Training Module

For ASHA Workers on Integration of HIV and Sexual and Reproductive Health

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Preface

Quality, non-discriminatory and inclusive health care is an essential human right for all. Sustainable Development Goal 3 (SDG 3) lays great emphasis on good health and wellbeing which needs to be achieved by 2030 across the globe. The objective of the SDG 3 is incomplete and unattainable without strong and resilient health systems that understand the holistic sexual and reproductive health needs and right of women accessing health facilities. It is important to understand and address the sexual health needs of the marginalized communities and ensure an enabling environment for access to health facilities. It is also equally important to understand the risk and vulnerability to HIV/AIDS of those women who visit health care facilities for their reproductive health needs like contraception and ante-natal care.

Access to health for the key population is particularly challenging due to the lack of awareness among health care providers on the specific issues and challenges they face. Ignorance, judgmental attitudes and insensitivity about their life situations by the health care providers often drive key populations away from health services. Similarly, women accessing the public health facilities for their contraception and other sexual and reproductive health needs are often not provided with the necessary information, counselling and services to diagnose their HIV status and provide necessary services.

India HIV/AIDS Alliance (Alliance India) in collaboration with UNFPA and Gujarat State AIDS Control Society is implementing the Sampoorna project to strengthen the capacities of public health facilities and community outreach activities in providing integrated SRH and HIV services.

The integration of HIV and Sexual and Reproductive Health (SRH) services in the healthcare system increase potential to access and increased uptake of services, better client satisfaction, improved coverage and reduced cost to women and less costly services, and improved realization of Sexual and Reproductive Health Rights (SRHR). Ultimately, integration leads to improved dual health outcomes related to SRH and HIV, such as treatment for HIV/STI infections, addressing the unmet need for unintended pregnancies and maternal mortality, cervical cancer screening and treatment and addressing gender-based violence.

This 'The Training Module for ASHA Workers' on Integration of HIV and Sexual and Reproductive Health" aim at strengthening the capacities of ASHA workers in delivering comprehensive SRH services to all women and girls in community settings. The curriculum primarily focuses on 1) Increasing knowledge of ASHAs on sexual and reproductive health needs of women living with HIV and key population groups such as female sex workers covering a range of topics like contraception, cervical cancer and pregnancy care 2) Addressing values and attitudes of ASHAs towards key populations and women living with HIV and 3) Coining practical ways ASHAs can adopt to increase access of women living with HIV and female key populations to sexual and reproductive health services and of women in general populations to HIV services. The module uses participatory methods like case stories, games and exercises, thus enabling participants to play an active role in their own learning process. We view this module as an incremental step to equip ASHA workers with the necessary information and sensitize them so that they can effectively support all women including those belonging to key populations and living with HIV. We sincerely hope that the implementation of the module will contribute to the quality provision of community-level SRH /HIV integrated services for all women and girls.

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List of abbreviations

AIDS	–	Acquired Immunodeficiency Syndrome
ASHA	–	Accredited Social Health Activist
ANM	–	Auxillary Nurse Midwife
ART	–	Anti Retroviral Therapy
HIV	–	Human Immuno Deficiency Virus
SRH	–	Sexual and Reproductive Health
SRHR	–	Sexual and Reproductive Health and Rights
FSW	-	Female Sex Worker
WLHIV	–	Women living with HIV
PLHIV	–	People Living with HIV
PPTCT	–	Prevention of Parent to Child Transmission
MSM	–	Men having Sex with Men
IDU	–	Injecting Drug User
TI	–	Targeted Intervention
ORW	–	Outreach Worker
RTI	–	Reproductive Tract Infection
STI	–	Sexually Transmitted Infection
IUD	–	Intrauterine Device
VHSNC	–	Village Health, Sanitation, and Nutrition Committee
VHSND	-	Village Health, Sanitation, and Nutrition Day
WBC	–	White Blood Cell

Introduction

I. Introduction

Module overview

ASHAs are community health volunteers and their work covers a range of sexual and reproductive health issues such as contraception, abortion, maternal and newborn health, reproductive tract infections/sexually transmitted infections including HIV/AIDS, and violence against women However, most of these services are geared towards married women in so-called traditional setups leaving out marginalized women from key population groups like female sex workers, and women living with HIV. Integration of HIV and sexual and reproductive health at the community level is an essential step to universal health coverage. Such integration will improve uptake of sexual and reproductive health services for women and girls from key populations and those living with HIV as well as HIV prevention services for the general population. This training module has been developed as an aid for orienting ASHA workers on issues related to the integration of HIV and sexual and reproductive health so that they can comprehensively deliver these services to all. The program is envisaging targeted intervention outreach workers to be a part of the training as and when relevant. Therefore, reference to outreach works can be found in different sessions.

Training frame

Objectives	• Build understanding of participants on key populations (female sex workers), and women living with HIV, and their context. • Build understanding of participants on stigma and discrimination, and their effect on access to sexual and reproductive health services and support for female sex workers and women living with HIV/AIDS. • Build understanding of participants on the need of HIV services for women and girls in the general population. • Increase participants' knowledge on contraindications and limitations related to contraception methods, RTI/STIs, abortion, pregnancy and delivery care for female sex workers and WLHIVs. • Increase understanding of ASHAs' roles in improving awareness and access to sexual and reproductive health services for female key populations and WLHIVs and HIV services for the general population.
Who can undergo the training?	ASHA workers. Can be adapted for other frontline health workers such as Anganwadi workers and outreach workers.
Duration of training	One day.
Number of sessions	Nine.
Training methodology	Participatory methodologies – collective brainstorming, interactive discussions, case study analysis, card game, participatory group work .
Batch size	20-25 participants in each batch.

Training agenda

Session	Time	Methodology
Pretest assessment	10 minutes	Questionnaire
Session 1 - Icebreaker (introduction, expectations, ground rules)	30 minutes	Participatory game
Session 2 – Basics of HIV AIDS and sexually transmitted infections	30 minutes	Quiz and interactive discussion
Session 3 - Relevance of women living with HIV and female sex workers in ASHA's work	30 minutes	Brainstorming and interactive discussion
Session 4 - Exploring values and attitudes	60 minutes	Card game, presentation and discussion
Session 5 - Integration of HIV and SRH	30 minutes	Interactive discussion
Session 6 – Sexual and reproductive health for women living with HIV	20 minutes	Interactive discussion
Session 7 - Stigma as a barrier to SRH services	60 minutes	Case study analysis and discussion
Session 8 – Working with FSWs and WLHIVs	90 minutes	Group work and discussion
Session 9 – Wrap up • Training feedback • Post test assessment	10 minutes 10 minutes	Questionnaire/ game Questionnaire

General guidelines for facilitators

- Encourage all participants to talk.
- Ensure participation of all trainees in all exercises. Involve all participants by including the quiet ones and controlling the talkative ones.
- Encourage participants to ask questions.
- During group exercises move around to help the groups. Try to identify and help non – active participants and ensure equal participation from all the participants
- Periodically ask question to check participants' understanding of training topics, reflect and summarize.
- Allow time for the participant to answer questions but give hints where appropriate. Respond encouragingly and positively to all answers but correct the errors gently.
- Ask open-ended questions to elicit different responses from different participants
- Respect participants‟ beliefs, opinions and experiences. Use examples from the participants' work environment as much as possible.
- Be neutral in your responses. Where necessary, challenge any stereotypes or judgmental attitudes and beliefs.
- Avoid writing every word and reading as this discourages participant involvement.
- Endeavour to write out the difficult new words; pronounce and explain them clearly.
- Avoid discussions that are off point or distracting. Whenever possible, postpone them.
- Do energizer exercises through the training course e.g.: at the beginning of the day to bring the group together and start on a positive note, after lunch or after a long session to recharge the group.
- Draw conclusions at the end of each session.

