

HIV PREVENTION AND GENDER MAINSTREAMING

A Training Manual for
Peer Educator Trainers
in the Apparel Industry in
Sri Lanka.



International
Labour
Organization

2011

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Acknowledgement

*The impact of AIDS is no less destructive than war itself, and by some measures, far worse.
- Kofi Annan, 7th Secretary General of the United Nations)*

This manual is the outcome of sincere efforts by several individuals and organizations. Dr. Indira Hettiarachchi, National Project Coordinator, ILO- Sri Lanka and Ms. Ayomi Fernando, Senior Industrial Relations Advisor / Training Coordinator of the Employers' Federation of Ceylon deserve a special word of thanks for initiating and providing technical guidance for the development of the manual

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Foreword

HIV and AIDS were identified during the early eighties. Biological nature of the infection, rapidity of transmission, the lack of curative treatment, and myths and misconceptions that surrounded the infection culminated in bringing about strong stigma and discrimination. Medical advances during the past three decades have changed the life expectancy of persons living with HIV and sociological interventions have removed much of stigma and discrimination but residual forms are observed still.

The importance of workers' health in maintaining high industrial productivity is accepted without argument. Loss of income both for the employer and the employee, pressure on families, and stigma and discrimination are the outstanding consequences, if one becomes infected with HIV. The world of work can make a tremendous impact on HIV prevention because most workers are at sexually reproductive age groups. The new International Labour Standard on HIV and AIDS and the world of work, 2010 (No. 200), adopted in June 2010, focus specifically on the issue of HIV and AIDS in the world of work. It is aimed at strengthening the contribution of the world of work to universal access to HIV prevention, treatment, care and support and contains provisions on potentially life-saving prevention programmes and anti-discrimination measures at national and workplace levels. It also emphasizes the importance of employment and income-generating activities for workers living with HIV, particularly in terms of continuing treatment.

The majority of apparel sector workers are young women, who contribute to earning much needed foreign exchange for Sri Lanka from foreign trade. However they are vulnerable to HIV infections. This manual for trainers of peer educators for young women and also men in the apparel sector provides a tool for a cost-effective HIV prevention education programme at the workplace.

I thank all who contributed to make this manual a success.

Donglin Li
Director
ILO Country Office for Sri Lanka and the Maldives

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
ILO	International Labour Organization
GBV	Gender Based Violence
MOH	Medical Officer of Health
NSACP	National STD/AIDS Control Programme
PHI	Public Health Inspector
PHNS	Public Health Nursing Sister
PHM	Public Health Midwife
PMTCT	Prevention of Mother to Child Transmission
SEARO/WHO	South East Asian Regional Organization / WHO
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

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BACKGROUND

This training manual on HIV Prevention and Gender Mainstreaming is being introduced at a time when already there is a plethora of guidebooks on the subject. Yet, although one can imbibe much useful information from these guidebooks, they have been designed to cater to populations in particular settings. This reason alone justifies the need for designing a training manual to suit our own workplace environments in the apparel sector with particular focus on HIV and gender.

In Sri Lanka, the majority employed in the apparel sector are those between 20 – 30 years. They remain a key source of earning foreign exchange to enrich the national economy. Being the country's biggest employer in the manufacturing sector, the apparel sector provides direct employment to over 300,000 persons of whom more than 80 per cent are young women migrants from rural parts of the island to Export Promotion Zones, Industrial Parks and other establishments. They stay in numerous boarding houses, most of which are crowded and lack adequate facilities despite high rents they command.

The knowledge, attitude and behaviour study conducted by the ILO in three apparel sector factories revealed that this group is sexually active and engage in risky sexual behaviours.

