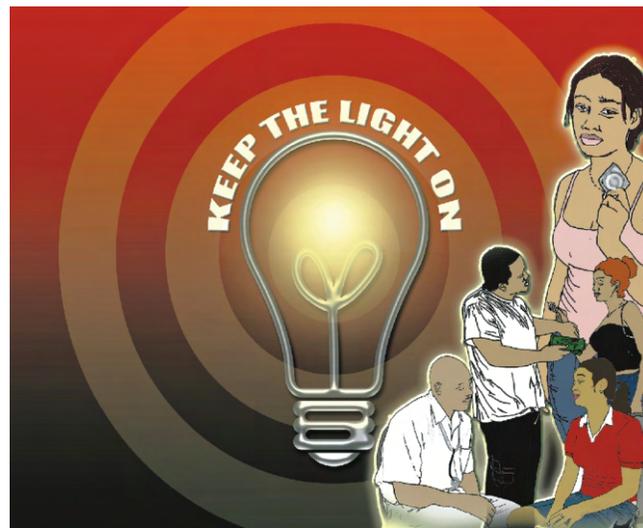


MINISTRY OF HEALTH GUYANA



National CSW Peer Education Manual



Government of Guyana National HIV/AIDS Programme
<http://www.hiv.gov.gy>



National CSW Peer Education Manual January, 2007

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Acknowledgement

We would like to express our sincere gratitude to all who have contributed to the making of this manual.

Special thanks go out to the Chief-of-Party, USAID/GHARP, Mr. Kwame Asiedu for his encouragement and support.

Particular thanks to Dr. Navindra Persaud Director, Monitoring and Evaluation, USAID/GHARP for his vision, guidance and encouragement in writing this manual.

Our many thanks are due to Dr. Shanti Singh, Programme Manager, National AIDS Programme Secretariat (NAPS) Ministry of Health (MOH), Jennifer Ganesh, National Behaviour Change Communication Officer, Ministry of Health (MOH), and other officials of the National AIDS Programme Secretariat (NAPS) for their guidance and support for the writing and compilation of this manual.

We would like to show our appreciation to a special lady, Ms. Bonita Harris for the numerous works she has done in putting together BODY WORK 1 & 2.

Thanks to Ms. Julia Rehwinkel-Roberts PHN Officer, USAID Guyana and team for reviewing the manual

We would like to thank all the participants of the various focus group discussions and workshops without whom there would be no project. Thank you all so much for your efforts and contribution to making this manual possible.

Sincere thanks go to the participating Non Governmental Organizations (NGOs) Artistes in Direct Support (AIDS), Lifeline Counselling Services, Comforting Hearts, FACT and The Guyana Responsible Parenthood Association (GRPA).

All of this could not have been possible without the participation of the commercial sex workers who participated in the pre-testing of this manual and for this, we sincerely thank them.

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Introduction

Guyana is the third-smallest country in South America is located on the north-eastern shoulder of the continent. It is divided into ten geo-political regions and according to the 2002 Census it has a population of 751,223 inhabitants the majority (71.5%) of whom resides in regions 4, 6, & 10. According to UNAIDS, Guyana has one of the worst HIV/AIDS epidemic among countries in the western hemisphere. Available data indicates that the HIV/AIDS epidemic is generalized in nature with an estimated sero-prevalence of 2.4% (Range 1.0 4.9%) among the adult population.

The highest number of AIDS cases occurs among persons within the working and productive group (ages 20-49 years) and it is estimated that a large percentage of persons are unaware of their HIV status. Some populations such as commercial sex workers, Men having Sex with Men (MSM) and those working in the gold and diamond mining industries have been shown to have a higher prevalence of HIV infection than that in the general population.

Sex Work in Guyana

Sex work is said to be illegal according to the laws of Guyana, persons caught soliciting sex can be charged with committing crime therefore, the actual number of sex workers that operate in Guyana is not accurately known. However, sex work is openly practiced in some places even though it is not supported. The majority of sex workers who operate in Guyana are usually found in major urban centers and the major mining and logging areas. Smaller number sex workers can also be found at specific bars and restaurants in the rural areas of the country. They operate from such locations as street corners, Bars and restaurants and brothels in the urban centers, some travel to the mining and logging areas of the country were they supply sex to mining and logging population and some even operate from their homes and can be reach via telephone.

In 2004 a mapping exercise was done among the CSW population in regions 4, 6, and 10 in preparation for a Behavioural Surveillance Survey found that there exist approximately 406 sex workers in these regions with the highest numbers in region 4.

The results of the study found that the level of HIV infection and other STIs is higher than that of the general population with prevalence rate of HIV infection at 26.6% as well as 15.4% prevalence of Syphilis in 2004 as shown in table one below.

Table 1: Female sex workers in Guyana - what do we know

No.	Indicator	Value
1.0	<i>Related to HIV and STI</i>	
1.1	Prevalence of HIV infection	
	1989	43.0%
	1993	25.0%
	1997	47.0%
	2000	31.0%
	2004	26.6%
	Prevalence of syphilis (RPR > 1:8)	15.4%
	Positive RPR	26.0%
	“Ever” received treatment for syphilis	13.1%
	Received treatment for a genital discharge in past year	8.2%
	Sought treatment more than one week after symptoms (discharge) appeared	(11/34) 33.4%
	Received treatment for a genital ulcer in past year	10.7%
	Sought treatment more than one week after ulcer appeared	(12/28) 43.9%
	Received treatment for salpingitis in past year	5.6%
2.0	<i>Indicator of sexual behavior</i>	
	2.1 Condom use last paying partner	89.3%
	2.2 Always use condom with paying partner in past month	72.7%
	2.3 Feel comfortable to ask paying partner to use condom	90.7
	2.4 Ever had anal sex with a paying partner	19.1%
	2.5 Used a condom use at last anal sex with paying partner	(67/86) 77.9%
	2.5 Had a condom at time of interview	27.9%
	2.6 Condom use at last sex with non-paying partner	46.0%
	2.7 Always use condom with non-paying partner in past month	37.2%
	2.8 Feel comfortable to ask non-paying partner to use condom	68.6%
	2.9 Ever had anal sex with a non-paying partner	18.2%
	2.10 Condom use at last anal sex with non-paying partner	(15/25) 60.0%

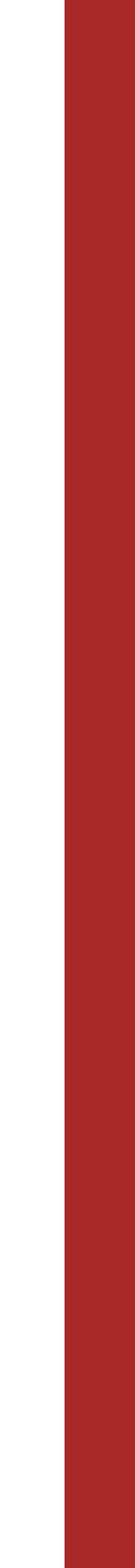
No.	Indicator	Value
	2.11 Ever had an abortion	42.8%
3.0	<i>Indicators of social status</i>	
	3.1 Live with a partner	19.1%
	3.2 Have another job	30.2%
4.0	<i>Indicators of Drug use</i>	
	4.1 Drink alcohol at least once weekly	60.2%
	4.2 Ever used marijuana Use marijuana at least once weekly	37.1% (108/167) 64.7%
	4.3 Ever used cocaine Use cocaine at least once weekly	8.2% (27/37) 71.1%
	4.4 use injecting drug	1.7%
5.0	<i>HIV testing behavior</i>	
	5.1 Ever had an HIV test	54.2%
	5.2 Knows HIV status (of those who were tested)	85.2%
6.0	<i>Indicators of HIV related knowledge, myths and beliefs</i>	
	6.1 No incorrect belief about HIV/AIDS	59.1%
	6.2 Comprehensive correct knowledge of HIV/AIDS	63.1
	6.3 Knows mosquitoes cannot transmit HIV	69.5
	6.4 Knows that meal sharing cannot transmit HIV	78.0
	6.5 Knows a healthy looking person can transmit HIV	97.3
	6.6 Believes that if an infected person has sex with many persons their life can be prolonged	19.7

Source: BSS Guyana, 2004.

In light of the above information, this project was designed to target CSWs and their clients as one of the main strategies for reducing the spread of HIV in Guyana. The CSW intervention project is a joint effort of the National AIDS Programme Secretariat (NAPS) Ministry of Health (MOH) Guyana, USAID/GHARP and a number of Non Governmental Organizations (NGOs) in Guyana. The main objectives of the project are to:

- Reduce HIV risk behaviors among CSW in Guyana through education and the promotion of condom use
- Promote/reinforce health seeking behaviors through improved access to diagnosis and treatment services
- Establish an effective communication/referral system among members of the target population
- Create friendly service environments

Members of the target population are reached through different strategies including peer education, and outreach by specially trained persons. This manual is intended to serve as a reference tool and use by the peer educators and outreach officers when training others and in conducting outreach work with the target group.



MODULE 1 -A

HIV/AIDS BASICS

Exercise 1: What is HIV? What is AIDS?

Specific Objective: to enable each participant to learn the basic facts about HIV and AIDS

Time: 30 minutes

1. Divide participants into two groups. Tell one group they will be the “HIV group;” tell the other group they will be the “AIDS group.”
2. Ask the HIV group to discuss A) what the three words in HIV are, and B) what they mean.
3. Ask the AIDS group to discuss A) what the four words in AIDS are and B) what they mean.
4. Ask each group to appoint one person to report.
5. Tell the groups to listen carefully to each report. After each report, ask participants to add any important information not supplied by the reporter, or to comment on anything the reporter said that may have been incorrect. The facilitator should also add/ correct as necessary from the information below.

HIV:

H- Human (only people can get it)

I Immuno-deficiency (it affects the body's defense against disease)

V- Virus (a small organism that cannot be cured by medicine such as antibiotics)

AIDS:

A-Acquired (you get the disease from someone else)

I- Immune (body's defense against disease)

D- Deficiency (deficient is the idea of lowering, lessening, not having enough defenses against disease)

S- Syndrome (a group of signs and symptoms define the disease, not just one sign)

Tell participants that many people confuse HIV and AIDS. AIDS is caused by HIV. People transmit HIV (in Guyana this is most often through sex.) People do NOT transmit AIDS.

Notes to Peer Educators/Fact Sheet

HIV means “Human Immuno-Deficiency Virus”

HIV is the virus that causes AIDS

- *Human* means that it affects only humans and lives only in humans. The virus does not live in toilets, mosquitoes, cups or spoons, on bed sheets or towels that people who have HIV might have used.
- *Immuno-deficiency* refers to a lack or breakdown of the immune system. The “immune system” is the body's resistance or defense system for fighting off infections. The virus attacks and eventually overcomes the body's immune system. The immune system is usually able to defend the body against many infections except HIV.
- A *virus* is a germ.
- The only way to tell for certain if we have the virus in our body is through a blood test. If the test shows that we have the virus, we are called HIV positive. If the test shows no evidence of the virus we are called HIV negative but our negative status is not yet certain, because of the window period.
- The window period there are up to 3 months between the date of infection and the date when a test result would normally show positive. So unless we have a negative test twice, spaced three months apart, and we are certain that during the three month period that we either abstained or used condoms every time we had sex, then we can not say that we are HIV negative. (See Exercise 4: The Window Period.)

AIDS means “Acquired Immune Deficiency Syndrome”

- To *acquire* means to “get or develop over a period of time”
- For “Immune” and “deficiency” see above. The immune system does not break like an egg; it breaks down gradually over time. It gets deficient, or less and less efficient, under the relentless attack by the multiplying numbers of the virus in the body.
- *Syndrome* refers to a group or collection of signs and symptoms (or indications) of diseases in a person who has AIDS, such as unusual weight loss (more than 10% of normal body weight), fever (from time to time stopping and starting or continuous), dry cough which hangs on, excessive tiredness, diarrhea for a long time (more than a month), swelling of the lymph nodes, respiratory tract infections including pneumonia, thrush, tuberculosis, night sweats or stroke.

Exercise 2: The difference between HIV & AIDS

Specific Objective: to enable participants to understand the difference between HIV and AIDS

Time: 60 to 90 minutes

1. Share the objective of this exercise with the group.
2. Divide the group into two and ask them to come up with three things that make HIV different from AIDS. Report as before with each group adding only new points.
3. After the groups have reported, present the information below. The groups' three points on the differences between HIV and AIDS may have been organised in other ways. That is okay. The main point was to get every participant thinking about and discussing the differences.

Knowing the difference between HIV and AIDS, can help sex workers ...

