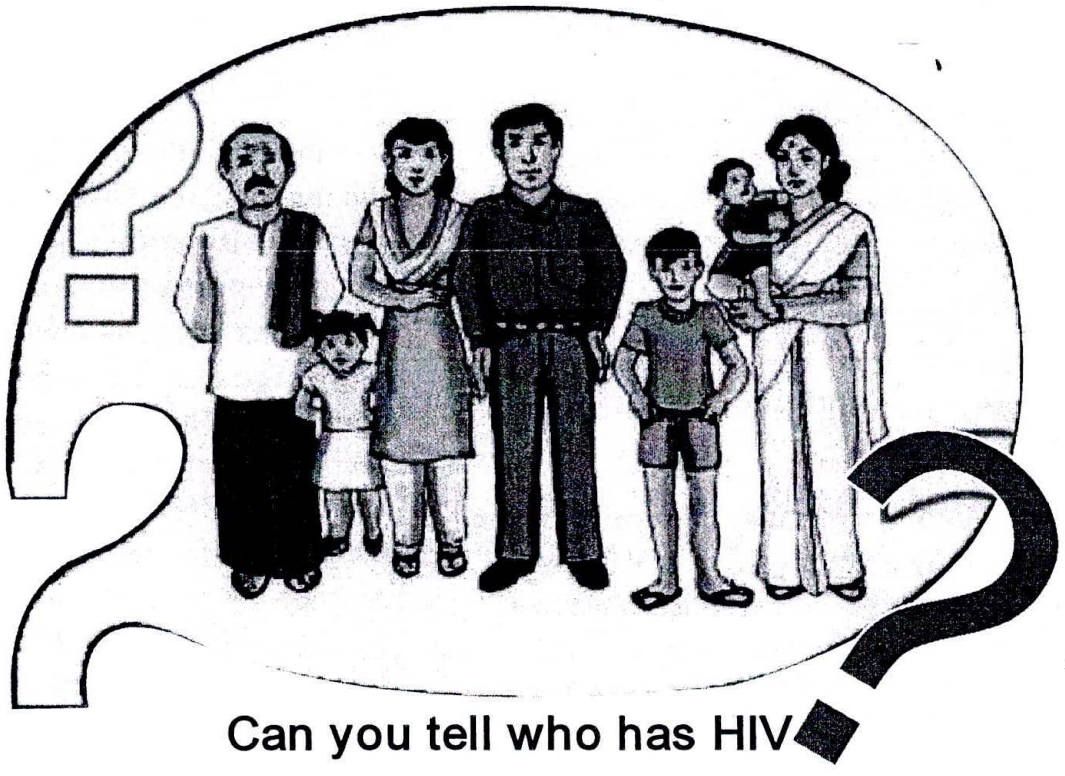
"No risk" behaviours

- The safest option is abstinence. Abstinence means avoiding intimate sexual behaviour - (oral, mouth-penis/anus contact/sex), vaginal intercourse and anal intercourse.

- One can engage in sexual practice that involve no penetration such as caressing or massaging any part of the body, hugging, masturbation (provided that sexual secretions do not come in contact with cuts or sores on the other partner's skin) and kissing that does not involve heavy exchange of saliva and **possibly blood.**

- Sex with one uninfected partner or mutual monogamy (even when partners are male). In this situation two conditions must be met - One, that both persons in the relationship must have intercourse with each other only (mutual); and Two, that both persons must be uninfected.

It is important to remember that by look it is impossible to find out if one is HIV positive.



'Low' risk behaviours

Using condoms correctly and consistently during every act of penetrative sex (oral, vaginal or anal sex) with every partner greatly reduces the risk of HIV transmission.

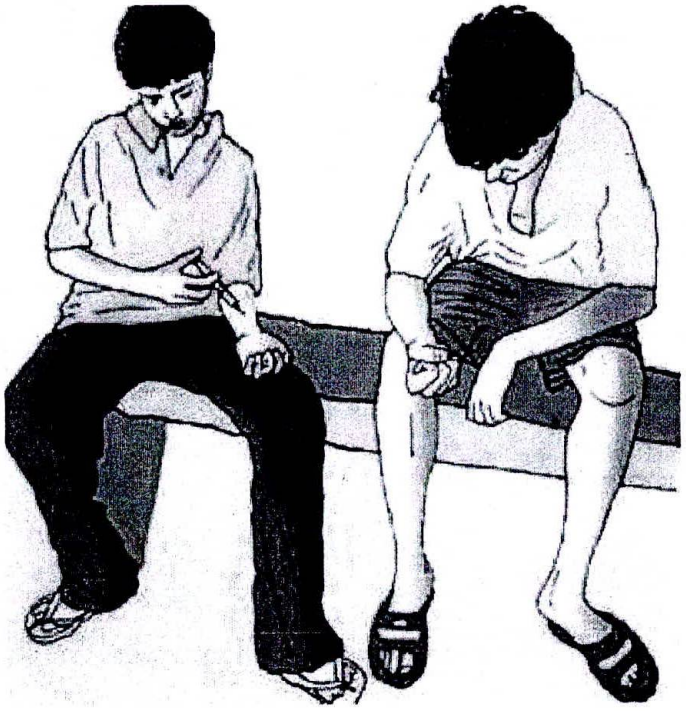
2. Sharing of needles and syringes

High risk behaviour

Injecting drug use is one of the fastest growing routes of HIV transmission. This is primarily because needles, syringes and drug preparation equipments are frequently shared, enabling rapid spread of virus.

Low risk/no risk behaviour

- All injecting and intra-venous drugs should be avoided.
- If an injection is needed, one can ensure that the syringe and needle are disposable or properly sterilized.
- The drugs should never be injected especially with shared needles and syringes.



Follow below given chart to explore the comparative risk of transmission of STIs and HIV during various behavioural practices.

PRACTICE	RISK	NOTES
Abstinence	No Risk	
Masturbation	No Risk	
Sex with a monogamous uninfected partner	No risk	It is difficult to know if partner is monogamous and uninfected
Sexual stimulation of another person's genitals using hands	Low risk/No risk	Risk is very low if there are no cuts or broken skin on hands especially if there is no contact with secretions, semen, or menstrual blood
Deep (tongue) kissing	Low risk/No risk	Risk is higher if bleeding gums, sores, or cuts in mouth
Oral sex on a woman (cunnilingus) with a barrier	Low risk/No risk	Risk is very low. Barrier must be used correctly. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by barrier
Oral sex on a man (fellatio) with a condom	Low risk/No risk	Risk is very low. Barrier must be used correctly. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by barrier
Vaginal sex with a condom	Low risk	Small risk of condom slippage or breakage - reduced with correct use. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by condom
Vaginal sex with multiple partners; condom use every time	Low risk	Having Multiple partners increases risk; however, correct and consistent condom use lowers risk
Anal sex with a condom	Medium risk	Risk of condom breakage greater than for vaginal sex. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by barrier

PRACTICE	RISK	NOTES
Oral sex on a man (fellatio) without a condom	Medium risk	HIV and STIs can be transmitted through oral sex; however, risk is lower than that of anal or vaginal sex. Safer if no ejaculation in mouth
Oral sex on a woman (cunnilingus) without a barrier	Medium risk	HIV and STIs can be transmitted through oral sex; however, risk is lower than for anal or vaginal sex
Vaginal sex using spermicides or diaphragm and no condoms	High risk/ Reduced risk	Spermicides may reduce transmission of HIV and STIs compared to unprotected vaginal sex. Very frequent use of spermicides (multiple times in single day) can damage tissues, increasing risk. Diaphragms can also reduce risk of some STIs
Withdrawal	High risk/ Reduced risk	HIV can be present in pre-ejaculate and, therefore, risk of transmission is high; however, withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other STIs
Vaginal sex without a condom	High risk	One of the highest-risk activities. Receptive partner is at greater risk
Anal sex without a condom	High risk	One of the highest-risk activities. Receptive partner is at greater risk
Vaginal sex using hormonal contraceptives or IUD and no condom	High risk	Hormonal contraceptives and IUDs do not protect against STIs or HIV
Sharing needles, syringes, drugs, or other drug paraphernalia	High risk	HIV and hepatitis viruses can readily be transmitted from infected person through sharing of injection drug work

4.2 SEXUALLY TRANSMITTED INFECTIONS AND STI MANAGEMENT

A person can get sexually transmitted infection by having unprotected sex with another person who already has the infection. These infections can be passed on during vaginal, anal or oral sex. Some STIs such as HIV (Human Immunodeficiency Virus) can be passed on to the baby during pregnancy, childbirth or breastfeeding as well. It can also be transmitted by using unclean injecting or surgical instruments or untested blood transfusion. Some of the ***common STIs*** *are Syphilis, Gonorrhoea, HIV, and Hepatitis-B.*

It is possible for a person to contract more than one infection and have multiple STIs at the same time. Some STIs show symptoms while some do not. **Many STIs are asymptomatic.** One may look healthy but still can be infected with STI and can transmit it as well to his/her sexual partner(s).

Common symptoms of STIs are

- Abnormal discharge from the vagina and penis.
- Continuous pain or burning with urination.
- Continuous itching or irritation of the genitals.
- Sores, blisters or lumps on the genitals.
- Pain in the lower abdomen.

Most STIs can be cured if treated in time and with appropriate medicines/drugs. Some like HIV do not have any cure at present. They can only be prevented.

STIs are serious health problem among young people, especially women. This is because their vaginal lining is delicate and has more surface area. Also their vaginal immunity is very low at young age. If STIs are not treated adequately they can cause serious reproductive health problems. Some can lead to infertility in women, sterility in man and complications during pregnancy.

A person who has an STI carries much higher risk of contracting the HIV infection. If the person has HIV as well as STI then he/she has a greater chance of passing on the infection to an uninfected sexual partner.

Management of STIs

The treatment of STIs is primarily based on changing the sexual behaviour that put people at risk and on promoting the use of condoms.

Following are the **main components in STI control and management:**

- Creating awareness among individuals at risk (female and male sex workers, truck drivers, migrant and mobile people, young people, etc.) on modes of STI transmission and ways to reduce risk of STI transmission.

- Explaining the association between STIs and HIV; and, that the same risk behaviours are responsible for acquisition of both the infections.

- Promoting safe sexual behaviours, education on methods of risk reduction including abstinence, reducing multi-partner sex, and consistent and correct use of condoms, as is feasible in the context of the individual.