List of energizers

Everyone stands in a circle. The facilitator starts by miming an action. When the person on their right says their name and asks “What are you doing?” they reply that they are doing something completely different; for example, the facilitator mimes swimming and says “I am washing my hair.”

The person to the facilitator's right then has to mime what the facilitator said that they were doing (washing their hair), while saying that they are doing something completely different. Go around the circle in this way until everyone has had a turn.

The group forms a circle. One person starts by saying “I am going to the market to buy fish.” The next person says, “I am going to the market to buy fish and potatoes.” Each person repeats the list, and then adds an item. The aim is to be able to remember all of the items that all of the people before you have listed.

Participants sort themselves into pairs. Each pair decides which one of them will be the 'mirror'. This person then copies (mirrors) the actions of their partner. After some time, ask the pair to swap roles so that the other person can be the 'mirror'.

To help people to reflect on the activities of the day, make a ball out of paper and ask the group to throw the ball to each other in turn. When they have the ball, participants can say one thing they thought about the day.

II. SESSIONS

Pre-test assessment

Time: 10 minutes.

Materials: Pre-test questionnaire [Annexure 1].

Steps
To understand the level of participants' knowledge on the training topics, ask all participants to fill the pretest questionnaire.

Session 1 - Icebreaker

Time: 30 minutes.

Learning objectives:
By the end of this session, participants should be able to:

- Introduce themselves.
- Express their expectations and fears.
- Match their fears and expectations to the workshop objectives.
- Establish ground rules.

Materials:

- Flip charts. On the flipchart, draw two columns. Head them as " covered in training" and " not covered in training".
- Markers.
- Different coloured post-card sized chart papers cut into rectangles.

Steps
1. Introductions: The facilitator can use either of the 2 exercises.

A. Interview another Participant

- Ask participants to walk around and find someone in the room they do not know well.
- After everyone has a partner they should interview one another for 2 minutes each.
- In the interviews, they should gather as much information as they can about one another. The questions can be about anything: name, what they do, where they are from, their families, likes and dislikes.
- After the interviews bring the group back together and have each participant briefly describe what they learned about the person they interviewed.

B. Names and an Adjective

- Ask participants to sit in a circle and have all introduce themselves one by one. They have to do this by using an adjective that describes them. The adjective should also begin with the letter their name starts with. (For example: Hello I am mischievous Mohan).

2. Expectations, fears and ground rules

- Distribute three different coloured cards to each participant.
- Ask each participant to write on the first card, topics that they expect to learn during this training, on the second card one fear and on the third card one ground rule. Allot ten minutes to complete the task.
- Collect and read aloud the topic cards one by one. If the topic will be covered in the training, paste the card on the Flipchart under —Topics Covered. If not, paste it under —Topics Not Covered. Explain the reason.
- List the sessions to be covered in the workshop on a flip chart.
- Brief participants about the participatory nature of the workshop.
- Read out the fear cards aloud and address them.
- Read out the 'Ground rules' cards and list them on a flipchart. Brainstorm with participants in case they want to add more to the list. Issues such as punctuality, respect for different opinions etc. are likely to come out.
- Paste the flipchart on a wall for participants to refer during the entire course of the training.

Session 2 – Basics of HIV/AIDS

Time: 30 minutes.

Learning objectives

By the end of this session, participants should be able to:

- Understand basics of HIV/AIDS and sexually transmitted infections (STI).
- Bust myths and misconceptions on HIV/AIDS.

Materials

Paper slips with statements written on them [Annexure 2), a bowl for keeping the slips, flipchart, markers, chocolates (equal to the number of participants), a chart paper divided into two columns headed as Group 1 and 2 for giving scores.

Steps

- Tell participants that they are now going to play a quiz.
- Divide participants into two groups. [Outreach workers attending training should not participate in this exercise].
- Keep all statement slips in a bowl. Pick one, read out the question and ask one group to answer. If the first group can't answer, let the other group answer. For the next question, pick the second group. Continue until all questions have been asked.
- Give each group, half a minute to answer a question. Assign them five points if they answer correctly. If their answer is partially correct, give two or three points (use your judgment). If the other group answers the question, give them five bonus points. At the end of the exercise give chocolates to all participants as prizes.
- Explain each answer to the participants [Annexure 2], and encourage a larger discussion on ways of transmission, prevention and management of HIV/AIDS and STIs.

Key learning points to be emphasized by the facilitator during the session

- HIV is the acronym for Human Immunodeficiency Virus. HIV reduces the body's capacity to defend itself from infections.

- AIDS stands for Acquired Immune Deficiency Syndrome. It is a "syndrome," a collection of symptoms and conditions that, taken together are classified as AIDS. An HIV positive person does not necessarily have AIDS. AIDS is an advanced stage, possibly fatal when the immune system has considerably weakened.
- HIV enters the body and attacks white blood cells (WBCs), multiplies inside them and infects other WBCs. Eventually infected WBCs are destroyed leading to a reduction in their numbers and thus reduced immunity.
- The only way a person can know if he or she has HIV is through a blood test which could be ELISA & or rapid HIV tests.
- When infected with HIV, a person may not immediately test "Positive". There is a period of around three months (2 to 12 weeks) before the body reacts to the presence of this virus and produces antibodies in quantities that can be detected in the blood tests. This period is called the window period.
- After a person is infected with HIV, there is usually no change in that person's health for quite a few years. The person feels well, is able to work as before and shows no signs of being sick ("asymptomatic"). This asymptomatic period could go up to 8-10 years in some individuals. The symptomatic period is when the person begins falling sick because their immune system is weakened.
- HIV infected persons are susceptible to catching opportunistic infections due to weakened immune system. These include fever, cough, cold and other respiratory infections such as Tuberculosis, Pneumonia and Gastrointestinal Infections, such as diarrhoea and certain types of brain infections.
- Routes of Transmission of HIV are
    - Unprotected sexual intercourse (peno-vaginal, peno-anal sex) with an infected person is the commonest way of transmission of HIV. HIV is present in high concentration in semen and cervical and vaginal fluids including the menstrual blood of infected persons. It is possible to get HIV infection from a single sexual contact with an infected person.
    - Infected blood transfusion including organ transplants and accidental exposures.
    - Sharing of infected syringes and needles.
    - From infected mother to child during gestation, at the time of delivery and through breastfeeding. Risk can be lowered by the use of prevention of parent to child transmission (PPTCT) medication.
- Living in the same house, working or travelling together, shaking hands, hugging, sharing food or drinks or sharing toilets with an HIV-infected person cannot transmit HIV.
- Those who should take HIV test include - any person who wants to be tested voluntarily, all pregnant women and women considering pregnancy, people with high-risk behaviours (e.g. multiple partners, sexual/drug abuse etc.). key populations such as Men who have Sex with Men (MSMs), sex workers and injecting drug users (IDUs), sexual partners of people who have high-risk behaviours, recipients and donors of blood, organs and semen, persons with STIs, persons having Hepatitis B and Hepatitis C infection, and persons having Tuberculosis.
- Sexually transmitted infections (STIs) refer to infections transmitted through sexual contact, caused by bacteria, viruses or parasites. A person with high-risk behaviour (i.e. one who practices unprotected multi-partner sex) and his/her partner can contract an STI.
- STI symptoms in women
    - Pain in the lower abdomen.
    - Unusual and foul-smelling discharge from the vagina.
    - Lumps on or near the genital area.
    - Pain or burning during sexual intercourse.
    - Itching in and around the genitals.
    - Sores, blisters, rashes or boils around the genitals.