1. Understand that you can NOT tell whether a client is HIV positive by looking at him
2. Think about HIV ... before sex
3. Understand the dangers of having sex in the dark in places where one can't see, with people whose sexual parts and parts they have no information about
4. Realize that *one* act of unprotected sex with an infected person is all that is required for transmission of the virus.
5. To take HIV/AIDS seriously HIV does lead to AIDS and dying before one's time, in what can be a very unpleasant manner.
6. Understand that it is less difficult to make changes in one's life and lifestyle now, instead of waiting until after being infected to make changes
7. Who *are* infected with HIV to remember that they *are* infected and can infect others

Keep the Light On!

Notes to Peer Educators/Fact Sheet

The Difference between HIV and AIDS

#1: Different things are happening inside the bodies of persons with HIV

- HIV is the infection stage of the condition; AIDS is the disease phase.

#2: The bodies of persons with HIV and AIDS look different on the outside. Persons with HIV look healthy; persons with AIDS look unhealthy.

- You can't tell when a person has HIV. A person who is HIV positive can look and feel as good as a person who does not have the virus...

A person who is HIV positive develops AIDS (or can be said to “have” AIDS) when he or she has three or more signs of diseases. A person with AIDS may have signs such as significant weight loss, thinning hair, skin diseases, frequent bouts of diarrhea, and enlarged lymph glands under the jaw, neck, armpits and groin. Thrush (a white furry coating) on the tongue, the roof of the mouth (and sometimes the vagina.) **Note: No one of these signs by itself means that a person has AIDS.**

#3: Persons with HIV and persons with AIDS lead very different lives.

- Persons with HIV can get on with their lives as usual, taking extra care over their health; persons with AIDS may be too sick, too often, to be able to carry on normally. They need care and medical treatment.
- Persons who are HIV positive have to be careful not to infect others or to get re-infected with the virus. Every time a person who is HIV positive is re-infected, the body's resistance is weakened. AIDS will develop sooner.
- Persons who have AIDS need a lot of care and attention, medical and otherwise.

Exercise 3: How can someone get HIV? ... Not get HIV?

Specific Objective: to enable each participant to understand how the virus is transmitted and is not transmitted

Time: 1 hour

- Share the title and objective of this exercise.
- Ask the group the following questions to get them thinking and to assess their knowledge:
 - Which is passed on from person to person, HIV or AIDS?
 - Is AIDS ever passed on from person to person?
- Now, ask the participants to form small groups of two or three.
- Ask half of the small groups to come up with 3 ways a person can get HIV.
- Ask the other half of the small groups to come up with 3 ways a person can't get HIV.
- After the first set of groups (the "How you can get HIV" groups) has reported, add points as necessary from the Notes to the Peer Educator/Handout below. Do the same thing after the second set of groups has reported.

Notes to Peer Educators/Fact Sheet

Persons can get HIV in three main ways

1. **Unprotected sex** (any kind -- vaginal, oral or anal --) including sex where there is no ejaculation or “come”) with an infected person. Chances of infection increase significantly when STIs are involved.
2. **Blood transfusion or any blood-to-blood contact**, including sharing of needles used to inject drugs.
3. **Mother-to-child** (in the case of an infected mother during pregnancy, during delivery or breastfeeding)
 - The virus can be found in three main body fluids semen, vaginal secretions (wetness in the vagina) and blood of the HIV infected person.
 - Mother-to-child transmission. Many babies (but not all) who are born to HIV positive mothers may pick up the virus either in the womb, during the birth process (where blood and vaginal fluids are present) or after birth through breastfeeding.
 - Infected persons can become re-infected with every act of unsafe sex. This increases the amount of HIV in the body.

Persons can't get HIV, from ...

- Handshakes, hugging, touching, swimming or bathing with an infected person, sharing (cup, plate, spoon) with an infected person, toilet seats, mosquitoes, using towels and clothes, sitting next to or sharing a bed with an infected person. (HIV cannot live outside the body). Hugging and kissing (if there are no bleeding gums and broken skin)
- Massaging; masturbation, that is, self-massage “pumping” (rubbing and stroking of self) or mutual-massage (rubbing and stroking by two partners) of the sexual organs. (Note: If one or both partners are infected, care must be taken to ensure that there are no openings on the skin where the virus can enter.)
Sex where both partners are not infected and remain faithful to each other

Apart from no sex, sex with a latex condom, used properly every time is the only way to reduce risk of HIV and other sexually transmitted infections.

- Sex with a latex condom is *safer sex*, *safer* than sex without a condom but the condom must be used correctly and consistently, that is, in the right way ... every single time ...

Exercise 4: The Window Period

Specific Objective: To enable each participant to understand and be able to explain the significance of the Window Period.

Time: 1 hour

Materials: pen and paper, calendar

1. Share the objective of this exercise.
2. Organise participants into pairs in two groups. Have one member of each pair explain what she understands about the window period to her partner.
3. After a few minutes, ask one group of pairs to work together in pairs to come up with a definition of the Window Period. Ask the other group of pairs to come up with an explanation of why it is important to know about the Window Period.
4. Ask one pair to volunteer to explain their answers to the rest of the participants. Tell the rest of the participants to listen carefully to see whether any important information has been left out of the explanations. Now ask a pair to volunteer from the other group to explain why it is important to know about the Window Period. Alternate between the pairs who defined the Window period and those who discussed why it is important to know about it. Ask participants to identify the most important points and any misinformation they hear. Write summaries of the groups' answers to both questions on a flip chart.
5. The following points should be included. Share them to reinforce the learning about the Window Period.

Notes to Peer Educators/Fact Sheet

The Window Period

- The Window Period is that period from the time of infection to the time when the usual lab tests can detect the anti-bodies to the virus in the HIV infected person.
- The Window Period can last between 6 weeks to 6 months. During this time the, commonly used tests cannot detect the anti-bodies to the virus. Therefore, if someone is tested during that period, the test result will be negative even though they are infected. Some labs describe the findings as “non-reactive.”

Why it is important to know about the Window Period

- During the Window Period a person can be carrying the virus and *not* know. That person can therefore unknowingly infect another person through sexual contact.
- If a person has been exposed to the virus and takes the test soon after, the test results may show up negative...
- Persons who know about the Window Period will know that they must take a second test after about six months to know if they were not infected as a result of the suspected exposure to the virus.
- Those persons will know that they must abstain from sex, or practice very safe sex, if they are to learn whether they were infected at that time that concerns them.
- Those persons will know that if they have unprotected sex while waiting to have their second test that they are exposing themselves to HIV once again, before finding out if they were infected in the first case. And of course, if they were really infected in the first case, they will be spreading the infection to another or other partners.

How to explain the Window Period

1. Say, "Let's say you had unprotected sex with someone on January 1, and you are worried that you may have contracted the virus then. Don't go the next day or the next week for a test. That is too soon. The anti-bodies to the virus will not have been produced or released into the blood yet."
2. Explain that the test looks for the anti-bodies to the virus. It doesn't look for the virus itself.
3. Use a calendar or draw or count off the first six weeks to mid-February. Explain that this would be a good time to go for a first test, but the person has to make sure that she does not have unprotected sex between January 1 and mid-February. Any exposure to infection by the virus would mean that the testing process has to be started all over again ... counting the weeks and months from that point.
4. But say that the test comes up negative. "Negative" does not mean the person is not HIV positive, it can simply mean that the infection is in the body, but the anti-bodies the test is looking for have not yet been released.
5. This is why the person needs to go for a second test. Again, the person has to make sure that she does not have unprotected sex meanwhile.
6. Take the person through to the month of June. Explain that it has been known to take up to six months for anti-bodies to HIV to show up in some bodies.

Exercise 5: How HIV can spread

Specific Objective: To enable each participant to understand how HIV can spread in a group or population

Time: 1 hour

Materials: slips of paper with + sign, “a” and “c”

1. You may share the general objective of this set, but do not share the specific objective of this exercise, until afterwards.
2. Prepare slips of paper for each participant. Mark one with a plus sign (+), one with the letter “a” and one with a “c.” Make the markings small so they are not noticeable.
3. Distribute one to each person, noting the person to whom you gave the one with the plus sign (+). Do not let the group know that there is anything different about the papers.
4. Tell participants to think of three persons in the group that they want to know better. Tell them to walk around the group with their piece of paper and have their three persons punch a hole in it with a pen or pencil.
6. Tell the person to whom you gave the paper with the plus sign to start the ball rolling. (Don't let that person think he or she is starting off for any particular reason.)
7. When that person (think of him/her as a peer group leader) has approached and got the three persons to punch their holes, tell the rest of the peer group that they can now do the same.
8. When everyone has selected and approached their three persons, tell the group to return to their places.

Note to peer educators

If someone approaches you, go ahead and play the game. Later on, during your comments, you can explain that although you did not intend to be a player, you went along (as most of us tend to do) taking the risk of exposure to the virus.

9. Ask the first person to stand and identify the three persons who punched holes in his/her paper.
10. Ask those persons to stand and take turns identifying their three persons.
11. Get those persons who are identified to stand and do the same. Carry on until all who were picked point out whom they picked.
12. Tell the group that the person with the plus sign is HIV-positive ... and that in real life, all the persons who had sexual contact with that person ... or persons he or she had sexual contact with could have been infected with the virus.
13. Pause for awhile to let this disclosure sink in.
14. Explain that the “a” stands for “abstinence.” That person would have had contact with an infected person, but not sexual contact. That person would be safe.

15. Explain that the **c** stands for “correct and consistent condom use.” That person would be safer, not hundred-percent safe, but much, much, much safer than persons who took no precautions ...
16. Tell persons: “Put up your hands if you would go ahead and have sex with a condom knowing that the sex partner might be HIV infected.” Ask the group what they think about their responses.
17. Have the group sit. Pass the ribbon and have persons say (i) why they chose the persons they did and (ii) what they think and feel about the exercise.
18. Give your own personal and general comments after everyone has spoken. There are some points below that you can also bring to the attention of the group.

Note to peer educators

1. The exercise shows that in a small community, one HIV infected person can possibly lead to the infection of a great many.
2. The exercise shows that a relatively small number of infected persons in a small country like Guyana can start an epidemic.
3. Everyone who is sexually active is at risk -- not just commercial sex workers (CSWs) and clients of CSWs. It is not just about whom “I” have sex with; it is also about whom “he” or “she” has sex with; and whom “they” (the partners of the partner) have sex with.

Exercise 6 High Risk, Low Risk, No Risk

Specific Objective: To deepen persons' understanding of stigma and to assess each participant's awareness of risks of HIV infection associated with certain behaviours.

Time: 45 minutes

Materials: Four (4) large sheets of paper with the following headings:

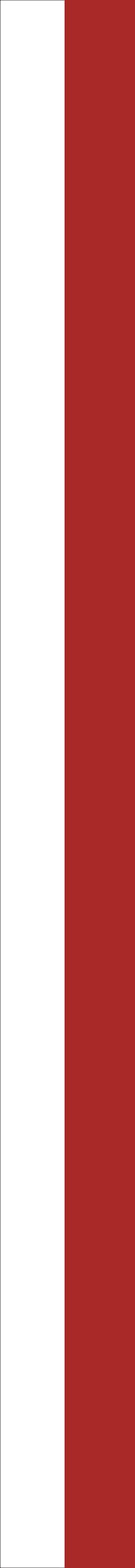
- High Risk Behaviour
- Low Risk Behaviour
- No Risk Behaviour
- Don't Know

"Behaviour cards" with the following statements:

- Having sex after getting "high"
- Having sex with a drunk or high client
- Having sex with a "nice looking client" without a condom
- Having sex with a client with a condom
- Mouth-to-penis sex (oral sex) with a client with a condom
- Mouth-to-vagina sex (oral sex) with my boyfriend without a condom
- Penis-in-the-behind sex (anal sex) with a client without a condom
- Penis-in-the-behind sex (anal sex) with a client with a condom
- Using a condom with my regular partner/boyfriend/husband, but not with clients
- Using a condom with my clients but not with my regular partner/boyfriend/husband
- Deep kissing
- Using a public latrine
- Being bitten by mosquitoes
- Caring for someone who has AIDS
- Drinking from a glass used by someone who is HIV positive
- Sleeping in the same bed with someone who is HIV positive, but without having sex
- Getting a tattoo
- Giving blood
- Touching and rubbing skin-to-skin

Process

1. Organise your group into a circle.
2. Have four large “Risk” sheets of paper either A) in the middle of the floor or B) hanging from the walls of the room.
3. Distribute behaviour cards, one card per person.
4. Tell each participant to read her card, making sure everyone understands the contents
5. Tell participants to either:
 - (If using option A,) take turns placing their cards on the selected “Risk” sheet and then, one at a time, give their reasons for placing them there or
 - (If using option B,) move to the place in the room underneath the “Risk” sheet that most closely reflects the behaviour on their behaviour card... Then describe their reasons for standing below that Risk sheet.
6. After each person reads out and describes her decision to place her card or stand below each “Risk” sheet, invite the group to agree, or disagree giving their reasons.
7. Ask someone in the group to help out, in the event of any “don't know” responses.
8. Correct and/or give additional information where necessary.
9. Tell the group that this exercise was intended to get them thinking and talking about
10. Issues of risk-taking and relationships, sex and HIV.