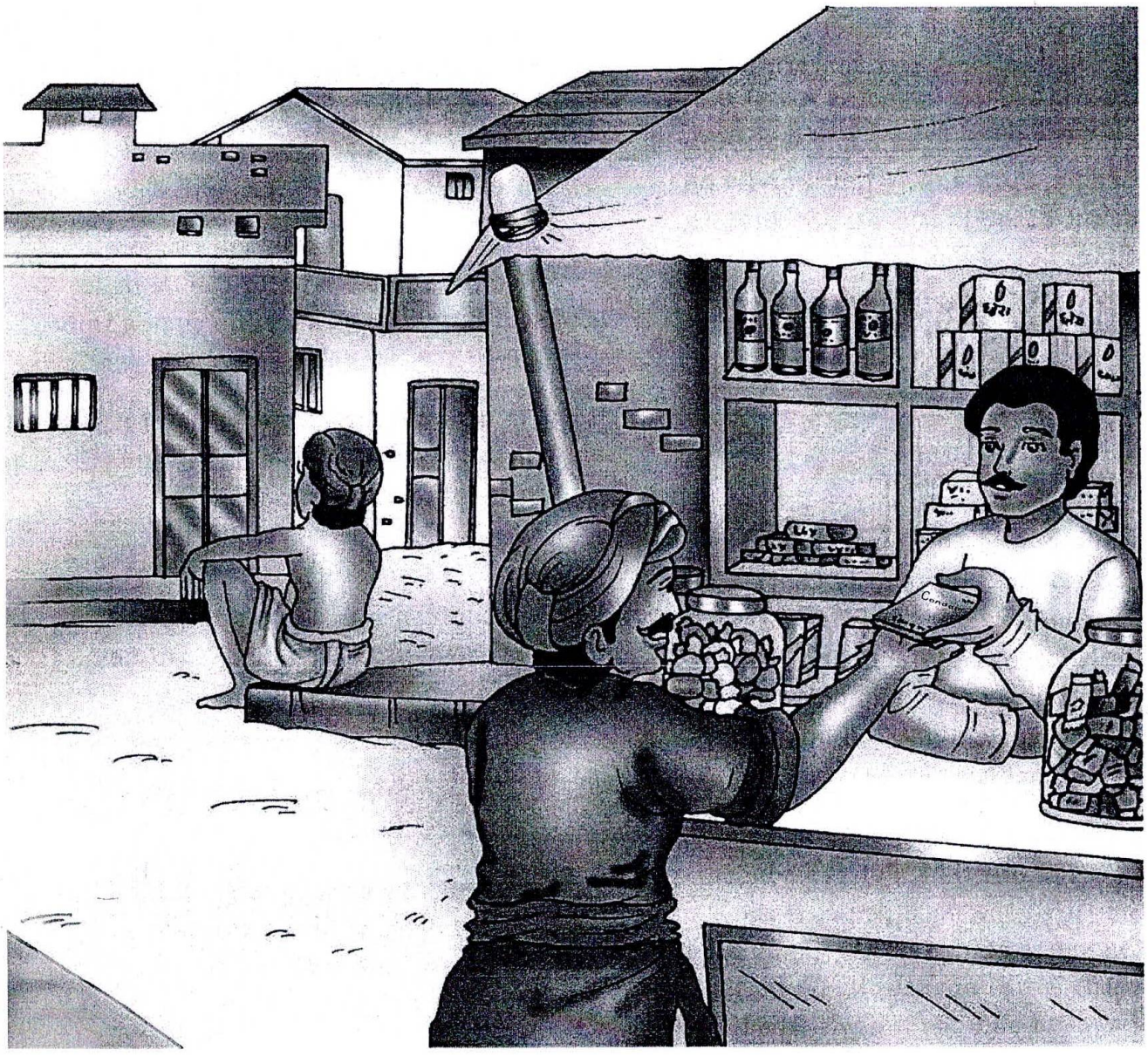
- Promoting condoms for safe sex and encouraging discussions on where and how to get the regular supply of condoms. Providing free condoms when they are available, demonstrating correct condom use and advising about consistent use of condoms.

- Promoting health care seeking behaviour, discussion about the treatment of STIs and where these services can be accessed (health services for STI prevention and management are available at primary health centre, and as part of general health services under RCH-II).

- Encouraging such person for bringing his/her partner for STI related counselling, screening and treatment.

4.3 CONDOM PROMOTION AND DEMONSTRATION

Condoms are the only contraceptives that protect against STIs, HIV and unwanted pregnancies. However they should be used correctly, consistently and every time a person has sex (vaginal, oral and anal). Latex condoms protect against HIV by covering the penis and providing a barrier against exposure to genital secretions, such as semen and vaginal fluids.



For oral sex, it is best to use a condom over the penis and or a plastic wrap or a cut-open condom to cover the vagina or anus.

While some condoms come pre-lubricated, others are not, and some people may need to use additional lubrication to increase comfort and prevent breakage, which is particularly important for anal sex. Only water-based lubricants, such as K-Y jelly should be used. Oil-based lubricants, such as vaseline, petroleum jelly, creams, lotions, or cooking oil damage the condom and make it significantly less effective and more likely to break during use.

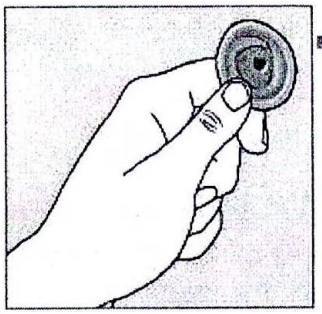
Use of male condom

1. While buying condoms, the expiry date should be properly checked. Condoms are good for 2-3 years from the date of manufacturing. They should be stored in a cool, dry place away from sunlight and not in hot moist places.
2. If the person is not circumcised, pull back the foreskin. Put the condom on the tip of the hard penis. If the condom is placed on the penis backwards it will not unroll. Do not turn it around and use it again but throw it and start with a new one.
3. Condoms have a reservoir tip at the end to collect the semen. Pinch the tip of the condom to remove the air and unroll the condom till the base of the penis. Make sure there is no air trapped inside.
4. Make sure that there is space at the tip of the condom and that the condom is not broken. With the condom on, insert the penis for intercourse.
5. After the intercourse the condom must be removed while the penis is still erect. Do not let the semen spill out of the condom while removing.
6. Tie a knot of the condom before throwing it. Wrap in a paper and throw it in the garbage.

Important Tips for Male Condom Use

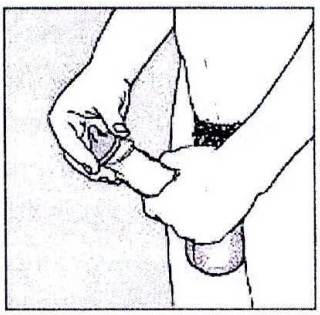
- ***A condom should be put on an erect penis only and should be kept on during the entire period of intercourse.***
- ***The condom should never be used twice.***
- ***Do not use grease, oils, lotions or petroleum jelly as lubricants. Only use water based lubricants such as KY Jelly.***

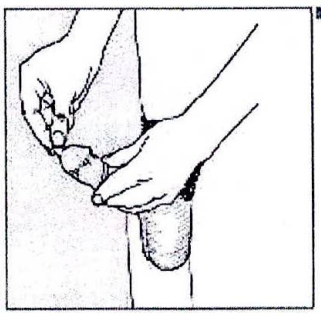
Before intercourse



1 Carefully open the package so the condom does not tear. (Do not use teeth or a sharp object to open the package.) Do not unroll the condom before putting it on.

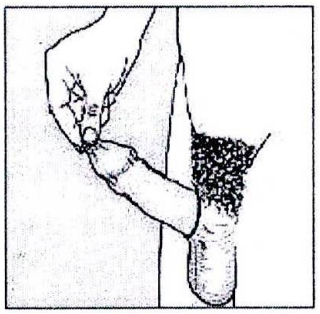
2 If you are not circumcised, pull back the foreskin. Put the condom on the end of the hard penis. Note: If the condom is initially placed on the penis backwards, do not turn it around. Throw it away and start with a new one.



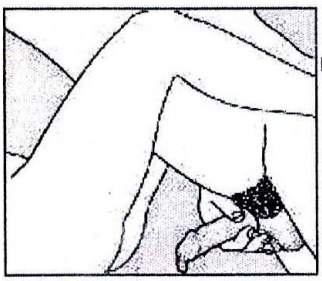


3 Pinching the tip of the condom to squeeze out air, roll on the condom until it reaches the base of the penis.

4 Check to make sure there is space at the tip and that the condom is not broken. With the condom on, insert the penis for intercourse

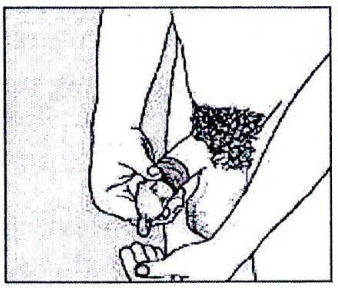


After the intercourse



5 After ejaculation, hold onto the condom at the base of the penis. Keeping the condom on, pull the penis out before it gets soft.

6 Slide the condom off without spilling the liquid (semen) inside. Dispose of the used condom.



Female condom

The female condom is a female controlled method and is empowering women to protect herself from unwanted pregnancy and STIs. The female condom is a strong, soft, transparent polyurethane sheath inserted in the vagina before sexual intercourse, providing protection against both pregnancy and STIs. The female condom prevents contact between male and female genital secretions, avoiding the transmission of STIs, including HIV. It is lubricated, disposable and can be inserted up to 8 hours before intercourse. It is not dependent on the male erection, and does not require immediate withdrawal after ejaculation. The female condom has no known side-effects or risks. It does not require a prescription or the intervention of a health care provider.

However, female condom may not be readily available every where and it is costly. The Link Workers and volunteers must explore if these are being made available locally through a government or private agency, at subsidised rates.

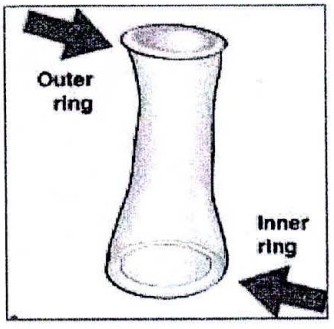
Use of female condom

1. Remove the female condom from the package carefully. Rub it between two fingers so that the lubricant is spread evenly. If more lubricant is needed squeeze it from the extra lubricant provided in the package.
2. The closed end of the female condom goes inside the vagina. Squeeze the inner ring and insert it into the vagina. Using the index finger push it into the vagina as far as it can go.
3. The ring at the open end should stay outside the vagina. Make sure the condom is not twisted.
4. During intercourse if the condom tears then remove it and insert a new one. Make sure the penis is guided inside the female condom.
5. After intercourse the condom should be removed while the women is lying down so that there is no spillage. Then wrap it up and throw in the dustbin.

Female Condoms should not be used if:

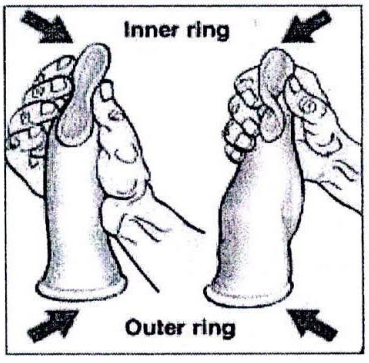
- **The packet is open**
- **The condom is brittle or dried out**
- **The colour is uneven or changed**
- **It is unusually sticky**
- **The expiry date has passed**

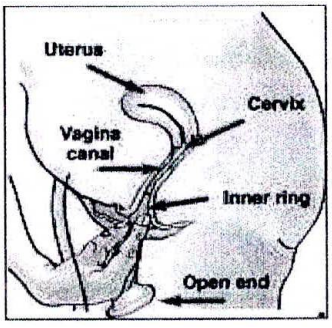
HOW TO USE A FEMALE CONDOM: A Pictorial presentation



1 The open end covers the vagina and the inner ring is used for insertion and to hold the condom in place.

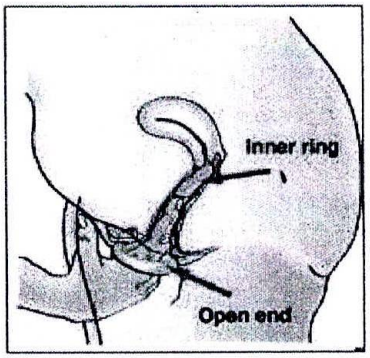
2 Hold the inner ring between your fingers and squeeze or twist the ring into a figure 8.