- STI symptoms in men include
    - Discharge or pus from the penis.
    - Sores, blisters, rashes or boils on the penis.
    - Lumps on or near the genital area.
    - Swelling in the genital area.
    - Pain or burning during urination.
    - Itching in and around the genital area etc.
- STIs increase the chances of contracting HIV and harm the body in different ways. A person with suspected STI and his/her sexual partner(s) should get timely diagnosis, management and treatment. Many STIs can be cured with proper treatment.
- A Condom is a thin sheath made of latex/plastic to fit on the penis to make sex safer. Correct and consistent condom use during sex is the most effective method to substantially reduce the risk of STIs including HIV. Condoms also prevent pregnancy by preventing sperm from entering the vagina.
- HIV cannot be eradicated from the body. Treatment can help to manage the infection by reducing the rate at which the virus multiplies in the body.

Management of HIV/AIDS include

- Treatment of opportunistic infections.
- Nutrition and positive living emphasizing healthy diet, exercises, stress reduction and relaxation techniques.
- Anti-retroviral therapy (ART) to all persons with HIV infection who are medically eligible to receive ART (as per national guidelines).
- Palliative care during the terminal stages of the illness through management of pain and supportive therapy.
- Care & Support encompassing ongoing counselling, referral services to organizations that provide vocational training, financial support or other support services and training of family members on home-based care.

Session 3 – Relevance of female sex workers and women living with HIV

Time: 30 minutes.

Learning objectives

By the end of this session, participants should be able to:

- See the significance of female sex worker (FSWs) and women living with HIV/AIDS (WLHIVs) in their work.

Materials: Flipchart, markers.

Steps

1. Ask participants to verbally list the beneficiaries and marginalized beneficiaries ASHAs are supposed to reach.
2. As participants say, list them on a flipchart. Add others, the group may have missed (Refer to the list below).

Beneficiaries

- Female sex workers.
- Children and orphans.
- Adolescent and young girls.
- Married women.
- Pregnant woman.

- Pregnant FSW.
- New mothers.
- Adolescent and young boys.
- Female migrants and mobile workers.
- women and girls with disabilities.
- women living with HIV.
- Pregnant HIV positive women.
- Wives of migrant workers.

3. Ask the following questions to the group
   a. Why do you think addressing marginalized groups are important? Why do you think addressing FSWs and WLHIVs are important?
   b. How would you feel if a client told you that they sell sex? How would you feel if a client told you that she is HIV positive and needs help?
   c. What do you know about FSWs and WLHIVs?
4. Write down the responses of the participants on a flip chart.
5. Conclude by emphasizing key points.

Key learning points to be emphasized by the facilitator during the session

- The National Health Mission (NHM) envisions providing accessible, affordable, and quality health care to all, particularly to the vulnerable sections. The mandate is also to guarantee a set of services with a focus on the marginalized population within each district.
- As health workers, we have to expand our understanding of communities and include those who are at the edges. You will need to interact with different kinds of beneficiaries who may have different lives and needs. Our work requires us to treat all clients/ beneficiaries irrespective of their caste, class, social and economic status, ability, HIV status, occupation and sexual orientation, as equal.
- The NHM is based on a rights framework, and the ASHA is the first point through which people can be mobilised to realise their rights. As health workers, we must internalize that everyone has the right to the highest attainable level of physical and mental healthcare free from discrimination and fear. FSWs and WLHIVs are no exceptions.
- Often we do not know enough about some groups. To succeed as health workers, we need to understand their context, and life to respond well to their needs. It also means spending more time and effort on those whose needs are more and who need to be pulled out of the margins.

Session 4 – Exploring values and attitudes

Time: 60 minutes.

Learning objectives

By the end of this session, participants should be able to:

- Explore their myths, beliefs, attitudes and, values related to HIV/AIDS, FSWs and WLHIVs and how itaffects work of health workers.
- Learn facts about FSWs and WLHIVs and their lives.

Materials: Statements written on cards [Annexure 3], flipchart and markers.

Steps

1. Divide participants into groups of four. Give each group four statement cards, and ask them to discuss, “Do you agree or disagree with the statement, and why?”
2. Tell the groups that there are no “right” or “wrong” answers and the objective of this exercise is to explore different views. Give the groups ten minutes to reflect and discuss.

3. Ask each group to report in the larger group and ask other participants to comment. Address the gaps as necessary [Annexure3].
4. Ask the following questions to generate discussion in the larger group
    a. Which statements were the most controversial, and why?
    b. How do our attitudes toward WLHIVs, and FSWs affect the way we behave toward these beneficiaries?
    c. How can we keep our values and stereotypes from negatively affecting our work?
    d. In what ways can we change our attitudes to these groups?
5. As a facilitator, remain neutral throughout the exercise. If a participant expresses extreme views that reinforce stigma, allow other participants to challenge these statements or, if no one responds, do it yourself.
6. Write down the participants' responses on a flipchart. Discuss their responses and provide factual information to clarify matters, as needed.
7. You can do a brief presentation on HIV/AIDS, FSWs and WLHIVs to give out facts or use the information given in the presentation to inform participants [Annexure 4].
8. Summarize the main points.

Key learning points to be emphasized by the facilitator during the session

- Some of the statements involve stereotypes—negative things we say and believe about WLHIVs and FSWs.
- Often we assume that these stereotypes are facts about other people when actually they are false. This leads us to judge people. We are socialized to judge other people based on assumptions about their behaviour.
- People living with HIV/AIDS (PLLHIV), sex workers, men having sex with men, transgender people, people who use drugs, are regarded as deviant and breaking social norms. So some people think that they deserve punishment and condemnation.
- Our views about the sexual practices of marginalized groups, such as FSWs and WLHIVs are a major reason for our judgmental attitudes. We might judge or stigmatize some groups for having “immoral” or “abnormal” sex (oral sex, anal sex, sex for money, sex with many people). Any sexual activity based on mutual consent that causes no harm to one's health, economic condition, and dignity, should be respected.
- Our values guide our attitudes and behaviour. It is all right for one to have a certain set of values but “judging” is wrong. We have no right to judge others—and judging ends up hurting people. We need to understand and respect key populations as human beings.
- Our culture in which we grow up and socialization determines our values and beliefs. Culture is continually changing, and so our beliefs and values also can change.
- Some people know little about key populations and PLHIVs and may not even be aware that they exist. Out of ignorance and fear they judge them unfairly or isolate/reject them. They are afraid that key populations will transmit HIV.
- When we know little about others, we often make assumptions or accept stereotypes about them. We attribute characteristics to a group and every one belonging to that group.
- By learning more about key populations, we will begin to overcome some of our fears or prejudice about them and be less judgmental towards them. At the same time, we should equip ourselves with scientific facts on HIV/AIDS – how it can be or cannot be transmitted.
- As health workers, we must be aware that our opinions have effects on other people. Some of these opinions are very judgmental toward PLHIVs and other key populations like FSWs. This may feel make them feel hurt and humiliated, and this affects their access to health services and how they protect their sexual and reproductive health.

- As health workers, we have a professional obligation to remain objective and non-judgmental with clients. We should not let our personal beliefs, values and attitudes come in the way of providing compassionate and high-quality care to clients.

Session 5 – Integrating HIV and SRH

Time: 30 minutes.