Summary of survey findings among female apparel sector employees:

- Nearly 65% of the total sample had satisfactory knowledge on HIV transmission
- Almost 26% believed that mosquitoes could transmit the virus and 30% believed that sharing a toilet with an infected person too was dangerous.
- Majority believed that it could be prevented by limiting sex to one faithful partner.
- Only 30% of the females knew about mother to child transmission.
- Nearly 76% did not know that excessive use of intoxicants could contribute to the risk of HIV infection.
- Attitudes towards the use of condoms was poor and 69.5% did not know correct use of condoms
- About 70% were not willing to work, share equipment, a toilet or the canteen with a PLHIV
- 20.5% had experienced sexual harassment at the workplace.
- Nearly 84% of married women and 83% of unmarried had been subjected to sexual harassment outside the workplace.

It is admitted that sexual affairs are basically a private matter. However, engaging in multiple sexual partnerships and other risky behaviours jeopardize the lives of the persons concerned, the contacts and would in turn have adverse implications on the industry as well. Therefore, the need for increasing awareness on HIV and AIDS, its prevention and gender mainstreaming as well as enhancing life skills to cope with situations which could make them vulnerable to HIV, cannot be gainsaid.

Distant from the loved ones and family members and whirling in a monotonous daily routine, they become nostalgic, lonely and bored. To overcome these circumstances, they seek means for pleasure and entertainment. Most of them develop an affinity for urban culture which becomes more fascinating compared to their native places. They make a good clientele for numerous entertainment shows. The concern here is two-fold: what sex education do they have? And how safely do they engage in sex?

Media reports are frequent about sex offences and some of these are connected to the world of work, where the apparel sector is no exception. Both the victims and offenders are highlighted in these reports. It is evident that much of these problems originate from inadequate awareness. In raising awareness, peer educators can play an effective and important role. They belong to the target group with much information on target group behaviour. On the other hand, innate capacities of the workers and their creativity can be diverted to a worthy cause through peer education.

This manual is the outcome of a series of consultations with academics; representatives from employers' and workers' organizations; NGOs specializing in reproductive health, gender and sexual health; and, medical and public health personnel. Their suggestions and guidance helped in no small measure to streamline the content to suit the intended target group.

Objectives of the Training Manual:

This manual is developed for trainers of peer educators in the apparel sector. It provides for a three-day training programme for peer educators on relevant technical themes and gender mainstreaming concepts in HIV prevention programmes.

The manual will contribute to creation of gender-sensitive peer educators, who will be able to:

- Better appreciate gender issues in general and those related to the workplace in particular,
- Identify factors related to HIV and AIDS and gender relationships that enhance the risk to workers,
- Appreciate the need to eliminate HIV related stigma and discrimination and recognize the rights of individuals living with and affected with HIV and AIDS,
- Better implement HIV prevention, care and support programmes in the apparel sector.

LINE-UP OF TRAINING SESSIONS

Day I					
Time / Session Title	Session Objectives	Content	Method	Materials Required	Evaluation
09:00 – 10:00 Session 1 Opening session	Establish an open learning environment. Assess the existing knowledge about HIV and AIDS and gender. Introduce the objectives and process of the workshop.	Registration of participants. Inauguration; Pre test; Introduction of participants. Setting ground rules, gathering expectations.	Exercise Dialogue Individual expressions	Registration forms; Participant information form; Pre-test questionnaire; Workshop objectives displayed on the wall; Stationery (pens, file covers, writing paper), oil lamp, box of matches and candle.	Q&A; Individual presentations/sharing
TEA					
10:00 – 10:15 10:15 – 11:45 Session 2 Basic Concepts of Gender and Sex	Differentiate between “Gender” and “Sex”. Develop awareness about gender as a social construct.	Difference between Gender and Sex. Gender from biological and sociological perspectives. Gender in the	Lecture discussion; Exercises; Group work and presentations; Role play; Case study	Demy paper; Permanent marker pens; Picture of the Values; Attitudes and Behaviour Tree; Pictures to highlight Aesop's fable of the	Q&A; Assessing the level of outcome of games and role play.