Module 1-B
Basic Facts about STI's

Exercise 1: What are STIs?

Specific Objective: To enable participants to recognise common STIs

Time: 1 hour

Materials: pen and paper, tape

1. Share the general objective of the exercise with participants.
2. Ask someone to explain what the letters STI stand for and the meaning of each word.
3. Explain that participants may have heard about STDs (sexually transmitted diseases) but the term STI (sexually transmitted infection) is now being used. When we hear the word “disease,” we usually expect to see symptoms, but since many “STDs” are silent (that is, no symptoms may be seen or felt), we now refer to them as STIs.
4. Divide the group into two. Ask one half to describe what different STIs look like. Ask the other half to describe what different STIs feel like.
5. Tell the group that what they have been doing is looking at some STI “symptoms.” Explain that a “symptom” is a “sign” or “indication.” However, it is very important to know that many STIs, especially in women, have **no** symptoms. This means that people often don't know that something is wrong. Go through the symptom list below

Notes to Peer Educators/Fact Sheet

Main symptoms of sexually transmitted infections in males

- Sores, ulcers, blisters, small hard lumps, rashes on and around the sex organs
- Itching around the penis and/or scrotum
- Burning sensation while passing urine; frequent urination “peeing”
- Discharge (or “leak”) from penis
- Swelling in the scrotum (bag with balls or testicles) and in the groin area

Main symptoms of sexually transmitted infections in females

- Discharge (or “leak”) from vagina
 - Sores, ulcers, blisters, small hard lumps, rashes around and in the sexual organs or “parts”
Pain, itching, burning, swelling in and around vaginal area
 - Pain during sex
 - Lower belly pain
 - Frequent urination “peeing” (there may be other causes for this.)
- ✓ Remember that some STIs, especially in girls/women, may not have any symptoms. So you can have an STI and NOT know it.
- ✓ Syphilis in pregnant women can be passed on to the growing fetus. Left untreated, syphilis progresses to more dangerous stages.
- ✓ Persons who do not pay attention to the sexual organs of their partners risk infection by STIs.

Keep the Light On!

Exercise 2: Box Hand

Specific Objective: to enable each participant to understand how STIs can spread in a group or a population

Time: 1 hour

Materials: Closed taped box (matchbox or shoe box) with letters “STI” marked inside

1. Ask persons in the group who have “thrown a box hand” before to put up their hands. If anyone doesn't know about “box hands,” have someone explain. Tell participants you are going to set up a different type of “box hand.” Do not tell participants about the specific objective of this exercise.
2. Hold up the box you have prepared and tell the group that anyone who receives it should hand it on to someone in the group they like or trust. Or, if participants do not know each other, someone they *think* they can like or trust.
3. After a few minutes, when most have been involved, stop the exercise. Make sure that a few (two or three) people didn't get the box.
4. Ask those who received the box to step forward.
5. Ask the person left holding the box to open it and share its contents with the group.
6. Ask the group to say what they think was the point of the exercise.
7. Ask each person to share some of their thinking and feeling about being included, or excluded, from the box hand. What did they learn about how quickly STIs can spread in a group or small population? What else did the exercise teach? Did anyone get the box more than once?

Exercise 3: Connections between STIs, HIV and AIDS

Specific Objective: To enable participants to understand the connections between STIs, HIV and AIDS

Time: 1 hour

Materials: pen and paper

1. Share the specific objective of this exercise.
2. Place persons into pairs. Ask each pair to come up with five reasons why knowing about STIs is important. Ask them to make connections with HIV wherever possible.
3. Ask one person from each pair to share their reasons. Each pair should only add new points to those already made. Explain that this is to test their listening skills. Here are some of the points that should be made Role Play

Ask two participants to perform this role play for three minutes

Anne is taken to the clinic by friends. The nurse examines her and tells her that she has an STI. The nurse then asks Anne to bring her regular partner for treatment. Anne becomes sad and tells the nurse that this is not possible. What do you think Anne should do?

Ask the participants the following questions:

- Why doesn't Anne want to tell her partner?
- What can the nurse do to convince Anne to tell her partner?
- How will Anne status affect her 'business'?
- If you should get an STI what would you do?

Jackie has an STI and has begun treatment. Her regular partner wants to know what the problem is and why she has to be going to the hospital so much these days. Her colleagues want to know why she is not on the road so much and why she is refusing business. What should she tell them?

Notes to Peer Educators/Fact Sheet

Important Points about STIs

1. **What are STIs?**
 - STIs are sexually transmitted infections. There are many STIs. Some are curable. Others are not. HIV is an STI.
 - If someone has an STI, he or she should not have sex, until it is completely cured.
 - If someone has an STI, she/he should let sexual partners know so they can be tested and seek treatment

2. **Signs/Symptoms** Some STIs, especially in girls and women, may not have signs, symptoms. A person may have an STI and not know it. The chart below shows various STIs

Common Types of STIs by Category of Symptoms			
Discharges	Sores/Blisters (Ulcers)	Swellings/Rash	Growths
Gonorrhea (Caused by bacteria)	Syphilis (caused by bacteria)	Bola bola (LGV)	Genital warts (caused by virus)
Chlamydia (caused by bacteria)	Chancroid (caused by bacteria)	Granuloma inguinale (caused by bacteria)	
Candida Vaginal Thrush	Genital Herpes (caused by virus)		
Trichomoniasis			

3. **Complications**
 - Untreated STIs can lead to serious health problems, including long term damage to the reproductive tract; harm or death of fetus (if pregnant ;) risk of cancer.
 - Untreated syphilis can lead to death.
 - Mothers can pass some STIs on to their newborn babies, some affect babies' eyes.
 - A person who has an STI is at a much higher risk of contracting HIV through sex from an infected person. This is because the sores, blisters, rashes, and soft spots in the skin provide openings for HIV to enter the system.

- STIs put additional stress on the body's resistance. Persons who are HIV positive and get (and/or keep) an STI (or more than one STI) are likely to get sick more frequently, and develop AIDS more rapidly.

4. **Treatment**

- Because different bacteria and germs cause different STIs, they need to be treated differently.
- Do not self treat; see a doctor. When a doctor prescribes treatment after an examination, it is important to take the full treatment even after the signs of the infection (infection) seem to have disappeared.
- There is no cure for the STI called HIV and genital herpes. Even if the infection is not curable, they should learn how to manage their chronic disease.

5. **Prevention/protection**

- The best protection (other than not having sex or only having sex with an uninfected partner) is to use a condom correctly, every time you have sex.
- But keep in mind that condoms are *not* 100% effective in the case of all STIs, because some STIs, like herpes, affect areas of the body not covered by the condom, like the mouth.

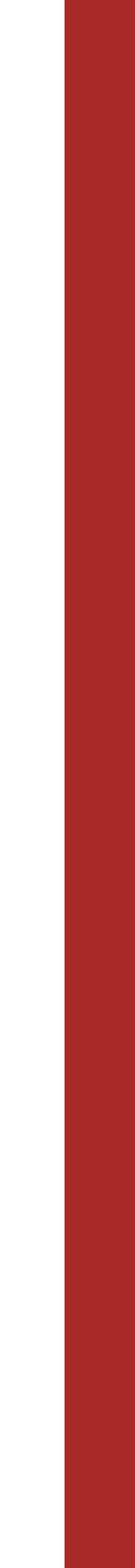
Exercise 4: One-Minute Role Plays: Risk Behaviours and Safe Behaviours

Specific Objective: To engage participants in acting or observing situations where risk behaviours or safe behaviours can follow

1. Share the objective of this exercise or session.
2. Describe the role play situation to the persons who will be doing the performance.
3. Give them a minute to think about it and decide who will play what role.
4. After the role play, ask the audience group to discuss the situation.
5. Ask them what behaviours are likely to follow from all the parties involved.
Ask the group for ideas on “safe behaviours” to put to the players.

One-Minute Role Play Ideas

1. A sex worker has been approached by one of her regular clients. He wants to have sex without a condom.
2. A sex worker who has not had any business for the night has been offered double her price by a client to have sex without a condom
3. A sex worker and her regular partner (who knows that she is hustling) are having an argument about using condoms. He accuses her of not trusting him.
4. A sex worker is having an argument with her regular partner (he does NOT know she is hustling) over using a condom. He accuses her of having another man.
5. An inexperienced sex worker has been approached by a rich client for a 'round about' i.e. sex in the vagina, oral and anus. An older sex worker calls her aside and speaks with her.
6. A sex worker's 12-year-old daughter has just told her that her step-father grabbed her towel while she was passing.
7. A sex worker is about to get into bed with her client when she notices that he is reluctant to take his shirt off. He tells her that he doesn't like undressing. What should she do next?
8. A sex worker's client is insisting that he wants to have sex in the dark and is threatening to take back his money if she puts the light on.
9. A sex worker is being offered to her boss's business partner who requests that she must not use a condom.
10. The client of a sex worker says that he wants to get a real feel of her without any barriers.
11. A sex worker's client wants her to get high with him so that they can have “better sex”



MODULE TWO
CONDOM USE
& NEGOTIATION
WITH CLIENTS

Exercise 1: Condom Smart & Condom Comfortable

Specific Objective: To enable participants to learn the correct use of a condom and increase their comfort level in handling condoms

Time: 60 minutes

Materials: 10 green plantains, condoms.

1. Organize the group in pairs. Give each person a condom, and each pair a green plantain. Have each person put on and take off the condom while being observed by the partner who is holding the penis-like plantain with one hand firmly wrapped around the last quarter.
2. Tell participants that they are to pay careful attention in order to check each other's condom use skills.
3. After everyone has had a chance to put a condom on the plantain, get pairs to sit in a circle. Now, pass a “plantain” (instead of the ribbon) and ask each person to take turns commenting on their partner's condom demonstration performance.
4. Do a condom demonstration yourself, making the points below as you go along. Use the condom use cue cards to reinforce what you show.
5. Make the point that correct and consistent condom use is the responsibility of both partners engaged in the sex act.
6. Bring the exercise to a close with participants taking turns talking about their feelings about and experiences with condoms. Pass a condom (instead of a ribbon) from hand to hand to designate each person's “turn to talk” time. Ask participants to think about things like seeing it, smelling it, touching it, feeling it, not feeling it and so on.

Tell me, I will forget.
Show me, I may remember.
Involve me and I'll understand.
[Chinese proverb]

Exercise 2: Condom Relay

Specific Objective: To enable participants to practice putting condoms on plantains correctly and under pressure and their comfort level in handling condoms

Time: 60 minutes

Materials: 10 green plantains, condoms.

1. Have 9 plantains and 9 condoms ready for this exercise. Ask for nine volunteers for a condom relay race. Give each person a condom.
2. Divide the nine into three teams of three. Have them stand in three lines, three-deep, facing the rest of the group.
3. Place one plantain on the ground in front of each team.
4. At the signal, the first persons from each team will run forward, extract the condom from the packet, fit condom correctly on the plantain, remove it, tie it and run to the back of the team.
5. The second persons then move forward and do the same.
6. Then the third persons do the same, bringing the relay to a finish.
7. Have the audience judge whether the condoms were fitted, removed and tied properly and which team won.