Learning objectives
By the end of this session, participants should

- Learn about the importance of integrating HIV and sexual and reproductive health (SRH).
- Know about different HIV and SRH services.

Materials: Flip chart, markers.

Steps

- Ask the group
  - What is the importance of integrating HIV with SRH?
  - What are the different HIV and SRH services you know about?
- List the responses on a flip chart.
- Discuss the participants' responses and conclude by drawing on key points.

Key learning points to be emphasized by the facilitator during the session
Why integrate HIV and SRH?

- Populations at risk of HIV and unintended pregnancies, such as young men and women, people who sell sex, and people with HIV, find it difficult to access the HIV and SRH services they need.
- While on one hand single young women and FSWs, for example, have difficulty accessing family planning services, which are geared toward the needs of married women from the general population, the other women from the general population may experience difficulties in accessing HIV services, which mostly cater to key populations.
- Services for family planning, maternal and child health, STIs, HIV, and abortion are provided separately and target different populations.
- HIV-SRH service integration is important to bring together services and increase access to critical SRH and HIV services for groups at risk, strengthen the quality of service provided to them, and help reduce stigma and discrimination.
- Integration would translate to better SRH services for key populations like sex workers and PLHIVs and better HIV services for the general population.
- Better uptake of services by all will lead us closer to the universal health coverage goal, which our country has committed to achieve.

HIV services include

- STI/reproductive tract infections (RTI) detection and management.
- Condom promotion (social marketing and free distribution).
- Integrated Counselling and Testing –
  - Counselling and testing Services for general clients.
  - Counselling and testing of groups with high-risk behaviour and STI clinic attendees.
- Prevention of Parent to Child Transmission.

        - HIV testing to every pregnant woman in the country, to detect all HIV positive pregnant women and eliminate transmission of HIV from parent to child.
        - Auxiliary Nurse Midwives (ANM) do community-based HIV screening at the Sub-Centre level.
        - Multi-drug ARV prophylaxis is currently being provided instead of single-dose Nevirapine.
        - Lifelong antiretroviral therapy (ART) (using the triple-drug regimen) for all pregnant and breastfeeding women living with HIV, regardless of CD4 (cells displaying immunity) count or WHO clinical stage or duration of pregnancy, both for their own health and to prevent vertical HIV transmission.
    - Care, Support and Treatment services
        - Through ART Centers, Centers of Excellence, Pediatric Centers of Excellence (PCoE), Facility Integrated ART Centers (FIART), Link ART Centers (LAC), Link ART Plus Center (LAC Plus) and Care & Support Centers (CSC).
        - Provides first-line ART, alternate first-line ART and second-line ART to eligible PLHIVs as well as paediatric ART.
    - Mass media, mid media and information, education, communication (IEC) activities to raise awareness on HIV prevention, and motivating access to treatment, care and support.

SRH services include

- Promoting sexual health.
- Contraception.
- Antenatal, intrapartum and delivery care.
- Safe abortion.
- Combating sexually transmitted infections, reproductive tract infections and cervical cancer.
- Infertility treatment.

Session 6 – Sexual and reproductive health for women living with HIV

Time: 20 minutes.

Learning outcomes

By the end of the session, participants will

- Understand additional considerations for SRH of WLHIVs.

Steps

- Tell participants that this session is about additional factors to be taken into consideration for SRH of WLHIVs. Ask participants to call out any such consideration they know about. Address the gaps and add more points. Encourage participants to ask questions.

Key learning points to be emphasized by the facilitator during the session

(Source - https://sti.bmj.com/content/80/3/167)

- STIs like Genital herpes, pelvic inflammatory disease, and chancroid can be frequent, severe and harder to treat in WLHIVs. Vaginal yeast infections and Bacterial Vaginosis can occur more frequently in WLHIVs and be harder to treat. STI screening and treatment is therefore important for the health of a woman living with HIV and her sexual partners.
- WLHIVs may have more missed periods, lighter or heavier bleeding, or more severe premenstrual syndrome which needs appropriate management.
- WLHIVs have a higher risk of cervical cancer. They should be screened regularly for the disease.

- Pregnant women living with HIV/AIDS have an increased risk of developing malaria and its consequences and therefore require additional precautions. WLHIVs can have healthy pregnancies but some may need to switch HIV medications. PPTCT regime for prevention of vertical transmission of infection should be provided. The risk of certain adverse pregnancy outcomes, such as intrauterine growth restriction and preterm delivery is greater in WLHIVs.
- Women with HIV can generally safely use any form of contraception to prevent pregnancy. But some HIV medicines can interact with hormonal contraceptives, including the injectables, pills, or implants. This can increase the chances of pregnancy. Some drugs including some ARTs and anti-TB agents also may interfere with hormonal contraception.
- Asymptomatic HIV positive women and those on ARTs can use intra uterine devices (IUDs) safely. IUD is NOT recommended for HIV-infected women with high risk of STIs (gonorrhoea/chlamydia).
- Spermicides are not recommended for women living with HIV and should not be used as an HIV prevention option by women at high risk of RTIs/STIs.

Session 7 – Stigma as a barrier to SRH services

Time: 60 minutes.

Learning outcomes

By the end of the session, participants will be able to

- Identify stigmatizing attitudes and discriminatory practices within healthcare.
- Understand the reasons for those attitudes and practices, and how these affect their clients/ beneficiaries.
- Identify practical things they can do to change the way they relate to their clients/beneficiaries.

Materials: Cards with case studies [Annexure 5], flipchart, markers.

Steps

Divide participants into groups of four. Give each group one of the case studies [Annexure 5]. Ask them to read and discuss the following questions:

- What happened in the case study? Is the situation realistic?
- Identify the stigmatizing attitudes and behaviors in the case study?
- What were its effects?
- What could have been done better?

Ask each group to report back on the responses to the above questions, and what they have learned from discussing the case study. Ask the following questions to generate discussion in the larger group:

- How does such stigma and discrimination affect WLHIV and FSWs' access to SRH services?
- What other forms of stigma have you observed that prevent access to SRH and HIV services? What examples can you give from your own experiences?
- As ASHAs, what can you do to change this?

Write the responses down on a flipchart and facilitate a discussion. Keep a record of the list of changes and park them for the next exercise. Summarize by drawing on main points.

Key learning points to be emphasized by the facilitator during the session

- Women living with HIV are more likely to experience stigma, discrimination and violence, including violations of their sexual and reproductive rights. Involuntary and coerced sterilization and forced abortion among women living with HIV has been reported in many countries including India.