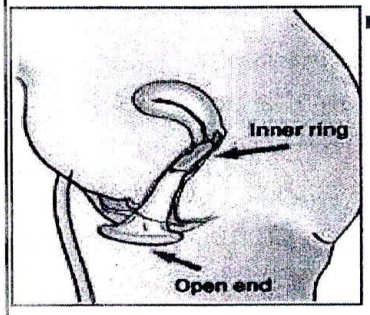




3 Push the inner ring into the vagina with your fingers

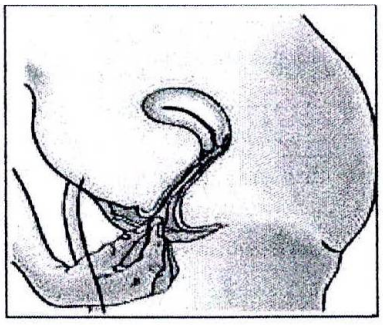
4 With your index finger, push the inner ring up as far as it can go





5 The female condom is in place

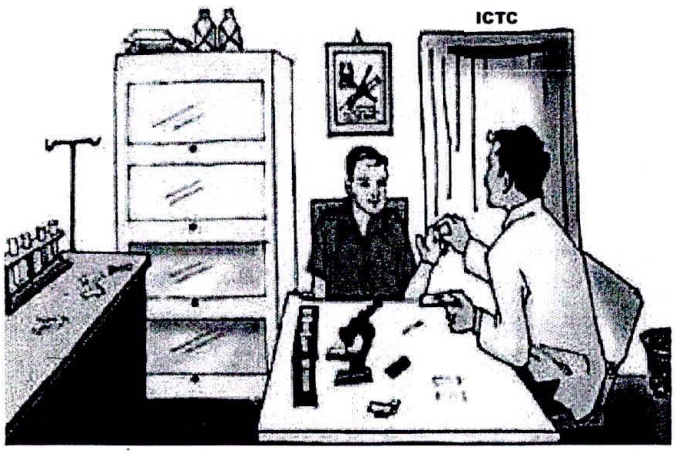
6 Remove the condom before standing up. Squeeze and twist the outer ring, pull gently, and dispose



4.4 GETTING TESTED FOR HIV

A person may have HIV without knowing about it. ***The only way to know if a person has HIV is through a blood test called*** *- HIV test. If antibodies against HIV are present in the blood then the person is said to be HIV 'positive'.*

If one has any suspicion of being exposed to HIV, or has been involved in behaviour that increases the risk of exposure to the virus it is advisable to take a HIV test. Such behaviours could be unprotected sex and/or shared injecting drug use with a partner whose HIV status is not known, transfusion of untested blood /blood products and use of un-sterilised needles.



Sometimes a person who is infected with HIV may show a negative test result. This is because the body takes 3-12 weeks to produce antibodies against HIV. This is known as the 'window period'. During this period the test results will be negative.

To know definitely if a person has HIV, the test should be repeated after 3 months. However HIV can be passed even during the '**window period**'.

Types of HIV Tests - There are 2 types of HIV tests:

1. **Screening test:** this is the fist test performed to know if a person is HIV positive or not. They are easier to perform and less costly. **ELISA** test is the most common screening test. If the test results are positive then a confirmatory test is performed.
2. **Confirmatory test:** This test is done when the results of the screening test are positive. They are expensive but more specific than screening tests. The **Western Blot** test is the most common confirmatory test.

Voluntary counselling and testing (VCT)

Voluntary counselling and testing is a process by which a person takes counselling voluntarily so that s/he can make an informed choice about HIV testing. HIV testing is done only when a person has consented for it, following the counselling. The HIV test results are kept completely confidential and given only to the person.

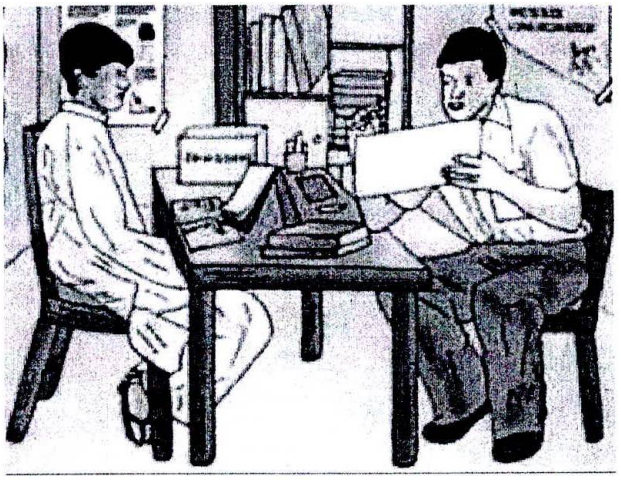
The benefits of counselling and testing are:

1. Knowledge about one's (HIV) status
2. Protecting one's partner
3. Early access to care and treatment
4. Preventing mother to child transmission
5. Adopting healthier lifestyle
6. Improved planning for the future
7. Motivation to initiate or maintain safer behaviours
8. Reduce stigma and discrimination

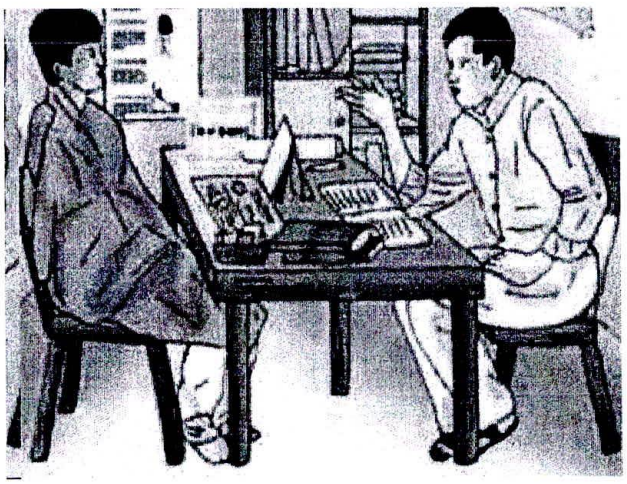
VCT process consists of:

1. Pre-test Counselling
2. Testing (described above)
3. Post-test Counselling
4. Follow Up Counselling

Pre-Test Counselling: The person is informed by the counsellor of the benefits and implications of taking the test. The correct information about HIV & AIDS is also provided and myths and misconceptions are dispelled.



Post-Test Counselling: The counsellor helps the person understand the implications of the test results before handing it over to him/her. If the result is **positive,** the counsellor provides emotional support to the person. When



the person is ready, the counsellor informs about various health care services and advice about nutrition, safe behaviour practices, and adopting a healthy lifestyle. Ways to prevent transmission of HIV to sexual partner/s is also explained to the person. The counsellor may also advice the person on how and whom to share the test results.

If the test result is **negative** the counsellor may discuss safe behavioural practices and other methods of risk reduction. The person is also advised about repeat test after three months.

Follow-Up Counselling: The counsellor will help the person deal with his/her HIV status and give information about various services available depending on the need and requirement of the person.

Integrated counselling and testing centre (ICTC)

One can avail Voluntary Counselling and Testing at ICTC located at all District Hospitals. NACP-III has proposed to scale up the ICT services to sub-district and CHC level. Link Worker should explore the information about the availability of ICT services in his/her district and motivate and encourage people to take up the VCT.

Under NACP-III it is proposed that all VCTC will be re-modelled as a hub to integrate all HIV related services and called Integrated Counselling and Testing Centre (ICTC). ICTC will provide entry point for both men and women requiring different services. For instance, pregnant women will be referred to PPTCT centres, those with STI symptoms to STD Clinics and those with TB symptoms to DOTS (RNTCP) Centres, etc.

4.5 PARENT TO CHILD TRANSMISSION OF HIV

HIV can be passed from mother to baby during pregnancy, during labour and birth, or during breastfeeding. But, not all babies of HIV+ mothers will be infected. ***With no prevention, about 1 out of 3 babies of HIV+ women will get HIV.***

A baby is more likely to get HIV if the mother has other infections, anemia, poor nutrition, or if she gets full blown AIDS while she is pregnant. If a mother has unprotected sex with an infected person while pregnant, she will have even more of the virus in her body, and the baby will be more likely to get HIV.

Preventing parent to child transmission (PPTCT)

Before Pregnancy

Link Workers can help young women and couples prevent pregnancies that they do not want, and help them stay healthy and safe if they are pregnant. For this they can:

- Make sure that all people in the community know about and have a FP method of their choice, especially male or female condoms to prevent STIs, HIV, and unwanted pregnancy. Refer them to a nearby clinic or provide condoms directly. Make sure people know about Emergency Contraceptive Pills (ECP) if they have had unprotected sex and where they can get ECP (or Link Worker can distribute the ECP directly).

- Get people to go for ICT because if they know they are infected, they can choose not to get pregnant or get PPTCT services right away if they do want to be pregnant.
- Help PLWHA and their partners protect themselves from getting pregnant, or if they decide to become pregnant, help them prevent transmission and re-infection.

- Raise awareness in the community about PPTCT and why it is good to go for ICT before deciding to have a baby.

PPTCT during pregnancy

To prevent parent-to-child transmission during pregnancy, the Link Workers can:

- Find pregnant women in the commuity and refer them to the clinic for at least 3 Antenatal Care (ANC) visits and VCT.
- Help young couples understand their risk for HIV and why PPTCT is important.
- Help couples practice safer sex, by telling young women and men why it is important to use condoms during pregnancy.
- Help women and their families plan a safe birth in a facility, or with a midwife trained in PPTCT. Work with the mother-in-law and/or partner so they understand and support safe delivery.
- Make sure that the mother has ARVs for herself and the baby by facilitating her linkage to the ART centre
- Work with local birth attendants (like TBAs, midwives, and others) to refer HIV+ women to a facility.

PPTCT during birth and delivery

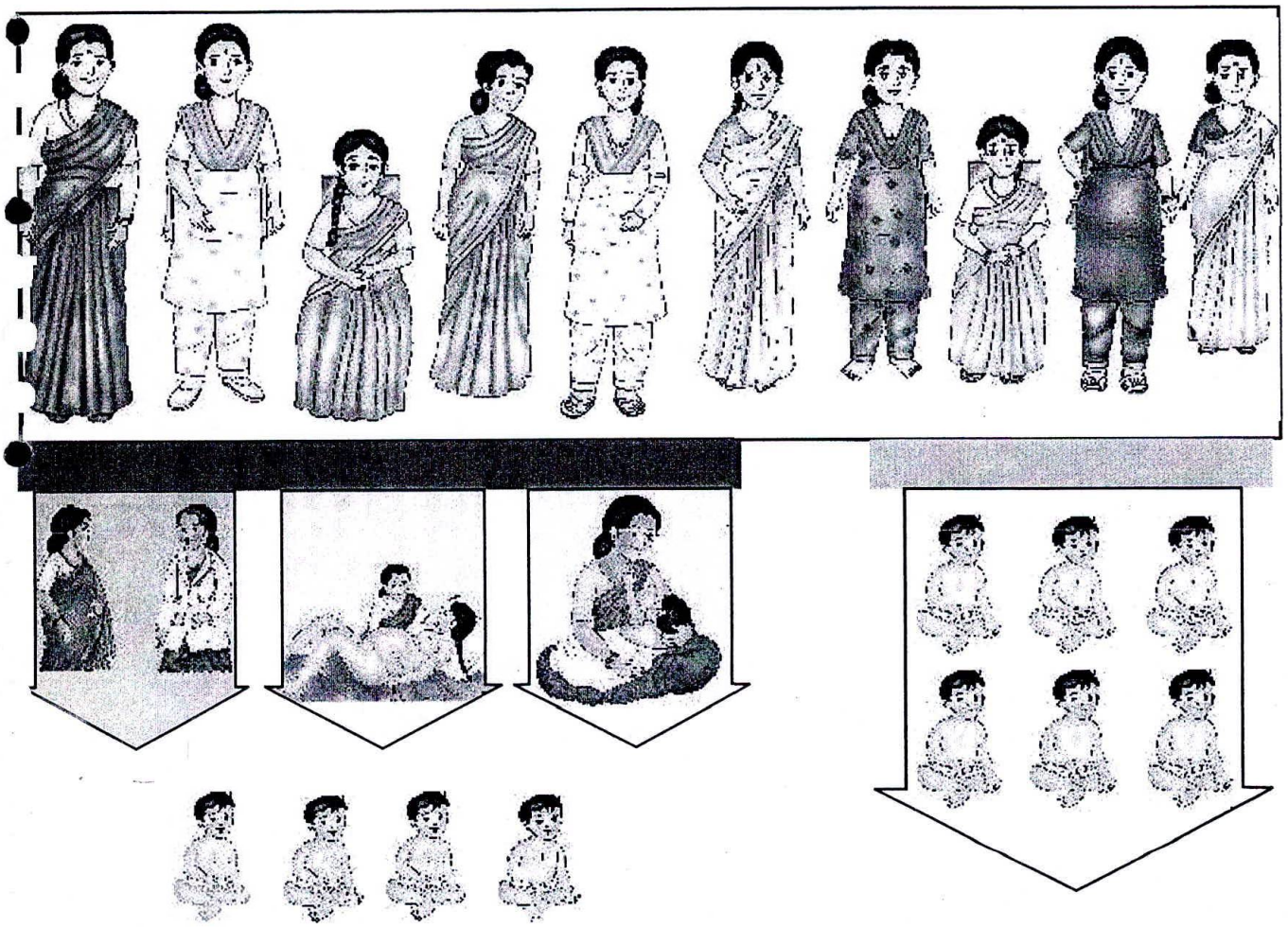
Both Health facilities and Link Workers can help prevent parent-to-child transmission during delivery by:

Linking to PPTCT Centre for:

- ARVs late in pregnancy (or during labour) and after birth for the baby
- Promotion of safer sex and condoms during follow-up after delivery
- Nutrition advice and supplements (like iron, folic acid, and vitamins)
- Promoting institutional delivery
- Advise regarding breastfeeding

PPTCT during infant feeding

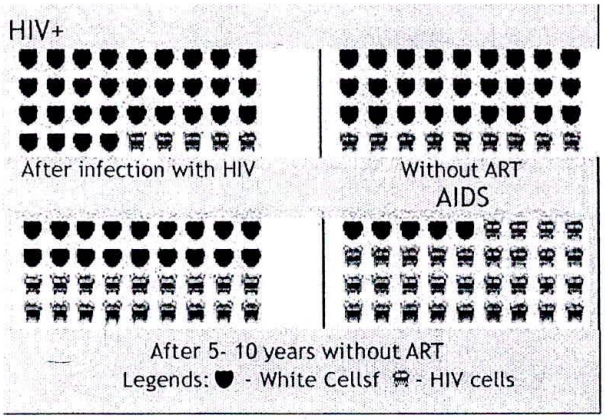
HIV is parent in breast milk in some quantity HIV can be passed to the baby through breastfeeding. The safest way to prevent transmission is not to give any breast milk to the baby. But for many women, breastfeeding alone is the best choice because it is very healthy, does not cost money, and prevents a lot of other infections that could harm the baby. However breast feeding can be stopped early (at 6 months) and baby switch to complementary foods/feeding.



4.6 ANTI RETROVIRAL THERAPY (ARTs)

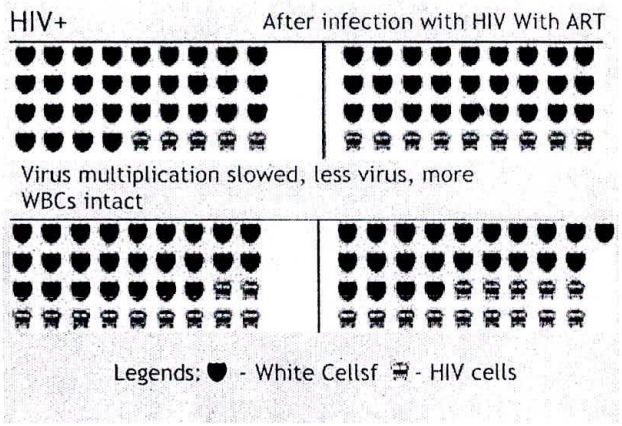
There is no cure for HIV & AIDS. But there are certain medicines called Anti Retroviral Drugs which can help a person who is HIV positive to live longer and have a better quality of life. The Anti Retroviral Drugs prevent the growth of HIV in the body and reduce its activity but cannot eliminate it completely.

When a person gets HIV, the virus enters the WBCs present in the immune system of the body. The HIV attacks these WBCs and starts to multiply in large numbers everyday. The number of WBCs starts decreasing and after some years they fall below a critical level. This is when the person is said to have AIDS. At this stage the person gets various infections because there are not enough WBCs to fight the infections.



If a person with HIV starts taking ARTs, before the WBCs fall below the critical level, the HIV will not be able to multiply very fast or destroy the WBCs.

The person can stay healthy for a longer time. When the body has enough WBCs it will be able to fight off various other infections. ARTs can also decrease the chances of mother to child transmission.



ARTs once started have to be taken life long:

PLWHA on ART need to achieve 100 percent adherence to ART to keep the correct amount of drugs in their bodies to fight the virus. Thus a person taking ARTs must always take the medicines in the right dosage and at the right time. Treatment should be followed strictly

and not even a single dose should be missed. Only then will the treatment be successful.

Poor adherence to ART leads to drug resistance, increased viral load, increased sickness and increased possibility to death.

Even when a HIV positive person is taking ARTs, they can still pass on the infection to others. They should therefore always practice safe sex with their sexual partners.

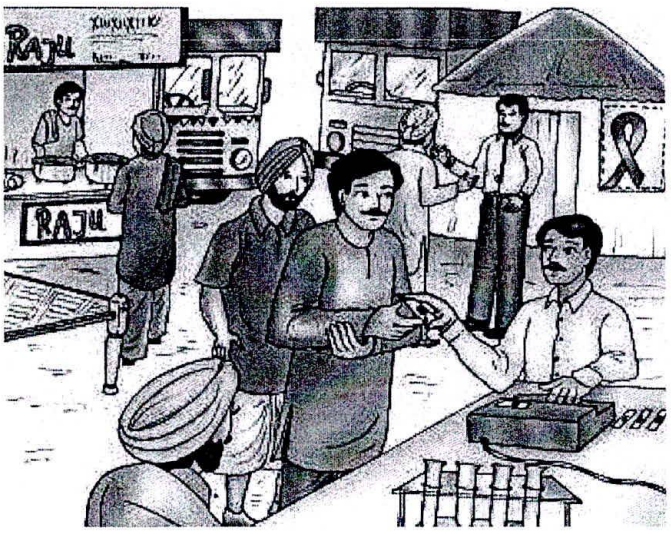
To facilitate adherence the Link Workers can do the following:

- Counsel and advice family members to support the patient and not to blame, isolate or make him feel guilty.
- Understand the regime of the medicine prescribed for the patient.
- Help and support the patient and family members develop adherence plan to ensure that medicines are taken by the patient exactly as prescribed by the doctor.
- It is important to involve a treatment supporter - a friend or family member chosen by the patient to help him/her remember to take the drugs and keep clinic appointments.
- A PLWHA support group in the district/block/village can be identified and the patient can be linked with the group for psychological support and to encourage adherence.

4.7 CONTINUUM OF CARE (PREVENTION, CARE, SUPPORT AND TREATMENT SERVICES)

It is observed that HIV related health services provided at the tertiary and district levels are not easily accessible to vulnerable and high risk populations like the CSWs, MSM, IDUs, truckers and migrants. The low demand for services from the general population in VCTCs and STI clinics is also a matter of concern. Therefore under NACP-III, it is proposed that services be integrated and scaled-up to ensure delivery at sub-district and community levels through existing infrastructure in the public and private sectors. Special attention will be given to demand generation, some level of which can be achieved in rural areas through the Link Workers.

Since many components of the National AIDS Control Programme will be delivered through the health system, the NACP-III will synergise its services with the NRHM, the Reproductive and Child Health (RCH) programme and the Revised National TB Control Programme (RNTCP).



The following preventive services will be provided at sub district level:

- STI services
- Access to Condoms
- Safe Blood
- Integrated Counselling and Testing Services and
- Prevention of Parent to Child Transmission

Besides preventive services, care and support and treatment for people living with HIV & AIDS will also be made available.

Integrated counselling and testing services

Under NACP-III, existing VCTCs and PPTCT centres will be re-modelled as a hub to integrate all HIV related services and called Integrated Counselling and Testing Centres (ICTCs).These will be established with the district, sub-district hospitals, CHCs and RNTCP microscopic centres.

ICTCs will provide entry points for both men and women requiring different services. For instance, pregnant women will be referred to PPTCT centres, those with STI symptoms to STI clinics and those with TB symptoms to RNTCP centres. Additional counselling services will be provided in PPTC centres for counselling and testing of pregnant women attending ANC clinics. All clients who access services from the ICTCs will be provided advice on prevention also. Further, counsellors at these centres will ensure access to the following services through linkages: IEC/BCC; Condom promotion; STI treatment linkages; Prophylaxis and early management of OI; DOTS for TB; and ART Services.

Linking care and support with prevention

Under NACP-III, all care centres (Community Care Centres, TB Clinics and ART Centres) will also focus on preventive strategies, thus ensuring that HIV spread is reduced from the affected individuals. This will also ensure that stigma and discrimination is reduced and more people living with HIV & AIDS are covered through interventions designed to change high risk behaviour.

Health service providers at village level

- Auxiliary Nurse Midwife - provides primary health care services, Antenatal care, Delivery & Postnatal care, immunization, and referrals.
- Accredited Social Health Activist - community mobilization and awareness on health and increase utilization of existing health services
- Aanganwadi Worker - nutritional support, recreational and primary education to the children in the age group of 0-6 years, support ANM to provide ANC and PNC to women
- Lady Health Visitor - provide health education
- Traditional Birth Attendant - provide care during pregnancy, attend delivery and support postnatal care of pregnant women.

PART -5

Understanding Risk & Vulnerability

5.1 POPULATIONS WITH HIGH RISK BEHAVIOURS

Not all people in a given community (or a population) are at the same risk of HIV. *A variety of factors place certain people at the higher risk of contracting HIV and other STIs. Some of these risk factors include, having multiple sexual partners, unsafe sexual practices, injecting drug use and drug and alcohol use followed by unprotected sex.*

As mentioned earlier, certain groups identified to be at high risk of HIV are sex workers, men having sex with men, injecting drug users and their partners and/or clients in the act. Certain groups like truckers, migrants and mobile populations, are also at increased risk of HIV and other STIs.

An important aspect to remember is that sex worker-client interaction has been identified as one of the factors that is driving HIV epidemic in India. The sex workers may be male, female or transgender. The clients may buy sex from any of the sex workers. Many of the clients and commercial sex workers have other steady partners (like spouses) as well. Such partners become highly vulnerable to HIV because of high risk behaviour of their partners

These high risk groups may be present as communities (such as brothel based sex workers, transgender, men having sex with men), mostly in urban and peri-urban areas where they are being reached through 'Targeted Interventions'.

However many of these individuals are dispersed in the communities in rural areas and are difficult to reach out.

Both sex workers and their clients (e.g. truck drivers) travel for or in search of work. Many of the sex workers in the rural areas may move along the highways during the day and return home (in the village) at night or may travel to close by towns for work and periodically return home. Their engagement in the commercial sex work may not be known to their families or the community around them.

This mobility of the commercial sex workers and their clients makes effective and sustainable prevention work more difficult as most of these populations are on the move or their behaviours are unknown.

5.2 SEX WORKERS : HIV RISK AND VULNERABILITY

Significantly higher rates of HIV infection have been documented among sex workers and their clients as compared to most other population groups. Several factors contribute to people turning to sex work: socio-cultural tradition, social isolation, low education, scarcity of jobs, low pay, and being a wage earner for the family (including children who are living with relatives).

Risk of HIV infection is, in part, a consequence of lack of social and economic power. The factors that can increase sex workers' vulnerability to HIV infection are:

- Stigmatization and marginalization: Sex work is not considered respectable. This results in isolation, social stigma resulting in discrimination. This limits sex workers' access to legal, health and social services, thus increasing their vulnerability to HIV.

- Limited economic options, in particular for women: As the economic opportunities are limited, sex workers may agree to have sex without condoms so as not to lose out on clients to earn more. Sometimes clients are also willing to pay more for having sex without a condom. Many a time they are coerced by their employers into unprotected sex as well.

- Limited access to health, social and legal services: Sex work is illegal, and therefore clandestine. Sex workers are routinely harassed by the local police and do not have legal recourse. They may be exploited by those in position of power or authority. Also many of the health care providers have a judgmental attitude towards those involved in sex work.

- Limited access to information and prevention means: Limited information, skills, negotiating power and access to means of prevention may lead directly to behaviour that puts sex workers and clients at risk of HIV infection. Unprotected commercial sex usually occurs because one (or both) of the participants do not care to protect their sexual health, do not know how to do so, or lack of means to do so (e.g. condoms, lubricant, safe-sex skills). Sex workers also often lack the personal power to negotiate safe sexual practices, and may be working under the threat or fear of violence.