Exercise 3: Let's Gaff about Condoms

Specific Objective: To enable participants to learn basic facts about condoms that they might not know or might take for granted. To enable CSWs to feel comfortable asking questions about condoms

Time: 45 minutes

1. Arrange participants in a circle or “u”-shape.
2. Explain the purpose of this exercise
3. Ask the following questions and facilitate a discussion about condoms:
 - a. What is the most important thing about a condom?
 - i. To be sure you have one before you need it!
 - b. How many times can you use a condom?
 - i. Once only. Use a new condom for each sexual act.
 - c. When do you put the condom on?
 - i. Only when the penis is erect.
 - d. What do you do if the penis is not circumcized?
 - i. Pull the foreskin of the penis back before putting on the condom
 - e. What happens if the condom tears or “bursts” during sex?
 - i. Stop having sex and put on a new condom! If the condom is of good quality and has been put on correctly, this is less likely to happen. However, if it does, withdraw the penis immediately and put on a new condom.
 - f. What else can a condom protect against other than HIV?
 - i. Other STIs like gonorrhea (leak), syphilis, (see Module 5) AND pregnancy
 - g. Did you ever think you would sit in a circle with other sex workers and talk about condoms?
 - h. Are some penises too big or too small for a condom?
 - i. NO, a condom can be stretched to fit over a forearm
 - i. Now you probably know how to put on a condom correctly. Do you know what the term “consistently” means?
 - i. Consistently means all the time. With every client and every sexual partner.
 - j. What if the woman doesn't get “wet” enough?
 - i. Most condoms are lubricated. If extra lubrication is needed, use a water-based lubricant like “KY Jelly.” Don't use petroleum jelly as it can cause condom breakage. Sperms or disease causing germs can enter the partner through damaged condom
 - k. Is it ok for a client's penis to touch my vagina, mouth or anus even if he doesn't put it inside me?
 - i. No. Avoid direct contact with the sexual organs before wearing a condom. Secretions from the vagina or penis may transmit HIV/STIs
 - l. Should people keep condoms in their pockets or blouses?
 - i. No, keys or other sharp objects in a pocket or sweat in a blouse can damage a condom. Sitting on condoms can also damage them.
 - m. Where should condoms be stored?
 - i. Store condoms in a cool, dark place. This is because heat, light and humidity can damage condoms.

Tips on Correct Condom Use

- Condoms are made of rubber. Heat weakens and destroys rubber so condoms should not be kept in back pockets and wallets or any place where they are exposed to heat (this includes body heat) or the sun. They should be kept in a cold or cool place until they are to be used. Pay attention to the expiry date or the date of manufacture on the packet. An old (over five years) or expired condom can break during sex. Two condoms do not offer double protection; rubber rubbing against rubber creates friction that will cause breakage.
- Use latex condoms. Stay away from flavoured or chemically treated condoms designed for oral sex and other purposes. The chemicals can affect the rubber and cause it to be porous, leading to possible seepage (in or out) of viruses that may be present. They can also bruise the tender tissue of the vagina walls. Bruises create openings for viruses and bacteria to enter. Do not rub any oily or greasy stuff on condoms; this will weaken the condom and cause it to break.
- Remove the condom carefully from the packet, making not to tear it and making sure it is still sealed and has not been punctured accidentally. Never open a condom with your teeth!
- The tip of the condom should be squeezed firmly between two fingers when it is being put on. This keeps the air out and leaves space for the semen to go after ejaculation. The condom can burst if the penis or air gets into the tip. Place condom on erect penis and roll it all the way down.
- In case the penis is not circumcised, it is important to role the foreskin back before rolling down the condom.
- After sex, with the tip of the penis facing downward, remove the condom carefully, but before the penis gets soft. Hold it at the base and make sure that no semen spills. If you have been grating coconut or cassava, make sure you have no cuts on your hand, because the virus from an infected partner can enter into your system through this opening.
- Tie it and put it in a covered garbage container. Do not drop it into a toilet as this will cause blockages.

CONDOM NEGOTIATION WITH CLIENTS

Exercise 4: Condom Negotiation Skills

Specific Objective: To equip sex workers with condom negotiation skills

Time: 1-2 hours

1. Ask participants to share some of their experiences successfully negotiating condom use with clients. That is, how who brought it up or proposed it, what happened, how it went, how it is going, and so on.
2. Ask whether any participants have tried to get clients to use condoms but have failed. Ask them to share their experiences.
3. Organise group into threes. Ask each trio to come up with one scenario (being as realistic as possible) where a sex worker is trying to get a client to use a condom. They should then come up with a strategy for the sex worker to get the client to agree to use a condom. The strategy should include a few statements that the sex worker can use when negotiating with the client.
4. After about 7 to 10 minutes, ask one person from each trio to describe the situation they were working on, and the strategy they decided on.
5. Ideas that participants come up with may include:
 - Say no to sex without condoms clearly and directly. “No” is a complete sentence! No condom, no sex.
 - State firmly and clearly that your life and health are more important than the fare
 - State firmly and clearly that you need to stay healthy for your children and/or family
 - Persuade the client that you will make putting on and using a condom very exciting
 - Tell the client that, in addition to your own concern for your safety, you are concerned about his safety; and the safety of his wife/family or other partners
 - Have condoms readily available
 - Have a choice of types of condoms, if possible
 - Propose other ways of having sexual pleasure without penetrative sex
 - Ask someone with influence, a madame, a pimp, brothel or bar owner, or another sex worker to intervene
 - Be on the lookout for clients or situations you may not be able to handle, and wherever possible, avoid them or have a well thought out escape route
 - Be on the lookout if the client is drunk or high, aggressive or nasty
 - Assure the client that wearing condoms will not reduce the total pleasure of sex
6. Ask participants if they learned anything new that they might try out in their future work?

Exercise 5: Condom Negotiation Role Plays

Specific Objective: To equip participants with condom negotiation skills through role playing real-life situations

Time: 1-2 hours

1. Show participants the cue cards on Condom Negotiation Situations. Ask them for ideas on what sex workers could say in the situations depicted.
2. Divide participants up in pairs.
3. Ask pairs to come up with condom negotiation role plays (using some of the tips just discussed) for the following situations:
 - Where the client is “under the influence or alcohol” or “drunk”
 - Where the client is high on a drug other than alcohol
 - Where the client is much older
 - Where the client is much younger
 - Where the client is known to be violent
 - Where the client is offering to pay more money
 - Where the client is offering to pay much more money
 - Where the client is offering alcohol to the sex worker
 - Where the client is offering drugs to the sex worker
 - Where the client is being aggressive
 - Where the sex worker is new to the business
 - Where the client want to bring in a male friend to participate
 - Where the client is emotionally disturbed
 - Where the client is lonely and feeling desperate and pleads with the sex worker
 - Where the client says the madame, pimp or other “gatekeeper” promised the sex would be without a condom where a policeman is threatening to arrest you if you do not have sex with him without a condom
4. Have the group examine each role-play performance from the point of view of the effectiveness of the communication skills of the person negotiating condom use. What did each role player do that was strong? How could each role player have been more assertive?
5. Have each participant take turns saying what she thought about the exercise and what she learned from the exercise.
6. Have each participant take turns saying how this exercise can be useful in their daily work.
7. Discuss with participants who stand to gain, other than participants themselves, from correct and consistent condom use with clients?

Tips for Condom Negotiation

Basic Elements of Condom Negotiation

1. Say NO to sex without condoms very clearly and directly
2. State your reasons for refusing sex without condoms in a firm way
3. Assure the client that in addition to your own safety, you are concerned about his safety as well
4. Always keep plenty of condoms available; have a variety of types if you can
5. Remember that even though you are dependent on madames, pimps, bar owners and other “gatekeepers,” they need you too to earn money. So it's in their best interest to promote condom use with all your clients
6. If more sex workers insist on condoms, that will make it easier for each sex worker to convince clients
7. If all sex workers insist on condoms, the clients will have no choice but to use condoms

Tips for specific types of clients

For men who have no previous experience with commercial sex workers

1. Explain firmly that you want to protect yourself and the partner. You will make sure however that it is a pleasurable experience in a variety of ways
2. Assure the client that you will help him put on the condom so there is no delay in having sex
3. Spend longer time doing foreplay so the partner is aroused enough to get maximum pleasure

For men who have previous experience with commercial sex workers

1. Refuse to have any kind of sex till there is an agreement on using condoms
2. Make sure the client has either brought a good condom or is willing to use your condom before you start
3. Assure the client that you will enhance his pleasure through a wide range of activities

For men who have consumed alcohol

1. Do not have any kind of sex if the client refuses to use a condom
2. If the partner is willing, but not able to put the condom on, put it on him yourself

For men who are mentally disturbed

1. Talk gently about the client's problems and show him you care
2. Assure the client that he has the ability to overcome his problems by his own actions

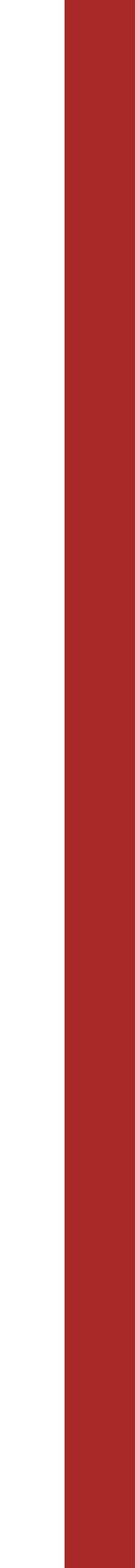
3. Firmly but gently, tell the client that although you are willing to have sex with him to help make him happy, you want to protect him and you from STIs/HIV. That is why he must use a condom with you.

For regular clients

1. Stress that you value the man as a client but also as someone important in your life and therefore you consider preventing STIs/HIV important for both of you
2. Gently but firmly state that protecting yourself is more important than keeping him as a regular client

For men who are aggressive

1. Get help from the “gatekeepers” (madames, pimps, bar owners, friends etc.) To convince the client to use condoms
2. Avoid direct verbal confrontation with the client; simply refuse to have sex without condoms



MODULE THREE

CONDOM USE

& NEGOTIATION

WITH REGULAR/INTIMATE PARTNERS
(Boyfriends, Spouses)

Module 3A

Condom use with my regular/intimate partner

For exercises on condom use please refer to:

- Module 3, Exercises 1-3
- Condom Use Tips
- Condom Use Cue Cards

Module 3B

CONDOM NEGOTIATION WITH Regular Partners

Exercise 1: Condom Negotiation Skills

Specific Objective: To equip sex workers with condom negotiation skills

Time: 1-2 hours

1. Ask participants if they have a regular partner, that is a boyfriend or spouse; someone who does NOT pay them for sex, someone they may live with. Ask them to describe that partner.
2. Then, ask participants to share some of their experiences successfully negotiating condom use with their regular partners. They may speak about who brought it up or proposed condom use, what happened, how it went, how it is going, and so on.
3. Ask whether any participants have tried to get their regular partner to use condoms but have failed. Ask them to share their experiences.
4. Organise group into threes. Ask each trio to come up with one scenario with a plan (this is NOT a role play) where a sex worker is trying to get a regular partner to use a condom. The plan should include a few words about the situation, why the sex worker is trying to get him to wear a condom, words of advice for the sex worker and a few statements that the sex worker can use when negotiating with the regular partner.
5. After about 7 to 10 minutes, ask one person from each trio to describe the situation they were working on, and the plan with statements they decided on.
6. Ideas that participants come up with may include:
 - Say no to sex without condoms clearly and directly. No condom, no sex.
 - State firmly and clearly that your life and health are more important than the fare
 - State firmly and clearly that you need to stay healthy for your children and/or family
 - Persuade your partner that you will make putting on and using a condom very exciting
 - Have condoms readily available; have a choice of types of condoms, if possible
 - Propose other ways of having sexual pleasure without penetrative sex
7. Ask participants if they learned anything new that they might try out with their regular partners?

Exercise 2: Condom Negotiation Role Plays

Specific Objective: To equip participants with condom negotiation skills through role playing real-life situations

Time: 1-2 hours

1. Show participants the cue cards on Condom Negotiation Situations with regular partners. Ask them for ideas on what sex workers could say in the situations depicted.
2. Divide participants up in pairs.
3. Hand out the Condom Negotiation with Regular Partner cue cards to several pairs. Ask pairs to study their cue card and come up with condom negotiation role plays (using some of the tips just discussed) to bring to life the situations depicted:
 - Partner says: “I know you use condoms with clients. I’m special, so you don’t need to use one with me.”
 - Partner says: “Condoms ruin sex for me. Got to have it ‘natchal’ with my girl or not at all.”
 - CSW thinks: “I can’t force my man to use condoms. If I even bring it up, he gets aggressive and abusive. Maybe I can suggest non-penetrative sex.”
 - CSW says: “My partner and I have agreed that we’re better off for now using condoms. Maybe someday when we both settle down, we can stop...but not for now.”
 - CSW says: “Baby, I’m protecting you as well.”

Other suggested role play situations:

- Where the regular partner is “under the influence or alcohol” or “drunk”
 - Where the regular partner is high on a drug other than alcohol
 - Where the regular partner is much older
 - Where the regular partner is much younger
 - Where the regular partner is known to be violent
 - Where the regular partner client is emotionally upset
 - Where the regular partner pleads with the sex worker
4. Have the group examine each role-play performance to see how well the role players communicated. What did each role player do that was strong? How could each role player have been more assertive?
 5. Passing the ribbon or a condom, have each participant take turns saying what she thought about the exercise and what she learned.
 6. Have each participant take turns saying how this exercise can help her relationship with her regular partner.
 7. Discuss with participants who would benefit themselves or their partners, from correct and consistent condom use?