- Stigma in the health setting can take many forms , including delaying or refusing services, providing differential treatment, ignoring, verbal abuse, breaking confidentiality, forcing clients to take an HIV test without their consent, isolating clients in separate wards, or excessive use of barrier precautions (e.g., gloves and masks) for routine tasks.
- **Isolation and Rejection**—based on ignorance and fear about HIV transmission or the behaviors of a marginalized group, the person stigmatized is forced to sit alone, eat alone, and live alone.
- **Shaming and Blaming**—gossip, name calling, insulting, judging, shaming.
- **Discrimination** —unfair treatment, such as refusing to conduct deliveries or operate on HIV-positive or marginalized clients, treating them last, refusing to treat them, or testing clients without their consent or disclosing their test results to others without their consent.
- **Self-Stigma**—PLHIV, and key populations sometimes internalize the stigma from society. They accept the blame and rejection of society, and withdraw socially or stop accessing health and other services out of fear of stigma and discrimination, and having their status revealed.
- **Stigma by Association**—People associated with stigmatized groups often face stigma themselves. Some health workers are stigmatized for working with HIV clients or clients from marginalized groups.
- Some health workers may be hesitant to provide care for WLHIVs because of fears of HIV transmission, negative, moralizing attitudes or biases towards WLHIVs, particularly regarding their sexual and reproductive health practices, fear of getting HIV through casual contact. Heavy workloads and stress are other causes of stigmatizing attitudes and behaviors. Service providers worry that women in the general population would stop accessing SRH services, if they are opened up to sex workers and HIV positive people.
- Stigma or the fear of stigma stops PLHIVs and key populations from accessing health services —getting tested for HIV and STIs, and getting condoms and lubricant, accessing SRH services, protecting their own health and the health of their sexual partners, disclosing their HIV status and getting counseling care and support.
- As HIV is associated with sex, our attitudes towards HIV are morally colored and anything associated with HIV is looked upon as immoral and wrong. Women and girls from general population may also be at risk of HIV as they may not know about their husband's/partner's sexual behavior, have more than one sexual partner, lack power to insist on condom use during sex or may experience violence and rape within relationships. Their risk and vulnerability is further accentuated as they are reluctant to access information and services on HIV/AIDS for fear of stigma and discrimination.
- As health workers, one can take responsibility for reducing stigma to these groups, and reducing overall stigma around HIV/AIDS by addressing it in staff and review meetings, challenging and changing our own personal attitudes and behavior—e.g., stop gossiping, challenge others if they stigmatize, holding meetings to develop and implement an anti-stigma code of conduct, and talking to groups working with key populations.
- As health workers, we must create a warm, welcoming, nonjudgmental and trusting environment, that is open to and respectful of all clients, so that all clients can freely seek services without fearing stigma and discrimination. This also means ensuring client privacy and confidentiality.

Session 8 – Working with FSWs and WLHIVs

Time: 90 minutes.

Learning outcomes

By the end of the session participants should

- List activities/strategies for engaging with FSWs and WLHIVs on SRH issues.
- List activities/strategies for engaging with women and girls from general population on HIV.
- Understand support needs to address SRH issues of FSWs and, WLHIVs and, HIV issues of women and girls in general population.

- Draw a health workers' code of conduct for engaging with FSWS and WLHIVs.

Materials: Chart papers, flipchart, markers,

Steps

Brainstorm with the group on the following questions

- What are ASHA's roles related to HIV /SRH services?
- What are TI outreach workers' roles related to HIV/SRH services?

Write the responses on a flipchart and address any gaps. Underline role overlaps if any between outreach workers and ASHAs.

Next, divide the participants into four groups. Ensure that ASHAs constitute two groups, outreach workers constitute the third group and a mix of ASHAs and outreach workers form the fourth group. Give the following instructions –

- ASHA Group 1: list strategies/activities for ASHAs to engage with FSWs and WLHIVs on SRH issues and support needed.
- ASHA Group 2: list ASHA strategies/activities for engaging with women and girls from general population on HIV/AIDS, and support needed.
- Outreach worker Group: In view of the listed roles, discuss how outreach workers can support ASHAs in delivering SRH services to female key populations and HIV services to women in general populations.
- ASHA+ outreach worker Group: What codes of conduct should frontline workers follow for addressing female key populations and WLHIVs?

Give the groups 15 minutes to complete their work. Ask the groups to report back, and facilitate a discussion to draw the main points. Direct the group to create a code of conduct they can refer to while interacting with key populations.

Key learning points to be emphasized by the facilitator during the session

- Below are ASHA's roles across HIV and SRH spectrum. FSWs and WLHIVs could be included in each of these services -
  - Pregnancy and delivery care: support for registration, identification of high risk pregnancies, check-up, iron tablets distribution, diet, and disease management.
  - Delivery: Arrange transport, escort for delivery, link with maternity benefits schemes.
  - Abortion: Counsel and refer women to safe abortion services, escort them and advice on post abortion contraception.
  - Contraception: Counsel families and individuals on importance and use of contraception - condoms, demonstrate condom use, advice on emergency contraception, advice and provision of oral contraceptive pills, hormonal methods, IUDs and links to sterilization services.
  - STI/RTI prevention and management: Raise awareness about causes, transmission and prevention of RTIs and STIs, counsel on importance of early treatment and partner management, promotion of condom, and safer sex behavior.
  - HIV/AIDS: Raise awareness about, causes, and prevention of HIV/AIDS, counselling people at risk to undergo testing, promote use of condom as a method of dual protection, PLHIVs to access ART.
  - Building awareness and mobilizing the community to prevent violence against women.
  - Supporting individual women facing violence, by linking them with appropriate legal and social support services.

- TI ORW's roles
  - Differentiated outreach based on risk and typology of sex workers through interpersonal behavior change communication.

- Promotion/distribution of free condoms and other commodities (e.g. lubricants for MSM, needles/syringes for people who use drugs).
- Linking individuals to basic STI and health services.
- Facilitating linkages to other health services (e.g. for Tuberculosis), and voluntary counselling and testing centres (VCTCs).
- Linking individuals to safe spaces (drop-in centres or DICs).
- Building community ownership through, mobilization, collectivisation and capacity building.

- ORWs and ASHAs can support each other
  - ASHAs can take the help of ORWs to understand the SRH needs and concerns of FSWs and WLHIVs.
  - ORWs can help mobilize and link FSWs and WLHIVs in need of SRH services to ASHAs.
  - ORWs can support ASHAs in linking women and girls in the general population to voluntary HIV testing and STI prevention and treatment services.
  - Have joint meetings to discuss issues related to female key populations and WLHIVs.
  - Help each other to develop a list of SRH referral services for female key populations and WLHIVs and HIV services for the general population.
- Different existing platforms and mechanisms could be used to engage with FSWs and WLHIVs
  - Mobilizing FSWs and WLHIVs to attend Village Health Sanitation and Nutrition Days (VHSND) s and include them in village health planning.
  - Ensuring that FSWs and WLHIVs are visited in their houses or places of residences for pregnancy and other SRH care.
  - Accompanying pregnant sex workers or WLHIVs to facilities for delivery.
  - Ensuring counselling of FSWs and WLHIVs on SRH issues.
  - Including TI outreach workers in village-level meetings of women's groups, and the Village Health Sanitation and Nutrition Committee (VHSNC), for increasing awareness on health needs of key populations and integrating them in village health planning.
  - Include representatives from FSW and WLHIV community in VHSNC, which is the platform for taking 'local level community action' for monitoring and planning community health.
  - Challenging stigma and discrimination against these groups among other health workers (ANMs, Anganwadi workers, ASHA facilitators etc.) and community women and important committees and groups like VHSNC, women's self-help groups and Mahila panchayats.
  - Inform FSWs and WLHIVs about various health and social schemes and support them to access appropriate reproductive and maternal health schemes.
  - Support FSWs and WLHIVs facing violence by listening to them and linking them to legal, shelter and health services.

Code of conduct – Can be used as a future reference for interacting with key populations and WLHIVs. This can be reviewed from time to time and new points can be added. Regular assessments of service delivery to key populations can be done, success stories documented and regular discussions on progress and learning with staff can be institutionalized.

- **Develop an understanding of "true" community** – A community has different kinds of people and it is the frontline health workers' responsibility to understand and respond to everyone's needs.
- **Ensure the right to health for all** - This means that everyone including key populations and WLHIVs should have convenient access to public healthcare facilities and services. These services should be affordable, offer good quality care to all and free from stigma and discrimination.