		contexts of the family, society and the workplace.		Fox and the Stork; Cartoon on equal opportunity; PowerPoint Presentation on “Gender”; Flip chart with pictures of a man nursing a child; pictures (or PowerPoint) of women attending to different kinds of work both traditional and non traditional; Gender differentials.	
LUNCH					
11:45 – 12:45					
12.45 – 02.00 Session 3 Gender Empowerment and Mainstreaming	Identify the need for gender empowerment in general and in relation to the working environment in the apparel sector. Identify the need of gender mainstreaming to respond to HIV in	Gender analysis; Levels of empowerment and an overview of gender differentials in the country including the industrial sector; Purpose of mainstreaming and its practical aspects.	Lecture discussion, Group work and presentations; Role play, Case study.	Flipchart with models of empowerment and definitions. PowerPoint presentation on “Gender” . Demy paper; Permanent marker pens.	Q&A; Level of interaction with the resource person.

02.00 - 03.30 Session 4 Basics of Human Sexuality and Reproductive Health	the workplace. Focus on skills development on gender empowerment and mainstreaming.	Assistance to be derived from empowerment and mainstreaming for preventing HIV, treatment, care and support.			
	Introduce the basic concepts of human sexuality. Develop awareness about factors influencing sexuality and ways of expressing and experiencing sexuality. Appreciate sexual health and associated risks and awareness about contraception and safe health practices.	Sexuality; Sexuality and gender; Body mapping; Different sexual practices; Sexual health; Cultural specifications; Reproduction process; Contraception; Sub-fertility; Safer sex practices.	Lecture discussion, Exercise; Group work and presentations; Case study.	Demy paper; Permanent marker pens; Flip chart; White Board; Outline drawings of a male and female drawn on demy paper, Drawings of male and female genitals (external and internal); Power Point Presentation or Flipcharts on human sexuality, physical, mental and social results of sexual relationships. Names of contraceptive methods written on pieces of hard paper;	Q&A; Level of participation in exercises.

					A PowerPoint presentation with diagrams of sex organs, reproductive process, specimens, contraceptive devices, materials, dildos and other relevant material.	
TEA						
03.30- 03.45						
03.45 – 05:15 Session 5 Basics of HIV, AIDS and STIs	Enhance knowledge about STIs HIV and AIDS including the link between HIV and STIs. Enhance Understanding of HIV and AIDS from a gender perspective.	Difference between HIV and AIDS; Mode of transmission; Myths; Diagnosis; Window Period; Signs and symptoms; Prevention; Treatment; Common STIs; Why STIs are a gateway to HIV; Gender & HIV.	Lecture discussion; Exercise; Group work and presentations; Role play; Case Study.	Demy paper; Permanent marking pens; A PowerPoint presentation on HIV and AIDS with an introduction to STIs.; Flash Cards with A, B and C of prevention; 04 Cards with pictures of 02 women and 02 men; Pictures of male and female genital anatomy (internal and external).	Observing the level of participation in exercises	

Day 2					
Time / Session Title	Session Objectives	Content	Method	Materials Required	Evaluation
09.00- 10.30 Session 6 Prevention of STI and HIV and use of condoms	Develop knowledge about the prevention of HIV and STIs. Develop knowledge and skills about using male and female condoms for the prevention of HIV and STIs.	Prevention challenges; Line up of risks; Correct method of using Condoms; Barriers to male and female condom use; How to overcome the barriers; Dual protection.	Lecture discussion; Quiz; Demonstration and practice.	Demy paper; Permanent marking Pens; Flip chart; White board; Male and female condoms and dildos.	Results of the Quiz; Ability to use a condom properly.
TEA					
10:30 – 10:45 10.45 – 12:15 Session 7 Gender Based Violence(GBV) at Home, Society and the Workplace	Develop awareness about GBV at home/society and workplace. Enhance awareness about the relationship between GBV and HIV. Empower participants	GBV at home, society, and workplace. Types of violence; Skills to prevent situations. Development of Life skills to surmount GBV.	Lecture Discussion; Role play; Case study; Group work and presentations.	Demy paper; Permanent marking pens; Flip chart; White Board; PowerPoint presentation / flipchart about women's rights.	Q&A; Group work presentations; Response to matrix; Outcome of the role play.