- Gender-related differences and inequalities: As male dominance in sexual matters is emphasized by cultural norms and traditions, women are often not in a position to decide the conditions under which the sex act takes place. In addition, the possibility of being subjected to violence becomes a potential or real threat. Same is true for transgender and male sex workers as they have little or no acceptance in the society.

- Sexual exploitation and risk of violence: Violence, including sexual violence, against sex workers by clients, pimps and police has been reported in all settings. Sex workers may find, for example, that trying to negotiate safer sexual practices and/or insistence on condom use may result in violence. Violent sex often causes sensitive mucous membranes in the genitals to tear, further increasing the possibility of HIV transmission.

- Exposure to risks associated with lifestyle (e.g. violence, substance use, mobility): When sex work takes place in the environment influenced by drug use and alcohol, the possibility of condom use or its correct use is significantly reduced. Sexual transmission of HIV between a non-injecting partner and an injecting drug user is another mode of transmission. In some regions, men and women engage in sex work to earn money to buy drugs.

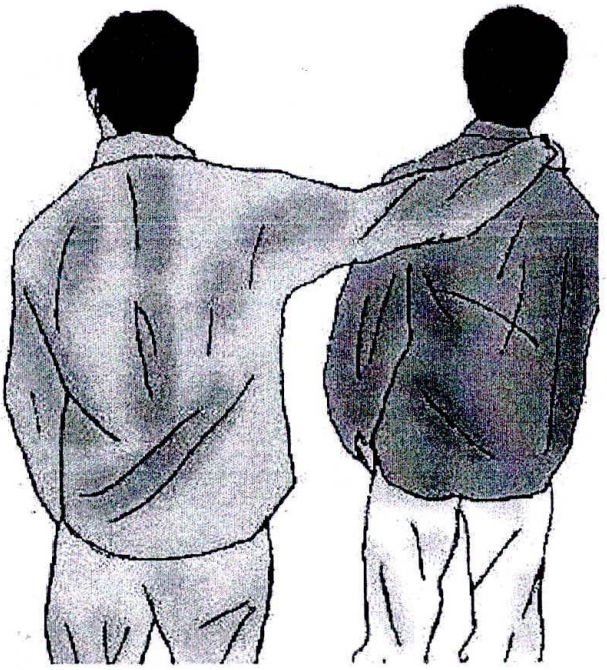
5.3 MEN WHO HAVE SEX WITH MEN OR MSM: HIV RISK AND VULNERABILITY

Sex between men can occur in different circumstances, which is also a matter of one's liking and choice. It may involve men who identify as homosexual, heterosexual, bisexual or transgender. In our country many of the men who have sex with men are often married. Social situations such as lack of availability of female sexual partners or social taboos preventing socialization between members of the opposite sex may play a role in such same sex sexual behaviour. Sex between adolescent males can also be a part of sexual experimentation.

In terms of HIV transmission, sex between men is significant because it involves anal sex. Unprotected anal sex carries very high risk of HIV transmission. As many of the men who have sex with men may also have sex with women, if infected they can transmit HIV to their female partners or wives.

It is recognized that because of denial, invisibility, stigmatization and illegality (often under both religious and civil laws and codes), men who have sex with men already face considerable risks of harassment, violence, and imprisonment. The risk of HIV & AIDS leads to further victimization.

The males who are penetrated (Kothis) are the most vulnerable in terms of male-to-male sex. Multiple penetrations in a day, multiple partners, extremely low condom usage by their penetrating partners, low levels of knowledge, extremely low access to STI treatment services, high levels of anal bleeding, and no lubricant use leads to high risk of HIV. In addition most of them are married and have children. Some of these men from low-income groups become sex workers as a source of generating an income.



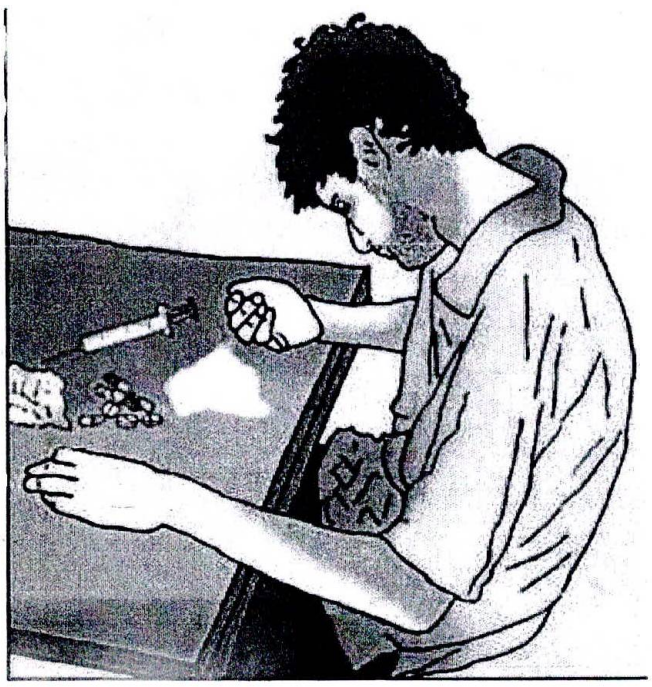
The men who generally penetrate (Panthis) are men of all ages, married and unmarried, from different socio economic groups and occupation. They enjoy sex with other men either because they like it; could not access female partner; and could not control their "body heat" and "need to discharge". Most of the Panthis are either married or will eventually get married. However most of them seldom inform their wives about their extra-marital behaviour with other males or transgender.

What this clearly shows that many of the men who have sex with men are more often than not also have female sexual partners. This places such men's wives or female partners at risk of HIV even if they themselves have no high risk behaviours or have been 'faithful' to their male partners/husbands.

5.4 INJECTING DRUG USERS: HIV RISK AND VULNERABILITY

In context of HIV & AIDS, the terms "drug user" and "injecting drug user" are very commonly used. These terms only refer to a person's behaviour; the fact that they use or inject drugs. More often than not, the drugs used by them are illegal drugs and against the law. The drug use is also socially unacceptable. Such nature of drug use makes the population of drug users clandestine and difficult to reach, especially in rural settings. It is also to be noted that a significant section of the drug users are youth.

People may use drugs for a wide range of reasons. Most choose to do so for recreation. People also use drugs to alleviate pain, to help them in the work they are doing or to cope with feelings of depression. A smaller number of people have drugs forced on them without their knowledge or consent, or have started under peer pressure.



Anyone who has unprotected sex, whether they use drugs or not, is at risk of getting HIV. However, people who use drugs may be at higher risk of HIV infection. This is because:

- Drug use negatively influences the decision making power of a person specially regarding condom use and usually leads to unprotected sex.
- Many forms of drug use are known to remove inhibitions, specially inhibitions about sex. This can mean that when people are taking drugs, they may be less likely to use condoms (or to use condoms properly) during sex.
- Stigma and Discrimination: As using drugs is against the social norms and law, and perceived poorly by the general population, those using drugs often face high levels of stigma and discrimination. This generally leads

to increased vulnerability to HIV. Many of the women are also forced into commercial sex work, which multiplies their vulnerability to HIV infection.

- Many drug users live in poverty, have poor access to health and welfare services and suffer ill-health and poor nutrition. All of these factors are known to increase vulnerability to HIV & AIDS. Certain drugs (for example, alcohol, cocaine and amphetamines) are known to damage the immune system, making users of these drugs potentially more susceptible to HIV infection, when exposed.

- Drug use and sex work are sometimes linked. People may sell sex in order to earn enough money to pay for their drug use. Some sex workers use drugs "occupationally", to make their work less traumatic. "Pimps" sometimes provide sex workers with drugs in order to entice them into it, or keep them in the sex work. Drugs and sex may be sold from the same locations.

- Drug injectors who share contaminated drug injection equipment (needle, syringe, cooker, cotton, water glass) are at high risk of getting HIV & AIDS, as well as other blood-borne diseases. This is because blood-to-blood contact is the most efficient means of HIV transmission from one person to another.

- Because of inequalities in power based on gender, female drug users are often more vulnerable to HIV & AIDS.

Through unprotected sex the drug users who have HIV may pass it on to their sexual partners who do not use drugs and thus make them highly vulnerable.

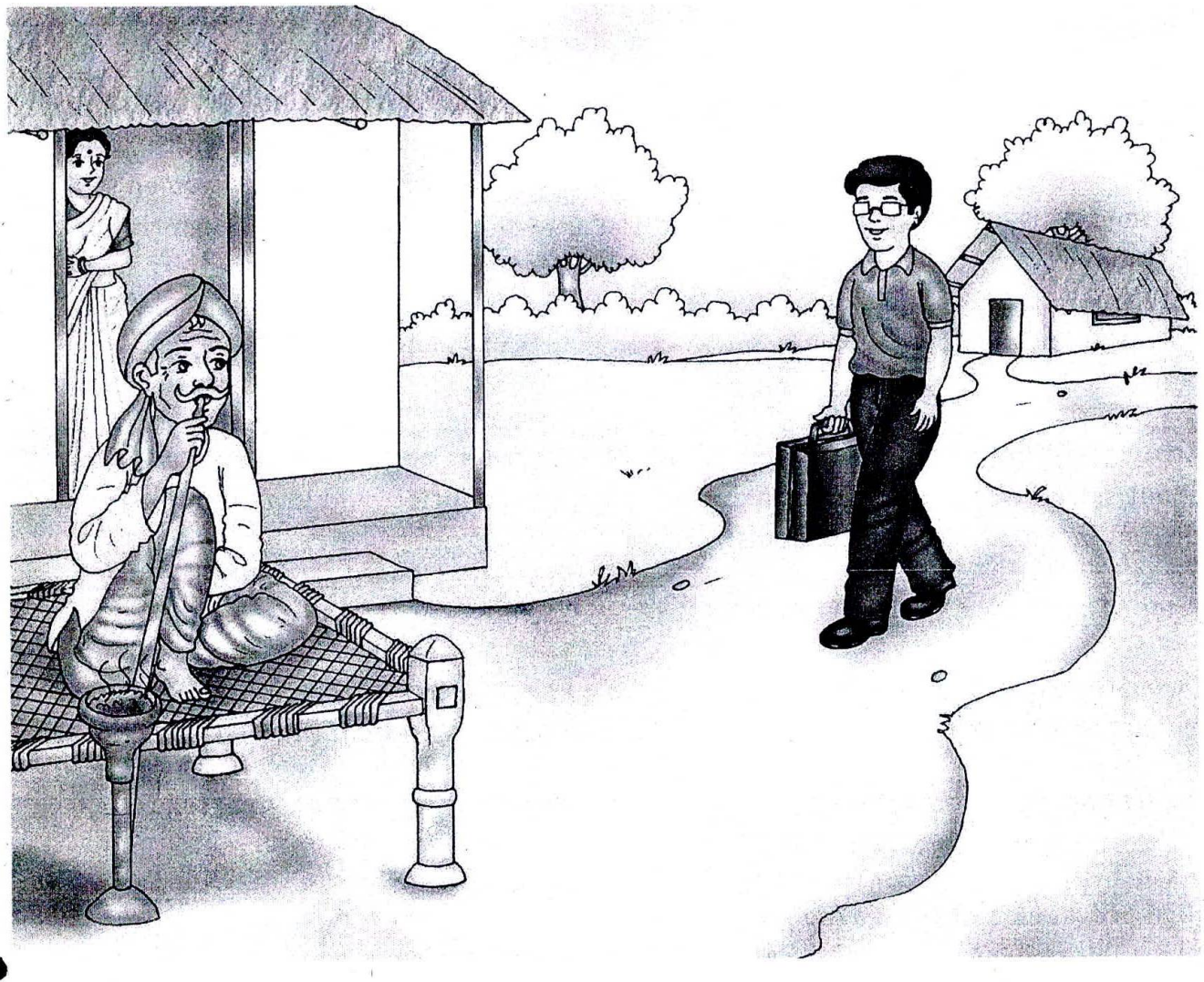
Link Workers can identify the drug de-addiction and rehabilitation centre as well as targeted intervention programme for injecting drug users. The drug users can be referred to such programmes and centres for drug de-addiction, rehabilitation and harm reduction.