- **Be kind:** Have compassion for all people and never be afraid to show that you care. Try not to refuse your services to any individual who really needs them.
- **Treat everybody equally**: Everyone irrespective of her or his class, caste, sex and religion, ability, HIV status and occupation has the right to be treated equally and live a life free from discrimination. This includes marginalized key populations and WLHIVs as well.
- **Keep learning:** Use every chance you get to increase your own knowledge either through reading books, or attending training programmes or asking questions.
- **Be a role model:** You must be a role model and practise healthy habits and Ethical, and just behaviours.
- **Be non-judgmental:** Avoid being judgmental towards people belonging to marginalized groups including key populations and WLHIVs**.**
- **Ensure privacy and confidentiality:** This relates to a human right and will help build trust with marginalized groups such as FSWs and WLHIVs. Breaching confidentiality is ethically wrong and will prevent these marginalized groups from accessing services.

Session 9 - Wrap up.

Time: 20 minutes.

Materials: Training feedback form [Annexure 5], Posttest questionnaire [Annexure 1].

Steps

The facilitator can choose between 1 and 2 or do both

1. Exercise
   - Ask participants to sit in a circle.
   - Ask each participant to share one learning from the training and one thing she would change to serve WLHIVs and FSWs.
   - Note them down on a flipchart.
2. Distribute the training feedback form [Annexure 5]. Give them 10 minutes to fill.
3. Distribute post-test questionnaires [Annexure 1] to all. Give ten minutes to fill the questionnaire.

III. Annexures

Annexure 1 - Pre and post test questionnaire

Instructions:

1. For each statement tick in the column that applies to you.
2. This is your personal assessment. Do not consult others.
3. Please write your name on the reverse of the sheet.

S. No.	Statement	TRUE	FALSE	DO NOT KNOW
1.	Female sex workers is a beneficiary of ASHA workers.			
2.	The role of ASHA is to reach out to women living with HIV/AIDS.			
3.	HIV stands for Human Induced Virus.			
4.	We can identify an HIV positive person by looking at her/ him.			
5.	Sexually transmitted infections can increase the chances of getting HIV.			
6.	Unsafe sex is the most common cause for HIV transmission.			
7.	Sharing food with an HIV positive person can transmit HIV.			
8.	India has the third largest HIV epidemic in the world.			
9.	India has a generalized epidemic of HIV.			
10.	Female sex workers do not belong to key populations.			
11.	Stigma and discrimination, police harassment and violence, increases female sex workers' risk of getting HIV.			
12.	Female sex workers only operate from brothels.			
13.	Targeted interventions serve women and girls from the general population.			
14.	Hot spots are places where key populations engage in risky behaviours.			
15.	Many female sex workers are married or have long term partners.			
16.	Health workers must follow extra precautions over and above universal precautions to prevent transmission of HIV.			
17.	Some STIs are harder to treat in women living with HIV.			
18.	Women living with HIV have a lower risk of cervical cancer.			
19.	HIV-infected women with high risk of STIs should not use intra uterine devices.			
20.	Refusing to conduct deliveries of HIV positive women is a form of stigma.			

Annexure: 2

Session 2 – Questions/statements for quiz
[Adapted from : Avert, HIV/AIDS quiz
https://www.avert.org/learn-share/quizzes?gclid=EAIaIQobChMIw7jpiPuh7QIVi3wrCh0QfA0tEAAYASAAEgKwVvD_BwE,
Training Module on HIV/AIDS, Mainstreaming Cell, National AIDS Control Organization,
http://www.naco.gov.in/sites/default/files/Training%20Module%20on%20HIV%20AIDS.pdf]

1. What are the full forms of HIV and AIDS?
   Explanation - HIV - Human Immuno Deficiency Virus.
   AIDS – Acquired Immuno Deficiency Syndrome.

2. Which part of the body does HIV attack?
   Explanation - HIV is a virus that attacks the white blood cells (WBCs). WBCs form an important part of the immune system of our body, defending us from infections.

3. What is the most reliable way to know that one has HIV?
   Explanation- Testing for HIV is the only way to know if one has HIV. Feeling sick or having had unprotected sex with someone living with HIV should prompt one to go for a test, but neither is a way of knowing HIV status for sure. Everyone will not get symptoms, and waiting to have them may only damage the immune system further.

4. Being HIV positive means the person has AIDS.
   Explanation - False. A person who has the virus and is harbouring HIV infection is called as HIV positive. This person does not necessarily have AIDS. AIDS is the advanced stage of HIV infection. As HIV progressively destroys the immune system, it may develop into AIDS at a later stage and this can be fatal.

5. If you have taken an HIV test already, then you don't need to do it again.
   Explanation - False. It is important to keep test results up to date. This means getting tested regularly, especially if one has unprotected sex.

6. There is no need for Persons with Sexually Transmitted Infections (STIs) to test for HIV.
   Explanation - False. The predominant mode of transmission of both HIV and other STIs is sexual. There is a strong association between the occurrence of HIV infection and the presence of certain STIs (Genital ulcer disease 10 times more chances, Genital discharges 5 times more chances) increase the chances of contracting HIV. Early diagnosis and effective treatment of such STIs an important strategy for the prevention of HIV.

7. What is a window period?
   Explanation - Once a person becomes infected with HIV, that person may not immediately test "Positive". There is a period of around three months (2 to 12 weeks) before the body reacts to the presence of this virus and produces antibodies in quantities that can be detected in the blood tests. This period is called the window period. During the "window period" the person although infected, may test negative for HIV antibodies and is capable of transmitting infection. It is recommended to not wait for the window period to end before getting tested. If you think you might have been at risk get tested right away. One can get tested again after the window period has crossed.

8. The sweat of an HIV infected person can infect another person.
   Explanation - HIV is not present in sweat. So the virus cannot be transmitted through casual skin to skin contact - for example by touching or hugging.
9. Insect bites can transmit HIV.
   Explanation - Insect bites cannot transmit HIV. When an insect (such as a mosquito) bites you and sucks your blood it does not inject the blood of the last person it bit. The HIV cannot survive in a mosquito.

10. Sharing of Toilet/Latrines with an HIV positive person cannot spread HIV.
    Explanation - True. Body fluids that contain a large concentration of HIV can transmit HIV. This includes – blood, semen, vaginal fluids including menstrual blood, cerebrospinal fluids, amniotic fluids and breast milk. HIV cannot live outside our body for long. HIV can be transmitted only if the body fluids with high concentration of HIV enter our body.

11. Washing after sex kills HIV.
    Explanation - Condoms are one of the most effective ways of preventing HIV. Neither washing nor pulling out can stop infection.

12. Is it possible for parents living with HIV to have an HIV-negative baby?
    Explanation – Yes. Antiretroviral medicine taken during pregnancy and breastfeeding can prevent the transmission of HIV from mother to child, so that parents living with HIV can have HIV-negative children.

Annexure: 3

Session 4 - Statements [Adapted from Kidd R., S. Clay, M. Stockton, L. Nyblade. 2015. *Facilitator's Training Guide For A Stigma-Free Health Facility.* Washington, DC: Futures Group, Health Policy Project].

1. Clients who are HIV positive should be treated the same as other clients.
Explanation - Anyone irrespective of their caste, class, ethnicity, creed, religion, occupation, and ability, sexual orientation, and HIV status should be treated equally and free from discrimination. This is their fundamental right.

2. Women living with HIV should be treated at a separate facility, away from other clients.
Explanation: No. As part of universal health coverage, the focus is on integrating HIV prevention, care and treatment into other health services. Some believe that PLHIVs should be isolated as they may spread HIV to others. The fact is that HIV does not transmit by casual contact through talking, holding hands or sharing food and drinks. For invasive medical procedures on HIV positive individuals, the use of universal precautions is sufficient to prevent transmission.