	to take measures against GBV.				
12:15 –01:00	LUNCH				
01.00– 02.00 Session 8 Stigma and Discrimination	Discuss approaches of counteracting stigma and discrimination related to HIV and AIDS. Discuss the approaches for providing care, treatment and support to persons living with and affected by HIV and AIDS through workplaces.	Explore reasons for stigma and discrimination, its impact on individuals and HIV prevention programmes. Mitigate such impact through workplace policies and programmes based on the ILO Code of Practice on HIV/AIDS (2001) and the ILO Recommendation concerning HIV and AIDS and the World of Work 2010 (No.200)	Viewing video, Role play; Lecture Discussion	Demy paper; Permanent marking pens; Flip chart; White Board; Video; PowerPoint presentation or a flipchart with necessary information for the session; ILO Code of Practice and the Recommendation No.200	Q&A. Outcome of the role play.

02.00 – 03.15 Session 9 Integrating HIV & AIDS Education into Workplace Programmes	Discuss the rationale for having a policy Orient the participants to the elements of HIV and AIDS workplace policy; as per the provisions of the ILO Recommendation 200, Code of Practice on HIV & AIDS and the Draft National Policy on HIV and AIDS and the world of work.	Process of developing workplace policy on HIV and AIDS Principles of workplace policy on HIV and AIDS	Lecture discussion, Exercise; Group work and Presentations.	Demy paper; Permanent marking pens; Flip chart; White Board; ILO Code of Practice for HIV/AIDS.	Q&A; Draft policies.
03:15 – 03:45					
03.45-05.15 Session 10 Behaviour Change Communication (BCC)	Develop knowledge of the basics of communication and introduce the concept of BCC. Enhance understanding of implementing BCC in	BCC as a different approach in prevention and control of HIV and AIDS; Learning from experiences; Peer education at workplaces;	Lecture discussion; Exercise. Group work and presentations; Role play.	Demy paper; Permanent marking pens; Flip chart; White board; PowerPoint presentation on BCC; Video on a BCC experience; Role play on peer	Q&A; Outcome of the role play; Outcome of the exercise.

	workplace programmes Enhance understanding about the peer education approach & necessary skills	Selection of peer educators. Basic awareness generation and training skills in peer educators		education sessions.	
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Day 3					
Time / Session Title	Session Objectives	Content	Method	Materials Required	Evaluation
09:00 – 10:30 Session 11 Development of peer education plans	Discuss components of peer education approach. Develop work plans for strengthening peer education approach at workplaces.	Preparation of peer education programme plan by the participants. Sharing of plans by participants.	Group work , presentations and discussion	Programme plans prepared by participants, Demy paper; Permanent marker pens; Flip chart; White board.	Work plans as presented and modified after discussions.
10.30-10.45 TEA					
10.45 - 11.45 Session 12 Final Session	Conduct Post-test and workshop evaluation.	Post Test and evaluation; Wrap up.	Presentation and discussion.	Post-test questionnaire.	Analysis of pre test and post test; Feedback of participants.

INTRODUCTION TO THE TRAINING MODULE

Targeted Users:

This training module is aimed at providing guidance to trainers of peer educators in the Apparel Sector. It contains session plans and relevant background information.



Expected Uses of the Training Module:

- Serving as a guide to organize and conduct workshops to train peer educators.
- Strengthening in-house capacity of enterprises to implement HIV prevention programmes for employees.
- Providing necessary resource materials for the sessions.
- Enabling to maintain equal standards in inputs imparted at training programmes conducted at different venues.



