

DRAFT

Guidelines for Behavior Change Interventions to Prevent HIV

Sharing Lessons from an Experience in
Bangladesh

Based on the Application of Lessons from Sonagachi,
Kolkata.

Best Practice Collection from the Region, UNAIDS
South Asia Inter Country Team



Joint United Nations Programme on HIV/AIDS

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Contributing Author: Geeta Sethi and Smarajit Jana
Consulting Editor : Deepika Ganju
Support in design and lay out: Enamul Haque & Yasmin

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CARE, Bangladesh, and the many NGOs and
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October 2003

Dedicated to people living with HIV
and
peer educators of sex worker projects
in Bangladesh

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Foreword

Guidelines for Behaviour Change Interventions to Prevent HIV/AIDS

Bangladesh is a country most vulnerable to HIV/AIDS. Behavioural factors such as the high prevalence of risk behaviour, economic factors such as poverty, social factors such as the disadvantaged status of women in society, geographical factors such as the close proximity to high prevalent countries and serological factors such as the increasing percentage of drug users reacting positive to the HIV antibody test are but some of the factors that make us vulnerable. Bangladesh presently shows low prevalence, however, there is high vulnerability for HIV/AIDS.

It is well known that interventions targeting vulnerable populations are a good investment for a country that is in this early phase of the epidemic. Bangladesh has been a country that has realised this. It has implemented behavioural change intervention programmes for vulnerable populations for a number of years and is now documenting them as a best practice.

For UNAIDS a best practice means accumulating and applying knowledge about what is working and what is not working in different situations and contexts. It is not reserved only for the 'ultimate truths' or 'gold standards'. While perfection is ideal, practicality is more important considering the urgency in which we have to respond to the epidemic.

This publication though meant to be a manual on guidelines has more than that. It skilfully mixes experiences of the implementing agency, CARE, Bangladesh while providing guidelines for field managers. It can also be used as a training manual for grassroots level workers. The lessons learnt are based on five years of experience working with sex workers on HIV/AIDS prevention. The project builds on experiences already gained in the Sonagachhi Project in Calcutta, India.

Readers of this publication will find many lessons not only related to HIV/AIDS prevention interventions, but also general concepts related to the HIV Virus and how it acts, methods of prevention and the importance of recognising the human rights of vulnerable populations. I congratulate CARE for the good work carried out in this field.

Ms. Suneeta Mukherjee
Chairperson, UN Theme Group on HIV/AIDS.

PREFACE

The spread of the HIV/AIDS epidemic has been rapid and devastating. Statistics show that around the world an estimated 5 million people were newly infected with HIV in 2002, and 27 million people have died of AIDS since the beginning of the epidemic. Currently 42 million people are living with HIV/AIDS, 90 percent of whom are in developing countries, many of whom are women and children.

The Asia-Pacific region is facing an emerging epidemic and effective steps need to be taken to prevent the transmission of infection. Although mostly confined to certain vulnerable groups, parts of India, Thailand, Myanmar and Cambodia have seen the burden of HIV enter the general population. It is estimated that there are 7.2 million HIV positive adults and children in the Asia and Pacific region, and it is unlikely that Bangladesh will be spared the impact of the epidemic without substantial efforts and focused programs for effective prevention.

Recognizing that Bangladesh is on the brink of an epidemic, the Health Minister for Bangladesh, **Dr. Khondokar Musharaf Hussain**, speaking at the National Strategic Review And Integrated Planning Workshop, January 2002, commented, “ HIV/AIDS is an unknown but hidden threat for Bangladesh. We are experiencing low prevalence situation with high risk behaviours, which may fuel the current situations if we do not act now for prevention on urgent basis.” Research from Bangladesh confirms that risk behaviors exist, perhaps to a greater extent than imagined.

With the HIV epidemic continuing to devastate the lives of men, women and children in the absence of an effective cure, this manual is a well-timed initiative to help program implementers to design interventions for vulnerable groups in developing countries to bring about behavior change and a shift to safer practices.

INTRODUCTION

No country is immune to HIV. Irrespective of culture and religion, all communities are vulnerable to HIV/AIDS and almost every country has people living with AIDS. No drugs or vaccines have been able to prevent or cure HIV infection so far.

Given the rapid spread of the epidemic, it is necessary to increase knowledge and awareness regarding HIV/AIDS and encourage communities to adopt safe practices. Behavior change intervention focusing on risky behaviors in certain sub-populations can prevent the epidemic from spreading. However, global experience shows that there is no ideal intervention model that can work in every setting to prevent the spread of the disease. Basic guidelines for planning, designing and implementing such interventions, and programs must be designed to suit the particular community and change their specific risk behavior.

What has been shown to be most effective in effective behavior change is a community-based comprehensive effort that combines awareness with services and advocacy and creates a supportive environment. This is often referred to as a ‘targeted’ or ‘focused’ intervention. Focused intervention requires a combination of skills, attitudes and philosophy on the part of the implementing staff to result in a change to safer behavior.

This manual seeks to share ‘best’ practice in the context of HIV/AIDS interventions so that program implementers can design appropriate projects based on past experiences. While recognizing that different models can be used for behavior change (for instance, indigenous leaders to advocate behavior change), this manual is based on behavior change communication through peer outreach, a strategy that has been successfully used in the Tangail brothel in Bangladesh. The experience in Tangail, which was based on earlier practices in Sonagachi, Kolkata, India has led to a systematization of the steps for intervention. This manual presents these steps to enable those who would like work in this area to design and implement a comprehensive behavior change intervention effectively.

The first section provides a brief overview of issues related to HIV/AIDS in the context of its transmission, the spread of the epidemic, the prevalence of HIV in Bangladesh, and the lessons learned on what does and does not lead to effective behavior change in communities. The second part lists steps for effective intervention among vulnerable groups. Action points are discussed in each step to guide program staff in implementing the step. Exercises have been designed to reinforce the action points. Each step lists points to ‘remember’ when implementing the step to sensitize project staff to related issues. Although this document has been written in the context of brothel-based intervention, the examples and exercises are relevant to other vulnerable groups as well. **Instructions for the use of this document as a training module are provided on the next page**

The Tangail experience has been discussed in tandem with the step-by-step guidelines to show how the intervention was implemented on the ground.

The third section provides guidelines on how to conduct research. Ethical issues to be considered when designing and implementing projects are discussed in the annexures. Some of the tools used in the Tangail project are also appended to facilitate data collection. **A complete set of tools that were prepared by CARE and baseline findings are available on CD on request from CARE Bangladesh which program implementers may find useful when designing projects.** These materials have been reproduced as they exist and have not been edited for consistency and clarity.

This manual can also be used for modular training – following instructions may be useful

HOW TO USE THIS MODULE

This manual encourages project managers and workers to examine concepts related to focused interventions for HIV through discussions. Exercises are provided to help understand critical issues and concerns in developing interventions for populations at higher risk.

Ideally resource persons from different backgrounds should be present to facilitate the use of the module. Other participatory learning techniques can be used with this basic module, and facilitators can adapt exercises to local scenarios.

It is suggested that at the beginning of each session there is a presentation by a resource person followed by a small group session. You can select one participant from each small group to read the module to the others in the group. The facilitators will help lead the discussion in every group. Work through the module at the pace of the group.

The exercises can be solved both individually and in small groups. When the exercise is complete, it should be shared with the course facilitator/group. People will answer at different speeds; thus individuals should not proceed to the next exercise until everybody in the small group has completed the exercise. After each exercise the whole group is encouraged to discuss the exercise.

GLOSSARY

- advocacy:*** an organised effort designed to raise awareness about and influence position, policy, programme or social constructs around an issue
- babu:*** regular lover/pimp-regular sexual partner who may or may not solicit clients
- bariwala:*** house owner/brothel owner
- chukris:*** young bonded sex worker
- ethnographic observation:*** the scientific study of an issue from the point of view of the community concerned, rather than from an outsider's perspective.
- exclusion:*** similar to marginalisation, but more extreme
- informed consent:*** voluntary agreement based on a clear, full and accurate understanding of the action/issue, as well as of all associated rights and the possible potential consequences of the agreement
- key informant:*** Person who can provide accurate, essential information related to a particular aspect of the issue
- lakh:*** 100,000
- marginalization:*** the process where individuals or groups are disempowered and isolated from the usual legal and social status of the larger cultural group
- mastans:*** musclemen
- peer:*** a like-minded or like-experienced person or colleague, who shares certain basic attributes
- perinatal:*** the period around birth or from 28 weeks gestation to the end of the first month of life

prevalence: the number of cases of an illness or condition that exists at a particular time among a defined population

sero-prevalence: number of cases of an illness or condition that are detected by testing the serum of individuals

samaj: society or organization

sardarni: senior madam, lady who organizes and runs a brothel or group of sex workers

sub-population: A group of people within a larger population with substantial significant characteristics in common, that have a bearing on the issue

syndromic management: a way of treating or managing cases of a disease or condition where the course of treatment is determined by the set of symptoms or signs being complained of

targeted intervention: focusing action on a specific population group or one aspect of their 'risk' behavior

ABBREVIATIONS and ACRONYMS

<i>AZT</i>	Zidovudine, a drug used for HIV treatment
<i>AIDS</i>	Acquired Immune Deficiency] Syndrome
<i>CSW</i>	commercial sex worker
<i>FGD</i>	focus group discussion
<i>HIV</i>	Human Immunodeficiency Virus
<i>IDU</i>	injecting drug user
<i>IEC</i>	information, education and communication
<i>IGA</i>	income-generating activities
<i>KITP</i>	knowledge, intent, trial and practice
<i>NGO</i>	non-government organization
<i>PRA</i>	participatory rural appraisal
<i>STI</i>	sexually transmitted infection
<i>UNAIDS</i>	Joint United Nations Program on HIV/AIDS
<i>WHO</i>	World Health Organization

PART I

**HIV/AIDS:
AN OVERVIEW**

1

HIV and AIDS

What does HIV stand for?

H	Human
I	Immunodeficiency
V	Virus

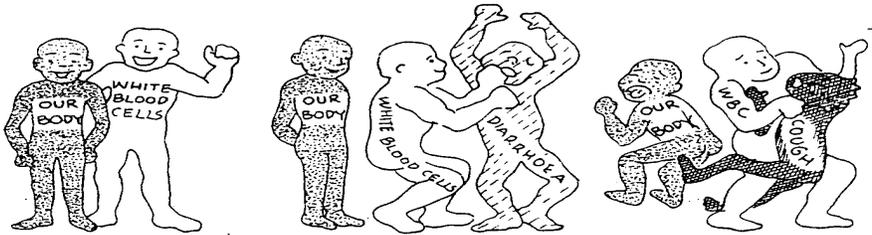
What does AIDS stand for?

A	Acquired
I	Immune
D	Deficiency
S	Syndrome

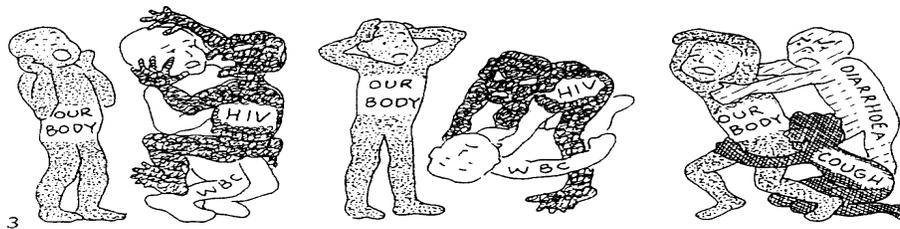
Facts about HIV/AIDS

- HIV is a virus that causes AIDS. HIV by itself is not an illness.
- AIDS is a condition in which a person is affected by a series of diseases because of poor immunity.
- An HIV positive person can lead a healthy life for several years before developing AIDS.
- An HIV positive person can transmit the virus to someone else even before he/she develops AIDS.
- All those who are HIV positive will ultimately develop AIDS.

How HIV Infects a Person

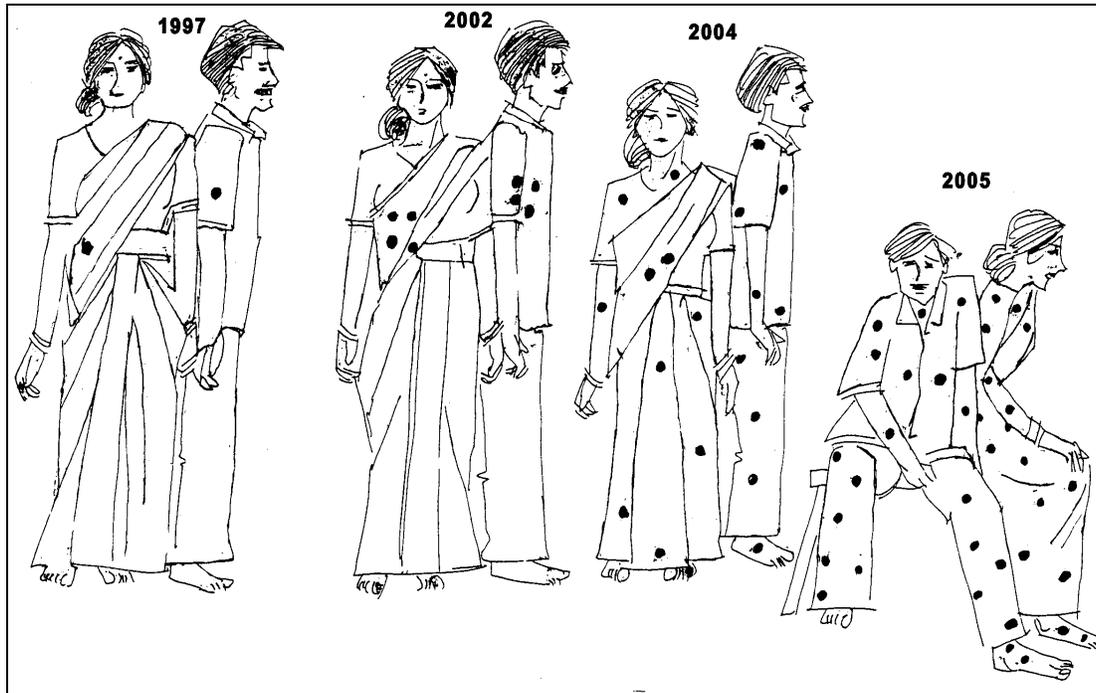


White blood cells are one of the constituents of the human body's defense system and help to protect the body from infection and disease. When a disease-causing agent enters the body, white blood cells multiply and stem the infection.



When HIV enters the body, white blood cells initially try to fight the infection. However, the virus attacks the very white blood cells that give the body defense against infection and kills the blood cells. Several new viruses are then released into the blood and enter more white blood cells. Thus the body's natural defense system is gradually broken down. Ultimately organisms that are normally present in the body or environment ('opportunistic') but do not cause any harm become active and multiply to produce infections.

Progression from HIV to AIDS



- denotes the HIV virus. Multiple dots indicate an increase in the HIV virus.

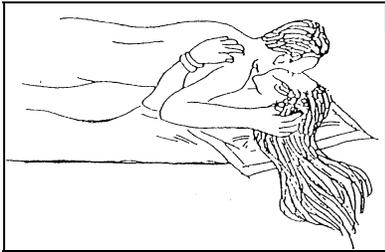
Over time the immune system of an HIV-positive person becomes weaker. Once the person develops certain infections due to poor immunity, he/she is said to have developed AIDS.

While the time taken for HIV to develop into AIDS varies, studies show that in developing countries with little access to treatment, approximately 20 percent of those infected will progress to develop AIDS in 5 years, and 60 percent will develop AIDS within 15 years of infection. Once AIDS develops, people generally live for an average of 1-3 years without any anti-retroviral treatment.

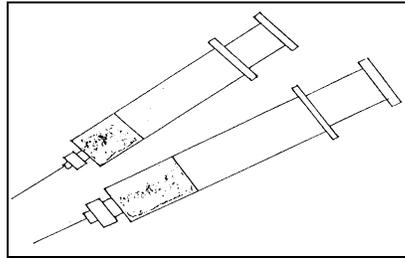
4

How is HIV/AIDS Transmitted?

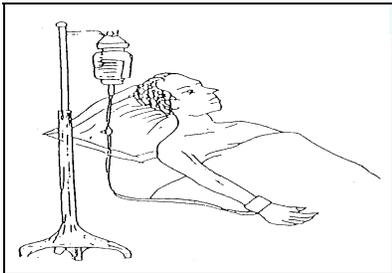
HIV is transmitted by



Unprotected sexual intercourse (vaginal or anal) with an HIV-positive individual



Sharing needles/syringes with an (vaginal or anal) HIV-positive drug user



Through transfusion of infected blood

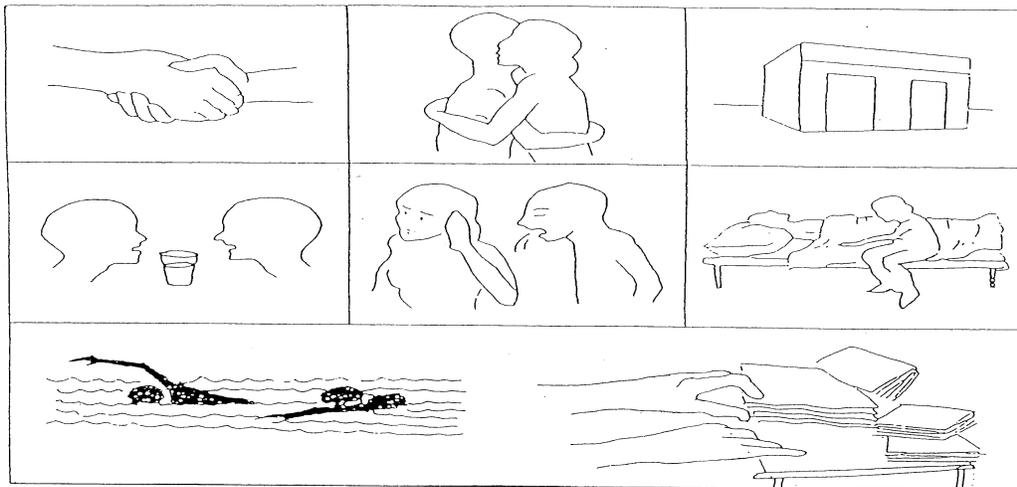


From an HIV-positive mother to her child during pregnancy, childbirth or breastfeeding.

HIV is NOT transmitted by

- Shaking hands with an infected person
- Embracing an infected person
- Drinking out of the same glass as an infected person
- Nursing an infected person
- Swimming with an infected person
- Touching anything that has previously been touched by an infected person

[These captions should be part of the visuals]



Why is it Important to Tackle the Sexual Transmission of HIV?

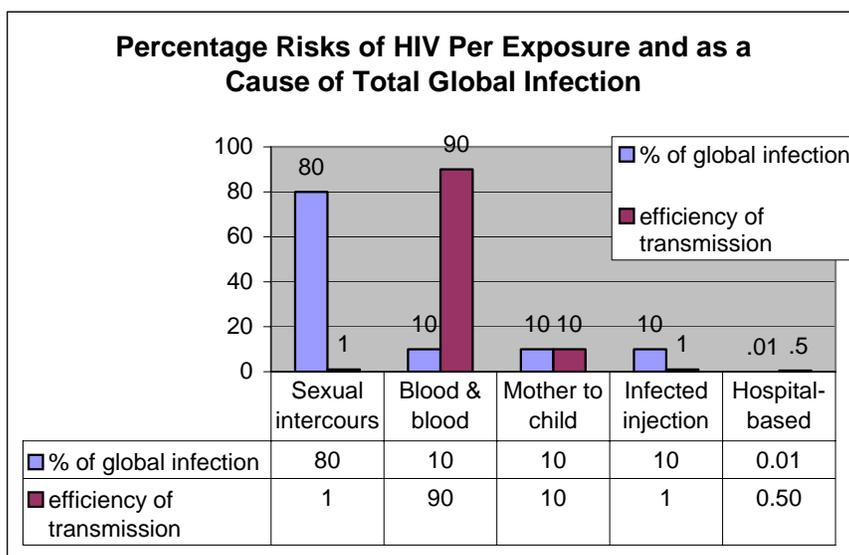
What are the differential risks of HIV infection from different sources?

Studies have shown that an individual is at greatest risk of getting HIV if exposed to infected blood--out of every 100 episodes of exposure to infected blood and blood products, 90 could result in HIV infection. The sexual transmission route is relatively less efficient—out of every 100 episodes of sexual intercourse, the chance of getting HIV is between 0.01-1.

Why interventions generally focus on the sexual transmission of HIV

- The sexual transmission route accounts for the majority of HIV infection worldwide (approximately 80 per cent).
- Since a person engages in sexual intercourse far more frequently than he or she is likely to be exposed to blood transfusion, the chances of getting HIV from sexual intercourse are much greater. Tackling the sexual route is therefore the most effective way of preventing the spread of the infection.

Interventions should not focus only on single modes of transmission, such as the heterosexual route or contaminated injection equipment. Studies of vulnerable groups have shown that the epidemic spreads to the general population through all these routes so it is important to focus on all risky behaviors.



Source: Global Report on HIV/AIDS World Health Organization, 1996

EXERCISE

To establish that sexual transmission leads to more HIV infections than blood-borne transmission

Assume that 0.1 percent of the adult population of Bangladesh is HIV-positive.

Assume that the number of transfusions each year in Bangladesh = 200,000 units

Based on the relative risks of transmission of HIV per exposure (given above), the possibility of transmission through transfusion will be=

0.1% (population HIV+) x 200,000 (no. of units of blood) x 90% (transmission risk)

or

$$1 \div 1000 \times 200000 \times 90 \div 100 = \underline{180}$$

Assume that the sexually active population in Bangladesh is=40 million

If 40 percent of the sexually active population has sexual intercourse 100 times a year, then the possibility of transmission will be=

40% x 40000000 (sexually active population) ÷ 2 (people per sex act) x 100 (number of sex acts a year) x 0.1% (HIV= adult population) x 1% (transmission risk)

or

$$40 \div 100 \times 40000000 \div 2 \times 100 \times 1 \div 1000 \times 1 \div 100 = \underline{8000}$$

No. of Infections transmitted through blood in one year is 180; and through the sexual route is 8,000.

6

Preventing HIV/AIDS

Since there is no vaccine available for HIV, the most effective way to prevent transmission is to avoid behaviours that put a person at risk of infection, such as sharing needles and syringes and having unprotected sex.

How does one prevent HIV infection from spreading in a sub-population?

- By focusing on the sexual route:
 - Early diagnosis and treatment of STIs
 - Promoting condom use
 - Promoting safer sex behaviors

STIs like chancroid, chlamydia, syphilis and gonorrhea could increase the risk of HIV transmission almost nine times.

- By focusing on infected needles and injecting equipment:
 - Needle and syringe exchange programs
 - Needle and syringe distribution programs
 - Substitution programs
 - Drug treatment programs

Programs with injecting drug users also need to promote safer sex practices because drug users transmit HIV through the sexual route as well.

- By screening blood and blood products
- By ensuring universal medical precautions are rigorously followed.
- By preventing the transmission of HIV from infected mothers to newborn children.

STIs, Drug Use and HIV

STIs and HIV

The presence of an STI, especially an ulcerative STI, and the sexual transmission of HIV are closely linked. As HIV infects a person through breaks in the surface of the skin or mucus membrane, the presence of an STI usually makes it easier for HIV to be transmitted. So it is important to treat STIs as soon as infection is detected.

As women and men with STIs are often asymptomatic, treatment-seeking and partner notification for such infections should be actively promoted.

STIs are infections that are mainly transmitted through the sexual route. STIs can be ulcerative or non-ulcerative.

Does STI prevention arrest the spread of HIV? The Tanzanian experience

Twelve communities in Tanzania with AIDS prevention programs were studied for two years. In six communities, STI prevention and care services were improved by setting up an STI reference clinic, ensuring a regular supply of antibiotics, training peripheral health workers and providing clients with information on STIs. The other six communities did not have such interventions.

Findings indicate that after two years while the number of new STI cases remained the same in both settings, communities with STI services had 40 percent fewer new HIV infections than the other communities. Moreover, the duration of STIs was found to be shorter after intervention.

Drug Use and HIV

HIV infection among the injecting drug community can spread rapidly. Moreover, infected drug users can spread HIV to their sexual partners, their children and the rest of the community. Preventing HIV transmission among injecting users is therefore critical.

Drug use does not cause HIV infection but the sharing of contaminated injecting equipment transmits infection.