3. Health workers have to inform the family members of a person who is HIV positive.
Explanation: Disclosing HIV positive status of a person without his or her consent pertains to a breach of confidentiality and is unethical.

4. Women living with HIV should not be allowed to have babies.
Explanation: A diagnosis of HIV does not mean that one can't have children. All women including those living with HIV have the right to have children. Since HIV can be passed during pregnancy, while in labour while giving birth, or through breastfeeding, appropriate management and care is needed.

5. Women living with HIV should be sterilized to prevent them from having babies.
Explanation: All women have the right to decide whether, when, and how many children they want to have. This is a part and parcel of their reproductive rights. WLHIVs can choose to have or not have babies. If they do not choose to have babies, they should be provided with information and support on a full range of contraceptive options. Those who opt to become pregnant should be provided with counselling, care and, medication to prevent vertical transmission of HIV and care for their own health.

6. It is all right for women living with HIV and PLHIVs to marry.
Explanation: Anyone including PLHIVs has the right to marry. It is a human right.

7. People who get HIV through sex deserve it because of their bad behaviour.
Explanation: Much HIV stigma is related to our values and attitudes around sex and morality. Because HIV is generally transmitted through unprotected sex, PLHIVs have been judged to be "promiscuous," "immoral," or to have engaged in sex outside of "normal" behaviour. We are no one to judge others 'behaviour. Such judgmental attitudes and behaviours are extremely hurtful and should be avoided. Rather than judging, it is important to extend our support to PLHIVs.

8. A health worker living with HIV should not be allowed to treat clients.
Explanation: This is based on the assumption that a health worker living with HIV will transmit the virus to the patient. Science says that HIV cannot be transmitted through casual contact or interactions where there is no exchange of body fluids. For invasive medical procedures on HIV positive individuals, use of universal precautions (hand hygiene; use of gloves,

gown, mask, eye protection or face shield, depending on the anticipated exposure; and safe injection practices) is recommended to prevent transmission. The emphasis should be on ensuring universal precautions, not on prohibiting a health worker from treating patients.

9 Clients have a right to know if a health worker has HIV.
Explanation: Universal precautions being followed by health workers is enough to prevent HIV. Disclosure of HIV status without his/her consent is unethical and should be strongly discouraged.

10. PLHIV/WLHIVs should be monitored closely by health workers.
Explanation: PLHIVs/WLHIVs are not criminals to be monitored closely. They require compassionate and high quality prevention, care and treatment support. HIV does not spread through casual contact and its transmission can be prevented by following universal precautions.

11. Sex workers love money and are too lazy to work. They could easily get other jobs.
Explanation: Often sex workers take up this work to provide financial support for themselves and their family members. They like money for the same reasons as anyone else. Earnings from sex work help women to pay their rent or build a house, buy food, send their children to school, support other family members, and buy new clothes. Reasons are diverse as for anyone else. Some want to remain in this work because of the financial benefits and do not want to leave it. Some are not happy with sex work, and would like to get out, but feel they have no alternative.

12. Sex workers have a right to say “no” to sex. No one can force them to have sex, even a client who has already paid them.
Explanation: Sex worker or no sex worker, non-consensual and forced sex is wrong and violates one's rights.

13. Sex workers deserve to get HIV because of their immoral behaviour.
Explanation: Disagree. Our values regarding what we think is “normal” behaviour can lead us to judge those who seem to live or behave differently. Much stigma around them is related to our values and attitudes around sex and morality and what we regard as normal sex. We may believe that sex workers are immoral and deserve to be unished. This affects what we believe about them and how we treat them. The fact is because of stigma and violence, key populations are forced to operate in a climate of secrecy and find it difficult to get information and advice on safe sex practices. As a result, they are more vulnerable to getting HIV and may be more likely to pass it to others. The focus should be to reduce this vulnerability, not increase it by condemning them.

14. All sex workers are HIV positive.
Explanation: No. HIV prevalence among sex workers is higher than in the general population. Sex workers are vulnerable to HIV because they have more sexual partners, may not be in a position to negotiate condom use due to financial pressures, or because of violence or rape. Many sex workers lack the power to insist on condom use with their clients. Some clients offer to pay more for sex without a condom and because this is their source of livelihood, they are inclined to accept, even though they know it puts them at risk.

15. It is all right for sex workers to get married and continue their work as sex workers.
Explanation: Many sex workers are married or have long term partners. Like anyone else, they have the right to marry and yet continue with their profession.

16. It is all right for sex workers to refuse other non-sex work related means of livelihood.
Explanation: It is up to a person what means of livelihood he/she wants to choose. All people including sex workers have the right to choose their work which could well be sex work, over another profession. Many sex workers, do not want to leave sex work because of financial benefits. The focus should be to make their occupation safe and hazard-free.

17. Sex workers show off and sell their bodies, so they deserve to be raped.
Explanation: Selling sex is part of sex workers' occupation. Forced sex without consent is called rape and rape is wrong regardless of who the victim is whether a sex worker or not.

18. HIV is the only serious problem sex workers face.
Explanation: Sex workers have many other problems. Rape and abuse from clients and long term partners, police harassment and abuse by pimps are some. Many face problems accessing critical health services other than HIV.

19. Sex workers are promiscuous and their relationships never last.
Explanation: The nature of their work demands that sex workers have sex with many people. But most do have lasting and long term relationships with their regular partners or spouses.

Annexure: 4

Session 4- Presentation

HIV women and key populations

India and HIV/AIDS

- India has the third largest HIV epidemic in the world.
- 0.2% HIV prevalence among adults (aged 15-49) = 201 million people living with HIV (2017).
- Between 2010 and 2017 new infections declined by 27% and AIDS-related deaths more than halved falling by 56%.
- Epidemic is concentrated among key effected populations.

Key populations (KPs)

Who?

Group who, due to specific higher-risk behaviours, are at increased risk of HIV & prioritized in the national AIDS response.

- Female sex workers.
- Male sex workers.
- Men who have sex with men (MSM).
- People who inject drugs (PWID).
- Hijras/transgender people.
- Migrant workers.

HIV vulnerability

- Experience widespread stigma and discrimination police harassment, violence, restrictive laws and policies, and criminalization of behaviors or practices putting them at greater HIV risks and preventing them from accessing crucial health services.
- Lack of rights and limited power make it difficult for them to control sexual decision making and other healthy lifestyle choices.

Key populations (KPs)

HIV vulnerability?

- Experience widespread stigma and discrimination, police harassment, violence, restrictive laws and policies, and criminalization of behaviors or practices putting them at greater HIV risks and preventing them from accessing crucial health services.
- Lack of rights and limited power make it difficult for them to control sexual decision making and other healthy lifestyle choices.
- Clients, partners, and spouses of key populations are also at risk of HIV.

Reach?

- Hard to reach with interventions as they are often mobile and hidden.
- Mapping of hot spots where key populations engage in risky behaviors provides data to plan prevention and treatment services.
- Targeted interventions offer prevention and care information, skills and services to Kps with in communities to minimize HIV transmission and improving their access to care, support and treatment services.

Female Sex workers

- Sex workers can be women (female sex workers), men and third gender/transgender, her we will talk about FSWs.
- Contrary to the popular sex work images of coercion, oppression, poverty, destitution and lack of agency sex work in India is diverse.
- There are sex workers who have been "trafficked" and coerced into sex work.
- There are those who have entered sex work of their own free choice.
- Many live in families and have multiple identities as mothers, wives, and sisters.
- Many have husbands or intimate partners with whom condom negotiation is difficult.
- Operate from both brothel and non-brothel settings including lodge, parlours, streets, highways, hotels and homes.