Directions for Using the Training Module:

- Trainers are requested to get familiar with the subject matter offered in the manual.
- All charts or tables cited in a session plan (under Activities or Tips for Trainers) are included in the reading materials.
- Tips for organizing training sessions are provided in the manual for the convenience of the trainers.
- The contents of the module are organized according to the sequence of workshop sessions. Modifications may not be necessary. In case the need for modification arises, it is strongly advised to obtain views of an experienced trainer.
- The nature of the subjects being somewhat sensitive, be open with participants and develop good rapport with them. They may be allowed to offer their opinion irrespective of the level of validity of views of a participant. Trainers should not criticize any idea expressed or allow others to do so because everybody has the right to express her or his own opinion. Participant's background, culture, and beliefs should be respected.
- Trainer's personal judgments, preconceptions and/or prejudices should not be forced on the participants. Effort must be made to maintain a healthy dialogue between trainees and the trainer to enable all participants to benefit from the training.



Proposed Activities:

- Activities that promote the coordination, interest and understanding among the participants.
- Activities to bring out ideas of the participants, which they can compare later with established facts.
- Use of ice-breakers to ward off any boredom or dullness observed in the participants. It should be remembered that: a yawn is a protest in silence!
- Making changes in the training environment (such as rearrangement of seating) is suggested to maintain vivacity.



Expected Results:

- Workers in general and women workers in particular become conscious about HIV and AIDS from a gender perspective.
- Women and men workers have the knowledge and skills about HIV and AIDS prevention and understand how gender relations impact on the epidemic.
- Peer educators are involved in HIV and AIDS prevention training in their respective workplaces.
- Peer educators impart knowledge and skills on preventing risky sexual behaviours and practice of safe sex (and consequences), and address related gender issues and rights.
- Participants develop positive attitudes to eliminate stigma and discrimination towards persons living with HIV and AIDS and to provide moral and physical support to them.

Session I

OPENING SESSION

Session Objectives:

Objective	Expected Result
Establishing a setting to enhance interaction among participants and between resource person(s) and participants	Inhibitions removed and interaction among participants enhanced.
Making participants aware about the objectives and process of training of trainers	Participants are clear about the objectives and process of training of trainers.
Assessing the existing knowledge about HIV, AIDS and Gender	Level of participants' existing knowledge is known as a baseline to assess the success of the programme.



Overview:

The need for maintaining a good learning environment is accentuated here. Each participant should have a feeling of acceptance within the group, right to express individual opinion, opportunity for display of special individual capacities such as dancing, acting, singing, drawing and the like, to be motivated to learn, and develop positive attitudes and skills. Therefore, this session aims at informing the participants about the management aspect, formulating some ground rules to uphold self-discipline and at helping to create a better learning environment for effective training, and managing their roles in a participatory manner throughout the duration of training.



Time: 01:00 hr.



Materials:

Registration forms, participant information form, pre-test questionnaires, workshop objectives displayed on the wall, stationery (pens, file covers, writing paper), oil lamp, box of matches and a candle.



Activities:

Activity I

- Commence registration 30 minutes before the inauguration.
- Announce that the workshop would commence once all are in.
- Keep an oil lamp ready in the middle of a tray of flowers.
- When all participants, resource persons and a responsible representative (or several of them) from the enterprise are in, make a formal request to participants to get seated. A circular arrangement is preferred for chairs.

- Request a representative of the establishment to welcome all present.
- Next, all participants stand and remain two minutes in silence to wish that the objectives of the workshop be fulfilled and the programme would strengthen them to prevent them and others from contracting HIV and to extend compassion towards persons affected by HIV.

Activity 2

- Request all to be seated again.
- Explain the importance and necessity of an intervention of this nature and the sequence of activities of the introductory session.
- Ask participants to stand in a circle.
- Offer opportunity to the representative of the establishment to light the lamp in the tray held by a participant with the room lights and fans switched off. Request participants to observe light from the oil lamp fill the room.
- Request participants to combine the significance of lighting of the lamp with the wish they made earlier.
- Play a recorded song which is suitable as a theme.
- Request the peer holding the lamp to pass it to the peer on the right hand side and keep on passing until it reaches the last in the group. At the end, the lamp is kept aside.
- Call for the significance of lighting a lamp from the participants. Repeat this question to obtain diverse views.
- Inquire as to why a tray of flowers accompanied the lamp.
- Invite participants to explain the nature of flowers in short answers.
- Ask the purpose of the theme song.
- Verify whether there is a relevancy of the theme song to this session.
- Pull all these ideas together and analyze.
- Ask participants to explain the purpose of this session and highlight some salient reasons.
- Thank all for participating in this session.