Reducing harm

Replacing used needles with clean syringes/ needles can effectively reduce HIV transmission among injecting drug users. The harmful effects of injecting can also be reduced by substituting less harmful methods, such as inhaling.

How do drug treatment programs reduce harm?

Injectors and drug users are enrolled in treatment outlets, where less addictive substitute drugs like methadone and buprenorphine are given to the drug user, usually by non-injecting routes, under supervision, preventing the harmful effects of injecting and activities associated with sharing needles and syringes.

8

Safer Sexual Behavior and Condom Use

HIV is present in most body fluids, particularly semen, vaginal secretions, breast milk and blood. Safer sex refers to sexual contact that does not allow these fluids to enter another person's body or come into contact with broken skin. Non-penetrative sex, such as masturbation, massaging and kissing minimizes the transmission of HIV infection.

Penetrative sex using a condom

Apart from abstaining from sexual contact, using a condom properly and consistently during sexual intercourse is the single most effective way to prevent HIV and other STIs. It is also an effective means of contraception.

People have a number of misconceptions about condoms. Some believe that condoms can break, or reduce sensation and pleasure. Demonstration and practice increase people's confidence and dispel myths about condom use.

How to use a condom [\[link to the visual\]](#)

- Use a new condom for each act of sexual intercourse.
- Carefully open the wrapper so that the condom does not tear.
- Place the condom on the head of the erect penis so that the condom unrolls onto the shaft of the penis. Among uncircumcised men, the foreskin should be pulled back to reveal the head of the penis before putting on the condom
- Allow space at the tip of the condom for semen to collect.
- Pinch the air out of the tip with one hand.

- With the other hand, unroll the condom to the base of the penis.
- Withdraw the penis immediately after ejaculation and before the penis softens. Hold the condom firmly against the shaft of the penis so that the semen does not spill.
- Carefully remove the condom.
- Knot the used condom and dispose of it.

Remember

- Check that the condom is not damaged
- Store condoms in a cool, dry place
- Check the date of expiry
- Be sure to only use water or water-based lubricants with condoms as some oils/creams can damage latex condoms

[Link visuals to the above text](#)

PICTURE ON INSTRUCTION TO USE CONDOM

Condom programs should focus on

- Making people aware that condom use is important for family planning as well as a protection against HIV infection
- Making sex workers and their clients aware of the importance of condom use for HIV prevention
- Making condoms easily available at low cost
- Ensuring that good quality condoms are supplied
- Making condom use sensuous, exciting and trendy

9

How the Epidemic Spreads

Unlike diseases like cholera and plague, HIV does not spread evenly in the population. Evidence shows that HIV/AIDS first affects one risk group (or populations at highest risk, such as sex workers, injecting drug users or men who have sex with men). Once it reaches a concentrated level in the group (usually 5 percent prevalence), it spreads significantly to the general population. It generally takes at least two or three years for the core epidemic to develop into a generalized epidemic.

Depending on the risk behaviors practiced, populations can be classified as:

High risk—those with high partner exchange, who receive infection and pass on infection, such as sex workers, injecting drug users and men who have sex with men

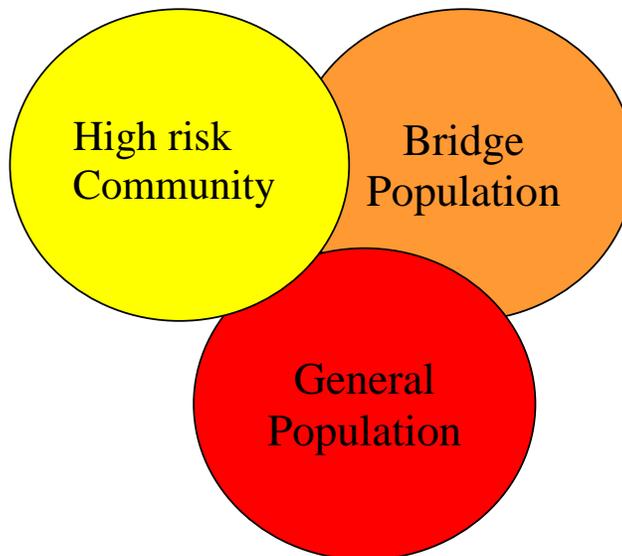
Bridge--those who pass on infection from high infection groups to low infection groups, such as clients of sex workers, migrant populations, mobile populations and uniformed people

Low risk—the broader population, who receive infections, such as wives of persons in the bridge population and partners of injecting drug users and bisexual populations.

Stages of the Epidemic

Low	Concentrated	Generalized
< 5% HIV in high-risk groups	> 5% HIV in high-risk groups and < 1% in general population	> 1% prevalence in general population
Intervention should concentrate on the high-risk population	Intervention should also focus on the bridge population	Intervention should also focus on behaviour change of young people and general population

Awareness program for young people is important at all stages of epidemic



Experiences from Thailand and India

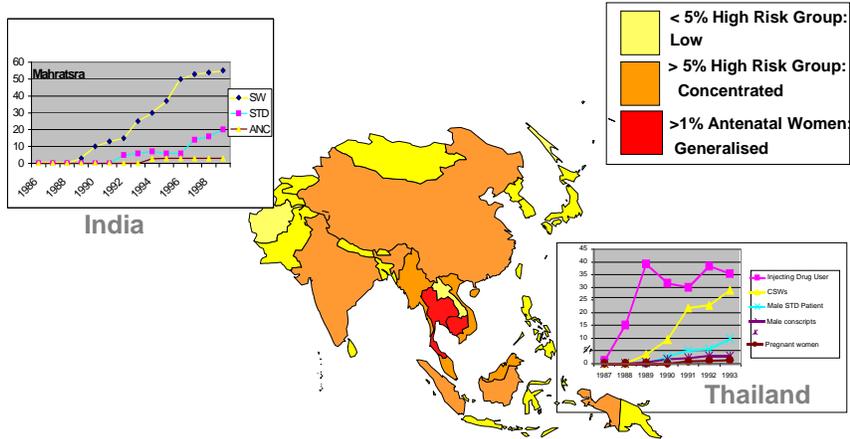
The epidemic in Thailand and India reflects a similar pattern of growth

Thailand

- In 1986, the first HIV-positive case was identified (an injecting drug user).
- By 1989, 40 percent of the drug users and 5 percent of the sex workers were infected with HIV.
- Over the next few years, people who had interacted sexually with these groups (i.e., male clients or the bridge population) became infected.
- By 1991, 6 percent of male attendees at STI clinics tested positive for HIV.
- In 1993 it was estimated that 1 percent of the general population was HIV-positive. (Source: Frerichs RR, Ungchusek K, Htoon M T et al Asia Pacific Journal of Public Health 8 (1) :20-26, 1995)

- **India** In Mumbai, Maharashtra, the first HIV case was detected among sex workers in 1986.
- After two years, HIV prevalence among sex workers reached 5 percent.
Six years later in 1994, the epidemic had become generalized, with 1 percent of women visiting antenatal clinics testing HIV-positive.
- In Manipur, HIV was first detected among injecting drug users, and then spread dramatically to almost half the drug users over the next two years (1988-90).
- By 1992, women in some antenatal clinics were showing HIV rates higher than 1 percent. (Source: Sarkar S et al Bulletin of Narcotics, 1994)

Similar Pattern of Progress in All Countries- Adult Prevalence of HIV in Different Risk Groups



Window of opportunity

To prevent a generalized epidemic, HIV infection should be controlled at the low epidemic stage when it is below 5 percent in vulnerable groups.

EXERCISE

Antenatal women are considered to represent the level of HIV among the general population.

Although there are many different sub-groups in a population, antenatal women in most conditions are easily accessible at ANC clinics, in a non-stigmatising situation. Since blood is drawn for other tests in antenatal clinics, it makes HIV surveillance at the clinic relatively easy, and ethical and unlinked anonymous testing feasible.

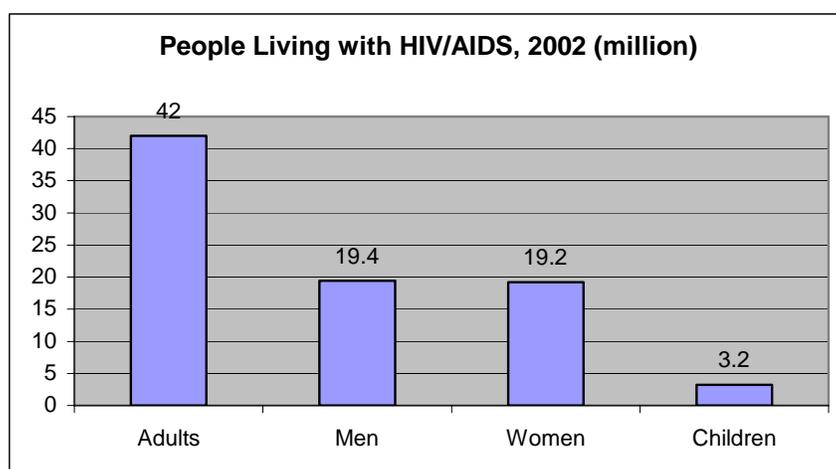
Apart from antenatal women, are there other groups of women among whom HIV may appear more quickly?

The HIV/AIDS Epidemic at a Glance

The Global Scenario

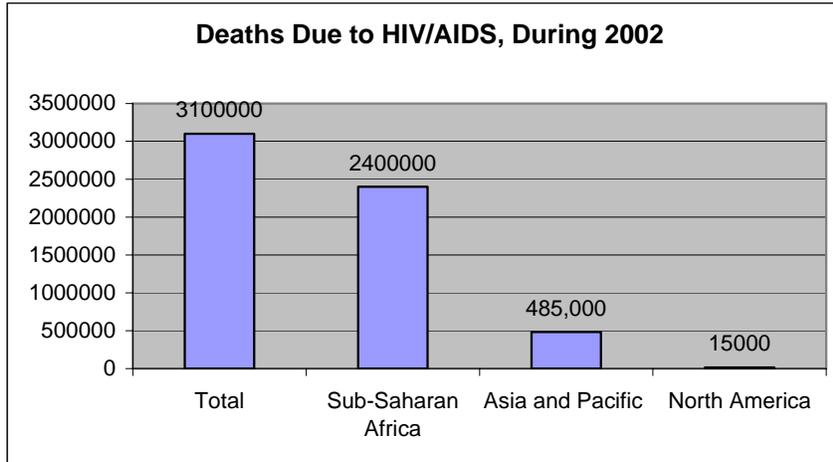
People estimated to be living with HIV/AIDS	42 million
Estimated new HIV infections in 2002	5 million
Estimated deaths due to HIV/AIDS in 2002	3.1 million

AIDS Epidemic Update, December 2002, UNAIDS/WHO, 2002.



Source: *AIDS Epidemic Update*, December 2002, UNAIDS/WHO, 2002.

Regional Highlights



Because of rounding, figures may not tally.

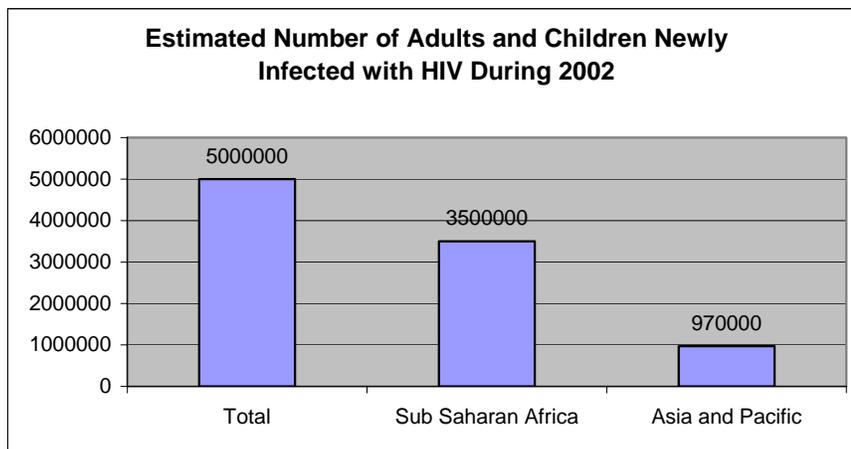
Unless otherwise stated, Asia Pacific refers to the UNAIDS regional classification of states excluding Middle East and Central Asia. Source: *AIDS Epidemic Update, December 2002*, UNAIDS/WHO, 2002.

AIDS cases are often underreported in developing countries. The ratio of AIDS cases and the actual number of people with HIV in a developing country is a few hundred to several thousand. This means that for each reported case of AIDS in a developing country, there are potentially up to 1,000 HIV-positive people.

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South and Southeast Asia

Compared to rates of HIV infection in Sub-Saharan Africa, the prevalence of HIV in Asia is low. Only in Thailand, Cambodia, large areas of Myanmar and sizeable parts of India is the prevalence of HIV among young adults more than 2 percent.



Source: *AIDS Epidemic Update, December 2002*, UNAIDS/WHO, 2002.

However, many Asian countries have large populations, which means population prevalence appears low in spite of large numbers of cases. Therefore, national averages are not particularly meaningful in the Asian context where epidemics have yet to mature (see Table).

Estimated Adult HIV Prevalence and Number of People Living with HIV in selected Asian Countries, 2002*

Country	No. HIV + (Projected)	HIV Prevalence (%)	Population (15-49 years)
South Asia			
Bangladesh	13,000	<0.1	72 340 000
India	3 970 000	0.8	533 580 000
Nepal	58 000	0.5	11 106 000
Pakistan	78 000	0.5	67 964 000
Sri Lanka	4800	<0.1	10 695 000
Southeast Asia			
Cambodia	170 000	2.7	6 314 000
Indonesia	120 000	0.1	118 163 000
Maldives	<100	0.05	141 000
Thailand	670 000	1.8	36 636 000

* Estimates for end 2001

Source: Report on the Global HIV AIDS epidemic 2002, UNAIDS WHO, 2002.

The current situation

- South and Southeast Asia is currently a low prevalence setting. However, with a large proportion of the world's vulnerable population living in the region, the epidemic is on the brink of becoming full-blown and generalized in the absence of effective intervention programs.
- Over 90 percent of HIV positive adults in South and Southeast Asia currently live in India, Thailand, Myanmar and Cambodia.
- Around a third of all infected adults in the region are women.
- The principle route of transmission is heterosexual intercourse, followed by injecting drug use.

The Epidemic in Bangladesh

Bangladesh is currently considered to be a low prevalence country for HIV as studies show that HIV prevalence is less than 1 percent among high-risk groups and less than 0.1 percent in the general population. However, there is enough evidence to suggest that high-risk behavior is being practiced in Bangladesh.

Unless effective measures are taken promptly and interventions for vulnerable groups are implemented, the epidemic in Bangladesh is likely to spread into the general population.

Vulnerable Groups and High-risk Practices in Bangladesh—Facts and Figures

- **At least 40,000 sex workers operate in Bangladesh. However, the number of street-based sex workers and call girls make this figure even higher. Some sources estimate the figure to be around 65,000.**
- **Approximately 120,000 truckers operate on long routes and most have unprotected sex during their travels.**
- **Many more young people have premarital (often unprotected) sex than is commonly believed.**
- **A large number of workers (many of whom are married) migrate out of Bangladesh every year and get involved in non-marital sexual relationships.**
- **There are approximately 15,000 injecting drug users in Bangladesh.**
- **Approximately 220,000 units of blood are required per year, of which 75 percent comes from professional donors. Injecting drug users constitute 20 percent of the professional donors.**
- **A large number of the 200,000-250,000 street children in Bangladesh are sexually abused.**

Source: CARE, Bangladesh and Institute of Epidemiology, Disease Control and Research, Bangladesh. Ahmed N. et al., ‘High Risk Sex Among Truckers in Bangladesh,’ paper presented at the Fifth International Congress on AIDS in Asia and the Pacific, Kuala Lumpur.

The Epidemic in Bangladesh

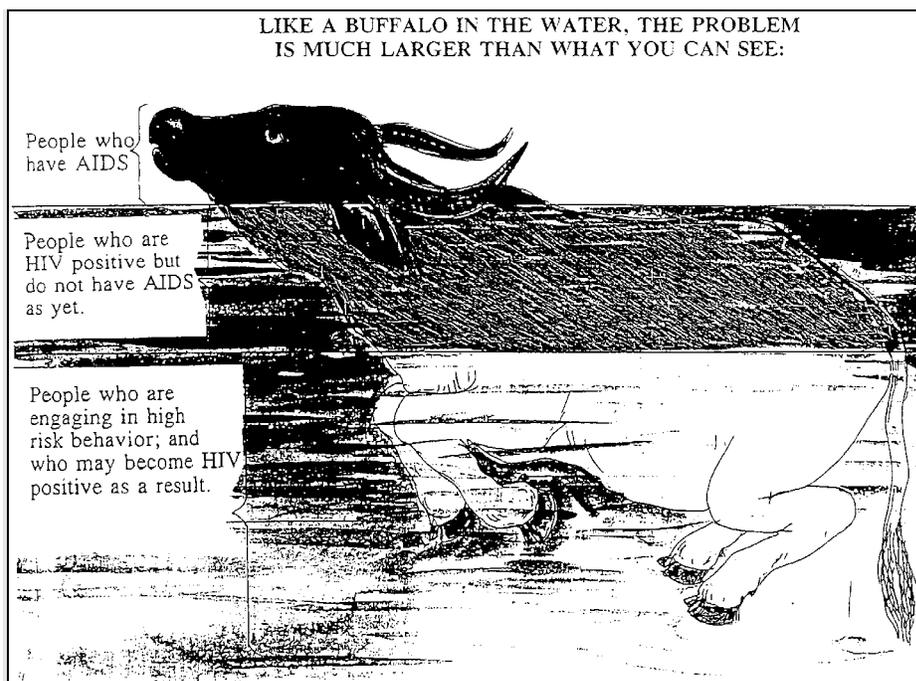
Bangladesh may have a small window of opportunity before the present low epidemic becomes a concentrated epidemic (i.e., HIV prevalence, which is still less than 5 percent in high-risk groups, becomes more than 1 percent in the general population). It is therefore critical to address the HIV/AIDS epidemic while it is still a low epidemic and has not yet reached concentrated levels in the vulnerable population.

Surveillance data shows that Bangladesh is on the brink of a full-blown HIV epidemic.

- High-risk behavior is widely prevalent in several sub-populations
- HIV is present among high risk behavior groups
- The prevalence of STIs is high in several groups although HIV is low
- Safer practices (eg consistent condom use, use of clean injecting equipment) are often not followed

EXERCISE

HIV/ AIDS in Bangladesh:



What does the picture above suggest? Match your answers with the information provided in this section on high-risk groups in Bangladesh.

EXERCISE

- **Based on the data on risk groups above, estimate the total number of vulnerable people in Bangladesh (total population 129.2 million).**
- **Grade them according to vulnerability to HIV infection (high, medium or low). Give reasons.**
- **The total number of reported HIV cases in Bangladesh is 188 (till date 2003). What could be the estimated number of AIDS cases and HIV-positive people? Write your answers in the space provided below.**

No. of people with AIDS	26
No. of people reported to be currently living with HIV	246
No. of people engaging in high-risk behavior who may become HIV-positive	

Whom to Target?

Population vs sub-population

A population is not a homogenous group with uniform patterns of behavior. It consists of a number of small groups or sub-populations, each with its own culture and norms. As the needs of one group may differ from another (for instance, interventions for sex workers may need to be different from interventions with young people or rural women), a single intervention for behavior change may not be effective for the general population, and separate interventions are needed for each sub-population.

What is targeted intervention?

Focusing intervention with more vulnerable groups is called targeted intervention or focused intervention.

Interventions should aim to cover all high-risk groups and saturate them to stop the HIV epidemic from spreading to the general population.

Why address a sub-population?

- As the spread of the HIV epidemic is predictable—reaching 5 percent prevalence in vulnerable groups and then significantly spreading to the general population---focusing on recognized high-risk groups before HIV really gains a foothold will prevent/slow down the spread of the infection to other groups and the general population.

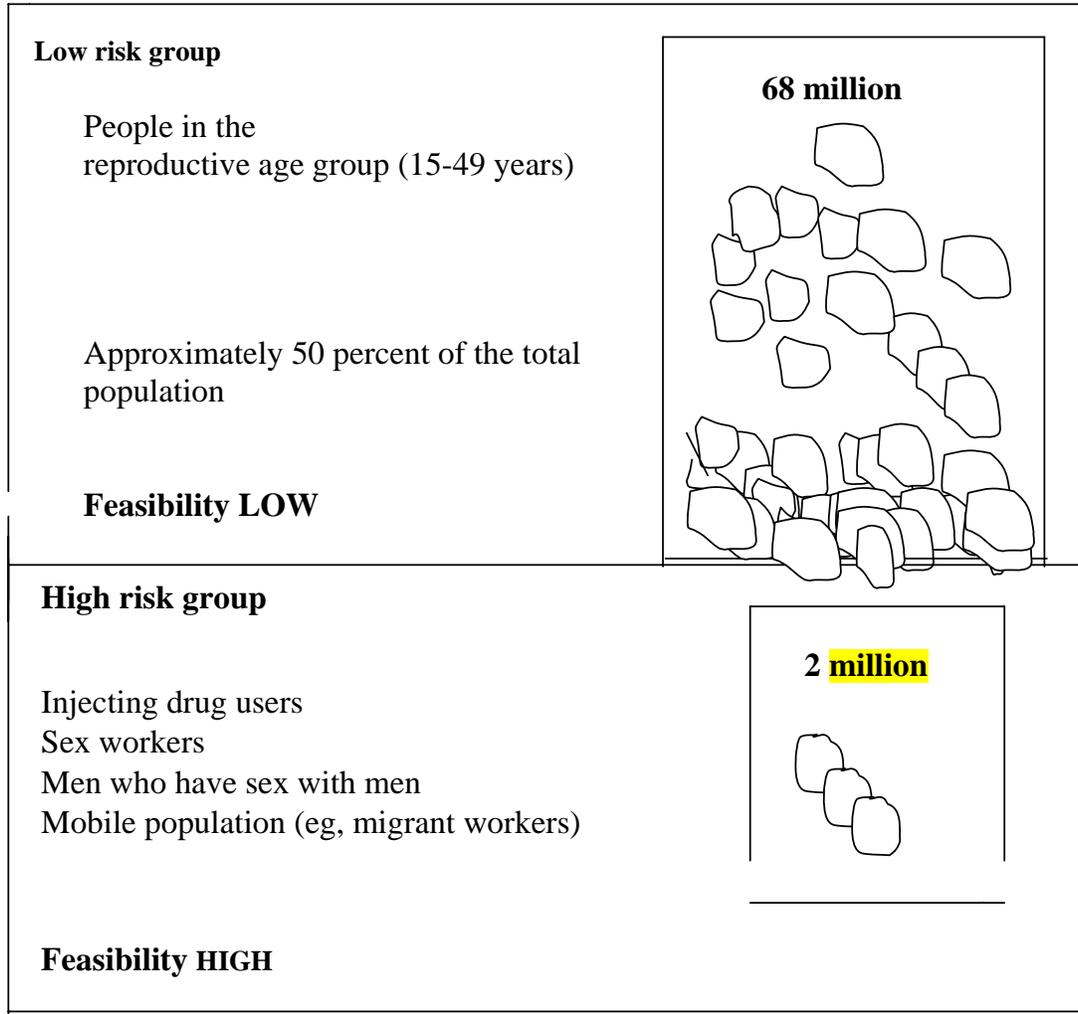
- Prioritizing prevention among smaller groups is a more cost-effective way of using limited resources than targeting the general population with all the services required.
- Focusing on vulnerable groups allows time to build interventions for the larger population

Need for a generalized intervention

Along with targeted intervention, preparatory work should be initiated to create a conducive environment in the general population for HIV prevention through advocacy, HIV/AIDS awareness programs, dissemination of appropriate materials, etc., to increase awareness and to reduce stigma.

Awareness programs for young people can often be implemented at very little additional cost and could have a tremendous long-term impact on the progress of the epidemic and future prevention.

Feasibility of Intervention--High Risk Vs Low Risk Groups in Bangladesh



NOTE : These figures represent the current situation in Bangladesh. Vulnerability is time-specific and valid only till the epidemic shifts to the general population on a large scale. Once HIV prevalence reaches approximately 5 percent in the general population, the vulnerability of any population in the reproductive age group becomes almost equal to that of people living in high risk situations (e.g., sex workers, men who have sex with men, etc.).

What Does Not Change Behavior?