In many of the hospitals the Psychiatry departments also provide drug de-addiction and rehabilitation services.

5.5 MIGRANTS AND MOBILE POPULATIONS: HIV RISK AND VULNERABILITY

The term migrant refers to people who choose to move to other parts of the country or state for work or to establish a new residence, which may be temporary or permanent. Many of them are mobile people who do not establish fixed points of residence for significant periods of time.

In India, rural to urban migration of men is the most common form of migration. Movement from rural to urban areas is driven by poverty, low agricultural productivity, population growth, and lack of economic opportunities in rural areas.



Most migrant workers are men in prime reproductive age groups i.e 15-29. They travel to their work setting, mostly in urban areas without their regular sexual partners.

Key factors that place migrant men at Risk for STIs and HIV:

- Living at major work sites, far from homes and families;
- Living and working in dangerous and stressful conditions;
- Feelings of isolation and loneliness that may foster sexual partnerships with sex workers or multiple sexual partnerships with both women and men;
- Complacent beliefs and attitudes about sexual risk and prevention and the unlikelihood of using condoms;
- Prior STIs;
- Consumption of high quantities of alcohol and/or drugs;
- Lack of access to basic health services,specially treatment of STIs;
- High prevalence of HIV in the community.

Some migrant workers leave and return to their place of origin one or more times to rest and visit their families between trips or during festivals and holidays. During their stay away from home many of the migrant workers engage in high risk behaviours and may contract STI and HIV infection. They can transmit the infection to their regular sexual partners back at home in the villages.

Young women are particularly vulnerable to STI/HIV infection. Faced with extreme economic hardship, women migrants are at particularly high risk of HIV infection.

Key factors that place women migrants at risk of STIs and HIV:

- Economic need, lack of employment opportunities, and low-wage jobs;
- Disproportionate rates of illiteracy and poverty;
- Poor access to STI/HIV & AIDS education and information;
- Women practicing survival sex to support themselves and their families;
- Sexual exploitation, rape, and physical violence;

- Inability to negotiate condom use;
- Increased restrictions in labour importing countries, leading to Illegal status, leading to police harassment, raids, and detention;
- High prevalence of HIV in the community.

Female partners of male migrant workers may know their partners are not monogamous while away from home. Wives of migrant men are also at high risk because of their limited negotiating power for safer sex. Wives are usually rendered powerless to demand safer sex because sex is viewed as a spousal responsibility or they are economically dependent on their husbands. Other factors that prevent women from insisting on condom use are social expectations and fear of disrupting family life.

The Link Worker can identify and contact the migrant and mobile people in their villages to inform and educate them about HIV & AIDS. The Link Worker can also refer them to STI management, ICTC and other relevant health services.

The Link Worker can develop rapport with the families of the migrant people in the villages and provide them information about the vulnerabilities of migrant people to HIV infection and STIs.

The Link Worker can educate the partners of the migrant people to protect themselves from HIV infection and STIs and can also provide them condoms.

5.6 TRUCKERS: HIV RISK AND VULNERABILITY

The term 'trucker' refers to both drivers and their helpers, called cleaners in India. They are men who travel along the truck routes of the country.

Truckers spend long hours driving across dangerous and often remote highways. They face monotony, exhaustion, and loneliness. Driving along truck routes and spending time waiting at truck depots removes men from the social and cultural norms they live with while at home with their families. The all-male environment attracts and also reinforces risk-taking.

Some truckers believe that after driving for many hours their bodies accumulate heat that only alcohol and sex can release.

Many of the commercial sex workers move along the highways and get their clients on the road and/or at stopovers, e.g., Dhaba etc. With little or no access to condoms and lack of much privacy often leads to unprotected sex. In addition, the competition among sex workers for clients not only drives prices down, it also adds to their lack of power. For example, it is difficult at times for a sex worker to insist that the client uses a condom when other sex workers are offering unprotected sex.

Some truckers also have sexual encounters with other males e.g. with their helpers. Many a time the truckers who have sex with other men do not identify themselves as homosexual.

Lack of gender equity is an important element in the spread of HIV among truckers and their partners. Sex workers, casual and regular partners, and wives often have less information about reproductive health, including HIV prevention, and less access to information and services. Low level of education also limits their exposure to the channels of information.

In addition, female sex workers often have less power to control their interactions with truckers and other men. Even when they know about safe sexual practices, that this is important,

and have the skills necessary to practice safe sex, they do not have the power to successfully negotiate health enhancing behaviour. Or they cannot afford to insist on condom use, either because they will lose clients and income or because they fear being physically harmed.

Wives of the truckers, in many cases do not know about their husbands' sexual activities while they are away from home. Using condoms with their wives would imply that the truckers are being sexually active during their journeys, so many do not use them. Because of rare use of condoms the truckers place their wives, sexual partners at risk of HIV infection and other STIs.

For these women (and for some of the men), the risk of getting HIV is one among many hardships of their lives. Some women feel that protecting themselves from HIV is less of a priority than other risks they face, partially due to fatalism and partially due to the need to provide for themselves and their families, often including children.

Furthermore, most sex workers have several "regular" partners or repeat customers. It is more difficult for women to ask these men, with whom they have long-standing relationships, to use condoms.

In some cases, women want or are pressured to have children and therefore resist using condoms with their husbands.

Link Workers can identify the families that have one or more members that are working as trucker. The actions to be taken by the Link Worker in such cases are same as for migrant and mobile people.

PART -6

Working with the Community

6.1 CREATING AN ENABLING ENVIRONMENT

Effective prevention, care and support for HIV&AIDS is possible in an environment in which human rights are respected and where those infected with or affected by HIV live a life of dignity, without stigma and discrimination. This requires reducing stigma and discrimination associated with the infected and affected persons and improving their access to various services (for prevention, treatment, care, insurance and legal services).

Greater involvement of people living with HIV & AIDS (GIPA)

People living with HIV & AIDS are important partners in the fight against the epidemic. They can be strong advocates for prevention as well as care, support and treatment programmes. PLWHA have now organized themselves into networks/formal and informal organizations/ groups at the national and state level and in some cases district and sub-district levels. Some organized groups of PLWHAs are now engaged in treatment education, positive living counselling, psychosocial support and positive prevention programmes. Their involvement can reduce stigma and discrimination in the society and contribute towards creating an enabling environment.

Reducing stigma and discrimination

Stigma and Discrimination (S&D) faced by people living with HIV & AIDS and marginalised populations such as sex workers, MSM and IDUs is one of the most serious obstacles to an effective response to HIV & AIDS. Stigma & discrimination often emanates from service providers - medical, non-medical, government and private sectors. It is also manifest in a variety of ways at work places and at community and family levels.

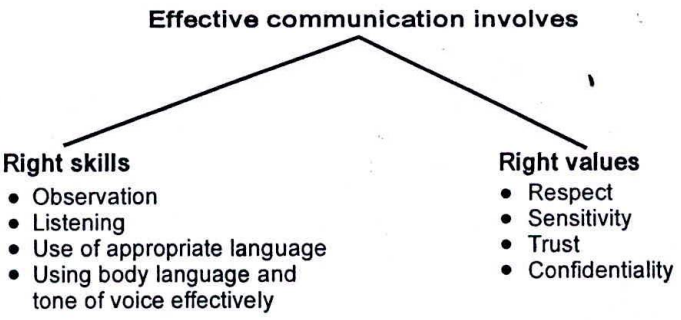
Addressing stigma and discrimination at all levels requires that awareness is created on various aspects of HIV & AIDS, service providers and counsellors are sensitized, media is sensitized to deal with issues related to sexuality, condom use and unsafe sexual practices and advocacy takes place on the rights based approaches with various constituencies (for example, members of Parliament and members of legislatures, Panchayat leaders, women's group leaders, youth leaders and faith-based organisations).

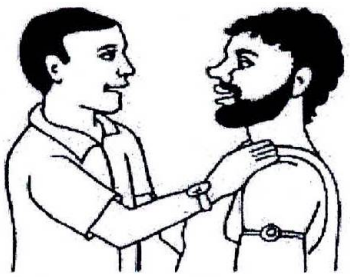
6.2 INTERPERSONAL COMMUNICATION

Interpersonal communication can be one to one or one to group and is the most common communication channel that will be used by Link Workers.

Some important aspects to remember are:

- Communication is a two way process- both have to talk, both have to listen (in one to one or one to group)
- Listen attentively, maintain eye contact
- Be attentive to a person's verbal as well as non verbal communication.
- Use a positive body language that shows that you are interested in what the others are saying. Use gestures, facial expressions and voice modulation that expresses interest and concern.
- Encourage people to ask questions or clarify doubts.
- Use simple, non technical language while providing information.
- Ensure confidentiality-do not share with others the personal information that has been shared with you.
- Do not judge other person's behaviour.
- Use sensitive language (for example do not refer to HIV positive person or affected persons as 'victims'. Avoid using language that is stigmatizing. Do not use terms like AIDS patients, AIDS victims, AIDS sufferers, AIDS orphans etc. The more sensitive language is to refer them as 'people living with HIV & AIDS', 'positive people'.
- Avoid non-verbal communication that portrays disgust or disrespect (facial expression, hand expression when touching a client's utensils or clothings etc.) for a positive person.





6.3 BEHAVIOUR CHANGE COMMUNICATION

Behaviour Change Communication (BCC) is a process of understanding people's situations, developing relevant messages, and using communication processes to persuade people to change their attitudes and behaviours and practices that place them at risk.

The target audiences in BCC includes the primary audiences whose behaviour needs to be promoted or changed or developed, the society and communities which influence individual behaviours and health service providers to promote positive practices.

BCC recognizes individuals as active rather than passive receivers of information and messages, who act on messages if they see a benefit for themselves.

Sustained behaviour change is effective only when combined with changes in the broader environment. The broader environment can be changed by mass awareness programmes, group meetings and discussions about the situations (e.g.gender inequality, stigma and discrimination etc.) and mobilising community actions to promote safe behavioural practices. Promoting gender equality and empowerment of women through education and other means are other methods to bring about positive changes in the broader environment.

Behaviour change communication can bring about following changes:

- Increased knowledge : BCC can ensure that people are aware of the basic facts about HIV&AIDS in a language or visual medium that they can understand and relate to.

- Stimulate community dialogue: BCC can encourage community discussions on HIV & AIDS such as risk behaviours and risk settings, environments and cultural practices related to sex and sexuality that create the conditions

for HIV transmission. It can also stimulate discussion of healthcare-seeking behaviours for prevention, care and support.

- Promote essential attitude change: BCC can lead to appropriate attitudinal changes about, for example, perceived personal risk of HIV infection, non-judgmental provision of services and greater open-mindedness concerning gender roles.

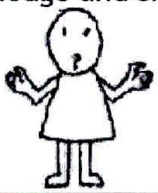
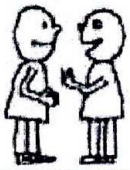
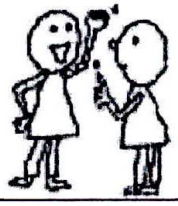
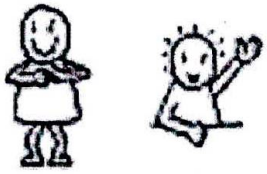
- Reduce stigma and discrimination. Communication about HIV prevention and AIDS and attitude towards marginalised communities and people living with HIV & AIDS can address stigma and discrimination.

- Create a demand for information and services: BCC can encourage individuals and communities to demand information on HIV & AIDS and appropriate services. BCC can also promote the utilisation of the services like STI Management, voluntary counselling and testing (VCT), PPTCT; clinical care for opportunistic infections; and social and economic support.

- Improve skills and sense of self-efficacy. BCC programmes can focus on teaching or reinforcing new skills and behaviours, such as condom use and negotiating safer sex. It can contribute to development of a sense of confidence in making and acting on decisions.