Activity 3

- Next, participants are asked to sit.
- Participant information forms are distributed among the participants to be filled within 05 minutes. The form contains cages for responses under : My name; My birthday; I was born in; I live in; What I like; What I don't like; My profession; In another 05 years I would like to be; My hobbies; I'm skilled in ...
- Having filled the form, each participant presents it to the group and hangs it on the wall thereafter. (Others are free to question each presenter for more information. Later participants can write any positives or negatives worth attention on the pictures of respective participants. Nothing should be obscene, sensitive, jocular, flippant or contemptuous. Only constructive criticism.)
(This exercise may be done in pairs where each person presents the other after interviewing. Pairs can be selected in several ways such as distributing cards with matching words, distributing shapes cut into two etc.)

Activity 4

- Pre-test questionnaire is distributed and 15 minutes is given to answer the questionnaire. It is not necessary to indicate the name of the person. Collect the papers at the end of 15 minutes.
- Resource person thanks everybody.

Activity 5

- Participants are separated into three groups. This may be done by counting in threes.
- One group is asked to frame a set of rules for the participants to follow; say switching off mobile phones etc. Next group is assigned to make a list of expectations (objectives to be achieved) out of the workshop and the last to collate the attitudes participants had from the beginning about the workshop. 10 minutes each may be allowed.
- Each group presents its outcome.
- The whole group refines the participant objectives, set of rules and comment on attitudes depending on one's own.
- Workshop objectives are compared with participant objectives and agreed.
- The set of rules and the list of attitudes are made known to all.
- Participants are asked about the purpose of this session.

- Session is summarized reminiscing on the sequence of activities from the beginning and discuss the applicability of the exercise.
- Cue participants to clap.



Tips for Resource Persons:

- It is appropriate that everybody who is present in the opening session participate in the activities.
- Many ideas may surface about the lighting of the lamp and the wish(es) they made. When there is no congruence in somebody's idea or somebody finds it difficult to establish such congruence, resource person may help to tie the expressed idea with the workshop.
- Make sure all participants use same number of minutes during the introduction.
- Special skills mentioned by the participants can be used in role plays or ice- breaking games.
- Suggest all to respect others' opinions and ideas.
- Be mindful about the sensitive nature of the subjects discussed during the workshop. Some, like those with a strong religious upbringing, may have inhibitions, which need to be handled carefully. Keep participants alerted that there is no vulgarity attached to these discussions.
- Make participants believe that it is their responsibility and commitment to make the training successful.
- Remind participants to respect the agreed rules. Display the rules written in large letters on the wall in a conspicuous place.
- Attitudes also may be written and be given to the resource person to compare with the outcome of the same exercise at the end of the workshop.

Session 2

BASIC CONCEPTS OF GENDER AND SEX

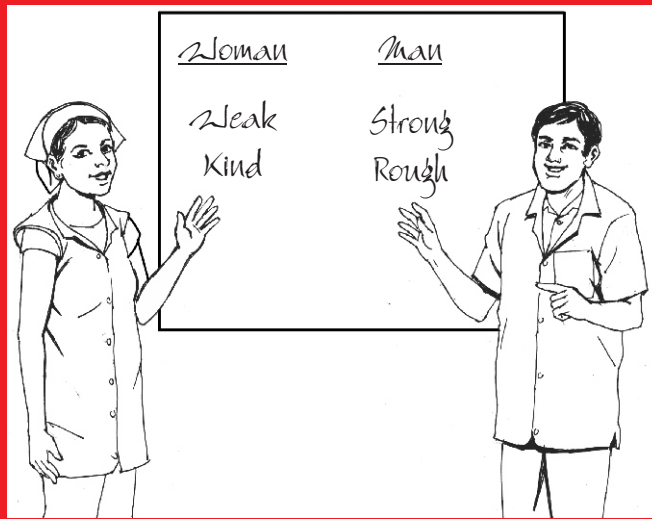
Session Objectives:

Objective	Expected Result
Differentiating between 'Gender' and 'Sex'.	Participants, - can differentiate between Gender and Sex. - are able to relate attitudes with the socialization process.
Developing awareness about Gender as a social construct.	- can explain three main roles: Productive, Reproductive and Community Management. - are aware about gender inequalities in general and inequalities specific to Sri Lankan social environment.