A number of approaches have been suggested to prevent the spread of the epidemic, such as promoting awareness of HIV, legal measures to curtail risky behavior and large scale or mandatory testing.

Awareness

While awareness is important, awareness on its own does not change behavior. For instance, while most smokers know that smoking is injurious to health, this does not change behavior.

Information is not enough

During baseline data collection in the Tangail intervention, 36 percent of brothel-based sex workers were aware that condoms prevent STIs, but only 2 percent used condoms regularly.

In Manipur, India, although more than 80 per cent of IDUs were aware of HIV/AIDS and that needle sharing can cause HIV, this knowledge did not change behavior. However, their continued risk behavior (needle-sharing) resulted in an increase in HIV prevalence from 54 percent in 1990 to 89 percent in 1994. Awareness alone did not change their behavior.[Sarkar S et al 1993 J of Inf]

Legal restrictions

Evidence shows that even if brothels are closed by the court or the police, the sex trade continues. Similarly, banning injectable drugs will not put an end to drug use.

Can the law change risky behavior?

The eviction of sex workers from the brothels in Kandu Patti following a negative court ruling did not lead to behavior change among sex workers or their clients. These women became street-based sex workers in Dhaka and the number of street-based sex workers increased.

Large-scale testing of sub-populations for HIV

It is often suggested that testing of people practicing risky behavior can reduce the transmission of HIV. However, testing may not present the true picture as people may be in the 'window period' (when recently infected persons do not test positive for HIV antibodies). Moreover, while it is not economically feasible to test large populations, testing without adequate counseling and information often results in people continuing to practice risky behavior and putting others at risk of infection. Mandatory testing has also been found to drive people underground.

Behavior is the result of group norms, peer pressure and environmental factors and does not necessarily depend on individual choice or knowledge of HIV status.

EXERCISE

List other examples of what does not change behavior.

What Changes Behavior?

The behaviors that drive the HIV epidemic are largely private, sometimes illegal and often difficult to talk about openly.

It is possible for people to adopt safer behaviors that protect them from risk, and there are now many examples from around the world of effective measures that can reduce risky behavior.

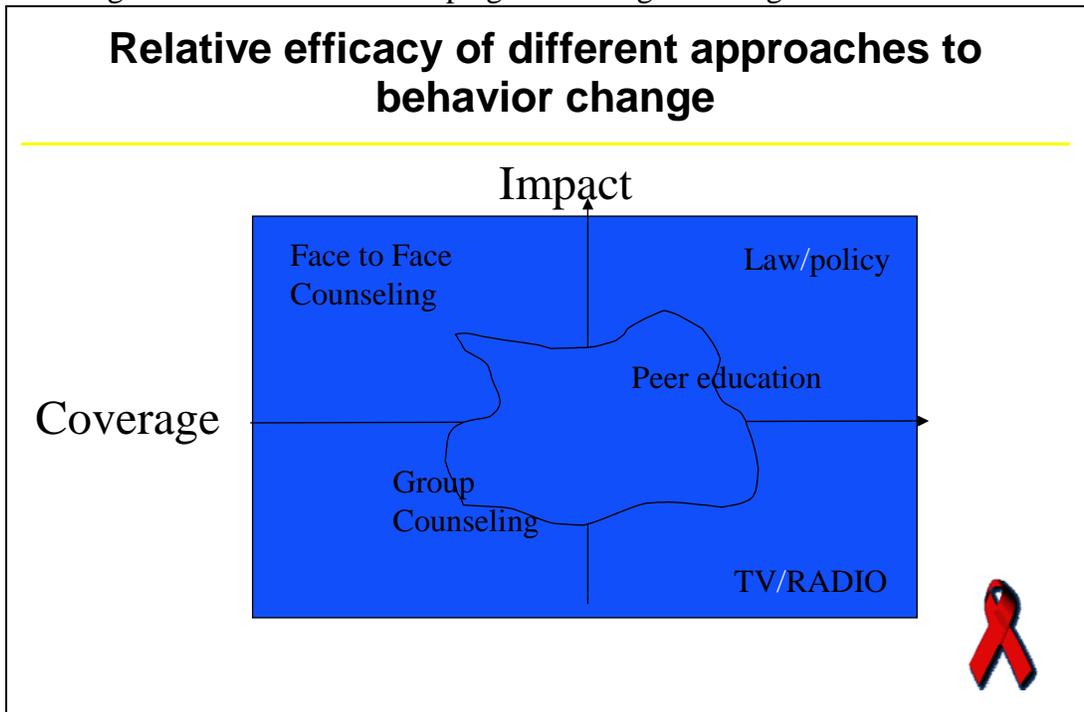
Behavior change is possible if:

- Intervention is started early, when HIV prevalence is less than 5 percent among vulnerable groups
- The approach is non-judgmental and does not worsen the situation of already marginalized groups
- Self-organizations of vulnerable groups (who are often marginalized) are involved in the intervention
- Flexible outreach is used rather than fixed facility intervention
- Peers are trained and involved in providing information on HIV, access to services such as STI treatment, delivery of condoms, bleach and needles.
- Interventions are oriented towards the community rather than the individual, and peer education transforms into peer pressure
- Peer educators are trained to provide information and access to services is ensured
- The strategy and means of behavior change are accepted by both the vulnerable group and the larger community
- Services for behavior change (e.g., condoms, treatment, syringes) are available

- The intervention is multi-sectoral and covers different factors that impact on behavior
- Intervention efforts are continued long-term

Why is peer outreach one of the most effective options for sustained behavior change in our setting?

Behavior change can be brought about in many ways. Each method has differing levels of coverage and intensity. For instance, face-to-face counseling is extremely effective for individual behavior change but has very little coverage while mass media campaigns have high coverage but are not intensive.



Peer outreach works well in group and community settings and is one of the most cost-effective options for behavior change.

Training some members of a vulnerable group (such as current/one-time sex workers or drug users) to educate and influence other members of the peer group has been shown to be an effective way of influencing people's beliefs and behaviors. Peer educators may also mobilize sufficient support to form pressure groups and demand large shifts in practices (e.g., brothels insisting on condom use for all clients). Peer groups often go on to form self-organizations to seek better conditions for their members.

Peers can effectively establish contact and reach hidden populations. Organizations may reach a few identified persons from the community through rescue homes, prisons, treatment centers, etc. Peers can recruit others who are 'hidden', particularly young entrants or young sex workers who have just been brought into the trade.

Peer education for behavior change in hidden populations

Various measures such as arrest, setting up detoxification centers and starting health programs were taken to reach injecting drug users in Manipur. However, no more than half the drug users in the state were located through these efforts.

Following these efforts, a street-based intervention for drug users was set up in the state based on peer outreach services (providing condoms, bleach for needle sterilization and HIV information). The peers were mainly one-time drug users. Within six months, 80 percent of the injecting drug users were in contact with services.

Interventions for behavior change should focus on:

- Addressing the community rather than individuals.
- Obstacles to behavior change like marginalization and stigmatization.
- Provision of non-judgmental and accessible services, such as an anonymous needle and syringe exchange facility run by peers.

No single intervention will work in all settings. Programs should be flexible and responsive to people's needs.

EXERCISE

- **How many different sub-groups of populations are you aware of?**
- **Can you think of anything that has made you change your behavior?**

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Steps of Behavior Change

Effective interventions for the reduction of HIV and STIs must aim to change risky and unsafe behavior practices. Behavior change is based on individual and group education about safer practices, delivering appropriate, accessible and acceptable services for HIV prevention, providing a referral point for services, ensuring community participation in implementing and designing the project, mobilizing the community and empowering members to ultimately implement the project.

Programs for behavior change address the norms and perceptions of the community that sustain risky behaviors and help members to realistically assess risk.

Behavior change is not a single-step process. Behavior steps are individual and people can change behavior at different stages. Change is made one step at a time.

Stages of Behaviour Change



Initially, people may be unaware of the need to change risky behavior. Once they are made aware of the problems associated with unsafe practices and the benefits of changing behavior, they need to acquire the skills and knowledge to change these behaviors. With constant support, motivated individuals will be encouraged to try out the new behavior, which may finally result in sustained behavior change.

However, ability to change behavior would require services that are acceptable and accessible, and an environment that encourages such behavior without any judgment.

Interventions must be planned to respond to the particular stage that the individual is in.

For instance, to reduce the prevalence of STIs in a community, the following interventions may be needed at each stage of behavior change:

Awareness

- Tell individuals how to recognize symptoms of STIs
- Tell the community how STIs can affect general health and well being.
- Address myths and misconceptions through various media.

Acquiring knowledge and skills for safer behavior

- Tell the group where treatment facilities are available, the services that are available and the working hours.
- Build skills for condom use and negotiation
- Develop skills to check injecting equipment

Motivation

Build community support and personal commitment to actively seek treatment and avail of services for behavior change through peers.

Trial

Provide support to encourage people to actively seek treatment, for instance, treat patients with respect at clinics

Maintenance

Encourage people to share treatment success with their family, peers

Success is defined as a behavior or attitude change that is sustained over a period of time. Peer pressure has been found to be an effective tool to ensure sustained behavior change.

Changing behavior takes time. As the group moves from one step to the next, they will need different messages and support.

The process of behavior change is not a direct journey and most people move back and forth between steps before achieving success.

Encourage and emphasize the positive aspects of accessing services (for instance, compliment persons for coming back to a drug de-addiction center after completing treatment) rather than blame individual for repeatedly coming back to use the service.

Story of the SHAKTI project, Bangladesh

Background:

By 1995 it was clear that the behaviour of marginalised groups can be changed provided a) the intervention is initiated early, b) peer outreach education is the main form of behaviour change communication and promotion of services, c) the means of behaviour change including STD management, condoms, and other necessary equipment are provided, and d) there is tolerance towards these marginalised communities in the larger social context.

By this time, the Sexual Health Intervention Project in Sonagachi, Calcutta had demonstrated that peer outreach education is possible in a developing country. At the same time, Thailand continued a lowering of HIV prevalence reinforcing the lesson that prevention is possible and works.

Given this background, CARE International and DFID decided in 1995 to initiate a project on awareness for sex workers in a brothel in Dhaka, and transport workers in Dhaka city. This was at a time when HIV prevalence among any high risk group had not reached even 1% .

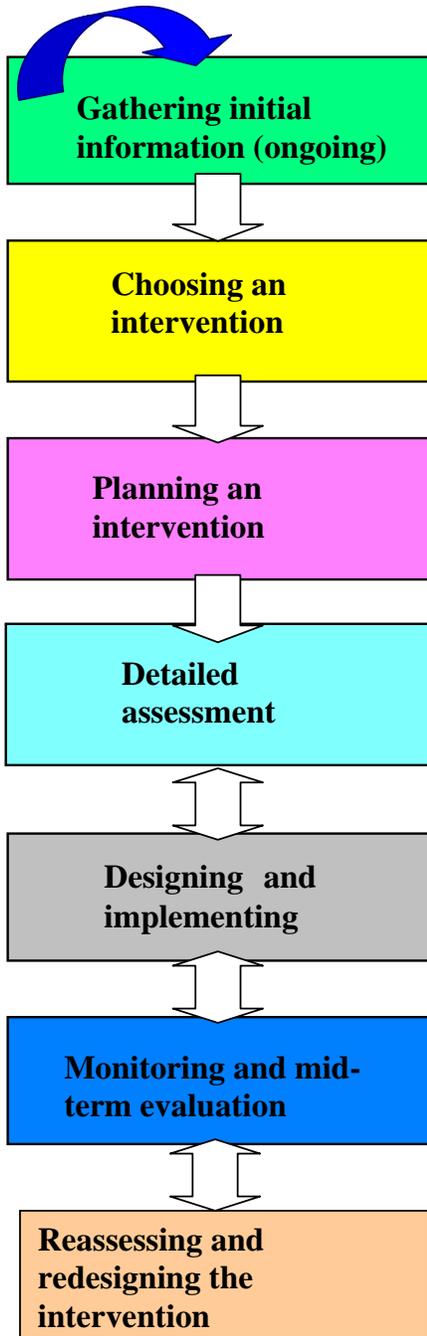
This decision marked a significant turning point for the NGO, which was in the process of transforming itself from a service delivery organisation to what it described as “an agent of social change”. HIV would be the first problem they would address in an urban area, representing a major shift from the rural poverty based approach adopted thus far. Another major shift was made. In consultation with the donor, a conscious decision was taken to make this a Behaviour Change Intervention project, rather than an “awareness” project. The implications of this were tremendous, as it implied a range of additional activities such as providing STD treatment, making condoms popular and available, and creating an environment that supports the use of these services.

Decision to shift from awareness to behaviour change intervention. Behaviour change intervention till that time remained on many counts either part of a research initiative or a minor social movement of marginalised groups like MSM or Sex worker populations in most parts of the world. Therefore the challenge was to develop a generic body of simple intervention steps that could be undertaken in different situations/settings by small NGOs or mid level staff of Govt program or large NGOs, who have never implemented such a project before. The mystique around intervention was to be unraveled and presented as universally applicable actions, based on proven principles. The potential for prevention this would tap was enormous.

The story of Tangail narrated below describes how this challenge was met.

PART II

Steps for Focused Intervention



The following section sets out some of the steps that have been found effective in designing and implementing interventions in Bangladesh. This module is based on the experience of CARE’s SHAKTI project, an intervention to reduce the transmission of HIV and promote safer behaviors among a population of brothel-based sex workers in Tangail. Not all these steps may be necessary or possible, and modifications may need to be made to suit particular vulnerable groups.

Generally, projects are implemented according to the steps shown here .

Fourteen steps discussed in detail in this section will take project workers through planning, designing and implementing an effective intervention. In order to start intervention, workers will need to know which risk-group to choose. Steps 1 and 2 will guide them through selecting a vulnerable group and an appropriate intervention site. At this stage it is important to assess both the needs of the vulnerable community and the feasibility of the intervention.

Any successful intervention is grounded in solid research that helps identify who is at risk, the perceptions

and beliefs of the group, the problems of the community (e.g., stigmatization, incorrect knowledge of HIV/AIDS), group behavior, the legal and social context of their behavior and barriers to behavior change. This is also the stage when intervention can begin in tandem with assessment, and the project can enlist the help of the community in collecting

Selection of the vulnerable group and location

Step 1: Identifying risk behaviors and vulnerable groups, and prioritizing an intervention group

Step 2: Selecting an intervention area by mapping

Getting to know the group

Step 3: Development of trust and building rapport with the community

Step 4: Rapid stock-taking and knowing the community better

Step 5: Selecting guides

Step 6: Providing services to the community

Design and implementation

Step 7: Collecting baseline information

Step 8: Peer outreach services

Step 9: Preparing education materials

Modifying your program and organization

Step 10: Monitoring and evaluation

Step 11: Creating an enabling environment

Step 12: Empowerment

Step 13: Sustainability

Step 14: Assessing your organization

information. Steps 3-6 will help workers assess the needs of the community and enlist their support and trust.

Having identified the needs of the community, it is necessary to design and implement an appropriate intervention that will address these needs and encourage the adoption of safer behaviors. Collecting baseline data that is comparable will help to measure the impact of intervention. Providing outreach services and IEC materials for behavior change are essential to the success of the intervention, and are covered in steps 7, 8 and 9.

Communities and situations are dynamic and continuously changing. With intervention, projects are constantly moving ahead. It is important to reflect on the program and reexamine strategies as the situation may have changed because of intervention or other factors. Moreover, the organization and the understanding of project staff may have changed. Workers will need to constantly review the aims and objectives of intervention and to modify and reorient strategies and activities, if necessary. Steps 10-14 will guide programs in this process.

Assessment and intervention need to be seen as closely interrelated. The SHAKTI experience has shown that assessment and intervention can be successfully integrated into a single phase of the project spiral.

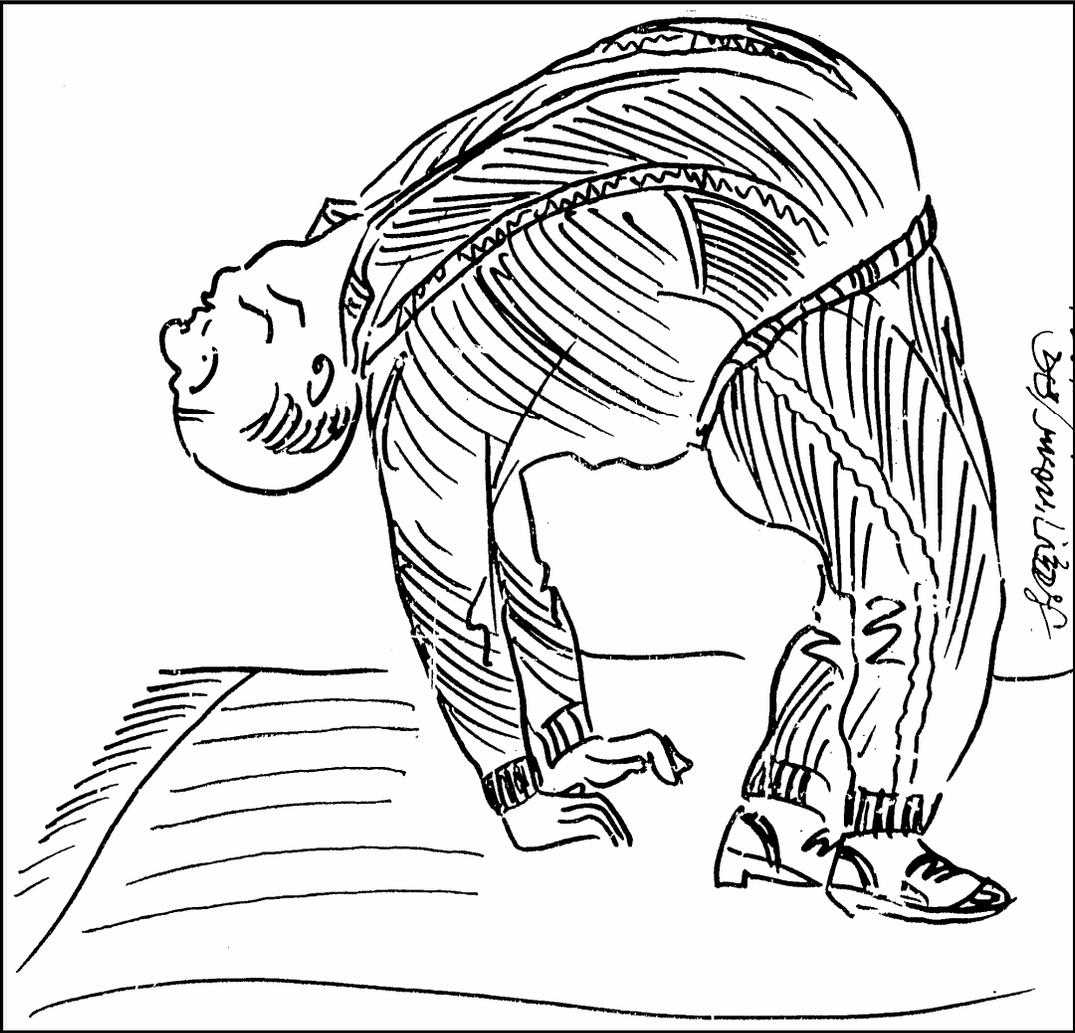
Once project activities (e.g., needs assessment) start and expectations in the community are raised, it is the ethical duty of program workers to provide the means to change behaviors.

Keep in mind the following ethics and values for successful intervention

- The needs of the community rather than the goals of the organization come first
- Self determination and community involvement are crucial when designing and implementing projects
- Transparency and sharing of information are vital
- Non-judgemental and non-discriminatory attitude among staff are essential
- Capacity and ownership in the community are necessary

Designing a Project

FLEXIBILITY AND NOT RIGIDITY MUST BE THE ESSENCE OF THE PROJECT



DESIGNING A PROJECT

1. RATIONALE

Before starting a project, it is important to know what your aims and objectives are. These will serve as a reference point throughout the project and help you modify strategies, if necessary.

2. AREA AND POPULATION

The plan should include the name of the area where you think intervention is needed, and an estimate of the population to be covered. Include baseline figures for HIV/AIDS and STIs, where available. If such information is not available, local examples from similar populations should be sought. Also, consider your organization's strengths, and the advantages of working in this area or with this population.

3. OBJECTIVES

Identify and document the aims and objectives of your project, and make them specific and measurable. Clarify what you aim to achieve and how you plan to do it.

4. STRATEGY

You need to clarify at the start your basic approach or strategy for intervention. You may wish to depend entirely on "peer outreach" or "staff outreach" or a combination of both. Experience suggests that peer outreach is very effective among marginalized sub-populations. Ensure that your methodology includes the following ideology, philosophy and values:

- ◆ Respect for the vulnerable group
- ◆ Rights-based approach
- ◆ Flexibility in planning and implementing activities
- ◆ Participatory approach
- ◆ Democratic systems of functioning
- ◆ Involving the vulnerable group in planning, implementation, monitoring and evaluation

5. ACTIVITIES

The activities for an institution-based project (e.g., brothel) can be based on the following framework.

Include

- **Direct** activities for institutional beneficiaries, such as STI treatment; as well as

- **Indirect** activities to establish and maintain an enabling environment within and outside the institution, for example advocacy with the power structure.

These should be designed in consultation with the community, and based on needs as well as institutional strengths and mandate.

6. STAFFING

Interventions based on peer outreach require fewer personnel than staff-based interventions. Categories of staff include peers, field workers, clinic workers (nurse, doctor), compounder and office administrator.

7. MONITORING AND EVALUATION

Plan how project activities will be monitored and how you will evaluate the impact of the project.

8. TRAINING REQUIREMENTS

Anticipate, plan and budget for initial and on-going training requirements.

9. TIMELINE WITH ACTIVITIES

Ensure you think about a realistic time-frame for the various activities. Things usually take longer than anticipated.

10. BUDGET

Include a breakdown of your anticipated costs over the life of the project.

STEP 1

Identifying Risk Behaviors and Vulnerable Groups, and Prioritizing a Group for Intervention

When planning an intervention for HIV prevention, it is important to understand the risks that expose individuals and groups to HIV. Once you have identified the groups most vulnerable to these behaviors, you will need to prioritize the group you will begin your intervention with. This can be done according to vulnerability of the group to HIV infection and feasibility of intervention.

Risk behaviors

Certain behaviors create, enhance and perpetuate the risk of HIV infection, such as unprotected anal or vaginal sexual intercourse with partners of unknown risk; sharing or reusing inadequately sterilized needles, syringes and other skin-piercing instruments; an infected mother breastfeeding her child; lack of adherence to infection-control guidelines in health care settings; and the transfusion of untested/unscreened blood.

Vulnerability

Vulnerability is influenced by a range of factors. These include:

- Personal factors—whether an individual has the knowledge and skills required to access services, and to protect himself/herself and others from

HIV/AIDS/STIs, as well as an individual's sexual history (number of partners, number of unprotected sexual acts)

- The availability and quality of services and programs—whether HIV/AIDS programs are culturally appropriate or services are accessible
- Societal factors-- laws (such as criminalizing the soliciting of clients or the act of being in possession of injecting equipment), cultural norms and practices and the socio-cultural characteristics of the community (such as poverty, gender, lack of employment opportunities, sexual abuse and lack of access to information) that act as barriers to prevention messages and the adoption of safe behavior.

Analyzing vulnerability to HIV/AIDS involves identifying these factors and understanding how they interact with each other.

ACTION

- List the behaviors and practices known to increase the risk of HIV transmission in the geographical area of interest to you.
- List the most vulnerable sub-communities, groups or sub-populations living in high-risk situations because of their life-style (such as injecting drug users), sexual preference (men who have sex with men), mobility (migrant workers), livelihood (sex workers), number of partners, number of unprotected sexual acts and nature of the sexual act, and availability of knowledge and skills to protect oneself and others.
- Decide on the most appropriate method of intervention (for instance, peer education).
- Gather secondary information on the number of persons in the group.
- Grade the groups according to possibility to HIV infection (resulting from personal behavior patterns, quality, coverage and access to services and programs, and societal factors such as poverty or migratory status). The frequency of exposure to HIV transmission through multiple routes to a large range of people through many partners should also be considered
- Assess the strengths and weaknesses of your organization. Think of what your organization can do and what it cannot do. Take stock of your organization in terms of number of staff, existing

skills, knowledge of and attitude to HIV/AIDS, sex and sexuality, and training requirements.