Female Sex workers

- Subject to arbitrary police harassment and other forms of violence by brothel managers and agents.
- Sex workers are one of the Kps targeted by India's National AIDS Control Organisation.
- Sex workers are 12 times more likely to be living with HIV than the general population and are difficult for services to reach.
- Sex workers are already stigmatized. When they get HIV, they are doubly marginalized.
- Apart from HIV they report other pressing health concerns including family planning, safe abortion, pregnancy and delivery services.
- Program focus is on preventing sex workers from infecting their clients than responding to their sexual and reproductive health needs.

The Sonagachi project, Kolkata

- Challenging the stigma of sex work.
- Reframing sex work in a rights - based discourse - women involved in sex work. have rights like all other people, but face rampant denial of rights.
- Position sex work as informal work like any other form of informal work where a person's labour is sold.

HIV and Women

- In India, women account for around one million out of 2.5 million estimated number of people living with with HIV/AIDS.
- Women are vulnerable/at risk of HIV because.
  - More biologically susceptible to HIV infection in any given heterosexual encounter
  - Early marriage, violence and sexual abuse.
  - Due to social norms around sexuality, abstinence and condom use are not feasible options.
  - Little negotiating power in their sexual relationships, including marriage.
  - Poor access to information and education on safer sex.
  - Poor access to health services due to less priority to their health, poor decision making
  - power & less mobility.
  - Poor access to HIV testing due to associated stigma and other factors- Most tests among married young women attending entenatal care are as compared to young women who have not given birth.

Women living with HIV

- Not a homogeneous group - married women, single women, windowed, sex workers, IDUs, living with disability etc with some being disproportionately affected by HIV.
- HIV/AIDS being linked with 'sexual misconduct and 'promiscuity' render women more susceptible to the stigma associated with HIV/AIDS. They bear blame for bringing HIV into a relationship or family; and being considered as vectors of HIV transmission to their children.
- More likely to experience violence, including violations of their sexual and reproductive rights.

Annexure: 5

Session 7: Case studies

1. Anita is a 20-year-old woman, pregnant with her first child. Around the time of her delivery, her family contacted the frontline worker. This was the first time they had approached her. The worker looked at her health facility card, which read "PMTCT". She then arranged transport and accompanied her to the nearest health centre. At the health centre, she went to the nurse on duty and showed her Anita's health card and explained to the nurse in a loud voice that she is HIV positive. She then left the health centre. While waiting, Anita saw this nurse and other nurses looking at her and whispering, which made her upset and nervous. She waited a long time for someone to help her; when her pain increased she shouted for help, but the nurses did not pay attention to her and kept doing whatever else they were doing. Anita saw other women being helped, but she was left to fend for herself.
2. Mana is a 17-year-old girl. One day, she began getting greenish vaginal discharge along with pain in her lower abdomen. She had been having unprotected sex with her boyfriend for a long time and had recently seen a hoarding indicating unprotected sex could cause infections like HIV. She suspected that her boyfriend has been dating other women, and was afraid about her HIV status. She went to the health facility to get treatment and be tested for HIV. When she told the doctor about her fears, the doctor looked at her suspiciously and began lecturing that she should never be having sex before marriage and that it is wrong for girls from good families to engage in such immoral acts. This is how people bring HIV into their bodies. Mana was upset and, wanted somehow get over with this and leave. She hurriedly answered the questions, picked up the prescription and left in a huff, without collecting the medicines. She could not bring herself to mention that she wanted to have an HIV test. She was now afraid to approach the chemist in her neighbourhood, for fear of embarrassing questions. She tore away the prescription and told herself that she would never go back to the health facility.
3. Uma is a 30-year-old sex worker. One day she approached the local health worker for advice on family planning. The health worker told her that she needed to visit other households but promised to come back after finishing her days' visits. A couple of days passed but the health worker did not return. Uma did not want to give up. She again met the health worker and politely asked for her time. Irritated, the worker said, "You'll just have to wait. We know you—ladies of the night! You wait all night for men, so why can't you wait a little? I have no other alternative but to serve you as this is my job. Otherwise, I wouldn't have bothered" Uma felt humiliated and wanted to challenge her, but words choked in her mouth as she struggled to fight off tears. In a small voice, Uma asked for information on some contraceptive options that she could try. The health worker said "you are supposed to use condoms, no other option is suitable for you. You better focus on condoms, otherwise you will be spreading HIV". Uma immediately left, vowing to never approach her again.
4. Neena is a sex worker. People in her community suspect that she is a sex worker and do not respect her because they think such work is immoral and wrong. She always tries to practice safer sex with her clients, but her boyfriend refuses to use condoms. She knows that he has other girlfriends and suspects that he is not using condoms with them because she keeps getting the same STI. The first time she went to the community nurse, she referred her to the health centre to get treatment for the STI. At the facility, the doctor treated her only reluctantly and told her that she needed to use condoms. Neena tried to convince her boyfriend to get treatment and use condoms, but he became angry and beat her up. He continued to demand unprotected sex from her and she became infected with the STI again. When she returned to the health centre, the same doctor saw her, but refused to treat her, saying "There is no use treating you because you will come back again." When she complained to the community nurse, she shrugged her off saying that the doctor is right and she should find ways to use condoms and not bother her. She is already overworked.
5. Naseem is a 27-year-old woman living with HIV. When she got pregnant she was delighted. She had heard about medications to prevent chances of HIV transmission to her baby. So she went to the doctor of her health centre. and asked her about the medicines. The doctor looked at her with a straight face and said that she should go for an abortion. The doctor also added that she has no right to bring an infected child into this world. When Naseem requested her to give information on the medicines she has heard about, the doctor refused outright. She said that Naseem should not even think about continuing her pregnancy, and should in fact consider sterilization, which is a permanent cure to all this trouble. She further mentioned that all HIV positive women should be sterilized for stopping transmission of HIV to the next generation.

Annexure: 6

Training feedback form

1. Did you like the training program ?
   - Yes.
   - No.
   - Can't say.

2. What did you like the most about the training?

3. What did you like the least about the training?

4. How will you rate each session and why?
   Rate on a scale of 1 to 5 (very good to very poor).
   1 – very good, 2 – good, 3 – average, 4 – poor, 5 – very poor

Sessions	1	2	3	4	5	Reason
1						
2						
3						
4						
5						
6						
7						
8						
9						

5. How appropriate was each session to the content to your work?
   Rate on a scale of 1 to 5 (very useful to not useful).
   1 – very useful, 2 – useful, 3 – average, 4 – less useful, 5 – not useful

Sessions	1	2	3	4	5
1					
2					
3					
4					
5					
6					
7					
8					
9					

6. Which training methodology did you like? Why?
Rate on a scale of 1 to 5 (very good to very poor).
1 – very good, 2 – good, 3 – average, 4 – poor, 5 – very poor

Methods	1	2	3	4	5	Reason
Introduction exercises.						
Quiz on HIV/AIDS.						
Brainstorming and interactive discussion on ASHA beneficiaries.						
Card game with attitude statements.						
Interactive discussions on integration of HIV and SRH and services.						
Stigma exercise with case studies.						
Group work on ASHA and ORW activities for engaging with FSWs and WLHIVs.						

7.

	What could have been done better?
Venue.	
Logistics (travel, food).	
Training content.	
Training methods.	
Facilitation Any other?	

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