The ultimate goal of behaviour change communication among high risk groups and highly vulnerable populations (young people, and women) will be to:

- ***Increase condom use***
- ***Reduce number of partners***
- ***Increase appropriate health care-seeking behaviour (like STI treatment, VCT etc) resulting in increased utilisation of available services***
- ***Reduce stigma and discrimination***

Stage	Effective communication bring about change in behaviours
Unaware to Aware 	**Tell the groups** about STIs, including HIV and the risk to health - their own and their partner's. **Help them understand** the need to know whether they have an STI or HIV.
Awareness to Concern 	**Point out** those unsafe sexual practices can cause STIs/HIV in anybody. **Emphasize** the need to seek counselling and testing for HIV if there is exposure to HIV or high risk behaviour **Reassure** the groups that most STIs can be cured with complete and proper treatment and this also reduces the risk of HIV. **Inform** them that safer sexual practices can help prevent STIs and HIV.
Concern to acquiring knowledge and skills 	**Give** them **information** on HIV & AIDS and its modes of transmission. **Encourage** them to ask questions so that you can **clarify doubts**. Outline different ways in which they can safeguard themselves. **Demonstrate** the use of condoms as a preventive measure. **Give information** on where to buy condoms.
Acquiring knowledge and skills to motivation 	**Convince** them that early and complete treatment can cure most STIs totally. **Listen** to any doubts/problems that they may have about treatment. **Give information** about or **refer** them to health facilities that are easily accessible to them. **Reiterate** that STIs and HIV can be prevented by adopting safer sexual practices.
Motivation to Trial 	**Encourage** them to seek health services, **remind** them to visit the health facility again if required or if advised by the doctor. **Reiterate** the need to continue treatment or practise a safe behaviour **Encourage** them to use a condom every single time, with every partner. **Clarify doubts** and help resolve problems related to condom use.
Trial to Success 	**Appreciate** their efforts towards caring for their own as well as their partner's health -- using a condom, going to a doctor, completing the treatment. **Encourage** them to continue health-seeking practices

6.4 STIGMA AND DISCRIMINATION

Stigma refers to unfavourable attitudes and beliefs towards people perceived to have HIV & AIDS and the individuals or communities with which they are associated. Because of its association with behaviours that are considered socially unacceptable, HIV infection is widely stigmatized.

Discrimination refers to unjust or unfair treatment of certain people because of their confirmed or suspected HIV positive status.

Stigma is a barrier to HIV prevention and care programmes. They deter individuals from finding out about their HIV status. It inhibits those who know they are infected, from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves.

Family members and community often shun a person living with HIV because of the feeling that the person indulged in what they consider an inappropriate behaviour.

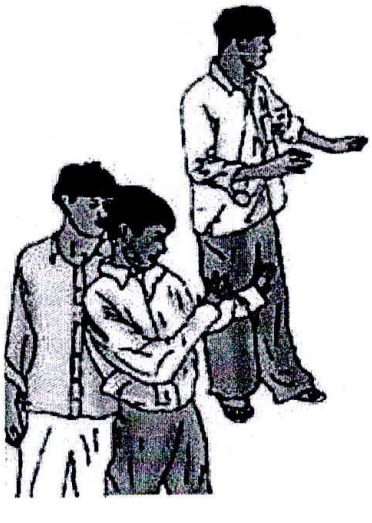
Often people have misconceptions about how HIV is transmitted, and this increases the discrimination as people are afraid of contracting the infection.

Stigma and discrimination from key people such as health care workers and family members can lead to limited access to basic care, support and treatment for HIV positive people. Due to stigma, hospitals sometimes refuse admission or care to those having HIV or AIDS.

Addressing stigma and discrimination

The cases of Stigma and Discrimination can be reported to DAPCU as well as the Link Worker can log onto **website of NACO by typing the address http://www.nacoonline.org/stigma.htm** and report such cases.

Stigma can be decreased when knowledge increased in the community at large, by promoting discussion about HIV & AIDS. This can be done through

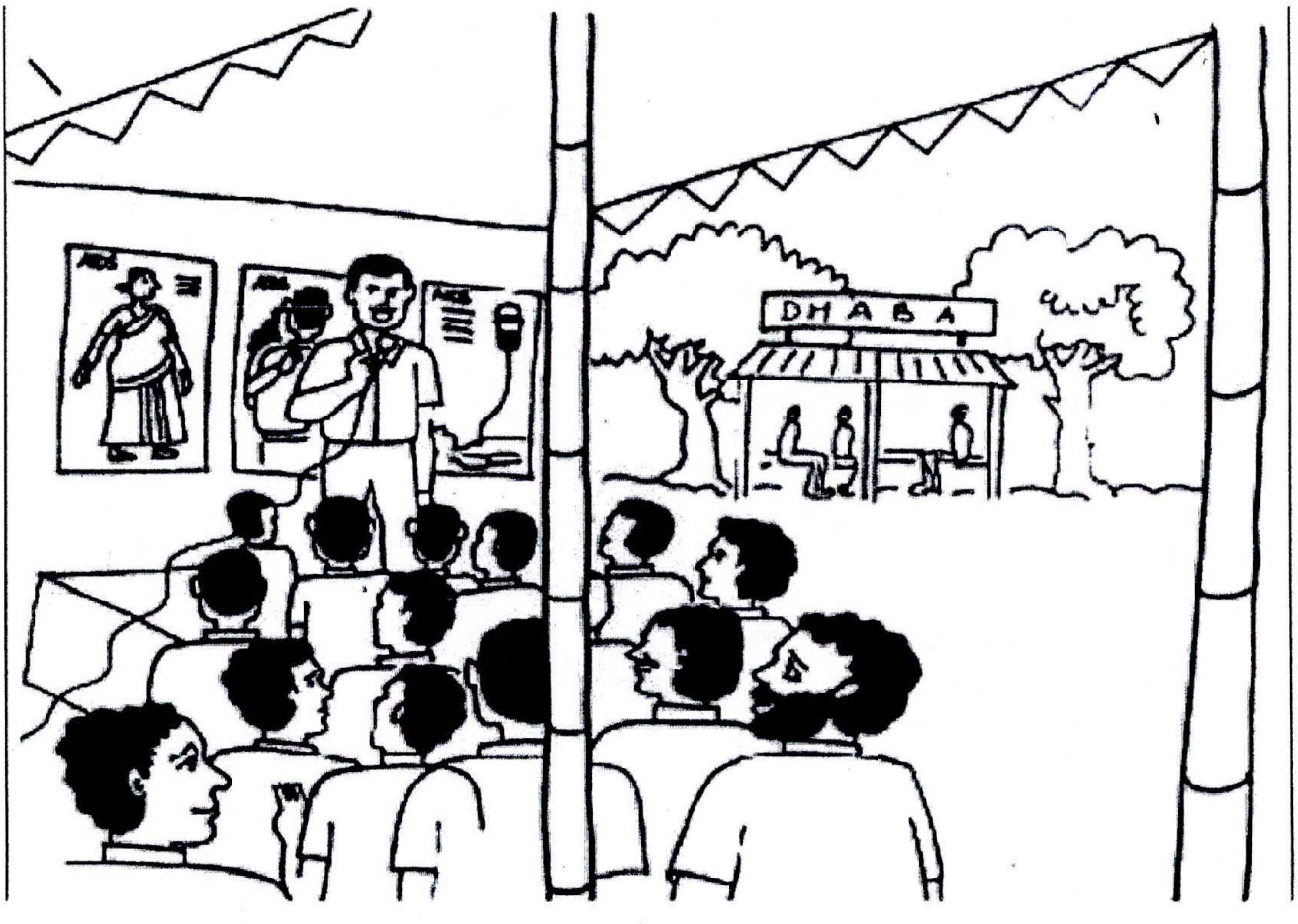


involvement of people living with HIV & AIDS, through awareness programmes, and media.

Information alone is insufficient to tackle stigma and deep seated fears about HIV. Greater contact with people living with HIV & AIDS can help to dispel these fears.

Local leaders like the PRI members , religious leaders and key community persons can play an important role in fighting stigma by imparting prevention messages, by acting as role models and treating people living with HIV & AIDS with compassion and understanding.

Moreover the availability of treatment makes this task easier, where there is hope of a better quality of life, people are less afraid of AIDS, they are more willing to be tested for HIV, to disclose their status, and to seek necessary care if, necessary.



My Action Plan to address Stigma and Discrimination

(To be prepared by the Link Worker in consultation with the supervisor, volunteers and key member of the community)

My Action Plan to address Stigma and Discrimination

6.5 HIV & AIDS AND HUMAN RIGHTS

Lack of recognition of human rights causes unnecessary personal suffering and loss of dignity for people living with HIV or AIDS. It also contributes directly to the spread of the epidemic since it hinders an effective response. For example, when human rights are not respected, people are less likely to seek counselling, testing, treatment and support because it means facing discrimination, lack of confidentiality or other negative consequences. The spread of HIV & AIDS is disproportionately high among groups that already suffer from a lack of human rights protection (example, sex workers), and from social and economic discrimination (example, migrants), or that are marginalized by their social and legal status (example, men having sex with men and transgender).

Recognizing and protecting human rights can help to:

- Empower individuals and communities to respond to HIV & AIDS.
- Reduce vulnerability to HIV infection.
- Lessen the impact of HIV & AIDS on those infected and affected.

To protect rights at the workplace:

Management must make sure that:

- There is no discrimination with a person who is HIV positive.
- They have a written workplace policy to protect the HIV infected person to give them a sense of security.
- They ensure confidentiality of information.
- No HIV testing of the candidates is done before employing them.
- HIV testing should not be a part of the annual medical check-up.

Right to treatment

The Medical Council of India says:

- No doctor can refuse to treat a patient without any reason.
- He cannot refuse to treat a patient because he is afraid of getting the disease himself. He has no reason to be afraid of getting the infection if he is following the universal precautions.

- These rules apply to everyone working in a hospital.

Right to confidentiality and privacy

- People with HIV infection and AIDS have the right to confidentiality and privacy about their health and HIV status.
- Health care professionals are ethically and legally required to keep all information about clients or patients confidential.
- Information about a person's HIV status may not be disclosed to anybody without that person's fully informed consent.
- After death, the HIV status of the deceased person may not be disclosed to anybody without the consent of his or her family or partner - except when required by law.

PART -7

Working with the Volunteers

7.1 ABOUT THE VOLUNTEERS

Under the Link Worker Scheme, the Link Worker would be the key personnel in the scheme. The main responsibilities of reaching out to key populations and highly vulnerable populations will lie with the Link Worker. The volunteers will support the field level activities of the Link Worker at village level.

1. Identification of volunteers

- One female and male volunteer each to serve 750-1000 population.
- Young women/men will be selected as volunteer.
- Should be Madhyamik higher secondary school examination appeared or equivalent. The selection would be based on their interest to understand and address the HIV & AIDS issue, specially stigma and discrimination against positive people and key populations. Their willingness to participate in the programme without any remuneration would be crucial.
- Should be a resident of the same village for which s/he will be selected.
- Preference to be given to SHG members/members of youth clubs, peers educators of NGOs, volunteers of NYKs, members of positive networks, CBOs.
- Volunteers should represent the caste and other key marginalised groups/ HRGs present in the village.
- Willingness to offer their time for working within the community as well as good rapport with the peer group and other community members.
- Prepared to address the sensitive issues of condoms and sexuality and to work with key populations and vulnerable population.

2. Selection process of volunteer

Link Worker in consultation with the Gram Panchayat and local NGO wherever available will select the volunteers from their respective areas of operation. Although volunteers won't be paid any remuneration, some sort of recognition would have to be given to them, such as a badge identifying them as volunteers and a bag for carrying papers/aids etc. This is in addition to a citation/ certificate to be given by DAPCU and District Health Committees.

Though the scheme speaks of one female and male volunteer for every 1000 population each Link Worker can look at 2 additional volunteers to take care of the drop outs.