- Consider the funding available for the project. Is your budget adequate for the group you wish to target, or will you have to focus on one or a few sub-groups within the group? (Unit costing for different interventions has been calculated for different settings.)
- Decide which group will be easiest to work with in terms of accessibility, resources and the skills and experience of your organization. Keep in mind the most feasible strategy for intervention (for instance, behavior change through peer outreach)
- Based on the information gathered, decide the group you would like to start your intervention with.

REMEMBER

- Risk-taking behavior may be the result of lack of information on HIV, inability to negotiate safe sex, or lack of access to condoms.
- Risk can be reduced if attitudes and skills of individuals are developed to adopt safe behavior.
- Preventing HIV cannot take place on its own. Factors such as the law, the police, education, employment and primary health care influence vulnerability to HIV and must be addressed as well.
- The HIV epidemic disproportionately affects individuals and communities that are marginalized or discriminated against for reasons of sex, age, sexuality and economic status. To address the vulnerability of such individuals and communities, it is important that interventions go beyond risk-reduction strategies.
- Vulnerable groups are often stigmatized for reasons of sexuality, sexual behavior, substance abuse or the fact of being HIV-positive. This stigmatization can limit the access to appropriate HIV prevention, care and support for people who may be most in need.

- In the context of HIV/AIDS, measures to reduce vulnerability create an enabling and supportive environment for risk reduction strategies to work.

Don't forget to identify who else is working in the area. This may help you to assess whether it is possible to gain an entry point into the community by building on existing services or providing complementary services. You may consider working in some other area if another organisation is already working here and providing HIV prevention services.

EXERCISE 1

List examples of high-risk behaviors and practices in your area, locality or district

High-risk behaviors

Low-risk behaviors

List examples of more vulnerable groups and less vulnerable groups. Try and identify groups that are involved in multiple risk behaviors.

More vulnerable groups

Less vulnerable groups

EXERCISE

Select a geographical area of interest to you (this could be a district, locality or community). Complete the following table to establish which group should be given priority in terms of intervention for HIV/AIDS prevention.

Group	Number	Possibility of Getting HIV	Frequency of Exposure to HIV Transmission	Accessibility of the Group	Feasibility of Intervention*	Total
Barbers						
Antenatal women						
Dentists						
Women in the reproductive age group						
Blood donors						
College youth						
IDUs						
Sex workers						
Surgeons						
Truck drivers and their assistants						
Daily wage laborers						

Ranking

Possibility of getting HIV: High = 3, Medium = 2, Low = 1

Frequency of exposure to HIV transmission: High = 3, Medium = 2, Low = 1

Accessibility: Accessible = 2, Hard to access = 1, Not accessible = 0

Feasibility of intervention: Feasible = 2, Not feasible = 1

Note: Prioritise groups with higher scores.

Step 1

Prioritising a risk group:

Although this project very clearly defined the risk group it sought to address, questions were repeatedly asked by UN agencies, donors, research agencies, and NGOs about the relevance of a sex worker intervention vis a vis general population interventions. There was also a concern that any intervention focussing on sex workers would further marginalise them.

In a low prevalence setting this question is likely to be faced repeatedly. In CARE a strategy paper was written to explain why sex worker intervention was a national strategic priority. This paper resulted in reinforcing the support of the donor and the management , however the larger debate on intervention priorities continued. This paper also helped to describe the essential elements of the sex worker intervention (mentioned above).

STEP 2

Selecting an Intervention Area

Once you have selected the group you would like to work with, you will need to know which intervention site to choose. Ideally a project site should be chosen according to the sustainability, feasibility and chances of success of the intervention.

Need for intervention vs feasibility of intervention

While we must move towards covering all high-risk groups, in the early phase of intervention we have to demonstrate success and ensure recognition for the project. To do this we need to start with vulnerable groups where the possibility of behaviour change is greater and the point of entry into the community relatively easy. This will ensure that the process of behaviour change gains momentum and will make it possible to deal with more difficult factors (such as violence) or more difficult groups to reach in future interventions. In state-wide interventions too, focusing on high-risk groups that can demonstrate success in early interventions will help build the capacity of the staff and make the possibility of up-scaling the intervention to the general population easier.

Generally, larger groups and high partner exchange suggest the need for early intervention. However, the feasibility of intervention is influenced by other factors such as low mobility, stable brothel structure, economic independence, fewer incidents of violence, existence of a community culture, feasibility of working with clients, the presence of other NGOs working in the area and the possibility of early success.

The following matrix could help you to determine the need and feasibility of intervention in potential project sites.

Table 2 A comparative matrix to determine feasibility based on selected criteria [

	Need for	Intervention	Feasibility	of	Intervention						
Brothel	Size (No. of Sex Workers)	Sexual activity (No. of Sex Workers x No. of Clients)	Brothel structure	Stability	Mobility of Commercial Sex Workers	Relative economic independence of Commercial Sex Workers	Incidence of Violence	Existence of community culture in brothel	Feasibility of reaching clients in the area	Existence of NGOs in the area	Possibility of early success
			-								
			-								

Gathering information on the vulnerable group is crucial for designing an appropriate intervention and ensuring that the project will be feasible. Secondary sources and key informants can provide valuable inputs on the community. In populations that are particularly hidden (such as young injecting drug users or street-based sex workers), snowballing through one-time drug users, sex workers in prison and drug users in treatment centers, for instance, can be a rich source of information.

Mapping

Mapping is an effective tool that can help to estimate the size of the high-risk population. It also provides a true picture of the physical layout of the area, which is critical for selecting an appropriate site for intervention. Maps can help to locate vulnerable populations (for example, brothels for sex workers, parks for injecting drug users or men who have sex with men). Crucial micro-data can be gathered through mapping, such as different locations frequented at different times of the day, the age-group and socio-economic background of sub-groups, which can feed into the program design.

ACTION

- Explore secondary sources of information to identify possible locations for intervention. For instance, to locate brothels, sources may include:
 - ◆ Staff and records from the Social Welfare Department, Health Department, etc.
 - ◆ NGO staff
 - ◆ Staff and records at STI clinics
 - ◆ The police
 - ◆ Key informants like truck drivers and rickshaw pullers
 - ◆ Service providers such as indigenous medical practitioners
- Make a list of information that is required to select the project site.
- Organize staff members into one or more small teams and select a leader for each team.

- Teams should be sent to visit potential intervention sites to verify the location of the site, locate the group or community and collect information. At these locations, identify key individuals who can help to locate other sites.
- When using secondary data, make sure that several sources of data and different methods of data collection are used because sometimes such information can vary significantly, depending on the informant.

REMEMBER

- Involve key informants and other members of the community as they can provide valuable information on the vulnerable group.
- Update your information regularly. As the situation is dynamic and numbers and patterns of behavior are constantly changing, estimates need to be continuously revised. It is important to be in the field and get as much data for oneself as possible.
- Rather than depend on a single source of data, combine different sources of data to arrive at an accurate image.

It is important to assess the sense of community within the vulnerable group when measuring feasibility of intervention

Interventions among high risk-groups such as sex workers, injecting drug users and men who have sex with men, have been found to be more feasible where there is a strong sense of community (reflected in common social activities, shared norms and bonding among the members) and a tolerant attitude in the wider community.

EXERCISE

The following table was filled in to select a brothel site for early intervention.

- **Why do you think these criteria were chosen?**
- **Could there be other criteria?**
- **Discuss the possibility of early intervention for each site (mark your comments in the last column).**

Table 2 :A comparison of brothels to determine feasibility based on selected criteria

	Need for	Intervention	Feasibility	of	Intervention						
Brothel	Size (No. of Sex Workers)	Sexual activity (No. of Sex Workers x No. of Clients)	Brothel structure	Stability	Mobility of Commercial Sex Workers	Relative economic independence of Commercial Sex Workers	Incidence of Violence	Existence of community culture in brothel	Feasibility of reaching clients in the area	Existence of NGOs in the area	Possibility of early success
Daulatdia	Small (+)	Low (+)	Favourable (+)	High +	?	High (+++)	+	+	+++	-	
Kandu Patti	Small (+)	Low (+)	-	+ -[both signs?]		++	++	+	+	+	
Tanbazar	Large (+++)	High (+)++	-	+		++	+++	+	+	+	
Tangail	Small (+)	Low +	++	++	High +	+	+	+++	++	-	

+ = Favorable -- = Unfavorable

• Why do you think Tangail was selected as the intervention site?

Step 2

Selecting the intervention area:

Initially, it was pre-decided that the project would be initiated in a brothel within Dhaka city. As this was the first such initiative, and marked a new direction for the organisation, failure would have been very costly, and would possibly result in delays of several years before similar activities could be started again. All such projects face a similar problem when they are first initiated, as failure can result in the organisation or the national programme dropping the activity at that time.

For first-of its kind projects one of the dilemmas faced frequently relates to the selection of the site. The dilemma is between choosing the most “important” “significant” or “risky” site vs. the most “feasible” site, where impact will be readily demonstrated, for the intervention. Further, if an intervention is meant to provide a long term training ground, the feasibility of success, and a relatively pleasant environment conducive to learning, are important.

Taking the CARE example, a large brothel in Dhaka, Kandu Patti, reputed to house 1,000 sex workers, was seen as the most “needy” place for an intervention .

However, following a site-visit and intensive discussions with local residents a project team, including external consultants, agreed

that the Kandu Patti brothel in Dhaka city was not a good site for the intervention for several reasons. Firstly, and most importantly, the Kandu Patti brothel had an unstable environment. The brothel owner was gradually displacing the women by erecting walls and closing off sections of the brothel in order to make way for businesses. The size of the brothel, both in terms of physical space and number of women, had reduced dramatically over the past year. While a year previously over 1000 sex workers lived and worked in the brothel, there were now no more than 300-400 women. In addition to this displacement, there had been several incidences of violence, including kidnapping of women. Though the situation was difficult one NGO had established an intervention involving syndromic management of STDs performed by a clinician and STD/HIV education performed by counselors and peer educators. Real numbers were achieved by good key informant interviews of several people in and around the brothel conducted by the project staff.

The possibility of success in such a setting was low due to the comparatively higher level of criminalization, and violence . Therefore, a balance had to be found in terms of optimum size of brothel, on the one hand and a difficult environment on the other. Identifying the most suitable place for an intervention, requires a careful listing all possible sites and examining each for the criteria these places may offer.

How Tangail was selected for NGO project:

In order to select an appropriate brothel for intervention, CARE staff collected initial information from different parts of the country and short listed four areas Tangail, Kandu Patti in Dhaka, Daulatdia in Rajbari, and Tanbazar in Narayanganj.

They used secondary sources of information, visited the actual places, conducted key informant interviews and in depth interviews of some of the target population. Two external consultants with expertise in HIV/AIDS prevention research and programming joined the project team to assist in the final site selection and to conduct the baseline qualitative assessment.

Finally, after a thorough investigation of all 4 sites, , with the help of external consultants, Tangail was chosen because of the following reasons:

- i) No other NGO was working in Tangail; this meant there was no risk of duplication of work.
- ii) It was easier to operate in Tangail from Dhaka than in Daulatdia
- iii) The stability of the brothel was high; it had been in existence for almost 120 years.
- iv) here was a clearly established hierarchical structure, as well as a brothel association (Samaj) of the SWs, two madams-sardarnis, and some landowners.

- v) The neighbours surrounding the brothel appeared to be more cooperative than in other locales. The brothel is well established within the community, and there several possible avenues for community outreach as the project matured.
- vi) This brothel also has an ideal physical structure. Off the main walkways within the brothel are entrances into courtyards. Along the edges of each of these courtyards are approximately twelve rooms in which the sex workers entertain clients. Besides being a place where sex workers and their children, clients, and others associated with the brothel gather to eat, talk, do household chores and play games, the courtyard space is ideal for group discussions.
- vii) Mobility of sex workers (coming and going to other places) was found to be less than in other brothels.
- viii) Violence was also less pronounced and the influence of *mastans* was negligible.
- ix) There was a good percentage of self-employed sex workers who enjoyed relative economic freedom in comparison to “*Chukris*” or sex workers who work under madams.

STEP 3

Developing Trust and Building Rapport with the Community

Building rapport and trust with the community are essential as this forms the basis for sharing critical information regarding patterns of behavior, and the dynamics and structure of relationships within the community that influence/determine behavior. It is this information, usually very private and protected as it can lead to further stigma, harassment and even arrest, that is the grounds for designing interventions, that must be understood, acknowledged and addressed by the intervention as well as by the community. Without access to this information, an intervention is unlikely to focus on the real needs and issues in the community, and therefore is less likely to be effective.

Populations at highest risk (for instance sex workers, men who have sex with men or injecting drug users) are often marginalized or criminalized. Outsiders are viewed with suspicion as interactions with the larger society, for example with the police and journalists, may have resulted in a breach of confidentiality, or stigmatized treatment, leading to a feeling of powerlessness as well as loss of dignity . As these communities are often not open to outsiders working with them, it is important for project staff to develop trust and build rapport with the community.

Building rapport and trust requires an attitude of genuine acceptance and belief in the potential of the community, particularly as future “owners” of the project. Developing this attitude may require training, which could be included in the preparation of the project. Training can also include techniques for building rapport.

True rapport and trust are based on honesty. It is important that project staff are always explicitly honest with the community – about who they are, what they represent, what the goals and objectives of the project are, what they can do and the limitations of the project. Unrealistic promises or misrepresentation can destroy trust and do long-term damage to the possibility of any future interventions with the community.

Some projects emphasize the importance of developing trust and rapport by including this as a criterion in evaluating staff performance and as a basis for salary increment.

ACTION

- Make a list of individuals who have some knowledge about the vulnerable group. Contact those who can provide information (key informants) or can take you to someone influential in the community.
- Identify dynamic individuals within the community whom members of the group may look up to. Ask them to introduce you to the community.
- Identify yourself, explain who you are and why you would like to make contact with the vulnerable group. Make sure (through both verbal and non-verbal statements, gestures) you convince them that you are non-judgemental, committed to confidentiality of information and have no intention of interfering in their personal lives.
- Contact all the key informants and local gatekeepers who can help you gather information for an initial rapid survey. Other NGOs in the area, government officials and service providers (like the local quack who may be providing services) are valuable sources of information.
- Explain why you need to conduct a survey.

- Reassure the group (verbally as well as non-verbally) (for eg. By asking for permission before taking notes, using a tape recorder, camera etc) that the information they provide will not be shared with the press or the police.
- Utilize every opportunity to demonstrate what you can do for the community.
- Try and identify points of entry into the community and through whom.
- Reassure the group about what you are doing and also be frank and honest about what you can not do.

Key Informants

A key informant provides information on how local networks and communities make decisions and the structures and processes they use. Key informants are an important source of information as they are knowledgeable about the topic or may have in-depth information on some aspects of the issue (e.g., injecting practices), and may be currently or may have recently been involved in the activity.

A key informant must have time, be willing to share information and provide help, and must be knowledgeable about the community.

The main objective of HIV interventions is to reduce risk behavior and harm. Unless this is made clear to the group you are working with and all the stakeholders, you will be viewed with suspicion.

Advocating with the major players in a community

- It is important to build trust and start advocacy with the local as well as the larger power structure, otherwise intervention efforts can get derailed.
- For sustained behavior change, a supportive power structure and community are necessary. One of the objectives of the project should be to change the perspective and view of the power structure and the community towards HIV/AIDS, risk behavior and marginalized communities as well as to interventions that could be bordering on the legal and ‘acceptable’.

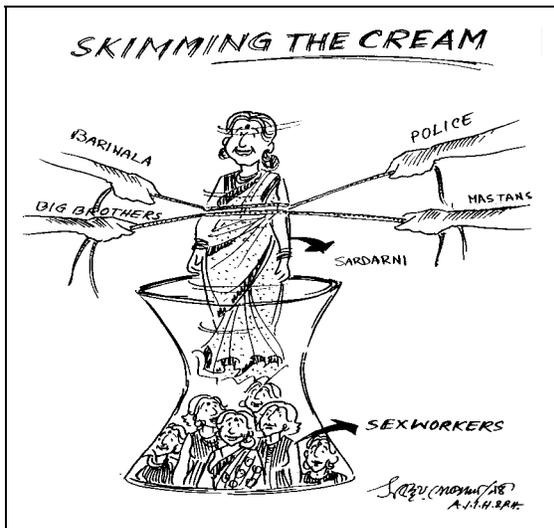
Persons who control power in the group and whose opinions matter make up the power structure.

People who do not directly control power but influence the group in some way (for instance, external donors, service providers) are key players in any intervention.

Get to know the local power structure and build credibility for effective intervention. Among brothel-based sex workers, power holders could be the madam, older sex workers, local shop owners, the police, pimps, local politicians, one-time sex workers, rickshaw-pullers, house owners staying inside or outside the brothel, or the sex workers themselves.

While advocating with the power structure is an extremely important aspect of intervention, it is not necessary to wait for endorsement from the power structure to start an intervention program. The intervention process and gaining the support of the power structure are simultaneous and the progression of the intervention can sometimes spur community leaders to support the project.

- **Who Pulls the Strings? The Power Structure of a Brothel**



REMEMBER

- Be conscious of your attitude. You must be non-judgmental at all times.
- Although the group may not be very encouraging in the beginning, you will need to try and win their trust and confidence gradually. Tell them why you have come to work with them.
- Respect the lifestyle and the working hours of the group you are working with.
- Listen, show respect, take your time and you will gain the trust of the community.
- The group you are targeting may be difficult to reach, may avoid contact with outsiders or suppress information.
- Many groups suffer from extreme poverty, unemployment, discrimination and related problems.
- Developing trust and rapport with all the stakeholders and the vulnerable community is critical to the success of your intervention.

- Developing trust does not mean that one has to lend or borrow money, share drugs or alcohol . In fact such behaviours may be counter productive.

EXERCISE

A group of researchers visited a brothel to collect information. They asked the police to accompany them as they were worried about their safety. The researchers assured the sex workers that any information they provided would be treated with full confidentiality.

- **Do you think that the information collected was valid?**
- **What was the non-verbal message given to the sex workers?**
- **What does this tell us about the researchers' perspective?**

Step3

Developing Trust and Rapport and Identifying the Power Structure of the brothel

The core of the project was seen as its ability to create an environment of tolerance so that sex workers could form groups, get trained as peer educators, and run services for themselves and for other sex workers according to the needs and preferences of the sex worker community. Such a project would obviously be based on the trust and support of the sex workers, stemming from regular interaction on a continued basis. There was a strong likelihood that the project would be viewed with suspicion and annoyance by the power structure unless they were assured that the nature and process of the project would not conflict with the groups in power.

Therefore, all the staff of SHAKTI project were divided into several groups and were encouraged to explore the already known and so far unknown power groups, structures, and mechanisms without raising any suspicion. Simultaneously, continuous discussions were held with the sex workers. Thus shop keepers, local police, leaders, press, house owners, madams/sardarnis, politicians, and musclemen in the area were listed.

A similar exercise among sex workers also revealed the existence of several sub groups among the sex workers: bonded sex

workers, very young sex workers, liquor selling sex workers etc. Each group was met with separately and discussions were held with them.

Staff followed specific guidelines when they met the community:

- a) ID card were shown to provide introduction of the staff. Visiting cards including home addresses were given to the people met. “We are not from police and press and do not share any information with them”, was explicitly stated
- b) The purpose of the meeting was explained, including information on HIV, its importance and impact on the sex industry and the lives of sex workers. What exactly would be done by the NGO was described with as much transparency as possible, including peer education activities, establishing and running a clinic, condom promotion etc. Explicit discussion was conducted about the non interference with the sex industry and timing of the business. Co-operation was also obtained for running of the project and peer education activities, to be run by the sex workers.
- c) Often it was necessary to bring several groups together outside the sex-work environment. This was done through a formal invitation to sex workers, madams, land-owners to come to the office for an organised discussion on HIV, and on the proposed project. The entire community thus participated in the project as valued partners from the start.

Trust and rapport building also involved another practical issue. Most of the acutely perceived needs of the sex workers (such as the education and care of their children; freedom to dress like

other women when they are out of the brothel – ie. to wear shoes and Shalwar Kameez; security for their old-age) related to issues outside the traditional concept of the project. Similarly, the sex worker community did, not initially see issues important to the project such as condom use, as very important. PRA techniques were used to encourage sex workers to describe what they valued most in their lives and what they needed most by drawing pictures and symbols on the ground.

It was decided that these priorities had to be addressed.

Access to education, "permission" from the police to wear shoes when going outside the brothel, and "permission" to be buried in the regular burial ground for Muslims were the most important issues they described. These entailed almost no additional cost, and could be delivered within the design of the project through effective advocacy and by establishing linkages with other Government /non-government organisations. Where CARE management agreed to the provision of the service (eg education of peer educators) the field staff did so; in other cases (eg education of the children of sex workers) they liaised with other organisations who were ready to provide the service.

There was another practical issue. The setting up of Clinics and provision of health services could contribute greatly towards developing trust and rapport with the community. Often Projects hesitate to provide these services prior to the completion of base-line studies as they fear that access to these STD services and condoms will influence the base-line findings, indicating higher figures for STD treatment and condom use than were actually

present in the community. CARE decided the advantages of providing services were great, and special care was taken to adjust the questionnaire to take account of the influence of the new services, specifically for projecting an inflated rate for STD treatment and condom use in the baseline survey.

The critical importance of trust, and a non-judgmental attitude were repeatedly emphasised to the staff.

The local police and the district collector were personally requested to withhold police raids during this period to prevent the possibility that the community identify the SHAKTI team with the police and its actions.

STEP 4

Rapid Stock-taking and Knowing the Community Better

It is important to get detailed information on the community, understand patterns of behavior, the processes and factors that influence or shape these behaviors, and what the behavior means to the community to be able to plan and design an appropriate intervention for behaviors change. In other words, we need to understand the context and significance of behavior or ways of life of the people themselves. This information is subjective and therefore can be collected and understood only through close interaction with the community. This interaction and understanding involves building a relationship of trust, and knowing the special vocabulary that is used by the community.

Qualitative research methods are used to collect and analyze this kind of information.

Qualitative Methods can help:

- Collect baseline information in order to initiate the intervention
- Begin the process of building rapport within the vulnerable community
- Understand the power relations within the community
- Identify potential resource persons in the community (e.g., guides and peer educators)
- Assist in the design and implementation of quantitative surveys
- Provide inputs for project design and implementation
- Identify potential obstacles to project implementation and possible solutions

What are qualitative methods of research? Qualitative research is a flexible, open-ended method of gathering in-depth information. Key informant interviews, focus group discussions, contextual studies, observation and rapid needs assessment are qualitative methods that have been effectively used in a number of interventions.

A key informant interview is

- A direct, face-to-face meeting that is used to gather information from individuals
- Conducted with a broad cross-section of people who have some knowledge of the subject
- Usually repeat interviews are conducted to get in-depth information

In interventions among sex workers, key informant interviews could be conducted with pimps, madams, the police and shop owners in the area.

Focus Group Discussion (FGD)

Focus group discussions help to identify behaviors, perceptions, attitudes, norms and beliefs of a certain group of people. They are

- In-depth dialogues among a small group of people (between 4-8 persons) who have something in common (e.g., one-time sex workers or current drug users)
- Organized with a small number of people to ‘focus’ on a particular issue
- Facilitated by a moderator

Focus group discussions can be organized for the following groups:

- Sex workers from the same brothel or street
- Injecting drug users from the same neighborhood
- Policemen who work in the intervention site
- Pimps/madams in the brothel
- Clients of sex workers

It is important to understand the culture, beliefs and barriers to behavior change while working with vulnerable communities.

Contextual studies provide information on the

- Social, legal and cultural factors which prevent the adoption of safer behaviors in a community
- Legal status of the vulnerable group
- Law enforcing practice in the area by the police, mastans, etc.
- Social status of individuals

Qualitative methods often call for spending long periods of time with the community in order to get the depth of information sought. However, the need for quick information of the qualitative type has led to the development of rapid assessment procedures.

Rapid situational assessment or needs assessment will help to get information quickly on people's perceptions and knowledge of risk behavior, and the needs and priorities of the community. This will enable the team to select possible approaches for intervention and entry points into the community. Needs assessment also provides an entry point for delivering services (e.g., setting up STI treatment facilities in a brothel-based intervention).

This process provides close contact with the community and opportunities to share experiences. It is also the time to build the capacity and skills of the group so that they can eventually work in partnership with the project team.