Exercise 3: Using “I” Statements for Assertiveness

Specific Objective: To help sex workers develop assertiveness when communicating with their regular partners

Time: 1-2 hours

1. Ask participants to think of a situation where they were trying to get their regular partner (boyfriend or spouse) to do or agree to something recently: (pay a bill, watch the children, buy some food, clean the house, keep an appointment, etc.)
2. Ask participants how they think a person feels when someone looks them in the eye and says “YOU did this,” “YOU were supposed to do that,” “YOU said you would do this,” etc?”
3. Now ask participants what they think an “I” statement is (as opposed to a “you” statement?)
4. Now read the definition of an “I” statement below:
“An “I statement” is a way of clearly expressing your point of view about a problem. “I statements” say how a problem affects you and how you would like to see it change. Good “I statements” are free of demands and blame; they open a door for discussion and allow the other person to make a response. Good “I statements” are clear (the person gets to the point) and clean (free of blame, judgment or accusations.)
5. Now explain the three ways below of forming “I statements” to participants:
 - a. “When you do 'X' it makes me feel __.”
 - i. “When you come home drunk, it makes me feel sad.”
 - ii. “When you shout at the children, it makes me feel so angry.”
 - b. “I feel __.”
 - i. “I feel angry”
 - ii. I feel disappointed”
 - c. “What I'd like is __.”
 - i. “What I'd like is to have money to feed the children.”
 - ii. “What I'd like is to talk it over calmly rather than shouting at each other.”
6. Now ask the participants to think of a “You” statement. Discuss what the corresponding “I statement” would be. Discuss 2 or 3 examples.
7. Now, divide participants into two groups. Tell each group to form a line facing the other group. One group will be the “YOU” group; the other group will be the “I” group.
8. Starting with the “YOU” group or line, ask each “YOU” participant to say loudly to the person opposite her a “YOU” statement. The person opposite must think of a response in the form of an “I statement.” For example:
 - a. The “YOU” person says: “YOU” always carry on late and come home drunk.”
 - b. The “I” person says: “I feel so angry when you carry on late and come home drunk.”
9. Go down each line, repeating if desired.
10. Discuss the results with participants. Ask if participants feel they can use this communication technique with their regular partners? Why or why not?

Exercise 4: Sex in the Dark

Specific Objective: To increase each participant's awareness of the depths of her ignorance of her regular partner's current or past sexual activities, and therefore the current state of her own sexual health

Time: 1 hour

1. Do not tell participants the name and objective of the exercise at this point.
2. Organize the group into pairs.
3. Ask participants to bring to mind their regular (non-paying) sexual partners
4. Give pairs about 10 minutes (5 minutes per person) to tell each other about their regular sexual partner.
5. Call time. Get pairs to re-direct their attention to you.
6. Ask whether the current or past sexual activities of any of the persons came up during the dialogues.
7. Spend some time listening to the type of 'current or past sexual activities' persons shared. If none were brought up, ask participants to share about what they know.
8. Ask each person to rate her knowledge of her regular partner's current or past sexual activities a scale of one to ten. A score of 10 would mean that everything is known about that person's current or past sexual activities.
9. Go around the group recording scores. Stick a square of masking tape with the score (the number given) on the floor in front of each respondent.
10. Starting with the high scorers ask the following questions. Follow up each and every precise answer with: "How do you know?" (Tell those not being directly addressed to answer silently to themselves.)
 - How many sexual partners other than you does your partner have?
 - Does your regular partner use good latex condoms correctly and consistently with his other partners? With you?
 - Does your regular partner have any sexually transmitted infections (STIs?)
 - Did he use condoms correctly and consistently partners he had in the past?
 - Did any of his past partners have STIs?
 - Did your partner's father or mother have any STIs before, during or after the pregnancy?
11. Ask the group if they can guess the point of the exercise. Share its name and objective.
12. Ask participants if they are having sex "in the dark" with their regular partners? Would it be good to find out more about their regular partners current and past sexual activities?
13. Would they use "I statements" when discussing their partner's current/past sexual activities with him?
14. If such a discussion is not realistic, ask participants what they can do to protect themselves if they need to continue having "sex in the dark."

Module Four

Counseling and Testing: Benefits

Exercise 1: What is VCT?

Specific Objective: To increase participants understanding of what VCT is and how it can help them

1. Share the name and objective of the exercise.
2. Show participants the Cue Cards that accompany Module 4, in order.
3. When showing each card, begin a discussion with participants by asking questions as follows:
 - **Card #1: Commercial sex worker talking to peer educator or friend about VCT**
 - What do you think is happening in this card? Have any of you ever discussed getting an HIV test with anyone? Please describe.
 - Can anyone tell me what VCT is?
 - Why should persons who do sex work go for VCT?
 - Do you sometimes think about your health, your future, and the future of your children or family members?
 - **Card #2: CSW entering VCT site**
 - Where is this woman in the picture going?
 - Would you feel comfortable entering a VCT clinic/site?
 - Do you think knowing your HIV status is important? Why or why not?
 - Could you put aside any bad feelings and go ahead and get counseled and tested for the sake of your children or family?
 - **Card #3: CSW getting counseled by counselor**
 - What is happening in this picture?
 - Does the woman in the picture look comfortable?
 - Do you believe that the counselor will keep her business private?
 - Do you have any questions about HIV/AIDS, safer sex, testing, and/or living with a negative or positive result that you would like to discuss in private with someone?
 - **Card #4: CSW getting blood drawn**
 - What is happening here? Does the woman look comfortable? Would you be comfortable having your blood drawn if you knew it could benefit your health and that of your children/family?
 - **Card #5 & #6 -- Post-test counseling:**
 - **Card #5 -- Negative:** How does this woman look? Would you be relieved to know that your test result was negative? Would you change your life in any way if you got a negative test result?
 - **Card #6 -- Positive:** How does this woman look? Do you think she is better off knowing that she is positive? Why or why not? Do you think she can get help if she is positive? Treatment? Learn to eat better and get better exercise? Live longer with treatment and healthy living and be able to care for her children/family?

- **Card #7: CSW and friend/colleague discussing her HIV test result.**
 - Is there anyone in your life, other than a counselor, whom you could talk privately about your HIV test result with if you got tested? What kind of a person is that person?
 - **Card #8: CSW and regular/intimate partner discussing her status, possibility of his going for a test.**
 - Do you feel you could discuss your HIV status with your boyfriend/spouse? Why or why not? What could be the benefits of doing so?
 - Do you think your boyfriend/spouse could be convinced to go for VCT? Why or why not?
4. Invite persons who have been tested to share their experiences. Here is a guideline.
- When, where, why, what happened, feelings and thinking, before, during and after
 - What was the pre- and post-test counseling like?
 - What they did with the results the information, not the paper
5. Ask participants if any of them would now go for VCT?

Exercise 2: Ten Good Reasons for VCT

Specific Objective: To move participants towards seeing the importance of Voluntary Counseling and Testing

1. Share the name and objective of the exercise.
2. Have participants work in pairs and discuss 10 good reasons for someone to have Voluntary Counseling and Testing.
3. Have half of the group look at commercial sex workers, and the other half look at clients or regular partners/boyfriends/spouses
4. After about 10 minutes, have pairs take turns sharing their reasons. Begin with the pairs who looked at CSWs.
5. Consult the list below to ensure that all areas are touched on. Bring participants' attention to anything that did not come up.

Voluntary Counseling and Testing for HIV is good for commercial sex workers, their clients and their boyfriends/spouses because it helps persons:

- To take care of their health whether they are negative or positive
 - To know their status if they have been exposed to the virus
 - To take steps to remain uninfected, if negative
 - To accept a positive diagnosis, and begin learning how to cope
 - To make plans for the future, make decisions, take action and start managing their lives effectively
 - To reduce additional risks to self, if positive, e.g., STIs and other infections, re-infection
 - To seek early management of opportunistic infections and STIs
 - To reduce possibilities of infecting clients, regular sex partners, and babies through mother-to-child-transmission
 - To avoid unwanted pregnancies
 - To start planning for the future for self, for children and family members
 - To be advised on and referred for various forms of support
 - Nutritional; medical; social; household; legal; economic; emotional and spiritual
6. Invite persons who have been tested to share their experiences. Here is a guideline.
 - When, where, why, what happened, feelings and thinking, before, during and after
 - What was the pre- and post-test counseling like?
 - What they did with the - results the information, not the paper

Exercise 3: What you don't know can't hurt you? Yes, it can!

Specific Objective: To assess participants' capacity to meet arguments commercial sex workers and their clients and boyfriends/spouses raise against voluntary counseling and testing [VCT]

1. Tell participants the name and objective of this exercise.
2. Have participants divide into two groups.
3. Give the two groups 10-15 minutes to discuss the topic given. One group should come up with reasons commercial sex workers give for not wanting to get voluntary counseling and testing [VCT]. The other group should come up with reasons commercial sex workers should go for VCT.
4. When they have come up with their reasons, have them form two lines facing each other. Starting with those against VCT, have each group state loudly and firmly one reason against VCT; to be followed by a good reason to counter that statement in FAVOR of VCT.
5. Continue until the group against VCT has used up all its reasons. Now form a circle and assess which group was stronger and more convincing.

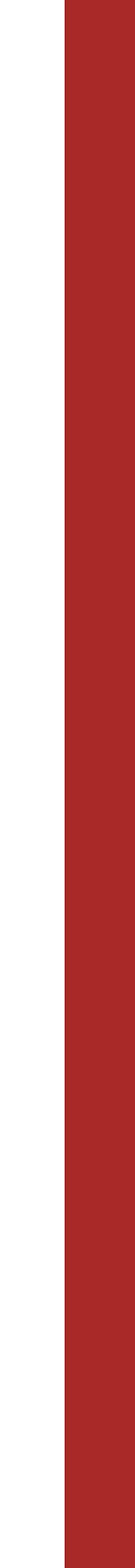
Arguments Against VCT may include:

- I'm okay!
- I usually use a condom with my clients
- Fear of stigma and discrimination
- There are no VCT services near where I live
- I'm afraid; I feel shame; I feel guilty
- If I have it then somebody gave it to me, so what if I pass it on!
- My partner at home would kill me if he knew I thought I might be HIV positive
- My boyfriend/spouse would leave me if he knew I was worrying about being HIV positive
- My boyfriend/spouse will accuse me of infecting him
- I will kill myself if I know I have the virus
- I can't handle the stress of knowing I am HIV+. Better not to know!
- God will take care of me. He knows best.
- The people at the clinics and labs are not “confidential,” not “respectful”
- The people who would see me coming and going would scorn me and pass around my business

Arguments for VCT

- Wouldn't you like to be free from the worry about whether you might have an STI or be HIV positive?
- Have you used condoms 100% of the time with your clients?
- Have you used condoms 100% of the time with your boyfriend/spouse?

- Have you ever had another STI, like leak, sores, etc.?
- God helps those who help themselves
- Do you have children? Do you care about their future?
- Would you want to have a child? Don't you want your child to be healthy?
- Are you expecting a child (mother to be) and could you have been exposed to an STI or HIV?
- Do you have a partner who may have other partners?
- Do you have a partner who may have unprotected sex with other partners?
- Have you ever had sex with someone who is HIV positive? How do you know one way or the other?
- Have you ever had sex with someone who had an STI? Are you sure?
- Have you ever had sex with a male partner who has had sex with a male partner? Are you sure?
- Have you ever had a blood transfusion?
- Have you ever shared a needle with a drug user?
- Have you ever had sex with someone who would answer yes to one or more of the above?
- Locations of VCT and other testing facilities ... and quantity and quality of services
- What if the testing facility does not provide pre- and post-test counselling?
- What if ... the person doesn't take a test?
- What if ... the test is positive?
- What if ... the test is "negative"?



Module 5

Referrals for STI & Other Services

Exercise 1: Needs, Benefits and Services

Specific Objective: To explore with participants the likely needs of CSWs who test positive for STIs, the benefits of being referred for STI and other services, and the specific services to which CSWs can be referred.

Time: 2 hours

Materials: pen and paper, chalkboard and chalk or flipchart and markers

1. Organise participants into three groups.
2. Ask the first group to do the following:
 - Make a list of the needs that a commercial sex worker (CSW) who tests positive (or who has an STI) might have. Remember, HIV is an STI.
3. Ask the second group to do the following:
 - List the benefits of being referred to others for help (“others” may include people, medical specialists and organisations)
4. Ask the third other group to do the following:
 - List the services (help) that people, medical specialists and organisations might be able to offer
5. Have each group report on their group findings. During the discussions on the group reports add points from the lists (“Needs...” “Benefits...” and “Services...”) below.
6. Ask participants to get back into their groups and look at these two questions:
 - What are the important things a CSW/peer educator should do BEFORE referring a peer?
 - What are the important things a CSW/peer educator should do AFTER referring a peer?
7. Add points from the notes “Five Steps in Referring Peers to Others for Assistance” below.