Role of volunteers

- Act as information post for services, linkages and referrals
- Coordinate the day to day functioning of RRC
- Can be a condom depot holder
- Establish rapport with local groups in order to gather more information about the possible key populations / individuals with high risk behaviours

7.2 TRAINING PROGRAMME FOR VOLUNTEERS

*The Link Workers will orient the **volunteers** over a period of 5 days, as part of training. The section of the handbook provides brief guidelines on how to approach **'on the job' training for the volunteers** which is envisaged as a 10 hour package to be delivered over 5 days in the first month after recruitment.*

Issues/ Themes to be covered	Time allocated	Materials to be used
First day Introduction and Overview	120 minutes	
Second day What are STIs and how are they transmitted?	30 minutes	Pictures and text in the Handbook
HIV & AIDS-Understanding the terms	45 minutes	Pictures and text in the Handbook
Modes of HIV transmission	45 minutes	Pictures and text in the Handbook Transmission game from the tool kit
Third day High Risk behaviours and reducing risk	60 minutes	Text in the handbook
Women and HIV & AIDS	60 minutes	Text in the handbook
Fourth day Skills for Condom demonstration	60 minutes	Pictures and text from the handbook. Use penis model for demonstration of male condoms
Promoting condom use	60 minutes	
Fifth day Links to health care services	60 minutes	Text from the handbook, Share pamphlets from SACS, DAPCU,
Pyramid game from the Tool kit (for VCTC) Role of volunteers	60 minutes	Described above
Total	**10 hours**	

Notes for the Link Workers :

- Use locally recognized terms and words to ensure that volunteers understand the information
- Assess the level of knowledge of the volunteers before the training (You can do this by asking some basic questions about HIV, condoms, STIs)
- Training should be participatory and interactive. Use the tool kit to convey the key messages
- Update the information available with the volunteers so that they can share any new information with the community (for example any new health facility or health service that has recently become available)
- Identify any new needs that emerge from the volunteers in terms of the information (or skills) that they should have
- Plan the interactions and meetings that will be a regular feature
- Explain to them about your activities and the support that you will need from them

Day One of the Training

The aim for the first interaction is to familiarize you and the volunteers with each other and at the same time provide a brief overview of the Link Worker Scheme and its objectives.

Introduction and Overview

1. Welcome the volunteers and tell them that, "We are all going to work as a team in the future. We have a common goal to achieve and that is to reach out to as many people with high risk behaviours as can be identified in the community and to link all those who need services, specially High risk groups, women and young people, with appropriate health facilities. This brief training will help you to develop required understanding of the issues and help them to carry out your roles and responsibilities more effectively".
2. Introduce yourself briefly and then ask the volunteers to introduce themselves to the group. They can talk about the villages that they come from and about previous experience (if any) of working on health issues. You can also ask them what motivates them to be a volunteer in this scheme.
3. Spend the first half hour to brief them on the Link Worker Scheme and its objectives.
4. Explain clearly what you mean by 'high risk groups' and the 'bridge population' and what are the factors that enhance their risk to HIV. If you

have information about certain high risk behaviours that are more common in the villages that you are going to cover, share it with the volunteers. Emphasize on the need to maintain confidentiality right from the beginning of the training.

5. Explain that there are others in the community who are vulnerable as well and these include women and young people. Discuss the most common reasons for it.

6. Tell them briefly about the status of the epidemic in the state and district.

7. Ask them if they have any questions. Decide the time and venue for the next day's meeting.

Day two of the training

The aim for the second interaction is to provide basic information about sexually transmitted infections, HIV & AIDS, and the modes of HIV transmission.

1. Ask the volunteers if they have heard about sexually transmitted infections or STIs. Do they know the local names for it or the terms that people use to describe STIs in the local community?

2. Explain what STIs are and how they are transmitted. Emphasize on following three key points:

- Many STIs are curable when treated adequately.
- STIs increase risk of HIV transmission.
- STIs can affect the anal region as well (in case of unprotected anal sex)

3. Explain the common symptoms of STIs in men and women. Tell them that if someone from the community has these symptoms or asks for more information; guide them to the nearest PHC as the services for STIs management are available at primary health centres and all facilities up to district level.

4. Explain about HIV (that it is a virus) and AIDS (a disease condition). Use pictures in the handbook to explain how HIV affects the immune system and leads to AIDS.

5. Use pictures from the handbook to explain how HIV is transmitted. Use the 'transmission game' from the tool kit to allow volunteers to revise what they have learnt.

6. Take time to discuss the misconceptions and myths that prevail locally regarding the transmission of HIV. Discuss how these myths should be addressed by them in the community.

Day three of the training

The aim for this interaction is to discuss high risk behaviours and also the factors that make women more vulnerable to HIV.

1. Share the following list of behaviours with the volunteers. Discuss with them the risks involved in each one of them and why some of them are high risk behaviours while others have a low risk for transmitting HIV.
   - Abstinence
   - Masturbation
   - Sex with a monogamous uninfected partner
   - Sexual stimulation of another person's genitals using hands
   - Oral sex on a woman with a barrier
   - Oral sex on a man with a condom
   - Vaginal sex with a condom
   - Vaginal sex with multiple partners; condom use every time
   - Anal sex with a condom
   - Oral sex on a man without a condom
   - Oral sex on a woman without a barrier
   - Vaginal sex using spermicides or diaphragm and no condoms
   - Withdrawal
   - Vaginal sex without a condom
   - Anal sex without a condom
   - Vaginal sex using hormonal contraceptives or IUD and no condom
   - Sharing needles, syringes, drugs, or other equipments
2. Share the following case studies and ask the volunteers to discuss the conditions or factors that make women more vulnerable to HIV/STIs.

Case study one

My name is Jayanthi. We are eight children in all. My mother and my uncle fought over property when I was eight years old. My uncle got us into debt and then left us. My family had problems. I wanted to study but no one encouraged me. My education was stopped as soon as I passed Class Five. At 15, I was married off to a man who turned out to be an alcoholic. A woman in the neighbourhood, noticing our poverty, told me I could earn money by participating in sex work. She told me she made a living selling sex. I listened to what she said, but was reluctant to do it for fear of the reactions I might get from my husband and the elders in my family. A year later my husband passed away. I went to this woman and she introduced me into sex work. I was very careful that no one should come to know about it. Gradually our family finances improved through my work. Whilst I was a sex worker I delivered a boy and I got him educated through my earnings. Now I want to give up commercial sex work. I want to stop because of the fear of HIV & AIDS. In the past not very much was known about HIV, but now I hear of many people getting AIDS. I want to give up the sex business for fear of leaving my son an orphan. But I cannot see any other option for me till the time my son starts to support both of us.

Points for discussion:

1. Identify the High Risk behaviours of the main characters in the case study?
2. What are the factors (vulnerabilities) that have made her choose sex work as a livelihood option?
3. What are the likely factors that make her vulnerable now that she is into sex work?

Case study two

My name is Lalitha. I lost my father at the age of nine. I have two sisters and a brother. My mother couldn't maintain the entire family so gave me to her brother. I was the only one who was given away like that. When I was 14 my uncle married me off to a middle aged man who used to work in a factory in Calcutta. He said that he earned well and will be able to give me a better life. I was too young to understand the implications of such a marriage. My husband promised to take me to Calcutta when he had saved enough money to rent a room for us. I only saw him occasionally; he used to return home on every Durga Puja with a lot of gifts for everyone.

Five years ago my husband tested HIV positive and he died two years ago. Till then I had never heard about HIV. I was also advised to take a test. My test came back 'Positive'; I had been infected through my husband. Thankfully my two children have tested negative.

When my husband's infection came to light, other problems poured on to us; we were treated as outcast. There was no money even to continue the children's education. When I was grief stricken and trying to cope with the situation due to my husband's much stigmatized illness, it was an organization which came to my support. They counselled me, supported me to work with them and encouraged me to counsel others who are affected by HIV. They have even put my children into their school where many other children who have lost their parents are studying.

Points for discussion:

1. Identify the high risk behaviours of the main character/s (Lalitha, and her husband) in this case study.
2. What are the factors that made Lalitha vulnerable to HIV?

Resource sheet 1

1. Identify the High Risk behaviours of the main characters in the case study?

- Unprotected sex (may be vaginal or even anal sex)
- Having mulitpartner sex

2. What are the factors (vulnerabilities) that have made her choose sex work as a livelihood option?

- Poverty and limited economic opportunities
- Lack of employment opportunities
- No support from family
- Limited /no access to information
- Gender inequalities (not having the same status as the male members in the family/community)
- Gender Inequities (not having equal ownership of resources as men in the family/community)

3. What are the likely factors that make her vulnerable now that she is into sex work?

- Limited information
- Inability to or limited skills to negotiate with clients (for safe sex)
- No access to means of prevention (like female condoms or male condoms)
- Fear of losing out on daily income (compulsion to earn so as to let her son complete his education)
- Fear of being stigmatized if the community finds out (may also reflect on her son)
- Sexual exploitation by people in authority (like local policeman, etc.)

Resource sheet 2

1. Identify the high risk behaviours of the main character/s (Lalitha, and her husband) in this case study.

Lalitha:

- Unprotected sex with her husband (who has high risk behaviours, and is probably HIV positive for some time before he is tested and status confirmed)

Lalitha's husband:

- Unprotected sex with multiple partners /sex workers

2. What are the factors that made Lalitha vulnerable to HIV?

- Gender inequality
- Traditional norms (like early marriage)
- Circular migration of her husband/ partner
- Unaware about their partner's sexual behaviours/unaware of risks to their own sexual health
- No negotiating power(huge spousal age gap) or limited negotiating power for safer sex
- Sex viewed as a spousal responsibility (hence cannot refuse sex)
- Economically dependent on husband
- Limited economic resources (that made her husband migrate)
- Suggestion of condoms seen as a sign of 'mistrust', 'admission of guilt'

3. Summarize the day's discussions by referring to the text used in the handbook (Women and HIV /AIDS and High Risk Behaviours)

Day four of the training

The aim for this day's interaction is to provide the skills for condom demonstration to the volunteers and also discuss ways in which volunteers can promote condoms.

1. Ask the volunteers if they know about the commonly available brands of condoms in the local area. What do they cost? Are there places from where free condoms can be procured? Are they aware of any programmes or agencies which are involved in social marketing of condoms locally?

2. Share the information that you may have about condom availability in the local area.

3. Explain to the participants that demonstrating correct condom use is as important as guiding people to the source of condoms. Most often failure of condoms is due to faulty technique (of using it) rather than the quality of the product.

4. Use the penis model from the tool kit and demonstrate how to use the condom. Explain all the precautions that need to be taken while buying and using a condom.

5. Let all the volunteers practice the demonstration of various steps in using a condom. Make sure that they are confident about doing it independently and are not embarrassed.

6. Discuss how and where volunteers can access condoms or maintain condom store so that they can make it available to those who need it. Help them to establish linkages with the local condom social marketing programme. In case they procure free condoms from the government health facility for distribution; explain the conditions in which the condoms should be stored.

Day five of the training

The aim of this day's interaction is to discuss about the health services available in the vicinity and to discuss the role of volunteers and make plan for the future.

1. Share the maps that you have prepared of the local area and the health facilities that have been mapped by you during the training.

2. Point out the various health facilities located close to the village. These may include government and private health facilities.

3. Discuss the services that are available at these health facilities and those that are not available locally. Explain to them about the

services that are available at the district and sub district level. (These services should include STI management, testing for HIV/ICTC, PPTCT programme, ART centres, treatment for opportunistic infections, RNTCP).

4. If pamphlets are available from the SACS, distribute these to the volunteers. Otherwise discuss the location of each of these facilities and the modes of transport (including cost) available to reach them. This is important information that should be available with all volunteers. Up date them regularly about any new services that become available (either through government or NGOs).

5. Discuss the activities that you will undertake in the local area. Explain to them about the support that you will need (for example, to carry out mapping in initial phase, and to conduct community meetings with vulnerable populations like young men and women in later phase.)

6. Chalk out a plan for the next two months, clearly defining the role of each volunteer. Reassure them that you will be available for providing them support just as they should facilitate your entry into the local community.

7. The volunteers who can read should go through the entire content of the handbook. Share the handbook and the toolkit with them. Orient them on the use of the tool kit.

PART -8

Maps of Population & Services

8.1 VILLAGE - 1

8.2 VILLAGE - 2

8.3 VILLAGE - 3

8.4 VILLAGE - 4

8.5 VILLAGE - 5

8.6 AVAILABILITY OF SERVICES