Rapid situation assessments

- Involve direct contact with the people
- Use a variety of methods and sources, including existing data, to gather information
- Consult a range of people
- Are problem-oriented and focused
- Are conducted rapidly (from a few days to a few months)

- Are inexpensive
- Are purposive and action-oriented

ACTION

- List the information you require from the situation assessment.
- List the persons who are well informed and willing to share information. These are your key informants and they can help you to gain an entry into the community.
- Sometimes people tell you what you want to hear because they want to please you, gain your acceptance or because they do not want to jeopardize others in the community. It is important to check the validity and reliability of information from other sources. Use your own judgment.
- Be flexible when conducting interviews but make sure that you cover all the required areas of information. Adapt your interview schedule to the situation rather than rigidly follow a pre-set questionnaire.
- Seek information from the widest possible range of stakeholders.
- The social context of relationships and the norms that influence people's risk-taking behaviors need to be identified.

It is important to recognize that it may not always be possible for people to speak openly or honestly.

Interviewers must be made aware of ethical guidelines and obtain informed consent from respondents that includes the right to refuse consent and guards against discrimination.

REMEMBER

- The process of needs assessment or rapid assessment should involve the community and help them realize the need for intervention.

- With smaller groups, willing respondents and well-trained staff, rapid assessment can be begun and completed in 4 - 6 weeks.
- Data collection is the beginning of intervention. Needs assessment should be done in such a way that it becomes part of intervention.
- Any judgmental attitude (even body language) may ruin the process of data collection and jeopardize intervention.
- The team may need to have flexible working hours (for example, when interviewing sex workers who do not always have regular timings for work).
- Interviews should be recorded and reviewed daily. Fieldwork-related issues may also need to be reviewed every day.
- Take stock. After initial information gathering for a week, sit down with your field notes and interview notes and try to review what you have learned so far. Check your first round of information. Go back to your regular key informants and try and check the accuracy of your data as well as discuss interpretation.
- Observation should be conducted simultaneously. This means spending time at the intervention site (for instance, a brothel) for as long as possible and observing the activities of the vulnerable community. Check if your observations at the site tally with what you have been told by the group.
- The project staff needs to know, understand and use the local vocabulary freely in order to enquire, record and report on risky behaviors in the community. Compiling an initial list may be helpful.
- The data from this initial situation assessment should be regarded as preliminary and should be revised as the team acquires more information.
- The more you know about the vulnerable population, the better prepared the intervention will be. In addition to information about the number of persons and their usual location, it is also important to get information about

people who intermingle daily with the vulnerable group (in interventions focusing on sex workers, this could include pimps, the local mafia and the police).

- When asking key informants questions, remember that their responses may be about actual behavior or perceptions and beliefs. For a successful intervention, try and find out about actual behaviors during interviews.
- You will need to come back to the information you collect in this phase to monitor the progress of the project, develop appropriate materials for behavior change and evaluate the impact of intervention.

Tips for data collection

Persons seeking information must be non-judgmental.

Try to cover the full range of sub-populations in the community to get a complete picture (for instance, bonded sex workers, new entrants, sex workers with babus)

Data is reliable only if multiple sources of data and multiple methods of data collection yield consistent results.

Should respondents be compensated for spending time with researchers?

In the case of sex workers, the fact that the time they spend being interviewed may possibly mean time away from a client must be respected. In principle this should be compensated. However, compensating a sex worker with money may not be the best option. Guides can help you decide the best way to compensate a sex worker.

Sex workers may also value non-monitory incentives. Often, being treated with respect is reward enough.

EXERCISE

List possible key informants for interventions with the following groups:

- **Street-based sex workers**
- **Injecting drug users**
- **Men who have sex with men**
- **Hotel- and residence-based sex workers**
- **Brothel-based sex workers**

What are the topics would you like to cover in your interviews?

Step 4

Rapid stocktaking and knowing the community better

The process of designing and implementing interventions in a systematic scientific way often begins with exploratory qualitative research, which is undertaken to gain an in-depth understanding of the community and of the larger context. This includes, for example, getting an accurate picture of the size and composition of the population, mapping the power structure, and collecting and understanding the nuances and significance of locally used vocabulary. This is followed by a needs assessment to design the components and activities of the project or a feasibility study to assess the relative suitability of different approaches. Finally a base-line study is done to establish start-of-the-project benchmarks which can be used for later comparison and assessment of impact (for example, relating to the frequency and regularity of condom use). Usually, external “experts” or consultants are contracted to undertake these studies, especially for the first round of research.

Following the completion of the studies and design process, staff are trained, services introduced and communities are motivated to participate. In many instances costing is done after all these steps are completed. This entire process usually takes more than a year.

SHAKTI project always kept in mind that the intervention had to be implemented rapidly and the purpose of all the studies was to better define the intervention and improve its quality and not scientific research.

Therefore, several things were done simultaneously. As soon as the brothel was selected, the staff was trained on sex and sexuality issues including, local and English names for different parts of the body, types of sex, and different forms of sex practices. This was done in order to develop non judgmental attitudes towards different forms of sexual practices and life styles associated with these practices. They were also made comfortable with the use of local vocabulary on sex activities which they may have to use during interviews.

Two consultants were hired; one was fluent in the local language, and had intensive experience of implementing a similar intervention in addition to knowing qualitative research. The consultants explained different aspects to be studied and the best method to do so, such as Focus Group Discussion or Key Informant Interviews or Ethnography. A schedule was prepared for this study. The consultant, who had vast experience in the field, gave one day of field training as well as class instruction. The whole study was completed in two weeks by the field workers, with the assistance of the community.

Some important points were kept in mind: the study was the first introduction of the whole team to the brothel, and therefore presented the first opportunity to build trust and rapport. A great deal of preparation and care went into ensuring that the community was properly informed, and that police activity was at a low level.

Regular field meetings and explicit discussion of dos and don'ts made the inexperienced workers who had never worked in an urban area, into a specialised and confident team.

To summarise, the experience of the SHAKTI project demonstrated that it was possible to conduct a qualitative study rapidly, collapsing the several steps of formative research into one well-thought study, by providing adequate attention to possible difficulties which could distort the picture. Secondly, the study was seen as the first step in intervention, and staff were therefore trained in rapport-building along with research skills. Appropriate choice of the external experts further enabled this combination of research and intervention. Finally, utilising the staff and community enabled very quick completion of the study, and a smooth transition to intervention.

STEP 5

Selecting Guides

Any intervention for high-risk behaviors requires the active involvement of members of the community from the beginning. Guides selected from the community can help the field team gain access to the vulnerable group, identify locations, help to estimate the size of the group, collect data for the initial survey and assist the investigator throughout the assessment. This also establishes as a norm the involvement of the community in making decisions for all activities concerning them.

Guides play a vital role in taking intervention forward.

Guides can

- Jointly develop the intervention with the project staff in the initial stages.
- Be trained to become peer educators in the future and eventually take on the project.
- Can introduce and advocate for the project in the community
- Set up contact and meetings between the staff and key individuals in the community.
- Interpret the situation in the community to the field staff
- Provide insights on local history (for instance, a series of events that may have led to a particular situation)

- Be the eyes and ears of the field staff when they are not there (tell the team the reactions of the community to the proposed intervention, for instance)
- Develop the skills to eventually take up intervention
- Ultimately provide leadership to the project

ACTION

- Encourage people to volunteer and form partnerships
- Discuss the role of guides and come to a consensus on what is expected of guides
- Ask key informants and other community members to suggest suitable guides
- Develop selection criteria in collaboration with the community
- Make contact with those who fulfill the selection criteria
- Discuss people's expectations of the job
- Select guides who are
 - ◆ Able to spend time on project work
 - ◆ Keen to work
 - ◆ Representative of the community
 - ◆ Accepted by the community
 - ◆ Able to communicate effectively
- Spend time with guides to help them internalize the value system on which the intervention is based, including respect, dignity and self-determination

Guides as Peer Educators

Since the basic approach of any HIV intervention is to adopt peer outreach for behavior change, it is essential to identify key persons who can be trained to become peer educators in the future and eventually take on the running of the project.

During the training period, potential peer educators can work as guides, which will help them establish relationships with

the project staff, gain credibility and acceptance with their peers, and become familiar with the project design.

A successful intervention is based on community ownership and participation. Since full involvement of the community takes a long time, selection of guides and involving them in decision-making is a good intermediary step.

The project has to be flexible to bring in different functionaries to join as guides, depending on the needs of the community. For instance, women may need guides to help them set up and run co-operatives for loans and savings rather than only provide peer education.

Step 5

Selecting guides:

During the qualitative study field staff were also looking for community members with different attributes (eg bonded sex worker, alcohol-seller, older women) who were taking interest in the activities and were keen to help. Field staff were actively encouraged to interact closely with such persons and seek their opinion at all stages of decision making, while not necessarily accepting their views. These persons were also called to the office for meetings (transport was provided to make this possible) and some of them became part of the research team, regularly discussing the several options in the field for data collection.

A special attempt was made to locate persons who had rapport and contacts with different subgroups such as bonded workers, or who represented each of the zones/clusters into which the 54 houses of the brothel were divided by natural boundaries.

Meetings between these selected persons were also facilitated.

Special care was taken to ensure that non-project office staff maintained a respectful and non-judgmental attitude during these meetings, as they were held in the Project office. In most cases, persons who showed interest did so mainly because of their concern for their community or because of the respect they earned by participating in the project.

One of the stated goals of the project was that the project be run by the community in future and involvement of the community at all stages of the project. Usually, following peer education, peer outreach workers work for the project on a regular basis and there

is thus involvement of sex workers in the project on a regular basis. In this case, the recruitment of guides for assisting in the qualitative study and helping the ongoing activity of the project provided an avenue for regular participation in all decisions making discussions even before peer educators were selected. These “guides” who showed interest in and assisted the project, and slowly became part of the team, were invited for peer education training immediately after the surveys. Persons who graduated through the course were formally made peer educators.

STEP 6

Providing Services to the Community

Some services (such as condom supply and STI treatment) are essential for behavior change. Unless you provide these services, the vulnerable group will not be able to adopt safer practices.

Each community also has a host of unmet basic needs that may not be directly related to HIV prevention (such as day care for children or sanitation among sex workers) but are vital for their daily functioning. The community may be so occupied with getting these basic services that they may not be able to pay attention to or see the relevance of HIV prevention till these priority issues are addressed. Providing these services or assisting the community establish these services will help them meet their basic needs, enlist their support for intervention, gain their trust and confidence, and provide an entry point for intervention.

You can identify the services the community needs during initial rapid needs assessment.

ACTION

- Identify the priority needs of the vulnerable group and the potential services that can be developed with the help of the community. Try and ensure that there is consensus

within the group and no resistance from the wider community for the services that are selected.

- Simultaneously talk to the local power structure and seek their opinion.
- Identify how to provide the desired service in partnership with the community and enlist their support in implementing the service. The provision of services depends on the
 - Mandate and strengths of your organization
 - Need of the clients
 - Other services is available in the community
- Ensure that the community participates fully in mobilizing resources and managing the service.

Involve the community in managing the project

Ask the group for inputs such as where the service should be located and convenient timings. Ensure that the service is accessible.

- Staff at the facility should be trained or professionals should be hired to provide quality services (for instance, a local private doctor or lawyer could be contracted to provide clinical or legal services).
- The timings of the service should suit the community.
- Discuss the possibility of sustainability by ensuring that the community values the service being provided. A simple way is to charge a small fee for the service.

When providing an essential service, ensure that

- Barriers to service provision have been considered (for instance, inconvenient timing, unsuitable location, police harassment) and solutions identified.
- The service is linked to favorable behavior change leading to a decrease in vulnerability to HIV/AIDS and STIs.

REMEMBER

- Each community must choose the services it needs.

Identify the need for services with the help of the community

Ask the group through focus group discussions or participatory rural appraisal methods to identify their unmet needs and list them in order of priority.

In interventions for sex workers, your list could include literacy, money, health, children, recognition by the wider group, being treated with respect, protection from the police, water, drainage, dustbins, electricity.

- The service you select will depend on the capacity of your organization to provide the service and the other services available in the community.
- It is not necessary for your organization to provide all the services that the community needs. Help the community to build on existing services.
- Establish minimum criteria for the service by ensuring
 - ◆ Client satisfaction
 - ◆ Service providers are non-judgmental and clients are treated with respect
 - ◆ Confidentiality
 - ◆ Basic standards of quality are maintained

- ◆ The community feels a sense of ownership for the service
- Develop a multi-sectoral response and build partnerships. For instance, you could work with existing income-generating services or schools to spread awareness about HIV/AIDS and STIs or let the community know where STI services are available.
- It is not necessary to directly provide all the needed services to the community. Often, it may be more efficient and beneficial to facilitate access to existing services or coordinate/collaborate with other agencies for service provision. However, when linking the community to existing services, the services may have to be adjusted to make them accessible and service providers will have to be oriented to the values of the project. For example, when linking up with existing STI services, it may be necessary to set up separate timings for sex workers that suit their working hours and to sensitize providers to the questions that they may ask
- When providing services, decide whether you need to
 - ◆ Provide the service directly (e.g., supply condoms through peers rather than through social marketing)
 - ◆ Collaborate with other service providers (e.g., use existing clinics to provide STI treatment)
 - ◆ Use other referral services (e.g., refer pregnancy cases to hospitals).

Selecting a service

You will need to choose services according to the needs of the vulnerable group you are working with and the capacity of your organization. The following is an indicative list of services that can be introduced prior to intervention. This is not a definitive list for intervention.

Brothel-based sex Workers	Street-based sex workers	Injecting drug users
Management of income and savings	Drop-in rest center	Drop-in center
	Hot meals	Provision of disposable needles and syringes
Medical services, including STI treatment	Stable income	Bleach
Credit or banking facilities	Mobile medical services, including STI treatment	Treatment for abscesses
Secure housing	Secure housing	Legal assistance
Legal advice/support	Legal advice/support	Condom distribution
Childcare	Credit/banking facilities	Primary health care
Basic education	Childcare	Rehabilitation
Literacy	Management of income and savings	Drug detoxification and substitution programs
Children's education	Literacy	
	Children's education	

Fixed Facility or Outreach?

You will need to decide whether you will provide a fixed facility or outreach service, how often to provide the service and who will provide the service. The following list can guide you in providing services for intervention.

Service	Site	Provider	Frequency
Condom distribution	Outreach	Peer educators	Daily
STI treatment	Clinic	Doctor	As required
Needle and syringe	Outreach	Peer educators	Thrice a week
Knowledge/awareness	Outreach	Peer educators	Once a week
Immunization	Clinic	Government personnel	Once a month
Medical referral	Hospital or private facility	Trusted and alerted medic, nurse or paramedic	As required
Legal/police referral	Specialist site	Trusted specific provider	As required

Establishing linkages for services

Linkages are connections or pathways to services beyond the scope of the project. If, in your work with a community, you generate the need for some kind of service that you cannot provide, you may need to develop links to providers who can deliver the required service.

If you work with marginalized groups such as sex workers or drug users, not all service providers will be happy to deliver services to the group you are working with. You need to identify these and work to ensure providers are willing to be non-judgmental and empathetic to the vulnerable group, and will support the desired behavior changes the project seeks.

ACTION

- Try to identify services that might be needed by the vulnerable group that you are unable to provide.
- Identify potential governmental agencies, non-governmental organizations, private agencies and individuals who can provide these services.
- Establish linkages with these different agencies.
- Share the goals of the project with these agencies and try to sensitize the providers to the vulnerable population.
- The group you are working with may have a range of needs, so be as comprehensive as possible.

Linkages may be needed for the following services in a community.

Service or Problem	Reasons for Referral or Linkage
Complex or resistant STIs	Tests and/or treatment
HIV/AIDS	Counseling and treatment
Tuberculosis	Tests and/or treatment
Rehabilitation	To wean drug users away from injecting drugs and encourage them to adopt safer drugs or abstinence
Pregnancy	Antenatal and postnatal care and delivery
Legal advice	In the event of prosecution/arrest
Credit facility	To save and plan for the future
Medical care	Immunization, emergencies or treatment of chronic conditions
Education	For self or family members
Child care	During working hours
Livelihood skills	To establish alternative livelihoods

EXERCISE

To provide sex workers access to health services, an STI clinic was set up close to a brothel by the government as part of an intervention. Although the facility was easily accessible, the sex workers did not use this clinic for two years. However, when a clinic run by sex workers was established inside the brothel, it was a huge success.

List the key factors you think make community-based services more effective than services established by outside agencies. You could consider the concepts of 'ownership' and 'acceptability'.

Step 6

Providing services to the community:

Respecting and responding to the priority needs of the community was an integral part of the project. The staff asked about needs both formally and informally, as part of the qualitative study, in the process of building rapport, through the use of special tools such as PRA and sometimes by listening as a friend. What the sex worker community desired most was self esteem, including the right to wear shoes outside the brothel (women without shoes were easily recognised as sex workers and treated disrespectfully); to be buried in the communal burial ground; opportunities to read and study; facilities for children to go to school; opening of bank accounts and respectful treatment by hospital staff when they reported for pregnancy or delivery. Most of them did not ask for alternative jobs, as a regular job outside the brothel would not protect them from the stigma of being branded as an ex sex worker and the resulting harassment. Most of them were also not very keen to go out of the business and even the older women who wanted options to earn outside sex work, preferred setting up small businesses and shops, or even to work as maids within the brothel rather than employment outside.

The staff realised that it was often possible to provide some of the services/conditions desired by the community through small adjustments in the program. Therefore, it was possible to accommodate most of these activities within the rubric of the project or by establishing links with a few other NGOs and Govt organisations. They linked up with NGOs and Govt organisations

providing education for children, antenatal and immunisation services. They also advocated successfully with Govt doctors in hospitals, police, the municipal corporation and religious leaders and were able to change most of the conditions the sex worker community wanted addressed. In some situations it took a longer time like permission to wear shoes, while in others it was immediate – as in the case of opening of bank accounts.

This part of the project mainly consisted of setting aside time for meetings for advocacy and linkage with other services and therefore cost very little to the project. In terms of returns, however, these activities paid a very rich dividend and placed the project on a very strong footing of care and respect which could not be achieved by the peer education programme alone.

STEP 7

Collecting Baseline Information

To measure the impact of intervention, in-depth baseline information on the community is required. Quantification accurately documents the baseline situation and tracks risk behavior over time among subgroups by providing data that is directly comparable.

Quantitative data is also an extremely useful means for advocacy. Most policy-makers as well as implementers start by denying the need for HIV related interventions in their country/community. Quantitative data provides evidence to demonstrate that action is required and cannot be easily denied.

What is quantitative research?

Quantitative methods gather information that can be analyzed in numerical form. Behaviors, perceptions, socio-economic data, etc., are either measured or counted, or questions asked according to a defined behavioral or clinical questionnaire.

Baseline information helps in

- Project design (in terms of identifying what needs to be done and how much is to be done, setting priorities and relative deployment of resources)
- Advocacy with different stakeholders and the community
- Monitoring and evaluation

Depending on the group you are working with, specific details are required to design an appropriate intervention. These could include the following in a brothel-based intervention:

- Socio-demographic characteristics (age, sex, marital status, occupation),
- Reproductive health characteristics (number of living children, number of abortions, contraceptive use, reproductive health problems)
- Sexual behavior (number of partners, types of partners, types of sexual practices)
- Knowledge and experience of STIs (types of STIs, health-seeking behavior, diagnosis and treatment),
- Knowledge of AIDS (routes of transmission, modes of prevention),
- Knowledge and use of condoms (for family planning, for STI prevention, frequency of use),
- Accessibility of condoms (where obtained, by whom, type/name of brand, cost)
- Structure of brothel-based sex trade (political characteristics, functioning of the sex trade)

Quantitative surveys with structured questionnaires are intensive and may sometimes involve invasive clinical examinations. To field a survey successfully and ensure participation of the community, you will need to build trust and establish your credibility in the community by:

- Explaining the reasons for conducting the survey to enlist the support of the group
- Treating respondents with respect
- Assuring the group that any information provided will be considered confidential
- Providing follow-up services that can produce effective results (e.g., STI treatment and referral)
- Avoiding any form of coercion
- Sharing findings with the community and initiating interventions

Laboratory testing for certain indicators like STIs/ HIV can accurately establish the prevalence of disease and indicate whether the intervention has been effective.

Training staff

It is important to train staff to conduct interviews. In interventions with sex workers, training could cover the following topics.

- ◆ Sex and sexuality
- ◆ STIs, HIV/AIDS
- ◆ Major ethical issues, including confidentiality
- ◆ Non-judgmental attitude towards the vulnerable group.
- ◆ Gender and treating people with dignity

ACTION

- Design your questionnaire based on the information collected in the needs assessment. The questionnaire should be simple, practical and easy to conduct in a field situation.
- Use local terms when enquiring about behavioral practices.
- If possible, have your questionnaire reviewed.
- Discuss the questionnaire with the guides and the vulnerable group to assess whether it is designed to gather the information that you really want.
- Pre-test the questionnaire and finalize it based on feedback from the guides and the community.
- Explain the objectives of the study to the vulnerable group before fielding the survey.
- Train field workers in the following areas:
 - ◆ Objectives and methodology of the baseline study
 - ◆ Operational plan
 - ◆ Conducting an interview
 - ◆ Role play

- ◆ Responding to commonly asked questions
- ◆ Legal and ethical issues
- ◆ Confidentiality and obtaining consent relevant to the study.

REMEMBER

- Without plans for intervention, clinical examination and detailed behavioural surveys are not recommended.
- It is important to develop systems for data collection, processing and analysis that are ethical, reliable, appropriate and simple to use in the community.
- Advocacy with power holders who are directly or indirectly involved with the trade will help explain the objectives of the baseline study and enlist their active support so that they facilitate the participation of the community in the research and survey.
- For representative information, ensure that the methodology is sound, the tools for data collection are pre-tested to give data you really want to collect, the field staff is appropriately trained and the community is involved in processing and analyzing the data.

In a brothel-based intervention, baseline information can be gathered on the following:

- The prevalence of STIs (e.g., the percentage of women with gonorrhoea or syphilis), supported by laboratory and clinical findings
- The existing health-seeking behavior and practices of health workers (who are the chief health care providers, who pays for treatment)
- The existing knowledge, intent and practices in relation to safer sex (knowledge of symptoms of STIs, beliefs regarding routes of transmission of STIs, knowledge of AIDS)
- The level of perceived risk of HIV/STIs by sex workers (practices adopted to prevent STIs)

- The extent of peer education and peer pressure
- The negotiation skills of sex workers
- The level of condom use (occasional, in the past 24 hours, in the past 7 days, with regular partners)
- The knowledge, intent and practice of sex among those who influence the sex trade
- The existing HIV situation

Designing a clinical survey

A clinical questionnaire can be designed to record the history of STIs, including the duration of symptoms of HIV related disease, and matched with results of clinical and laboratory examinations by a physician.

When fielding a clinical questionnaire, ensure

- Voluntary informed consent of individuals at the time of the interview as well as before clinical examination
- Confidentiality when conducting interviews and examinations
- Clinical history taking and examination are standardized otherwise you may have skewed results that are not representative
- Referral and treatment services for non-related complaints (such as pregnancy, psychological disorders) are identified prior to conducting the survey
- Samples are collected in a linked manner with the name or code number of the participant for which they have given consent. Samples should be delinked for HIV tests, which should be anonymous.
- Follow-up mechanisms should be ensured to treat respondents with positive laboratory results

EXERCISE

- **What kind of problems do you expect to encounter during baseline data collection?**
- **How can these be avoided?**

Step7

Collecting baseline information- conducting a baseline survey in the selected brothel area:

This project was the first of its kind in the country and as a demonstration project undertaken against a background of popular criticism of NGOs spending money on sex workers, had the additional burden of proving that what it was doing was effective. The indicators chosen to assess impact needed to be objective and measurable. Therefore, a carefully designed baseline study was conducted to document current status of both behavioural and biological markers.

Behavioural markers included not only direct behaviour, like consistent condom use, but the precursors of behaviour change, such as information about condom and HIV prevention, the desire to use condoms, difficulties in and inconsistency in the use of condoms, were also measured. Information about STD services and other services, the availability of condoms and of peer education was collected.

For the biological markers, syphilis could not be used as the prevalence in the community was very low, and would not therefore indicate changes in a few years of intervention.

Gonorrhoea had the difficulty of showing high resistance to several drugs routinely prescribed under syndromic management, and hence also would not show a significant change. The only option was to use the presence of Chlamydia. The detection of Chlamydia requires very sophisticated tests and had to be done outside the country from a university at UK. This substantially strengthened the potential of the demonstration effect of the project. The baseline study design required sampling and random selection of sex workers, careful design of the questionnaire, training of staff, recruitment of study subjects through sex-worker Guides, and a clinic and internal examination for blood and endocervical samples. Pending laboratory results, presumptive treatment was given. Such activity needed extensive organisational and management skills.