NOTE TO FACILITATOR: This exercise should be done together with the Module 4 exercises on VCT, since an important function of CSW/peer educators is to refer their peers for VCT services.

NEEDS OF A CSW WHO TESTS POSITIVE

- Emotional support through counseling, support group discussions
- Support from regular partners (if feasible)
- Support from family members (if feasible)
- Spiritual support
- Advice on how to continue support children and other family members financially and in other ways
- Support on seeking alternative employment
- Advice on planning for future of children, adoption, etc.
- Material support (food, clothing, shelter, etc.)
- Specific and detailed information on STIs, HIV/AIDS and treatment
- Financial support/advice
- Legal advice/assistance
- Assistance in accessing services (medical, psychological, social, financial, legal, spiritual)
- A friend/peer to talk to AFTER going for services
- Advice on living positively: nutrition, reducing stress, etc.

BENEFITS OF SEEKING TREATMENT FOR STI's

- Avoiding severe complications and even death that can result from untreated STIs
- Avoiding HIV. People with STIs are at increased risk for HIV
- Getting peace of mind through clarifying myths and misconceptions about STIs
- Helping your regular partner. Learning how to communicate with him about the need to use protection, avoid infection or re-infection, get checked for STIs, test for HIV and get treated
- Understanding and avoiding the health risks associated with self medication and other forms of improper STI treatment

SERVICES OFFERED IN GUYANA

- **Counseling and testing for HIV** -- (GUM Clinic, GRPA, Skeldon Hospital and New Amsterdam Hospital)
- **Screening for STIs** -- (GUM clinic, GRPA, Skeldon Hospital and New Amsterdam Hospital)
- **Support Groups** (GRPA, Lifeline Counselling Services, Artistes in Direct Support, Comforting Hearts, FACT.
- **Home Based Care** -- (Care for one's self and/or other family members living with HIV/AIDS)
- **Services for Orphans and other Vulnerable Children** -- (Help and Shelter, Comforting Hearts)
- **Material support**, food, clothing, hampers
- **Spiritual support** (pastoral counseling, fellowship, etc.) (Churches, Mosques, Temples)

NOTES TO FACILITATOR

FIVE STEPS IN REFERRING PEERS TO OTHERS FOR ASSISTANCE

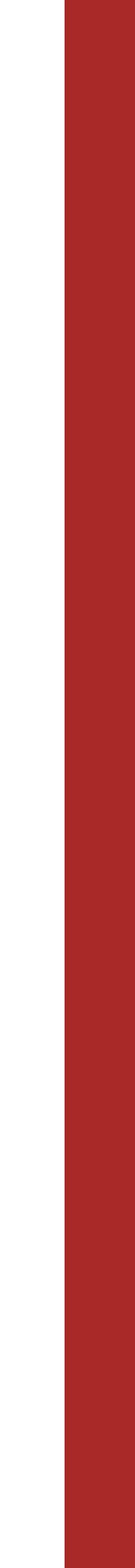
1. Find out peer's needs
2. Discuss with peer the benefits other persons, agencies and organisations can offer
3. Be confidential. Do not talk about peer's situation. Defend peer from idle talk. Seek and get agreement from peer before approaching others.
4. Make the contact and set up appointment for peer
5. Follow up, and if necessary try something else

FIVE-STEP REFERRAL PROCESS

1. Find out peer's needs. They may include the following:
 - Counselling, for peer, for partner, for family
 - Specific and detailed information on STIs, HIV, AIDS and treatments
2. Peer educator and peer can work together to match peer's needs. Individuals, inside and outside the peer's support group, institutions and agencies, governmental and non-governmental can offer and discuss benefits. Benefits may include:
 - Practical assistance in the form of financial support, medication, housing, home care and Specialized services such as, counselling, family planning, information and legal aid on adoption' (see more benefits above)
3. Seek and get agreement from peer before talking to someone else.
 - Seek the peer's consent before referring or bringing in others
 - Protect the confidential information and identity of the peer
4. Make the contact and set up appointment for peer
 - Make calls and help fill out forms that may be necessary for the peer to get the service or support needed
 - Let peer know the date, time, place and person/agency he/she has to see
 - Make appointment to see peer for feedback
5. Follow up. After the peer has been referred to someone or someplace for assistance, the peer educator, will need or may need to do the following:

- Enquire about the results of visit or talk or appeal
- Find out whether peer is satisfied
- Above all, maintain contact. Do not abandon your peer after referring him/her.

The more and more you listen,
The more and more you hear;
The more and more you hear,
The deeper and deeper your understanding becomes.
[Dilgo Khyenste Rinpoche, Tibetan teacher]



Module 6

Stigma and Discrimination

Exercise 1: Experiences with Stigma & Discrimination

Specific Objective: To sensitise commercial sex workers to stigma and discrimination by having them examine their personal experiences

1. Tell persons that you will be asking them to think of experiences they have had in the past with stigma and/or discrimination. Ask persons to think of times when they were treated unkindly, ignored, laughed at, shamed, insulted, called names, talked about, teased, rejected by parents, relatives, people in the community because of something about their body (skin colour, hair, eyes, size or general appearance), clothes, family situation, or their sex work ... for example
2. Invite participants to take turns sharing any one experience, and saying how they felt.
3. Briefly note some of the main feelings associated with stigma and discrimination.
4. Tell the women that you want them to think of times in their lives when they have been guilty of stigmatising or discriminating against someone - children, friends of their children, family members, people in the community, sister sex workers ... because of race, home situation, HIV/AIDS or other diseases, disability, and/or mental health ... For example
5. Close the session with the following observations:
6. Most persons have had experiences, some very hurtful, with being stigmatised and discriminated against.
7. Many of these experiences take place in the family ... amounting to emotional violence from persons expected to show love and give care.
8. Persons are often unaware that they are stigmatising and discriminating.

Exercise 2: High stigma, Low stigma, No stigma

Specific Objective: To deepen persons' understanding of stigma

1. Read the notes on stigma on the pages that follow to help enrich the discussion.
2. Share the name and objective of this exercise with your group.
3. Tell persons that you want them to take turns deciding whether the items you will be listing are *High Stigma*, *Low Stigma* or *No stigma*.
4. Move around the group systematically, calling out one item at a time, giving each person a chance. When someone has stated her view, you can allow those with a different opinion to say what they believe and why.
 - Explore different responses to the following general topics: blood in different situations; the different types of sex; the different ways of getting HIV; whether men see things differently from women; whether age, religion, culture, or occupation make a difference in the amount of stigma attached to someone or something; whether men or women are more stigmatized? Wait until others have spoken before you offer alternative views to facilitate and enrich the discussion.

5. Use items from the list below. **(As this exercise is field tested, GHARP should add ideas that may be offered by CSWs themselves):**

blood from menstruation ... blood from a cut finger ... blood on female underpants ... blood on male underpants ... urine ... pus ... vomit ... TB ... diabetes ... hypertension ... leak ... cancer ... anal sex [penis in the behind] between men ... male/female anal sex ... male/female oral sex [mouth to penis] ... oral sex [man's mouth to woman's vagina] ... diarrhea ... baby wearing diapers ... adult wearing diapers ... woman having sex with many partners ... man having sex with many women ... pregnant 13-year-old girl ... 13 year-old boy whose girlfriend is pregnant ... woman who has been raped ... man who raped a woman ... man who is raped by another man ... death from cancer ... death from heart attack ... death from AIDS ... suicide ... HIV from 'blood transfusion' ... HIV from sex work ... faithful wife getting HIV from unfaithful husband ... HIV from homosexual sex ... woman giving female domestic worker dirty underpants to wash ... man giving female domestic worker dirty underpants to wash ... not able to read ... being blind ... not able to speak as a result of being born deaf ... being black ... being white ... being albino ... being poor ...sex worker from particular locations in Guyana...sex worker-drug addict...sex worker-alcoholic...skinny sex worker...fat sex worker...Indo-Guyanese sex worker...Afro-Guyanese sex worker...

6. Organise participants in pairs or threes to note the different things that come together to make HIV and AIDS high stigma conditions. Take reports from each of the small groups.

Notes to Peer Educator

Stigma and Discrimination

1. **Stigma** is the marking of individuals or groups who have, or are thought to have, or to be, something people consider negative, for example, TB, HIV, 'prostitution.'
2. **Discrimination** is any action that is unfair and unjust. When family members stop sharing utensils (cups and spoons) when they know that loved ones are infected with the virus this is discrimination. For some persons, the fears associated with HIV is so strong that even when it is pointed out that they were happily sharing stuff before they knew the person was infected it makes no difference. Fear is a very, very strong feeling that 'emotionally hijacks' the rational, thinking brain.
3. The **stigma** attached to HIV is often related to how people think the HIV-positive person got infected.
4. There has long been stigma attached to persons who are homosexual or bisexual or who are sex workers or whose sexual practices are considered immoral. Thus old stigmas are added to new stigma.
5. Fear is a big part of **stigma**. HIV stigma carries with it fears of contracting multiple diseases, being sick for the rest of life, and dying in an unpleasant way. There are deep-seated fears associated with sex. There is the fear of judgment, punishment and God. Some of the fears that are associated with HIV and AIDS are as a result of a lack of information, not enough information or misinformation.

The consequences of stigma and discrimination

1. Stigma leads to labelling, name-calling, prejudice and discrimination.
2. Stigma is behind the negative thinking, language, attitudes and behaviors that people living with HIV or AIDS get from family members, partners, friends, clients and other commercial sex workers, communities, health care providers.
3. The stigma attached to HIV/AIDS and sex work leads women with HIV or AIDS to expect *and* experience discrimination, neglect, and abandonment, loss of income, loss of position, loss of friendship, and loss of family support, isolation, abuse and violence.
4. The stigma attached to HIV and AIDS and sex work affects the quality of care CSWs living with HIV or AIDS get and expect from family members and health care workers.
5. Because of stigma attached to sex work CSWs often do not seek professional care. They treat themselves with antibiotics or do nothing and hope the infection goes away.
6. Because of the stigma attached to HIV, commercial sex workers and their partners who test positive expect to be victims of stigma and discrimination. They are therefore afraid to get tested to find out if they are infected. When sexually active people don't know that they are infected, this leads to the spread of HIV.

Exercise 3: "Ifs"

Specific Objective: To help persons get a better sense of themselves, and come face to face with the stigma attaching to HIV in their lives

1. Put the statements below to the group to answer *yes* or *no* silently.
2. Have persons take turns saying what they were *thinking* and *feeling* during the *Ifs*.
3. Go through each "If" one at a time, and have persons say:
 - The different things that *yes* answers might mean
 - The different things that *no* answers might mean
 - The different things we can learn about stigma and HIV from *yes* and *no* answers
4. Close the exercise by reading the piece in the box below and asking each person to say one change she will make, one thing she will do, as a result of what she learned.

1. If I had HIV, I would know how I got it.
2. If I had HIV, I would feel ashamed, helpless and hopeless.
3. If I had HIV, my family, my friends and partner would continue to treat me exactly the same as before.
4. If I had HIV, my regular partner is the first person I would tell.
5. If I had HIV, I would want to continue having sex.
6. If I had HIV, my regular partner would accuse and abuse me if he is also infected.
7. If I had HIV, and my regular partner did not, he would support and care for me.
8. If I had HIV, I would tell my clients.
9. If I had HIV, I would continue with my sex work, but use a condom every time.
10. If I had HIV, and I told my clients, they would feel comfortable using a condom.
11. If I had HIV, I would tell my children.
12. If I had HIV, my family would feel that I am a burden.
13. If I had HIV, I would feel like a burden on my family.
14. If I had HIV, my family would do everything they could to help me care myself.
15. If I had HIV, I would talk to other sex workers about taking care of themselves.
16. If I had HIV, other sex workers would speak unkindly about me
17. If I had HIV, other sex workers would make it hard for me to work

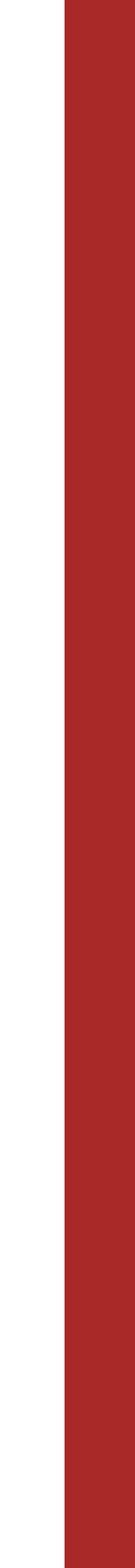
Exercise 4: How I feel About Who I Am and What I Do

Specific Objective: To help commercial sex workers understand the connections between stigma, self-image, and HIV

1. Pass the 'talking thing' and have each person take turns saying "How I feel about who I am and what I do," and *why*.
2. After everyone has spoken, have each person assess *how the group as a whole feels* about who they are and what they do. Which of the following would they pick?
 - Very good
 - Good
 - Okay
 - Not too good
 - Bad
 - Very bad.
3. Organise the group into pairs.
4. Have half of the pairs spend about 10 minutes discussing:
 - Why commercial sex workers who do not have a good self-image might be more likely to get infected with HIV, than those who think well of themselves.
5. Have the other set of pairs spend their time discussing:
 - Why male clients with little self-respect, and little respect for women, are more likely to expose CSWs to HIV infection.
6. After the pair-group reports, ask those persons who could be described as feeling 'very good' or 'good' about themselves when responding to the question at #1, say
 - Whether feeling 'good' about themselves can help them if they are HIV-positive?
 - What advice and counsel they would give to their sisters who did not feel as good?
7. Close with each person saying what they learned about stigma and about themselves as a result of this exercise.