In order to comply with sampling requirements, very high level of participation

of sex workers (pre-selected by sampling procedures) in the study was required. Further, this level of co-operation was required at the very out-set, when the project was being set up. Since the methodology of the base-line required high levels of compliance for sensitive invasive procedures (drawing blood as well as internal examinations), the situation was extremely delicate and was poised on high levels of trust as well as following of high ethical and humane standards and the delivery of quality, client- centred services.

Implementing this exercise was the acid test for the Team – a successful outcome would result in incredibly high levels of group morale, trust and cohesion. Any problems perceived by the community could totally destroy the fragile relationship being established and cause a set-back which could result in long-term damage to the establishment of a similar project, as well as strong national and international criticism for the NGO. In this case, the compliance achieved was approximately 90%. The process of conducting the Baseline Study placed the Project on firm ground of understanding the intricacies of a little-understood community

and shared commitment in the community. Success in conducting the baseline study made the inexperienced team more confident.

Baseline information on the community was collected rapidly so that intervention could begin without delay. Project staff were given basic information on HIV and trained for three days on topics such as sex and sexuality, STIs, HIV and AIDS, family planning, ethical issues, confidentiality and data collection. The team would meet each morning to review the previous day's work and discuss issues related to fieldwork.

A total of 105 in-depth interviews, key informant interviews, observations and focus groups were conducted over four days with sex workers, house-owners, madams and potential clients in Tangail on perceptions and beliefs, patterns of behavior and barriers to change. The study showed low awareness of AIDS, infrequent use of condoms and the need for STI treatment.

Quantitative surveys were also fielded based on the self-reported behavior of 300 randomly selected sex workers. Questionnaires were pretested with the field staff for content and to check whether the questionnaire elicited the desired response. The survey was also pretested among the guides. The results showed low condom use, the presence of a number of STIs and the absence of HIV. To meet the needs of the community, a clinic was opened in partnership with the sex workers, and treatment provided based on syndromic management. The Shakti project thus vividly

demonstrates that it is possible and effective to link assessment and intervention.

Participants were provided free medical examination and blood and endo-cervical samples were tested for VDRL, TPMS, chlamydia and gonorrhea. Another 166 women (of 466) were tested for VDRL, TPHA and HIV (anonymous).

Key information gathered through qualitative assessment and sample survey in Tangail

1. Socio-demographic characteristics of the informants

- Age
- Marital status
- Education

2. Reproductive health characteristics

- Living children—gender, age, schooling
- Abortion--number, complications
- Contraceptive us--type
- Reproductive health problems

3. Sexual behavior

- Number of partners
- Types of partners
- Types of sexual practices

4. Knowledge and experience of STIs

- Types of STIs
- Health-seeking behavior
- Diagnosis and treatment

5. Knowledge of AIDS

- Means of transmission
- Modes of prevention

6. Knowledge and use of condoms

- Knowledge of condoms
- Family planning

- STI prevention
- Use of condoms
 - Family planning
 - STI prevention
 - Frequency of use
- Accessibility of condoms
 - Where obtained, by whom
 - Type/name brand
 - Cost

7. Structure of brothel-based sex trade

- Political economy of sex trade
- Structure of the sex trade
- Functioning of the sex trade

8. Attitude towards the project

Qualitative and quantitative baseline data indicate that sex workers in the Tangail brothel come from 43 out of the 64 districts in Bangladesh. Their average age is 24, literacy rate is 14 percent, and they have an average of 3 clients per day. Ninety percent are aware of STIs such as syphilis and gonorrhea and their symptoms.

Lessons learned

The high prevalence of STIs (60 percent) and low condom use (7 percent) suggest that HIV could spread rapidly if suitable measures are not taken. The low prevalence of HIV (0 percent) underscores the need for focused intervention.

It was found that baseline information can be distorted or skewed. In Tangail, for instance, nearly 45 percent of the sampled women responded correctly when asked about the mode of transmission of HIV/AIDS suggesting a high level of awareness. However, all the women (with the exception of two) had acquired this knowledge from the project staff and the guides trained by the NGO *just before* the survey was initiated. The fact that this knowledge was recently acquired was established from the results of the qualitative survey done three months before.

STEP 8

Peer Outreach Services

To prevent the transmission of HIV, it is important to encourage the community to adopt safer practices. Behavior change is based on delivering appropriate messages through repeated contact to encourage less risky practices, providing appropriate services for HIV prevention and creating an enabling environment to ensure behavior change is feasible. However, as vulnerable groups often do not visit fixed facility centers for services like STD treatment, buying condoms etc.(or visiting such facilities has too high a ‘cost’ in terms of revealing their behavior, exposing themselves and their loved ones to stigma, arrest, etc.) communities may need to be provided services where they live and work (for instance, street-based sex workers can be made aware about condom use while they are waiting for a client instead of asking them to come to the clinic for education). This is generally called ‘outreach’. Outreach has been found to be one of the most effective means of providing HIV prevention services.

Outreach services

Outreach is at the heart of any behavior change intervention for vulnerable people. It is an effective way of making initial contact with the community and gradually convincing the group that the help being offered is genuine.

Outreach services are an essential complement to fixed facility services as they can

- ◆ Be assessed/utilized more easily, with less stigma, fear and ‘cost’
- ◆ Address the felt need of the sub-population
- ◆ Meet the perceived need of community as well as the project (condom use and education for behavior change to reduce HIV infection)
- ◆ Involve beneficiaries from the very beginning as peer outreach workers and ensure their participation
- ◆ Be designed in the context of the culture and beliefs of the group and can be adapted over time to meet the community’s changing needs.
- ◆ Create confidence and develop the capacity of outreach workers so that can eventually manage the project.

The main components of outreach for behavior change are

- ◆ **Being in repeated contact with the vulnerable group**
- ◆ **Ensuring that the means of behavior change are available**
- ◆ **Ensuring that the community supports the intervention**

REMEMBER

- Enable the group assess the impact/outcome of risky behavior and see the possibility and advantages of changing behavior
- Involve members of the community in identifying appropriate strategies. Try not to impose your views.
- Go slowly and steadily. Don’t try and achieve everything in the beginning of the project. Help

groups to set milestones to mark progress and indicate positive change

- Provide the group with different options for behavior change. The group may need to adapt the options suggested to meet their particular needs.
- Try not to discuss methods/actions that are impossible for the vulnerable group to accept/use.
- Provide beneficiaries with individual choices.
- Try and establish linkages or referrals for services that the project cannot provide.

Groups gradually modify their behavior and adopt best practices if they are considered desirable and acceptable, and appropriate services are available to make behavior change possible.

Desirable vs acceptable means of behavior change and providing options

Desirable means of behavior change may not necessarily be acceptable to the community. For instance, abstaining from sex may be the 'best' or most desirable method to prevent the sexual transmission of HIV but it is a very *unrealistic* option.

Reducing the number of sexual partners is an effective means of behavior change but is not a realistic option for sex workers. While the most feasible option for sex workers is to use condoms for all sexual acts, it may not be possible for sex workers to negotiate condom use with every client.

In such cases, more realistic minimum goals (atleast) should be set, such as avoiding sex during menstruation, or in the presence of an STI, or insisting on condom use for anal sex.

ACTION

- Involve the community in designing strategies for outreach
- Involve the community in identifying the package of services.
- Identify who will provide the service and how often the service should be provided.
- Monitor outreach visits in terms of coverage, whether the special needs of sub-groups (e.g., bonded sex workers, babus, female drug users) are being met and the effectiveness of services being provided.
- Ask the staff to provide feedback on the project.

Peer outreach

Outreach services can be provided by project staff or members of the community or through linkages/arrangements with other NGOs/service providers. Services provided by the community themselves underlie the concept of peer outreach. Peer outreach workers are also called peer educators.

A peer educator is a person from the vulnerable group/community who works with his or her colleagues to influence attitude and behavior change. Peer educators are responsible for providing information on HIV/STIs and harm reduction, and promoting condom use among colleagues/peers, which ultimately results in peer pressure for behavior change. They can also distribute condoms, needles and syringes. They also provide basic data for monitoring the project.

Peer education is considered to be one of the most effective and sustainable tools for changing group behavior. Peer educators play an important role in project implementation as they

- Can help to build trust and establish credibility with the vulnerable group as vulnerable groups are more likely to respond to people who are from the community.
- Provide a vital two-way link between the project staff and the community.
- Provide important information about the vulnerable group to other stakeholders and the wider community.
- Reach a large number of people effectively.
- Provide a link between the service and the community (for instance, by introducing people or accompanying them to the service facility).

Field Code Changed

Selecting peer educators

- Treat guides as potential peer educators during qualitative and quantitative surveys or when getting to know the community.
- Give priority to existing guides and key informants if they are suitable to join training for peer education. Ask them if they are willing to work as peer educators.
- Explain why you want to work with them.
- Tell them how much time they will need to spend working as peer educators.
- Explain the method of selecting peer educators that includes undergoing training , passing a formal examination .
- Use similar criteria for selecting peer educators as for guides.
- Get key community leaders to endorse your choice of peers. It is not necessary to include them on the selection panel.
- Initiate training of selected persons as peer educators.
- Conduct tests for skill in the use of flip charts, demonstration of condom use, information and motivation.

- Give formal recognition as a qualified peer educator after the tests.
- Work out a possible strategy for a peer outreach cycle in collaboration with selected peers.

Planning a peer outreach cycle

- Involve peer educators in designing effective outreach strategies as they know and understand the behavior patterns of the vulnerable group.
- Work out realistic working hours and contact cycles in collaboration with outreach workers (for condom distribution or needle exchange, contact should be frequent to ensure a continuous supply; for monitoring visits, once a month may be sufficient).
- Divide the work among peer educators and the project staff realistically. Agree on clear patterns for supervision and support and how often project staff need to make contact with beneficiaries and peer educators. Also, work out and agree on reporting formats and frequency of outreach visits.
- Make a list of outreach activities, such as condom distribution, HIV/STI awareness (group and/or individual sessions) and focus group discussions to identify problems and solutions.
- Depending on the outreach strategy, try to determine the number of staff and peer educators that will be required. The staff-peer educator ratio will depend on distance, hours available to the contact person, frequency of contact, amount of time to be spent on each contact, whether the contacts are for individuals or groups, and the number of sites of contact.

Training peer educators

As the success of a project depends on effective outreach, it is important to train peers to provide the necessary services (e.g., information on HIV or condom use) to the community. Moreover, as peers are the visible face of the project and will interface continuously with other stakeholders including donors, Govts, NGO's etc. and the government, they will need to appropriate training.

ACTION

- List the objectives of training. Initially peers could be trained to:
 - ◆ Understand the epidemic, risk factors and the objectives of the project.
 - ◆ Communicate effectively with colleagues/peers, for instance, use role plays to practice negotiating condom use
 - ◆ Use non-textual materials, such as diagrams and visuals, to convey messages
 - ◆ Use appropriate examples from their own life experiences to illustrate issues.

- Select an appropriate training method (role play, video, group work or brainstorming).
- Select appropriate IEC materials and adapt them to local conditions.
- Develop a flexible training schedule. This should not interfere with the business or work timings of peer educators.
- Include peers in staff meetings as they play a crucial role in designing and planning intervention projects.
- Peers should be trained to observe and report on what is happening in the field, and their feedback should be taken seriously.

- As peers are responsible for outreach, they should be trained to do the monitoring and reporting as well.
- Develop simple monitoring tools with peer educators (for instance, a color-coded map to show condom use among sex workers in a brothel).
- Define the content of the training. For peer educators working with sex workers, this could cover:
 - ◆ STIs, HIV and AIDS, other reproductive tract infections, pregnancy and contraception
 - ◆ Preventing STIs and HIV/AIDS
 - ◆ Common beliefs regarding ill health and well-being
 - ◆ Communication and negotiation skills to ensure condom use
 - ◆ Using condoms
 - ◆ Using flip charts and other education materials
 - ◆ The role of peer educators in the intervention
 - ◆ Basic monitoring skills
- Use real-life experiences of peer educators as examples in training.
- Training should use participatory learning and action methods so that participants
 - ◆ Are fully involved in the training process, and their opinions and experiences are considered useful and relevant.
 - ◆ Perform the activities themselves (for instance, using condoms or using bleach to disinfect needles)
 - ◆ Draw their own conclusions and use their skills and knowledge to solve problems in the field.
- Always treat peer educators with the utmost respect and dignity as valued colleagues.

Try and build the following attributes in peer educators so that they can ultimately manage the project and take it forward:

Self-respect

Assertiveness

Ownership of the project or a sense of being part of the project activities

As the project evolves, the kind of inputs needed and the role of the peer educator changes. It is important to have flexibility, create an enabling environment and provide avenues for ongoing capacity building. You may need to continuously identify new peer educators with appropriate skills and ideas.

EXERCISE

Addressing myths and misconceptions in the community is an important aspect of peer training. Can you suggest some techniques to dispel the following myths?

Some sex workers believe that:

Applying oil or antiseptic ointment after intercourse provides protection against STIs
Condoms burst easily
Clean and hygienic people are less likely to get STIs or HIV
Condoms are not necessary when having intercourse with regular partners

Fill in the following details when planning a peer outreach cycle

- ◆ **Who will provide outreach--project outreach staff or peer outreach workers?**
- ◆ **How frequently they would contact the same person?**
- ◆ **Can they make repeated contact?**
- ◆ **Are the contacts of good quality/effective?**
- ◆ **Are the same groups or individuals being repeatedly contacted and others left out?**
- ◆ **Are the needs of special groups or sub-groups being addressed (e.g., bonded sex worker, *babus*, female drug users)?**
- ◆ **Do the providers find the outreach activities boring and repetitive?**
- ◆ **How flexible is the content of the outreach program?**

Sex workers in an intervention asked to be trained in public speaking and how to deal effectively with the media after the program gained wide recognition. Some communities may request additional training on legal issues.

List some of the services that the group you are working with may need as the project evolves.

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Step 8

Peer outreach Services:

Following training and examination of the sex workers initially recruited as guides , they were graduated to peer outreach workers. A detailed and very specific job description was developed to ensure that an outreach cycle was completed, such that every sex worker would be reached with an adequate dose of information on HIV , STD , and condoms every fortnight. In addition, each sex worker would be part of a group education session every six weeks. Peer educators were responsible for monitoring their own activity in terms of describing how many sex workers they could educate, how many condoms they could provide etc using simple tools designed by them. The number of peer outreach workers was determined by the total number of sex workers to be reached, as well as the number of hours each one agreed to work. A small monthly honorarium was paid. Peer educators not only provided outreach services, they became an integral part of all decision making processes of the project. Since the turnover of the peer educators was high, a larger number of workers than immediately required had to be trained. For 600 sex workers , 40 Peer Educators were recruited. The criteria for selection was locally defined by the project staff. The main qualities looked for were motivation, availability of time and ability to reach the different subgroups to which they were assigned.

STEP 9

Preparing Education Materials

Information, education and communication play a vital role in encouraging and supporting behavior change and creating a supportive environment. Information is the first step in changing behavior. Education helps to internalize information about HIV/AIDS in terms of assessing risk to oneself, knowing how to protect oneself, knowing which services are required and where to access them. Communication gets this information to those who require it the most.

Different kinds of information, education and communication are necessary for different constituencies—e.g. the community, service providers (such as health care professionals) and stakeholders. Education materials should be designed to address the beliefs and culture of particular sub-populations and meet their special needs.

ACTION

- Identify your audience and the specific needs of the group.
- Based on information gathered during needs assessment or through focus group discussions, decide which behaviors and attitudes of the members of the group put them at risk of HIV/AIDS or impact on the effectiveness of intervention and should be modified. Get to know what

material and messages the group has been receiving and try and identify additional needs.

- You may need to use individualized, interpersonal channels of communication, particularly for hard-to-reach vulnerable groups, rather than methods aimed at the general population, like mass media.
- It is not realistic to assume that the entire audience will be able to make a complete behavior change from unsafe to safe or supportive behaviors. Focus on a few more easily changeable aspects.
- It is useful to provide options and steps to changing behavior (for instance, for sex workers, using a condom for every sexual encounter, or if this is not possible, using a condom during anal sex or during menstruation).
- Identify the kinds of messages that are required. Review the existing resources or start preparing new materials (tips on developing appropriate materials are in the annex).
- Existing materials may need to be modified to suit the group you are working with.
- Be sure to pretest your materials through focus group discussions and individual interviews for recall, appropriateness and potential impact.

Other than the vulnerable community, IEC materials should also influence and inform a wide range of players from project level to national level , these include local influential people such as policy makers, the media, film makers, professionals in different sectors, health workers and service providers, opinion makers in the community, and peer educators

REMEMBER

- It is important to choose appropriate methods of communication. For instance, flip charts can be effectively used to communicate

messages in small groups and to individuals, videos in larger groups and real life experiences and role models among peer educators. Traditional channels of communication, such as folk theatre and story telling, are effective in rural communities. Existing community networks can be effectively used to convey messages close-knit groups.

Creating your own materials

Often the target audience has had no formal education and a variety of tools are needed to convey messages effectively. For instance, pictorial charts or pocket books that can be carried easily can be used to explain the need for behavior change. Tools, such as card games or snakes and ladders, can also be used creatively to raise awareness and convey messages.

- Depending on your audience, use a mix of methods and techniques to convey messages. Displaying posters/calendars where sex workers and their clients can see them is also effective.
- Adjust the message and method to the stage of behavior change. Messages to generate awareness and knowledge would need to be designed differently from those that encourage sustained behavior change. Regularly update the materials, especially statistics, and include new services.
- Understanding behaviors and beliefs is important in formulating effective targeted materials. This will help to design appropriate messages for behavior change for the vulnerable group.
- Ensure positive rather than negative messages. 'Do...' rather than 'Do not do...' messages are more effective. Reinforce messages by providing positive examples to illustrate that change is possible and has a positive outcome. Address the fears and doubts of the community.
- Integrate messages into media that can be displayed such as posters or calendars. Experience shows that the credibility of messages, their retention, and action on the information increases if the same messages are echoed through a range of sources and media.
- Wherever possible, materials should be based on real life experiences as these have maximum impact, are relevant, can be

understood and often have an emotional tone that makes recall easier.

- When conveying messages on HIV transmission and prevention, ensure that services for prevention that you are advocating (like STI treatment and referral, condoms, clean needles and syringes) are available or establish links to such services. Include details, such as addresses of these services, as far as possible.
- Materials should be culturally acceptable to the vulnerable group.
- Existing material should be assessed for relevance and effectiveness, and adapted if necessary.
- IEC efforts must be on going.

A community is not static. As the project evolves, behavior patterns and information levels change. It is important to keep updating the materials and messages to suit the level of behaviour change in the community.

- In mass awareness it is important not to target particular groups because it may lead to greater marginalization and stigma of the group, and the feeling among members of the community of being singled out.
- Maintaining confidentiality is essential. When using photographs or other pictorial examples, it is important not to include details that can identify the person without permission as it can lead to complications.
- Make sure you address all myths and misconceptions in the group and do not create any new ones.

IEC material alone will not lead to behavior change but supports activities that lead to the achievement of goals and objectives for behavior change.

Effective messages help groups make a personal commitment to make the desired behavior change, acquire the skills to effect the change and create a safe and supportive environment for groups to practice safe behavior. Involve members of the community when developing messages and materials. Discuss appropriate channels of communication with the group as they will know what will work best in the community.

EXERCISE

Information on HIV/AIDS, STIs and safe behavior can be provided in different situations in many different ways. For instance, it can be integrated into the school curriculum or adult education classes, provided in doctors' waiting rooms as handouts, printed behind railway tickets, etc. How many different situations and methods of communication can you list that can support peer educator programme in a brothel?

Step 9

Preparing education material:

Training and outreach education always require a range of different education materials, which are ideally revised and changed frequently. These materials and the process through which they are developed are seen as concrete evidence of the project's activities and relationship with the community. Visitors and donors always ask for such material. In reality, it is very difficult and time-consuming to prepare such material of good quality at the desired frequency. Therefore, SHAKTI decided to use existing materials proven as effective in other projects rather than preparing their own. They found that even materials from the Sexual Health Intervention Project in Sonagachi, Kolkata, which depict a different cultural setting were very popular among the peer educators and sex workers in Tangail. The need varied from materials providing general HIV information to materials for motivation, peer pressure and even clearing misconceptions like "half of the blood in the body was needed for an HIV test" by showing 2 cc red-coloured water occupying half a tea spoon. Similarly, a myth about easy breakage of condoms was dispelled through a demonstration that showed a full coke bottle of water poured into the condom did not break it.

The most important part of outreach was the regularity of the cycle for education, distribution of condoms and referral for STD services and monitoring the quality and quantity of education.

STEP 10

Monitoring and Evaluation

When designing a project, we have an overall goal or aim of what is to be achieved (e.g., to prevent the transmission of HIV to and from sex workers or injecting drug users). To achieve this aim and get where we want to, we express the goal in specific, measurable, achievable, realistic and timebound (SMART) objectives. Concrete steps have to be taken to achieve these objectives (for instance, providing clean needles, STI services or basic information on HIV/AIDS). These are the activities of the project.

The purpose of monitoring (continuously collecting information about program implementation) and evaluation (analyzing this information) is to assess how well the project is achieving its aims and objectives, and whether interventions need to be modified to make them more effective. Measurable indicators are used to monitor progress.

Ideally, objectives should be developed in partnership with the community within the overall goal and purpose of the project.

Collecting and assessing information

Monitoring and evaluation

- Helps to assess the effectiveness and impact of the program so that interventions can be reoriented, if necessary
- Provides detailed information on how the project is progressing and whether any changes are necessary to achieve the project goals
- Creates greater efficiency and effectiveness by breaking down activities and assigning responsibility
- Establishes accountability for everybody by monitoring activities and responsibilities

- Informs donors about which resources are being used, and whether they are being used efficiently and as planned
- Ensures a coordinated and organized schedule of supervision of work and workers

The three stages of monitoring and evaluation

- Identifying indicators to measure progress
- Collecting and analyzing data
- Reviewing and modifying existing interventions and developing new programs, if necessary

What is an indicator?

An indicator measures the progress made towards an objective and shows you if intended changes are happening. For instance, if the objective of an intervention for sex workers is to market condoms through outreach workers, the indicators could include the number of outreach visits per week, number of sex workers contacted on each visit, number of condoms sold.

Depending on the aims and objectives of your project, you will need to select indicators that show if your program activities are having the desired impact.

Three kinds of indicators can be used to monitor and evaluate whether the intended changes are occurring:

- **Input indicators**, such as money and the number of staff recruited and training etc
- **Process indicators**, or what is happening on the ground (for instance, number of STI cases treated, number of training sessions conducted, number of STI cases treated in the clinic, the number of injecting drug users seeking treatment)
- **Output indicators**, or the direct effect of an intervention (proportion of sex workers received HIV knowledge, STI treatment etc)

It is important to identify initial indicators as this allows documentation of inputs, activities, outputs, number of beneficiaries and coverage. However, as the project develops, the objectives of the project may change and you may need to constantly redefine what you mean by them and identify new indicators. For instance, knowledge of STI/ HIV and how it spreads may be an initial program objective that may need to be redefined after the early phase of intervention as the community may also need to be informed about preventive measures and clinical follow-up.

Monitoring

- Provides information on whether you are doing what you have set yourself to do to achieve the goal
- Indicates where there is movement and areas that need attention so you can take necessary steps to address gaps or modify what your doing
- Assesses the coverage of intervention.
- Enables you to see how to change what you are doing

Depending on the intervention, different information needs to be collected. Project staff, project clients, external evaluators and community members can collect information for the regular monitoring of the program.

In any intervention, every player is accountable and needs to monitor his/her progress and performance according to measurable targets. These targets provide an overall goal and sense of purpose, are explicit and can be monitored, are time-bound, and are challenging. A peer educator may, for instance, set a target of contacting 100 sex workers or drug users in one week, or ensure that within a month a certain proportion of the vulnerable group will be able to correctly state one method of protection against HIV.

Different performance indicators are required at each level (for example, at the field level, peer educators and clinic staff will have different goals and targets and therefore different indicators will be used).

Monitoring can be based on self-reported information (by asking ‘how often’) as well as objectively assessed. Try and

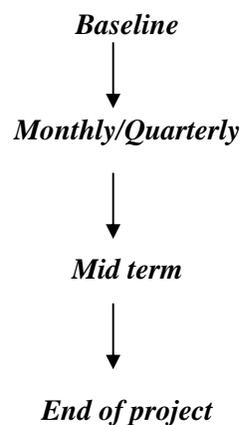
- Confirm whether the information is about actual or reported behavior
- Find ways to confirm responses
- Use indicators that can be objectively verified

Monitoring can be based on primary or secondary sources of data

- Primary information is based on observable facts (such as what the group is doing) or objectively verifiable behavior (for instance, how many needles were returned)
- Secondary information is based on reported sources, such as minutes of meetings recorded by peer educators, clinical reports, number of condoms distributed and number of drug cycles dispensed.

ACTION

- Design a monitoring plan at the beginning of the project. This will show that activities are being carried out as planned as well as help you identify and modify problems during the project cycle. Ideally, monitoring should start prior to intervention (i.e., from baseline) and continue throughout the duration of the project. Evaluation should be done at the program planning stage and periodically thereafter.



- Identify the goal and objectives of the program
- Identify the indicators to measure progress and outcome
- If the findings show an intervention is not progressing as planned, reassess the program and introduce more appropriate activities.

Monitoring Tools

Different monitoring tools are required at various levels. For instance, program activities can be monitored by using checklists, checking work plans or using reporting and feedback forms. In clinics, a list of attendees, medical records and details of drugs dispensed can be useful.

For peer educators, monitoring tools should be simple and easy to use.

- ◆ Maps can be used to show actual coverage (peers mark the houses that they visited on a map of the area)
- ◆ Diaries can be used to record daily activities (for instance, peer educators note how many people they visited on a given day, what each one said, how many condom demonstration sessions were conducted, comprehension of IEC materials)
- ◆ Color codes can be used to assess indicators (for instance, how many sex workers know how to use a condom correctly, how many are using condoms consistently). Daily registers or diaries can be effectively used (for instance, to note how many people were visited). Minutes of meetings, monthly /weekly reports can also provide information on the impact of intervention.

As far as possible, involve peer educators and beneficiaries when designing monitoring tools and interpreting information.

REMEMBER

- It is important to have external evaluation (both mid-term and end of project) as it is an objective way of assessing the progress and effectiveness of the intervention.
- Involve the community in monitoring the impact of interventions and share findings with them.

EXERCISE

You need indicators at two levels--at the field level to be collected by the community and at the office level. List the indicators and the monitoring tools that can be used in each situation and by whom (eg, peer educators, clinic staff, project director).

Step 10 Monitoring and Evaluation:

The project is monitored by qualitative and quantitative data on self-reported behavior. Outcome and impact are measured by serial cross-sectional surveys for VDRL and unlinked HIV. The National AIDS Committee and UNAIDS are a part of the monitoring process.

As mentioned earlier, this project had designed careful biological, clinical, service delivery and behaviour change indicators in order to document the impact of the project, if any. These data were being collected through initial, mid project and end project surveys supervised by the National AIDS/STD Programme specialists and external consultants. The indicators included components reflecting change both within the sex worker community and the environment in which the project operated particularly changes in the endorsement of the local people and groups in power.

The indicators were:

Input	Process	Output	Outcome
Training of staff	No of peer education sessions held	% aware on HIV, STD and condom	% consistent condom use
STI Clinic Established	Clinic attendance for STDs	% received treatment of STI	Average duration of STD
Condom availability	Condom distributed	% having access to condom	% reduction in new STDs

Training on advocacy	Advocacy meetings conducted for different subgroups	% persons endorsing the project	Lessened No. of obstructions to project implementation including reduction in violence to sex workers offering condom use and peer education
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However, the desired outcome could be achieved only if the peer educators, who were the main human resource for the project, could continuously monitor their own activities, identify gaps, if any, in the activities, and make necessary changes. They would then be able to observe changes in those indicators that would finally influence condom use. Special pictorial monitoring tools were developed by the sex workers themselves. Every room in the brothel was represented through a drawing, and the name of each resident written in the appropriate place. Colors were used to indicate how many times the PE had met the person, whether she could complete an education session, whether condoms were given, whether she had the knowledge and intention to use condoms, and whether she was asking clients to use condoms and finally, if she was actually using them on all occasions or how often. These tools were used, with pre-decided color symbols for each item. Knowledge of STI/HIV was marked in red, desire to use a condom in blue, no. of customers the worker used a condom with in yellow (over a given period of time), and how many times she used a condom consistently in green. The information was then collated and summarised in bars and graphs to describe the monthly status of knowledge, intent, trial and practice of condom use.

To help peer educators plan their monthly activities, a monitoring board was used in Tangail. The board is posted in the place where peer educators gather every day for literacy education, training or daily discussion.

The board displays the numerical situation regarding current condom usage, and the knowledge base of sex workers, etc. A picture of what is happening in the entire brothel is thus displayed in front of the peers. From the information on the board each peer educator can assess and plan for his/her own cluster. It can help decisions such as which sex workers to build knowledge with, or which sex workers to encourage condom use, or which sex workers to push for consistent condom use.

At the same time, peer educators become informed about what is happening in other clusters., Sex workers could examine the whole brothel diagrams and immediately observe absence or presence of colour clusters. This indicated at a glance which houses were not reached by peer education, where sex workers are in the intention or trial stage, and think of reasons to explain why condom use was low in spite of high knowledge and intent. The display of information also created a sense of healthy competition among them.

A bin survey was also used to assess condom use. A plastic can with a cover was supplied to sex workers in the brothel to meet their sanitation needs. Sex workers were encouraged to use the bins to dispose of used condoms. By checking the bins, peer

educators could get an idea of how many condoms were actually being used. Periodically, peer educators would count used condoms on a particular day and tally the number with the number distributed on that day. They would also tally the number of sexual acts self-reported by the sex workers, and the number of condoms reported being used.

These data were self reported and often higher than the actual figures, but had the tremendous effect of actual use of data for midcourse correction.

Similarly the power-environment was monitored by the project staff .All possible people in power were listed, and colours were assigned to them to indicate their status in terms of endorsement or hindrance. This helped alert the staff to situations which may require immediate intervention and trouble shooting.

After one year of brothel-based intervention, condom use was 20 percent. The project started working with house owners, the district administration and *babus* to push towards adopting a 100 percent condom use policy.

STEP 11

Creating an Enabling Environment

Typically a vulnerable population lives and works in an environment that has many disabling elements. Often engaging in activities that are bordering on the illegal (such as sex work or homosexuality), they face social, legal and other barriers (stigma, marginalization or police harassment, for instance) that may come in the way of changing behavior norms and adopting safe practices.

Providing services, supplying condoms and raising awareness by themselves, therefore, may not necessarily result in sustained behavior change. Interventions also need to address barriers to change and work towards creating an enabling environment or ensuring the right conditions for change among individuals and the community. It is also critical to advocate with policy makers, law enforcers and opinion makers to ensure a supportive environment for intervention.

What are the barriers to behavior change?

Power relations within the sex/drug trade and across the trade (those who influence the conditions of life and life style, such as local health care providers) can create barriers to safer practices. Unless these are addressed, individual efforts to change behavior will encounter difficulties, as in spite of intent to change individuals will face too much resistance. For instance, if sardarnis in the community oppose seeking STI treatment or block access to health care, few brothel-based sex workers can benefit from a 'quality' service. Or if local health care providers used to providing services of dubious quality at high fees see the provision of free/low-cost quality care as a threat, they can create legal problems or violently oppose the intervention. In some cases, sex

workers may have the knowledge and means to access condoms but may still require a supportive environment to make the necessary behavior change. This means that only a few highly motivated and ‘rebellious’ individuals can change their behavior rather than the safe behavior becoming the norm, (where the majority of the community changes behavior which is required to prevent an epidemic.

It is, therefore, necessary to create an environment that is enabling for the community as well as your organization, where the potential positive effect of the intervention can benefit the maximum number of people at minimum ‘cost’ (psychological, physical, social) to them, and where the intervention as well as your workers do not face a hostile environment.

It is also necessary to address laws and the interpretation and enforcement of laws to create a supportive environment for behavior change and effective intervention. For instance, the police and other law enforcers could sometimes use laws to arrest or harass members of the community as well as NGO workers. Moreover, unfavorable laws and the resulting criminalization of vulnerable groups lead to an environment of fear, shame and crime where violence is common and used to reinforce the fear, shame and marginalization of the community. In brothels, for instance, mastans may use violence and fear of shame to extort money from clients and sex workers/drug users. On most occasions no one takes action to protect legitimate rights because of fear and shame, police raids and police harassment. Unless this is addressed at both the level of legislation and enforcement in the project area, intervention may be repeatedly interrupted and cannot work.

ACTION

- Examine the existing laws to see whether they support an enabling environment. Constant advocacy to amend laws with different groups, particularly policy makers (such as the Ministry of Social Welfare and Home Ministry), the local administration, the police, religious leaders, key

opinion makers and the community is important.
Advocacy should be ongoing.

- Involve other partners such as women's commissions, the Social Welfare Board, human rights organizations and women's activists in advocacy and project activities.
- Establish a rapport with opinion makers and include them where possible. Give them importance, recognition and responsibility. Support this with additional access to services that they are gatekeepers to, so they feel empowered and good about promoting safe behavior.
- It is particularly important to identify well-known personalities in the community who can 'champion' causes and take up issues publicly.
- Motivate the wider community to support safe behaviors. In interventions with sex workers, interventions can be planned for clients, for instance, to create a supportive environment for condom use without interfering in the business.
- Organize educational or awareness programs for different groups (for instance, police, truck drivers, rickshaw pullers, students and migrant workers).
- The power structure is not simple or linear—it has complex interlinkages, some of which can be mobilized for your cause. Utilize the credibility of your organization, favorable position in the community, and linkages with and endorsement by the government and other partners (donors, national and international bodies) to tilt the power equations in your favor.
- The media can be a useful ally—it requires skill and continuing interaction to get the kind of coverage that is helpful rather than discriminatory or derogatory. In some cases, mass media campaigns with explicit messages have been effective in changing behavior.

Establishing a close relationship with the community is essential as it provides insights into the power structure, and gives you greater credibility and leverage.

REMEMBER

- The environment must be supportive at the individual, community and national level for sustained behavior change. Without the encouragement of the wider community and policies and programs at the national level, it would not be possible for the individual or group to change norms of behavior.

Step 11

Creating an enabling environment:

One of the essential prerequisites of intervention is a conducive environment that allows/supports the formation of sex workers' groups for peer education and for a series of health and non-health related activities. The emergence of such groups, however, can lead to a sense of uneasiness and discomfort among other players. SHAKTI identified all possible individuals and groups who might feel threatened by these kinds of activities, met them, explained to them about the projects and assured them that this project was not going to affect them negatively. In order to do this, a separate team was formed specifically for this task. A list of all possible people and groups to be contacted was prepared, and the team conducted a series of meetings with them, repeatedly. One important principle followed was to regularly keep them informed about all significant activities of the project. At the same time, the Project did not necessarily wait for their decisions to implement different aspects of the project.

While these activities were conducted at the project level, another series of activities were conducted at the national level. The National Program Manager of the Govt. HIV/STD prevention project and his team were officially appointed as advisers to the project and continuously kept informed about the developments. Opportunities were used whenever possible, to present the progress of the project to Parliamentarians, and Govt. officials of several departments. The sex workers were specially trained to make an effective presentation about the project, using slides.

They made presentations and conducted discussions in several meetings including national meetings of NGOs and national and international AIDS conferences.

STEP 12

Empowerment

Vulnerable groups face stigma and are often marginalized by society, which leads to low self-esteem and a feeling that they have little control over their own lives and environment.

Empowerment is a process that enables individuals and groups to act independently in their own interest and the interest of the community by overcoming different barriers. This requires building a sense of self-worth and self-esteem among individuals and the community, as well as the perception and ability of being able to control one's own life and practices. It involves setting goals for oneself based on accurate and complete information, and working towards achieving these goals based on the services and support available.

Bringing marginalized people together and letting them see that their lives can be changed and they can move on to a stronger, independent life encompasses the essence of effective empowering interventions.

Empowerment does not happen in a vacuum. Groups and individuals are empowered vis-à-vis a particular power structure. Therefore, interventions should focus on particular power structures that act as barriers to behavior change.

By making members of vulnerable groups feel that they have a future and a reason to protect themselves against the AIDS virus, that behavior change is worth the effort and that together they can make it happen, it is possible to empower members of vulnerable groups.

An effective intervention requires empowering individuals and groups within the trade as well as players from the wider society. Different strategies and efforts are required for each.

ACTION

At the individual level

- It is important for individuals to recognize their self-worth, dignity of the self and their profession . To build these values, set up an ongoing dialogue with individuals and the community centering around key issues, such as decision-making. Keep in mind the following:
 - ◆ Give importance to the individual's role in the processes of empowerment and change.
 - ◆ Discuss attitudes to the community, to risky behaviors and practices through repeated, in-depth meetings.
 - ◆ Recognize the objective conditions influencing behavior that result in continuity of the behavior as well as those that provide options (for instance, economic status).
 - ◆ Different people change and become 'empowered' at different speeds. Give everyone space for this.
 - ◆ Look at the positive aspects of the present situation such as the scope it offers, rather than only the negative aspects that tend to depress and disempower groups and individuals.
 - ◆ Barriers to empowerment need to be addressed and skills (such as reading) and facilities (such as crèches for children) developed.

Capacity building is an essential component of empowerment. It provides a range of opportunities that can address the interests and aspirations of the community in terms of what they want and see as allowing their talents to flower and their creative impulses to flourish. Capacity-building could go beyond the usual stereotypes (such as training in tailoring) to cover activities/options that appeal to the community (such as setting up a beauty parlor, dance classes, or training in public speaking or work as consultants for peer educators projects). It can also build the skills of individuals to talk at meetings, present views, discuss and negotiate with authorities, talk with the media and document experiences.

It is necessary to involve the community as equal partners in articulating the philosophy underlying the intervention in interactions with the wider society.

At the community level

Stigma, compromised rights and dignities operate at the community level but are experienced at the individual level. Therefore it is important that the community comes together to bring about more equal status and empowerment.

ACTION

- Involve the community in all aspects of project design, implementation and monitoring.
- Include representatives from vulnerable groups in decision-making meetings with other partners and the wider community. This will help establish the worth of members with other constituents and players as well.
- It is important to give peers job status in the organization. This will help to endorse the image of the community as valuable, dignified and productive, and support their aspirations for change.
- Develop self-help groups.
- Support the creation of self-organizations.
- Provide necessary capacity development for the community to acquire the skills they aspire to (e.g., public speaking, literacy).
- Advocacy with the local power structure to allow activities of the marginal group that may not have been encouraged in the past (for instance, sex workers in a brothel were forbidden from wearing slippers when leaving the brothel but after advocacy with the power structure, the practice was reversed).

At the societal level

Interface is necessary at two levels--community members should interact with society and non-trade related persons should interact with the community.

- Facilitate the entry of community members into wider forums of social and rights dialogue. Make them visible, give them a voice and let them tell their own stories. Bring them in contact with human rights groups and women's activists.
- Promote interaction with mainstream forums, such as seminars and conferences, where the community can contribute by sharing their experiences.
- Develop platforms for participation, starting from within the community.
- Organize visits of significant persons into the community and create a space for them. This changes their perspective and understanding of the vulnerable group. It can also influence power equations if power brokers view this interaction as support from significant stakeholders.
- Organize programs within the community (e.g., a drive for improved sanitation) that bring in a variety of people and result in change. This will demonstrate that change is possible and help to focus on areas that require attention.

The ultimate aim of HIV/AIDS interventions is to enable people to exert control over their own lives and risk through a process of individual and collective empowerment, and to develop responses in the wider community that create an environment in which safe and protective behavior can be practiced.

EXERCISE

The following steps were taken to promote empowerment and sustainability in a sex worker project in Dhaka. This has resulted in more than 40 per cent condom use.

- There was no community organization in the group.
- The project staff discussed the possibility of forming an organization for the sex workers. Once the group showed an interest, the staff worked with the group to set up such an organization.
- Sex workers with leadership qualities were identified.
- Space was provided for an office and for members to meet.
- The staff helped the group develop administrative skills like keeping records of money, and taking notes during meetings.
- The sex workers were helped to raise funds to support the organization.
- The organization then began working to change the laws relating to the sex worker's lives.

List other steps than could encourage empowerment in the group.

Step 12

Empowerment:

The project supported the formation of self-help groups of the sex workers and encouraged them to undertake activities that were needed by the sex worker community. This included, for example, education of all sex workers, improvement of the sanitary conditions, electricity, and a savings and loan co-operative. Identifying their own needs and then meeting them was a tremendously satisfying and invigorating experience for the community.

Cultural groups run by the sex workers organised social functions like picnics and sports. Coming out in public places, doing the everyday things that non-sex workers do, and participating in main-stream public events similarly helped to break the boundaries of stigma and marginalisation.

These activities were supported at the project level, community level and state level. Donors were also encouraged to directly contract the self-organisation of sex-workers to undertake intervention in other parts of the country.

STEP 13

Sustainability

Experience shows that intervention must continue long term to be effective in the long run. Over a period of time, people's interest flags, new people come in, new areas receive priority, and some projects fade away. For lasting change, advocacy must continue and resources must be available. The importance of long-haul efforts has been recognized in various sectors, but most especially in those that require sustained behavior change.

Any intervention for behavior change needs to be sustainable. A sustainable intervention is one that will continue beyond the life of the original project, and have a continued beneficial effect on the vulnerable group, eventually becoming a part of its sub-culture.

Sometimes, "success" results in loss of resources, as donors and planners shift their focus to areas requiring more urgent attention. It is therefore critical to create systems and structures for sustainability.

Socio-political sustainability

Usually, 'sustainability' is assumed to refer to continued availability of economic resources. However, when we consider a community-based project, socio-political sustainability, in its widest sense, is far more critical in ensuring that an intervention and the subsequent changes are institutionalized and become an integral and valued part of the community. When this occurs, the community and society can generate the required resources.

Socio-political sustainability requires:

- Ownership of the project by the community.
- The capacity to run the project --technical, managerial (including financial) and programmatic-- has to be developed in the

community, as ownership cannot be operationalized without adequate skills to direct and implement the project.

- Acceptance and support by the larger society is crucial to sustainability. If society sees this initiative as important, as something that is to be upheld and continued, the space as well as the various types of support necessary for sustainability will be forthcoming and the project can continue.
- In order that the initiative continues as a “living” movement constantly responsive to the changing situation in the community (rather than just as an extension of original activities), that is able to negotiate with the larger society in which it is located, certain structures and processes must be developed. These can include a Governing Board, patrons, executive committee, annual meetings, linkages to other organizations and movements, membership of other networks and consortiums.
- To realize these objectives requires genuine commitment from the community as well as from the larger society.

ACTION

- Develop a sense of ownership of the project in the community.
- Consider the issue of sustainability at the start of the project.
- Work towards developing the range of capacity in the community to sustain the initiative. If this is not possible, set in place procedures for accessing (through paid service) what is required.
- Draw up a plan to develop self-reliance in the community, help the group develop administrative skills and allow them to set their own agenda.
- Continually develop linkages with the larger society, encouraging their involvement and support of the initiative, particularly in removing barriers to furthering the aims of the project.
- Set up the necessary organizational structures and mechanisms. For instance, draft mission statements,

constitutions and procedures of functioning to develop a sustainable organization.

- Undertake the necessary steps to register the organization. Get recognition from the Government so that activities can continue.
- Funding and organizational support may be required initially. Develop linkages to provide support if it is not in your capacity.

Step 13

Sustainability:

Questions were always asked about the sustainability of the whole project or of different components of the project. Particularly when investment of resources for infra-structure development was involved, as in setting up an STD clinic, or for long-term payments such as free distribution of condoms, payment of honorarium to sex workers etc., the question arose. Theoretically, in most situations, sex workers could pay for condoms, or for STD treatment and they could possibly work free of charge for the Project, impelled by their own motivation. In reality this does not happen unless the community can identify itself as a group, can organise itself, and most importantly, can get the social space and tolerance to access STD services in a non-stigmatised way, can promote and discuss condoms openly without fear of harassment, or can work for themselves without fear of reprisal.

Therefore, all these investments and expenditures were justified till groups were formed and were sufficiently empowered, demand for condoms by sex workers as well as clients was generated, and there was sufficient tolerance for the sex workers to carry out such activities. Simultaneously, a planned process was undertaken to shift from free of cost condom distribution to the sale of condoms without subsidy. Other organisations (Marie Stoppes) with the specific mandate and funding for the provision of STI/RTI services were given charge for the running of the clinic; and efforts were

made to secure recognition from the national authorities for different forms of sex worker groups and activities. In practice free condom distribution could be stopped after three years.

STEP 14

Assessing Your Organization

Assessment is required at various levels. For instance, the organization's policies and priorities should be reviewed as some agencies have policies which make the provision of some services (eg abortion) or the implementation of certain principles (eg. Hiring HIV Positive staff) difficult. The organization's willingness and flexibility to form partnerships or work with certain constituencies may also need to be assessed.

Part of the project's role may be advocating with their own staff to ensure they have the right values and attitude when working with marginalized groups.

ACTION

- Ensure your organization staff has a non-judgmental attitude towards the behavior of the vulnerable group and always treat members of the vulnerable group with respect otherwise the program can get derailed. You may need active advocacy for this from senior members.
- Provide training on HIV/AIDS for all your staff, including support staff.
- Some projects will need attendance at odd hours, so ensure working hours are flexible and the staff is aware of safety issues.
- Project staff need to be fluent and comfortable when communicating about sexuality. Training may be needed to make them familiar with local terms for sexual organs and sexual acts. Create an environment where one can talk about sexuality. Support them in case they feel awkward.

EXERCISE

Before studying the sexual practice and risk behavior of sex workers, the sexual practices of the project staff of an NGO was assessed through an anonymous survey. The results showed that many staff members had experienced sex with the same gender, or had had sex with more than one partner prior to or after marriage. This allowed the sex workers and project staff to acknowledge that sex workers are not the only group who have multi-partner sex and indulge in risky behavior and helped to create a non-judge mental attitude among the staff members.

What does this tell you about risk behaviors and vulnerable groups?

Step 14

Assessing the organisation and Making necessary changes:

Once the site for intervention was decided the most important issue was preparing the staff and the organisation for the new and uncharted challenges that this intervention presented. The staff had never worked in an urban setting before. Dealing with the urban milieu, officials, local functionaries and significant players (eg. Shopkeepers, policemen, local musclemen, service-providers) was an entirely different experience from the rural setting. Further, the staff were required to work in a brothel. None of them admitted to having been in one before, and they had to deal with their personal inhibitions, family anxieties as well as social disapproval in addition to the work-related difficulties.

There were also issues related to staff safety that the organisation had to face. The work-environment for field-level workers has always been tough – earlier, women field workers had encountered strong social disapproval and even violence when they started using bicycles and motor-cycles to reach their field-sites. In this case, the social disapproval as well as actual threat was likely to be high as brothels were not places women go to, and the environment around them was criminalised and marked by violence. The management was therefore convinced to make a

major change in the policy regarding transport for field staff – for the first time office transport was provided for female field staff going to difficult sites. This was a fundamental change as access to office cars was earlier based on hierarchical position. Secondly, taking into account the difficulties likely to be faced as well as the relative inexperience and high staff anxiety, all staff worked in pairs, which was a departure from the individual-based system. It also required a change in the staff assessment as achievements could not so easily be ascribed to a single staff. This marked the beginning of a real team-approach, shared accountability and shared achievement

Working with sex workers required a significant change in the attitudes of the staff. By and large sex workers were viewed very negatively – as “fallen”, morally improper women who were looked down upon, and any social interaction with them was not even considered. The Project staff shared these views.

The project would require sex workers to come to office, sit and discuss issues as equals, be served tea by other office staff, be transported by office Drivers etc.

Considering these issues, the following steps were taken:

- a) A staff orientation was conducted for all CARE staff all over the country with basic HIV information and condom demonstration.
- b) The Country Director was invited to the staff meeting. He ensured all flexibility and talked directly about attitudes toward sex

work and sex workers. He promised to visit the field himself as soon as feasible.

c) Explicit discussions were held about the security concerns of staff, particularly of women staff working in brothel areas. Specific “dos and do nots” were listed for the staff in the field area, for protection and safety.

d) The future management of the project was clearly delineated in terms of the goal of the project being run and managed by the community themselves. SHAKTI staff was to serve as intermediate agents, and their success was in this ultimate shift in leadership.

d) Special training on sex and sexuality was conducted for all staff.

e) A small but significant step was permission for field staff to print their own visiting cards – this gave them increased credibility and status through organisational affiliation which was an excellent leverage in conducting countless advocacy meetings.

g) Special routines, including the provision of transport and of a co-worker were adjusted for staff working at night.

i) Entry criteria for recruitment of staff were relaxed to facilitate recruitment of persons with special knowledge about HIV positive persons and families, or marginalised behaviours and groups.

j) Performance evaluation was based on process achievement rather than physical targets eg yearly increments were granted to staff who earned the confidence of the sex workers, demonstrated by requests to solve different problems related to their lives, rather than on the number of contacts made.