Notes to Peer Educator:

- Stress that CSWs who are more stigmatized and discriminated against are usually more vulnerable to acquiring HIV because they may not feel good about themselves.
- Make sure that participants see that CSWs who feel good about themselves are more likely to protect themselves from HIV.
- Stress the point that even though they may face stigma and discrimination because they are CSWs and/or for other reasons, they must learn to recognize how this affects their feelings, learn to get support wherever they can and recognize when and how they may put themselves at risk for HIV.



Module 7
Male Attitudes about Sex

Exercise 1: Thinking and talking about Men

Specific objective: To get commercial sex workers thinking about how men and their attitudes contribute to putting women at risk

1. Select and read aloud one of the sentence fragments below. Ask participants to think about how they would complete each statement. (Use the cue cards intended for Module 7.) After a moment, have participants take turns completing and expanding on their statements, as they wish.

- Men like women who...
- Men think women should...
- Men think condoms are...
- Men want children because...
- Men think taking care of children is...
- Men think their sons should ...
- Men think their daughters should...
- Men think family life is...
- Some men leave their families because...
- Men like having many sexual partners because...
- Men like partners who...
- Men drink alcohol because...
- Men like women to drink or get high because...
- Some men like drugs because...
- Men think work is...
- Men think sex workers are...
- Men think sex work is...
- Men think God is...

2. Ask participants how certain attitudes of men affect them as sex workers? Do these attitudes make their work easier? More challenging? How do these attitudes put them at risk for HIV/STIs?

Note to facilitator: The purpose of this exercise is to get CSWs thinking and talking about how male attitudes lead them to put themselves and women at risk for HIV/STIs. The discussion should include whether, by understanding men/male clients a bit better, CSWs can practice safer sex, stay healthier and remain able to take care of their children an/or families.

Exercise 2: From Boys to Men

Specific Objective: To engage participants in connecting what boys and men want and need to how that affects girls and women

1. Do not tell participants the name or objective of the exercise at this time.
2. Divide the group into four groups.
3. Have one group discuss *what boys want*; one discuss **what boys need**; another discuss *what men want*; and another *what men need*. (Note: Do not let the groups know that they are being given different assignments.)
4. Now assign each of the four groups one of the following topics/questions, being sure NOT to let the groups know each other's question: 1) “what do boys want?” 2) “What do boys need?” 3) “What do men want?” and 4) “what do men need?” Allow about 10 to 15 minutes for the groups to discuss their topics and decide who will report back to the whole group on their views.
5. Ask each group to report on their views one at a time. Announce the question to all participants just before each group reports.
6. Ask participants for feedback on what came up. Ensure that everyone is given a chance to speak. Here are issues you can pose after the start of the discussion:
 - What are the differences in what boys and men want?
 - How are the things boys want the same as the things men want?
 - Are some of the things men want things that humans want?
 - How is “being human” different from “being a man”?
 - What role do women play in helping boys become men?
7. Invite participants to comment on any things that surprised them.

NOTE TO FACILITATOR: The point of this exercise is to get CSWs to reflect on the fact that men were once boy children. That while men do influence boys in growing up and taking on social and gender roles that can be detrimental to women, women also play a role in raising boys to men. Are there things CSWs can make to help boys become better men?

Exercise 3: "Think of your father!"

Specific Objective: To enable participants to explore the connections linking sex, fathers and HIV

What to do

1. Lead participants in a deep breathing exercise. Three long, deep breaths out, in, out, in, out, in. They should pay attention to each breath as it leaves and enters the body.
2. Tell participants the name and objective of the exercise.
3. Have participants close their eyes, listen, think and feel, as you stop after each point:
 - Imagine your father's semen released from the seminal vesicles, the prostate and testicles and fast forwarding into your mother's body.
 - Imagine *one* of the millions (200 to 400 million and more) of your father's sperm suddenly bouncing up on your mother's "ready body" egg and finding itself at its center. Imagine your mother's egg, thirty times the size of the sperm, closing up around your father's sperm cell. Think of your father!
 - Imagine yourself, starting to form ... and your little body developing during the months you spend in your mother's womb. Think of your father!
 - Imagine your mother laboring to bring you into the world, either prematurely or around nine months. Think of your father!
 - Imagine your baby body at the time of your birth. Imagine yourself, year by year, through childhood and adolescence while you think of your father.
4. After a few minutes, tell participants to continue to keep their eyes closed. Have them spend some quiet time thinking about the part their fathers played (or did not play) in their lives as boys, young men, adult men and how this shaped their feelings about themselves, sexual attitudes and behaviors.
5. After about five minutes, gently call on participants to open their eyes.
6. Have each person take turns sharing some of what came up. (Pass the 'talking thing' systematically from hand to hand, without excluding any one. If someone chooses to pass, have a second round to give persons another opportunity to share.)
7. This may be an emotional session, so be on the lookout for persons needing a comforting touch or squeeze from fellow participants sitting nearby.
8. After everyone has shared, have a 'hug break.' Have the group stand in a circle with everyone hugging the person to their left, the person to the right, and at least one other person across the circle.
9. Resume the session by having the group review:
the main ways HIV is transmitted sexually (any type of unprotected sex), and mother-to-child-transmission (MTCT) of HIV (during pregnancy, childbirth and breastfeeding) telling or reminding participants that it is especially dangerous for a woman to become HIV infected during pregnancy and breastfeeding, because the level of the virus is especially high soon after infection
10. Close by having each person say what *three things* she can do as a commercial sex worker to protect her children from being infected through mother-to-child- transmission (MTCT) of the virus

Adapted from Bodywork II, Men in Mind, Bonita Harris

Exercise 4: Living with Men, Living with Humans

Specific Objective: To engage participants in thinking and talking about men being manly and being human, and how this can improve their lives

1. Do not tell participants the name or objective of the exercise at this time.
2. Divide the group in half. Divide each half in pairs.
3. Have one half of the pairs discuss what *being a man* means to them; and the other half, what *being human* means to them. (Note: Do not let the two sets of pairs know that they are being given different assignments.)
4. Allow about 10 to 15 minutes for the pairs to discuss their topics and decide who will report back to the whole group on their views.
5. Have the pairs who discussed 'being a man' report first.
6. When they have reported, announce that the other half of the group had been asked to discuss what 'being human' meant to them.
7. Have these pairs report.
8. Ask participants for feedback on what came up. Ensure that everyone is given a chance to speak. Here are issues you can pose after the start of the discussion:
 - Do humans behave better than animals?
 - How was 'being human' different from 'being a man'?
 - How does this play out in male parenting behaviors
 - with children in the early childhood, and
 - with adolescents (teenagers)
 - Compare with female parenting behaviors for both age-groups
 - How does this play out in man/woman relationships and sexual relationships? [Remind participants that sexual relationships are not all man/woman.]
 - What are men like with respect to
 - not being able to meet financial obligations to the family
 - loss of income
 - health-seeking behaviors
 - getting tested for HIV and other STIs
 - dealing with negative and positive test results
 - caring for children, in good and bad health
9. Share name and objective of the exercise. Ask whether anyone has a problem trying to think of their men as being less “manly” and more human.
10. Close by asking each participant to identify relationships where men have shown them more human qualities.

Adapted from Bodywork II, Men in Mind, Bonita Harris

Module Eight

Reproductive Health & Contraception

Exercise 1: Genital Hygiene

Specific Objective: To clarify practices that support good genital hygiene

Time: 30 minutes

1. Ask participants to explain what they understand by the phrase “genital hygiene”
2. Ask participants to rate their genital hygiene on a scale of 1 to 10 with 10 being perfect genital hygiene.
3. Pass around a marker for each person to mark her rating on a sheet of paper
4. Now, have each person hold up the appropriate cue card(s) and explain what she understands about genital hygiene using cue cards
5. Organise participants into threes or fours and give each group about 5 minutes to think and make a list of genital cleaning agents
6. Take reports. Each group's spokesperson should explain points with examples that should include.
 - Knowing that the vagina is a self cleaning organ
 - Knowing that the vagina contains acid that kills infectious bacteria
 - Practicing good sexual hygiene- practicing washing the vagina after sex (without harsh methods of cleansing)
 - Always washing and wiping the vagina from front to back to avoid transferring bacteria from the anus to the vagina
 - Not putting anything into the vagina or anus that may carry germs
 - Learning to wash the entrance to the vagina and anus with a mild, non- perfumed soap
 - Not washing the vagina with vinegar, lime or harsh soap.
7. After each small group reports on its deliberations, invite others to add their thinking.
8. Have each person take a second look at her genital hygiene rating and say whether there needs to be any change in her score (in the light of the discussion and new insights.)
9. Close exercise with each participant identifying one person with whom she will have a good genital hygiene discussion somewhat along the lines of the session. This discussion should begin with a personal rating, then giving views on what contributes to genital hygiene, etc. like the exercise above. Make it a homework assignment with participants reporting back to the group or to one member of the group. In the case of the person-to-person report, make sure that contact numbers are exchanged.

Exercise 2: Reproductive Health - Organs

Specific Objective: To enable participants to understand the multitude of factors that contributes to reproductive health

Time: 60 minute

1. Find out, by a show of hands, who understands the term 'reproductive health.'
2. Ask a few of the 'knowers' to explain to the rest of the group, the meaning of the following: *production, re, reproduction, health, and reproductive health.*
3. Divide the group into pairs, handing them copies of the cue cards for reproductive health.
4. Have each pair come up with ideas of what is important related to reproductive health for sex workers, using the cue cards to stimulate ideas.
5. Give the pairs 15 minutes to discuss and prepare to report to the whole group. They can use the cue cards to support their presentations.
6. After pairs have reported, enlarge on points made, and add points not mentioned, from the list below:
 - Knowing where one can get more reproductive health information
 - Knowing about the reproductive organs and understanding how they work
 - Understanding the menstrual cycle, egg and sperm cell production
 - Understanding the physical and psychological risks of early sex
 - Understanding the risks associated with pregnancy, childbearing and child rearing for their children (“the unready.”)
 - Understanding the role of nutrition; cigarettes, alcohol and drugs; stress; infection and disease; contamination by toxic and poisonous agents in the bodies of women and men engaging in unprotected sex and in children they produce
 - Keeping free of infections and disease, especially HIV, before, and especially during pregnancy, and after, especially if planning to breastfeed
 - Testing for HIV and other STIs
 - Preventing mother-to-child-transmission of HIV
 - Having the economic, emotional, social and spiritual resources for raising healthy children, as well as children with HIV or other disabilities. Knowing where to go for more information and support.
7. Close with each participant thinking about and then saying three things she will do to develop and maintain good reproductive health.

Exercise 3 Contraceptive Methods

Specific Objective: To clarify participants understanding and knowledge of different contraceptive methods.