PART 111

Annex

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Annex 1

Guidelines for Key Informant Interviews

Qualitative information can be gathered from a number of sources. Guidelines for some methods, such as key informant interviews, focus group discussions and participatory rural appraisal, are presented here

Guidelines for Key Informant Interviews

- Prepare a list of areas on which you would like information, and possible questions.
- Introduce yourself, and include any information that will add to your credibility and build trust with the respondent. (this will differ for different informants – for service providers it could be that this project is in partnership with the government; for sex workers it could be that you are working with an NGO they trust). Explain clearly why you need to gather information. Reassure the respondent that you intend no harm to anyone.
- Guarantee confidentiality and establish privacy.
- Ask permission to record the interview. Often respondents do not mind if you take notes as it makes them feel like an ‘expert’.
- Start with neutral questions and establish rapport with the respondent.
- Try not to ask leading questions or ask questions in a way that shows judgement or bias.
- Probe, cross-check and get details on areas that are relevant and where the respondent appears to have reliable information. Ask for a specific example, with details of date, time, and so on. This helps to verify information as well as get details on different aspects. For example, the last time the police raided this place, was it in the morning? Who else was here? 'That's interesting, can you

tell me about the last time- what happened? Or ‘Can you tell me more about that?’ Or ‘Can you go over that again?’

- It may sometimes be difficult to ask a question directly, or respondents may be uncomfortable answering some questions. In such cases, try and get the information indirectly. For example, possible questions you may want to ask to assess the environment and find out if the area functions as a brothel that are related to the situation/context are:
 - ◆ Is this an area where the police request to be posted?
 - ◆ Does this area have many criminal elements?
 - ◆ Are there certain types of people who visit this area?
 - ◆ Is this is a violent area for women or men?
 - ◆ Are there any nightclubs or drinking places that are open late?

- Find out about the respondent’s life, particularly in relation to the issue, and history, if it is relevant (for instance, if the respondent is being interviewed as a member of the vulnerable community).
- You may wish to find out more about the life and experiences of the respondent to gain an insight into patterns of behavior in the community. For instance, who are the people the respondent usually injects with, how many people are present, are they the same persons each time, the dynamics of the situation and how different forces act to influence behavior.
- Try and make the interview less than 90 minutes. Repeat interviews may be necessary to obtain complete information, to cross-check details, or to explore new areas that come up during the course of research. Always keep this option open with the respondent.
- Ensure you do not pass on or reveal information from one informant to another.
- Record discussions in detail, including the exact vocabulary used for significant terms, quotations that are particularly striking and indications of emotional content

(for instance, ‘angry’, ‘cynical’). It will help if your field notebook is small enough to keep in your pocket or purse.

- Ask for names and contact details of other persons who may have information on the same or related areas that complement what the respondent has shared.
- After each interview write up your notes in detail while the interview is fresh in your mind.
- Add your observations, comments and questions, and identify areas for further probing. Write up tentative insights and interpretations, and check these with other staff.

Possible Key Informants in Qualitative Surveys

The police, truck drivers, pharmacists, sardarnis, clients, pimps, brothel owners, clinicians, hospital staff, shopkeepers, babus, traditional healers, religious workers, sex workers, drug users and professional injectors.

Guidelines for Focus Group Discussions and Participatory Rural Appraisal

- Be clear about the information you would like to focus upon and make a list of key issues. Share the key issues with the participants so they know what to talk about.
- Ask key informants to help you select participants. Explain that you require a variety of opinions, and go over the list of participants before they are invited to ensure that you have a representative group of people. A number of focus group discussions are usually required to cover all angles of the topic and the entire range of experiences.
- Discussions should be conducted in familiar surroundings, preferably in a community meeting place or a neutral open space.
- The moderator should try and involve all the participants, and not let one or two individuals dominate the discussion.

- Be sure to have two persons to take notes. These should be reviewed at the end of the session for completeness and accuracy. Comments and observations can be added.
- Write up detailed notes after the discussion

Assessing the Size of the Vulnerable Group: The Capture-Recapture Method of Estimation

One way to estimate the size of groups such as street-based sex workers or injecting drug users is the capture-recapture method. In Dhaka, the assessment took two weeks. During the first week, the project staff and guides distributed a card with a logo printed on it to every sex worker identified by the guides. As many of the women move from one location to another, the sex worker was first asked whether she had received a card earlier. This was done at every location identified during needs assessment.

In the recapture exercise, a different colored card was printed with the address of the NGO. The recapture exercise was initiated a day after the capture exercise was completed. The recapture exercise was conducted in the same way and followed the same routine in terms of day and time. The locations covered in day one of the capture exercise were covered in day one of the recapture exercise as well. When distributing the cards the sex workers were asked if they had received any cards earlier. Those who had received the card in the capture exercise were given a new card. Those who had not received the card

were given both the old and the new card. Below is a simple explanation, using the example of estimating the number of fish in a pond.

M1 = the number of fish captured in the first catch (all the fish in this catch were dyed with a particular color and thrown back in the water)

M2 = the number of fish captured in the second catch

C = the number of fish in the second catch that were a part of the first catch (identified by their color)

N = total number of fish in a pond

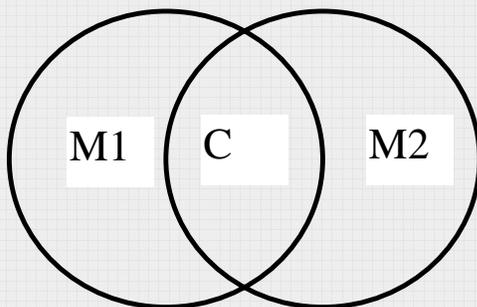
Thus:
$$N = M1 \times \frac{M2}{C}$$

Using the capture-recapture method to estimate the floating sex worker community in Bangladesh

Introduction:

SHAKTI-Project is the HIV/AIDS prevention and control initiative of CARE-Bangladesh. As part of project strategy, SHAKTI wanted to start a programme intervention for street based female sex workers of the Dhaka city. Dhaka is the capital of Bangladesh with an approximate population of 8 million people. At the beginning of the intervention it was necessary to have an estimation of the target population. At first secondary data sources like police, social welfare department, different Non Government Organizations (NGOs) and sex workers were contacted and data were collected. The estimated number of street based female sex workers from those secondary sources varied from mere 1200 to 12000. That necessitates a formal estimation to get a closer idea of the actual number. The project decided to apply Capture-Recapture technique to estimate the number of street female sex worker in the Dhaka city. Another NGO, Marie Stopes Clinic Society (MSCS), who also work with female sex worker was also a collaborating partner in estimation process.

Capture-recapture is an established and well accepted sampling tool in wild life studies. The method is also in growing use to estimate hidden population like sex worker or drug users. This method estimates the true population size by evaluating the degree of overlap among two incomplete counting. This method assumes that if C numbers of subject overlap in the two separate counts, the total subjects in the defined area will be $M1 \times M2 / C$, Where M1 and M2 are the number of two separate counts.



$$M1 \times M2 / C$$

If M2 is any point the total number of count of a (hidden) population, it represents only a portion of the total population and needs to be multiplied by a correction factor. $M1/C$ is the correction factor, if M1 is the number of people counted on first occasion that on a repeat count only yielded C number of people from the previously identified group

Objective :

To estimate the number of street based female sex workers in Dhaka City. (Street based female sex worker is someone who negotiates with the client in the streets, parks, railway stations, movie halls and may or may not have sex in the street setting)

Study Area : Out of 15 thana (police station)sub unit of Dhaka city 13 thanas were selected for the estimation exercise

Methodology :

1. Recruitment and training of sex worker as guide :

Forty-five sex workers from the 13 thanas under study were recruited to work as guide. The “Guides” would link between general sex workers and project staff during the study. Many of those sex workers were previously working with other agencies MSCS. These sex worker guides were given training in two stages. Overall purpose of intervention, issues of confidentiality objective, methodology and purpose of this estimation were discussed. The process of the estimation was discussed in details and using role plays and simulation techniques.

2. Mapping and identification of the locations:

The total investigation team was divided in to five small teams. These small teams with the help of sex worker guide mapped all the locations (where sex workers waited for client, rest or some times have sex with the client) in the study area. More that 60 locations were identified through this process. Mapping was done through snowballing when every sex worker known in each location were asked about the next location they might know about.

3. Estimation of the street sex workers:

Capture Exercise:

Sex worker guides were posted at each known location of the city who would identify other sex workers by first identifying herself, explaining about the need for planning purposes required for intervention, assuring about confidentiality and non requirement of identifying information. Then she would distribute a colored card (red) with logos of the two collaborating agencies (CARE-Bangladesh and MSCS) among the all sex workers in all the identified locations. The sex worker would also be requested to identify other workers they knew in that area. To avoid duplication of card distribution, before giving card to sex worker, she was asked whether she had received any such card before. If she had not received a card, then only the card was given to her. If she mentioned receiving a card she was asked to show the card. If she did not carry the card but claimed to have received the card earlier, a card was shown to her for confirmation and verification. This was done at each and every location. The card distribution time varied in to day or nighttime or both in different locations depending on the pattern of sex workers' activity in that location. Some of the locations needed 24 hour's coverage by the card distribution team. The number of card

distributed were submitted to the office every after the end of every team working hour. The total process took 7 days.

Recapture Exercise: For this exercise, a different colored card (pink) with logos of the two collaborating agencies (CARE-Bangladesh and MSCS) was used. The recapture exercise was started one day after capture exercise was completed and followed the exact same routine as capture exercise in terms of location, day or time. While distributing the card the guides asked the sex workers whether they received any red card earlier. Those who received the red card earlier were given the new pink card. Those who did not receive any card during capture exercise were given both red and pink cards altogether. The numbers were tallied who received only pink card and who received both pink and red cards together.

Results :

M1 = Number of sex workers captured on first counting (given red card during the first round of distribution): 2517
M2 = Number of sex workers captured on second counting (given pink and red card together during the second round of distribution) : 2449
C = Number of sex workers recaptured (in the second counting who also received card in the first counting and given only pink card) : 1412
N = Estimated number of street based sex workers in Dhaka city
 $M1 \times M2 / C$ 4336

Limitations:

Ideally, such two counts would be independent of each other so that the other one does not influence probability of one count. (Usually this method is applied using two separate methods like Police records of registration and street count). It is obvious that relative earning of people in previous occasion would influence the next client seeking behaviour. Also Sex work in street of the capital city is also seasonal because of varying employment opportunities in rural areas, **which** could not be adjusted in the study

Conclusion:

Capture-recapture method was useful in planning the interventions, services outreach etc. These helped narrowed the range of “guess” and also helped the next step of sampling for recruitment of street sex workers for behavioural and STD survey.

Annex 2

ETHICAL ISSUES.

When gathering information on the community, it is important to keep in mind certain ethical issues to ensure that intervention can be successfully implemented. This section some values that are essential to intervention. In addition, samples of tools used in the Shakti project to gather quantitative information are provided. These can be adapted to meet the information requirements of particular projects.

Ethical issues

- Community participation is essential in planning and implementing the program.
- Informed consent without any form of coercion must be sought for all surveys and examinations. Preferably, consent should be in writing. Explain the benefit and possible risks (including loss of status, stigma) associated with participation.
- Strict confidentiality should be maintained, and one-to-one surveys should be conducted in private. Respondents should be encouraged to discuss issues freely.
- Surveys and examinations are not recommended unless you plan a related intervention and provide appropriate services.
- Systems to remove personal identifiers from results and maintain reports confidentially must be in place and functioning.

An example of draft guideline for surveillance provided below can be useful to understand the issues involved

Draft Ethical Guidelines for Second Generation HIV Surveillance

Background:

Primarily surveillance covers marginalised population groups (eg IDU, SW, MSM), as they are perceived to be more vulnerable and there is higher likelihood of HIV being first detected in these groups.

However, the sheer act of selecting specific groups for surveillance results in stigma and labeling of these groups as vectors of the disease, and further serves as a kind of confirmation from socially “respected” sources that these groups practice socially and at times legally unacceptable behaviour. Simultaneously, focusing on these population groups makes them “visible”, and while this can increase stigma, it also opens the possibilities of making services accessible.

Surveillance will be undertaken by institutions, organisations, researchers who belong to mainstream, privileged, section of society. The socio-cultural-political factors that determine the status and power equations between the mainstream and marginalized groups could come into play, in various ways, during the surveillance process, or can be perceived as “coloring” the process.

Hence, the adoption of and adherence to ethical guidelines is very important.

As UNAIDS perceives surveillance as an integral part of intervention, not as isolated research, it is equally important to ensure that the conduct of surveillance does not adversely affect individuals, groups or community at both, the objective and subjective levels of perception. If the surveillance is perceived as having unpleasant or damaging impact/effect, the very purpose of surveillance in forming a sound basis for intervention, based on trust and partnership, is defeated.

Guidelines:

1. The ethical review process should begin with planning of surveillance and extend to dissemination of findings, and associated interventions.
2. In planning and implementation of the programme participation of the community is essential.
3. The implementing institution should develop a detailed workplan in consultation with community members.
4. Informed consent - To reduce any imposition by researchers on less advantaged populations, particularly those who are dependant on participating institutions for a service, informed consent without any form of coercion or influence is essential. The consent format should be developed by the representatives of the community. The form should clearly and simply explain the benefit and possible risks (including loss of status, stigma) associated with participation in the surveillance.
5. Confidentiality – Group Confidentiality presents a dilemma as the act of disclosing site-specific data (important for focusing interventions) results in the HIV status of a particular group in an identified area being public knowledge. This could ignite negative sentiments. Attempts must be made to disclose data in a way that does not permit identification of specific location except where it is required for an intervention (eg. Information that Brothel X has k% HIV+ sex workers in comparison with Y, with no identified +ve sex workers, can result not only in a decline of clients, but in extreme actions like eviction and persecution).

6. Provision of Services – as the methodology of sero- surveillance includes the collection and testing of blood for STDs, the individuals identified as positive must be given appropriate, quality treatment facilities that uphold high ethical and professional standards. Similarly, where behavioural surveillance is done, services that contribute to change in behaviour must be provided, in a way that does not directly and immediately affect the quality of data collected.
7. Non-discrimination – All surveillance is conducted on a scientifically selected sample, selected by pre-determined criteria. The surveillance itself may be seen as a positive service by members of the community or stakeholders, pressurising and skewing the selection of individuals to be sampled/tested. Therefore it is important that the sampling methodology and research process thoroughly explained not only to individuals selected for the research, but to the community as a whole and to key stakeholders. Further, provisions must be ensured for voluntary testing (including counseling and treatment for STDs as appropriate) for interested members of the community, so that they do not feel excluded and negatively discriminated.
8. Dissemination- a) While sharing the data with different constituencies the apprehensions and doubts of the participating groups must be respected. b) The process of dissemination in the community should be done such that the community is able to utilise this information as they see fit, for various purposes. c) The research process and the dissemination should establish the ownership of the data with the community, rather than with the research institution.
9. Capacity Building – As surveillance is an on-going process, integral to a scientific, evidence-based response, all stages starting from planning and designing surveillance to implementation and including the ethical review, should adopt a policy and strategy to develop adequate capacity both at community and country level.
10. Grievance redressal- it is advisable to constitute a committee for redressal of grievances from the start, with participation of the community, and an independent arbitrator, acceptable to all parties.
11. Compensation- While planning surveillance sufficient provision should be made to compensate participants for possible negative consequences of participating in the research. The form of compensation, decisions regarding whether it is to be given, and the disbursement will be decided in consultation with the community.

Situational assessment can generate the following information

- The size and location of the group
- Cultural, social and economic features (such as average income, violence experienced, social networks and the relationship of the power structure to the community)
- Details of different sub-populations (for instance, in interventions for sex workers, information on bonded sex workers, free sex workers, new sex workers, sex workers with babus, sex workers without babus)
- Potential obstacles to behavior change (fluid and changing)
 - Individual barriers
 - ◆ Weak economic position
 - ◆ Low social position
 - ◆ Poor communication skills
 - Structural barriers
 - ◆ Babus are not keen on condom use
 - ◆ Sex workers spend approximately 7 days without treating STIs
 - ◆ Bonded sex workers have very little freedom and decision-making powers
 - ◆ The police and other controlling external pressures
 - ◆ A highly mobile vulnerable population
- **Factors that can help in intervention**
 - ◆ Compounder plays a vital role in influencing the community
 - ◆ Babus influence individual sex workers and the community
- Opportunities for entry into the community
 - ◆ Gate keepers who can help set up an intervention or help project staff gain credibility
- Channels of communication preferred by the community
 - ◆ Person-to-person contact
 - ◆ Videos and audio cassettes
- Local terminology

- Attitude of the community towards the proposed intervention
- Attitude of the project staff
- Identification of possible guides

Tools for Data Collection and Research: Sample questionnaire , guidelines for sampling and biological test are available on request from CARE- Bangladesh. *A few examples is produced below from the summary results of the baseline survey of the above study*

Results of the survey

Socio-demographic profile of the sex workers (n=316)

Age (years):	23.7 (\pm 6, range 12-40)
Religion (%)	
Hindu	3
Muslim	97
Illiterate (%)	86.4
No. of years in the profession	7.4 (\pm 5.9, 1 month to 28 yrs)
No. of years in the present brothel	6.0 (\pm 6.2, 0 month to 35 yrs)
District of origin	43/64 districts in the country
Type of sex worker (%)	
Bonded (owned by the madam)	17.1
Independent	83.9

Reproductive and sexual profile

<i>Ever conceived</i> (%)	70.3
Experienced abortion (%)	59.9
No. of clients in the past 24 hours	2.9 (\pm 2.7)
Anal/oral sex	Common, yet to be quantified
Sexual relations during menstruation (%)	59.2

Sexual relations with babu (%)	62.9
Average no. of sexual partners in the last 24 hours	3.8(± 1.8)
Estimated no. of sexual acts in the brothel/ per year*	522,000* @ 2.9 x 300 working day x 600 workers (n=316??)

Awareness of STIs/AIDS

Awareness of STIs/AIDS	%
Syphilis	90.8
Gonorrhoea	69.3
Both	65.0
HIV/AIDS	34.7
Condoms prevent STIs	37.7
Perceived vulnerability to STIs	74.4
Intend to use a condom	27.8
Ever tried a condom (last 24 hrs)	14.6
Consistent condom use** (last 24 hrs)	6.3

** in more than 50 percent of occasions

STI profile of Sex Workers: Laboratory markers

Marker	Positive (%)	CI (%)	n
HIV	0	0-1.0	
TPHA+ve	60.1	55.5-64.5	466
VDRL+ve			
Dilution 1:8	6.8	4.8-9.9	466
All dilution	28.3	24.3-32.7	466
Chlamydia	18.6	14.41-23.58	296
Gonorrhoea	20.3	15.93-25.39	296
Chlamydia or gonorrhoea	28.0	23.07-33.59	296

Note: Endocervical swab tested by PCR for chlamydia and gonorrhoea

Collecting Data on STIs for a Baseline Survey

Baseline surveys have different objectives, depending on the type of intervention planned. In a brothel-based intervention, for instance, the following data was collected through a baseline survey.

- The prevalence of selected sexually transmitted infections supported by laboratory and clinical findings
- The health seeking behavior and practices of sex workers
- Knowledge, intent and practices in relation to safer sex
- The level of perceived risk of HIV/AIDS/STI by sex workers
- The extent of peer education and peer pressure
- Negotiation skills of sex workers
- The extent of condom use
- The knowledge, intent, and practice of sex among the influencers of sex trade
- The current HIV prevalence rate
- Perceived vulnerability to STIs

Apart from helping in monitoring and evaluation, data from individually sampled interviews can be used to check the validity of data collected by other methods.

Designing a behavioral questionnaire

A behavioral survey can collect the following information.

- Patterns of risky behavior (e.g., number of partners per week, episodes of injecting, whether injecting equipment is shared, if so, how [both needles and syringes; syringes only, etc.], sex without condoms with babus)
- Health seeking behavior and practices of the vulnerable group.
- Existing knowledge, intent, trial and practices in relation to safe sex.
- Understood/perceived risks of HIV/STIs
- Extent of peer education and peer pressure
- Negotiation skills
- Condom use

Annex 3

Developing behavior change communication materials

It is necessary to design appropriate materials for different audiences (for instance, sex workers, clients of sex workers, clinic staff, injecting drug users, policy makers) and different purposes. Materials must be constantly revised and updated based on new information available, level of services available in community and on the situation of the sub-population.

- To design effective materials, you need to know the following for each sub-group.
 - ◆ Do members of the group understand and practice HIV preventive behavior?
 - ◆ What terms do they use to describe risky behavior?
 - ◆ What types of information might motivate them to change risk behavior?
 - ◆ Do they understand the advantages of practicing safer sex?
 - ◆ Do they think they could be infected with an STI or HIV/AIDS?
 - ◆ What are the myths and misconceptions regarding STI transmission that prevail in the group?
- Find out what materials will be appropriate (flip charts, photos, videos, comic strips and plays are some options).
- Develop a story line with messages in partnership with the community.
- Find out the types of messages required through focus group discussions or interviews.

- Pre-test the materials with the community based on the following questions:
 - ◆ What messages are the materials conveying?
 - ◆ Do the messages make sense to you?
 - ◆ Do they provide you with all the information you need to know?
 - ◆ Are they appropriate and relevant to your situation?
 - ◆ Do you think your friends would understand the messages?
 - ◆ Do these materials and messages make you feel motivated to change in any way?
 - ◆ Do they provide information on services required for behavior change?

- Based on responses from the group, you can decide whether or not to adapt existing messages and materials. Ask yourself:
 - ◆ Have the materials been appropriately used?
 - ◆ Were they effective? How did the audience react to them?
 - ◆ Do you need permission to modify or use the existing materials/messages?

- Make sure you have a variety of materials that different groups can understand clearly, regardless of how well they can read (for example, sex workers, mastans, babus)
- Try and avoid negative messages, as they often have an adverse impact on the audience.
- After finalizing the materials, pre-test them with the vulnerable group.
- A theme slogan or catch phrase that conveys the message works well. The message should be simple, easy to recall and conveyed in one or two sentences.
- Plan to deliver more than one message. It is important that each new message pushes the audience toward the next step in the behavior change process.

Keep in mind the following points when developing IEC materials

- Mention the benefit(s) of making the desired behavior change. Support this with relevant information.
- The messages should be clear and simple
- Highlight the main points
- Limit the number of ideas being conveyed in a single message
- The information should be context-specific
- Find credible sources to deliver the information
- The visuals should be appropriate and clear to the group.
- Flip charts should not have too many confusing messages.
- Repeated use of sequences may be boring. It encourages the audience to memorize, rather than understand and apply their knowledge to their own experiences.
- Existing materials should address the questions and issues raised by a particular community.

Don't forget!

Effective messages help the audience to:

- **Make a personal commitment to make the desired changes.**
- **Acquire the skills to implement the changes**
- **Create an enabling environment for practicing the behavior.**

The most effective way to reach the audience is to use a combination of the following materials:

- ◆ Flip charts
- ◆ Brochures
- ◆ Slides
- ◆ Posters
- ◆ Cartoon strips
- ◆ Videos
- ◆ Audio tapes
- ◆ Films
- ◆ Plays
- ◆ Music
- ◆ Folk media

Post script

The overall project from its mapping to beginning of full implementation took less than six months without any major problem. Earlier, it took almost three years to learn about the ways and the steps of interventions in Sonagatchi Brothel of Calcutta. SHAKTI not only became a model project in Bangladesh it was also documented as one of the best practice studies for sex worker intervention at global level.

After four years the sex workers from Tangail were contracted as consultant for setting up similar project in other districts of Bangladesh. When asked what exactly they would do they described the exact fourteen steps of this project has gone through and written in this manual. Sex workers had never taken part in theoretical discussions on steps involved in targeted intervention. They could practice what they have been implementing.

In SHAKTI , professionals initiated the project , now the sex workers were scaling up to nation wide intervention.

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