Time: 60 minutes

1. Find out, by a show of hands, who understands the term 'contraceptive'
2. Ask a few of the 'knowers' to explain to the others what they know
3. Divide your group into fours
4. Have the different groups discuss what they know about the different contraceptive methods. Give them each copies of the “cue cards” for contraception to use to stimulate thinking.
5. Give the pairs 15 minutes to discuss and prepare to report to the whole group. They may use the cue cards to support their presentations.
6. After groups have reported, enlarge on points made, and add points not mentioned, from the list below:
 - Getting and acting on contraceptive methods information, making behavioral changes where necessary
 - Knowing about contraceptive methods and understanding how they work
 - Avoiding sex without a condom
 - Knowing that the condom is the only contraceptive that protects women from pregnancy and contracting STIs including HIV
 - Understanding how to use condoms correctly
 - Family planning (in the broadest sense, not just preventing pregnancy)
 - Understanding the role of nutrition; cigarettes, alcohol and drugs; stress; infection and disease; contamination by toxic and poisonous agents in the bodies of women and men engaging in unprotected sex and in children they produce
 - Keeping free of infections and disease, especially HIV, before, and especially during pregnancy, and after, especially if planning to breastfeed
 - Testing for HIV and other STIs
 - Preventing mother-to-child-transmission of HIV
 - Understanding how other forms of contraception including the IUD, sponge, the pills (oral contraceptives), and injectables work, bearing in mind that these methods do not protect against STIs
7. Close with each participant thinking about and then saying three things she will do to develop and maintain good and proper contraceptive use

Fact Sheet on Female Reproductive Organs

Female Reproductive Organs

The parts of the female that are involved in sexual activity, pregnancy and childbearing are called reproductive organs. These are outside and inside the woman's body, but for this manual, we will focus on the parts inside the woman's body. These include the ovaries, fallopian tubes, the uterus (womb) and the vagina. These organs lie inside the lower part of the abdomen, in the “pelvic” region and are protected by bones and muscles.

The fallopian tubes

The two fallopian tubes connect the ovaries to the womb on either side. When the egg is released from one of the ovaries every month, it is pulled into the fallopian tubes and is very gently moved along the tubes toward the womb. (See cue cards)

The uterus (womb)

Before pregnancy, the womb is about the size of a small mango. The lower end of the womb is called the cervix, and it connects with the upper part of the vagina. (See cue cards)

The cervix

The cervix is sometimes called the neck of the womb. It connects the womb to the vagina and normally has a very small opening. This protects the uterus from infections. During pregnancy, this opening stays small so that the baby can be inside the womb and during labour the cervix opens up (dilates) so the baby can be born. (See cue cards)

The vagina

The vagina is the channel between the womb and the outside. Menstrual blood flows out of the womb through the vagina. The vagina also produces fluids; the amount of the fluids, and their colour and texture varies at different times if the month. (See cue cards)

The vulva

The vulva is the area around the opening of the vagina which can be seen from the outside. The outer folds of skin called the labia majora, are thick and covered with hair. The two inner folds of skin, called the labia minora are much thinner. They cover and protect the vaginal opening. These inner folds form a hood around the clitoris, a small sensitive organ above the vagina that responds to stimulation and makes sexual intercourse pleasurable. Inside the vaginal opening is a pair of glands that produce a thin fluid, which moistens the vagina especially during sexual excitement. (See cue cards.)

Fact Sheet on Genital Hygiene

It is quite common for women to be concerned with cleanliness and 'smelling sweet'

However, it is not healthy to douche, scrub with antiseptic, use perfumed soaps or vaginal deodorants. These kill the natural acid and an infection or allergic reaction is more likely to occur by using such cleansers

It is important to remember that the vagina is a self-cleansing organ and has its own way of dealing with bacteria.

The moisture in the vagina contains acid that kills infectious bacteria. All that needs to be done is:

- Wash the entrances to the vagina and anus everyday with a mild, non-perfumed soap.
- Always wash and wipe from the front to the back, to avoid transfer of bacteria from the anus to the vagina.
- Wash the genitals after sex.
- Don't put anything into the vagina or anus that may carry germs.

Fact Sheet on Contraceptive Methods

The Condom

Condoms are made of latex and should be put on a man's erect penis before sexual intercourse. When a man ejaculates (comes) the semen containing the sperm is collected in the tip of the condom. There is a small chance that the condom may tear during sexual intercourse, especially if it is not worn correctly or if it was not stored in a cool place before it was used. It is important that the man be careful to withdraw his erect penis from the vagina with the condom still on, so the semen does not spill into the vagina.

Condoms are made in different sizes, shapes and colours and they may come with or without lubrication. They should be used only once as they are likely to tear if used a second time. Wearing condoms greatly reduces the chances of pregnancy. They also provide protection against sexually-transmitted infection (STIs), including HIV. If used correctly and consistently, the condom is 98% effective at preventing pregnancy. Lower success rates of 85% to 98% account for failure to use condoms correctly and consistently. Other than abstinence, condoms offer the best protection for sex workers against pregnancy AND STIs.

The Diaphragm

Diaphragms are 'domes,' made of thin, soft rubber. They form a physical 'barrier' to sperms though you have to use a spermicide (chemical) with them as well.

You can't just buy a diaphragm 'off the peg' at a chemist for the simple reason that women's vaginas come in various sizes (particularly after they've had children). So you need to have your vaginal size assessed by a doctor or family planning nurse. She or he will then prescribe the size you need. Most importantly, she or he must teach you exactly how to put the diaphragm inside and how to get it into exactly the right place. If you haven't been taught how to do this, you'll probably position it so that it doesn't cover your cervix; this would leave you wide open to getting pregnant.

Remember, the diaphragm does NOT prevent transmission of STIs.

Spermicides

Spermicides are chemicals that destroy sperm. One advantage of these products is that you can buy them from any pharmacy without prescription. But these agents really shouldn't be employed on their own, because they're not effective enough. If you use them by themselves, there's a high chance that sperm will get through sometimes and cause pregnancy.

Experts agree that chemical contraception should only be used in combination with a 'barrier method' - such as a condom, diaphragm or a cervical cap. The chemicals make these barrier methods more effective. In other words, fewer pregnancies will occur if you use a condom, diaphragm or cap with a spermicidal chemical. From time to time, manufacturers may suggest that these agents are so good that they can be used on their own! Don't pay any attention to these claims.

IUD

IUD' stands for 'intrauterine device.' ('intrauterine' means inside your womb.) An IUD is a small device that is shaped in the form of a “T.” It's very small not much longer than a matchstick -- and made of plastic and may contain copper or a natural hormone produced by your body. The hormone in the IUD (progestin) causes the mucus in the cervix to thicken so that sperm cannot travel through the fallopian tubes to reach the egg. However, if fertilization were to occur, the IUD would prevent the fertilized egg from implanting in the lining of the uterus. The IUD can stay in your body for several years. The IUD must be inserted into the uterus by a doctor

An IUD could comfortably sit in the palm of your hand. Your womb (uterus) is actually about the size of your clenched fist. So if you close your hand round a matchstick that gives you a rough idea of how an IUD sits inside your womb.

The IUD is approximately 98% effective at preventing pregnancy. But remember, the IUD does not prevent transmission of STIs.

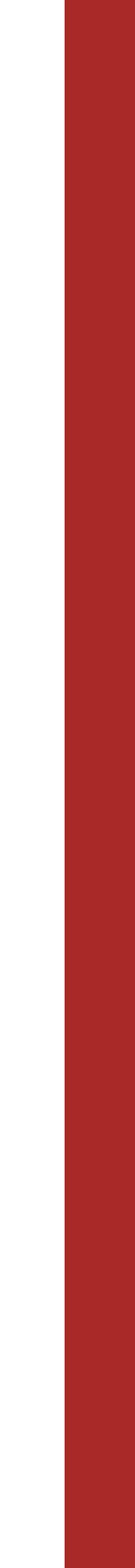
Oral Contraceptives

The tablets often referred to as “the pills” contain artificial forms of hormones (chemicals) produced by the body. The pill is taken daily to block the release of eggs from the ovaries. The most common type of pills is called the combined oral contraceptive or COC for short. The other type is called the progestin-only pill (POP) or the “mini pill” The pill lightens the flow of your period and has other health benefits, including reducing the risk of ovarian cancer as well as iron deficiency (“anemia.”)

However, the pill may add to your risk of heart disease, including high blood pressure, blood clots, and blockage of the arteries, especially if you smoke. If you are over age 35 and smoke, or have a history of blood clots or breast, liver, or endometrial cancer, your doctor may advise you not to take the pill. The pill is 95 to 99.9% effective at preventing pregnancy. However, the pill does not protect against STIs.

Injectables “Depo-Provera”

With this method women get injections, or shots, of the hormone progestin in the buttocks or arm every 3 months. Women should not use Depo-Provera for more than 2 years in a row because it can cause a temporary loss of bone density that increases the longer this method is used. The bone does start to grow after this method is stopped, but it may increase the risk of fracture and osteoporosis if used for a long time. It is 97% effective at preventing pregnancy. You will need to visit your doctor for the shots and to make sure you are not having any problems. It does not protect against STDs or HIV.



Module 9

Alcohol Abuse/Drug Use

Exercise 1: Drunk & Disorderly

Specific Objective: To engage participants in making connections between alcohol abuse, violence, sex and HIV

1. Have participants spend a few moments silently recalling personal experiences with 'drunk and disorderly' behaviors and the physical, emotional, mental and spiritual damage caused in their work, their relationships and their families and in families they know. Tell participants to go as far back as they can from early childhood, through adolescence to today.
2. After 2-3 minutes, say the following phrases out loud one by one, pausing for a few seconds after each to make sure participants heard and understood.

ALCOHOL, DRUGS, VIOLENCE, SEX, SEX WORK & HIV

- **Drunk & Disorderly**
 - **Pure Madness**
 - **Fear Factor**
 - **Threatening Behavior**
 - **Broken Spirits**
 - **Slamming and Banging**
 - **Shame and Blame**
 - **Gang Rape**
 - **Blood & Guts**
 - **Heart Break**
- 3.
 4. Share the name and objective of the exercise.
Ask each person to select one item she has personal experience with and relate the experience to the group, making the alcohol, violence, sex, sex work and HIV connections.
A personal experience can be direct or indirect. It may not have actually happened to the person relating the experience, but she may have witnessed or
 - heard of an experience that touched her deeply.The sex connection may or may not have involved actual or immediate sexual
 - contact, but may affect present or future sexual feelings and relationships.The HIV connection need not have involved actual infection, but the possibility
 5. of exposure or infection.
Close with participants saying three things they can do to contribute to behavior change in this area of life.

Exercise 2: My boyfriend or spouse drinks ... or does drugs

Specific Objective: To give participants an opportunity to think about, describe and learn from each other about handling peer problems with alcohol and drugs

1. Share the objective of this exercise with the group.
2. Ask each participant to imagine a situation where a commercial sex worker approaches a peer educator with a problem with a boyfriend or spouse who drinks ... or does drugs.
3. Now ask a volunteer to imagine that she is talking to the peer educator or counselor about the alcohol or other specific drug use of her boyfriend or spouse and how it is affecting her life, her work, and the life of her children or family specifying the type of alcohol or drug, preferably one the peer educator knows about.
4. Ask another volunteer to imagine how the peer educator or counselor should handle the situation.
5. If time permits, ask for pairs of volunteers to role play similar scenarios.
6. Have participants evaluate and offer suggestions on each peer educator or counselor's "handling" of the situation with the CSW.
7. Now, have half of the group discuss, in pairs, the connections between alcohol use and abuse and STIs, including HIV.
8. Have the other half discuss, in pairs, the connections between drugs (users, sellers, clients and family members of the two groups, separately) and STIs and HIV.
9. Have one person from each pair report to the group.
10. Ask for feedback from the pairs on their thinking.
11. Ask for comments from the group about whether the exercise achieved its objectives.

Exercise 3: At the Rum Shop...in my home

Specific objective: To get participants to consider the impact alcohol and/or drugs have on their lives, their work, their health and their children and families

Show participants cue cards that depict the following scenes:

1. Drinking at the rum shop
2. Drinking at home
3. Drinking in the bedroom
4. Clients and/or sex workers doing drugs

Divide participants into four groups, giving each group one of the cue cards to study and discuss. Tell them they are to have a discussion and come up with some conclusions to report back to all participants later.

Now ask all the participants the following questions:

1. What do you see happening in the picture? What do you think the persons in the picture are feeling?
2. How do you think drinking and drugging affect the amount of time these people have for other important things?
3. How do you think drinking/drugging affect their decisions?
4. How do you think drinking/drugging relate to unsafe sex? To condom use?
5. How do drinking/drugging relate to physical and emotional abuse?

Now ask participants to consider how drinking and drugging affect their lives? Their work? Their ability to negotiate condom use? Their feelings about themselves? The decisions they make in their lives? Their relationships with their children and/or families? Have alcohol and/or drugs led them to experience any kinds of abuse? (sexual, emotional or physical) violence

If time permits, divide participants into groups to develop 2-minute role plays on each scene.

Conclude by asking each participant what she thinks she can do to improve her life, or the lives of her children/family or boyfriend/spouse in relation to drugs and alcohol?

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