Overview:

Although the working environment of participants is similar, they are from different social backgrounds pertaining to different parts of the country. As such, it is likely that their cultural values, beliefs, attitudes and behaviour are varied from each other. This could influence their individual perspective of gender and related issues.



Time: 01:30 hrs



Materials:

Demy paper, permanent marker pens, picture of the Values, Attitudes and Behaviour Tree, pictures to highlight Aesop's fable of the Fox and the Stork, cartoon on equal opportunity, PowerPoint presentation on "Gender", flip chart with pictures of a man nursing a child



Activities:

- Inform that each participant is expected to think of a word that describes man and woman.
- Write the headings "Woman" and "Man" in a demy paper side by side and hang it on the reverse side of a white board or a flipchart. Ask participants to think of a single word each that expresses "Woman" and "Man" and write the two words under each heading written on the demy paper. Give blue pens to females and red pen to males. This is the exact opposite of traditional colour coding for males and females (pale blue and pink). Now, turn the board in order that participants can see what they have written. Give a maximum of 05 minutes for participants to comment. Next, strike off the heading "Woman" and write the word "Man" as the heading instead. Do the same to the heading "Man" also. Question participants whether the qualities expressed by words written to explain woman are not applicable to man also after the change of headings.

- Display a dummy paper with sex characteristics and gender characteristics written in a scramble. Invite participants to mark “g” for gender and “s” for sex. Next show them the accepted sex/gender matrix to compare. Explain the Productive, Reproductive and Community Management roles of either sex.
- Recap this with the picture of Values, Attitudes and Behaviour Tree, which represents values and norms (roots), institutions (trunk) and behaviour (crown).
- Emphasize that gender roles are learned behaviours. These roles condition women and men about the activities, tasks and responsibilities considered to be masculine and feminine. In meeting family needs, swapping of gender roles is required.
- Explain that a gender analysis of the roles and responsibilities of women and men in a given context (e.g. workers) enables ascertaining the existing gender imbalance.
- Use the cartoon to exemplify equal opportunity, which portrays a fox administering a test to a group of animals standing in a row that include a monkey, an elephant, a tiger, a buffalo, etc. with a view to selecting some animals out of the group. There is a tree in the background. The fox says: To ensure fair selection, you all get the same test. You all must climb that tree!
- Mention briefly the issue of transgender. Transgender is an umbrella term that applies to persons, who do not identify with the initial gender identity assigned to them at birth because of their sex. Transgender persons may express their genders in a variety of masculine, feminine and androgynous ways that often do not conform to norms and expectations traditionally associated with their sex at birth, and they often face high levels of discrimination and exclusion.
- Describe the instruments such as, The Constitution of Sri Lanka, ILO Conventions, Universal Declaration of Human Rights (UDHR), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the like, that establish equality.
- Discuss Sri Lankan socialization process and gender issues specific to different ethnic groups of Sri Lanka.
- Request participants to divide into two groups to brainstorm on gender discrimination at the workplace and in society. Give five minutes to list observed instances of discrimination. This should follow a discussion about the steps to overcome discrimination. Herein, pay attention to the following:
 - In society, inclusive of workplaces women and men are assigned responsibilities, tasks and activities according to their gender/sex.
 - Different values are ascribed to these different tasks.
 - The Gender Division of Labour varies from society to society and from one culture to another.
 - It changes over time due to changing social contexts.



Tips for Resource Persons:

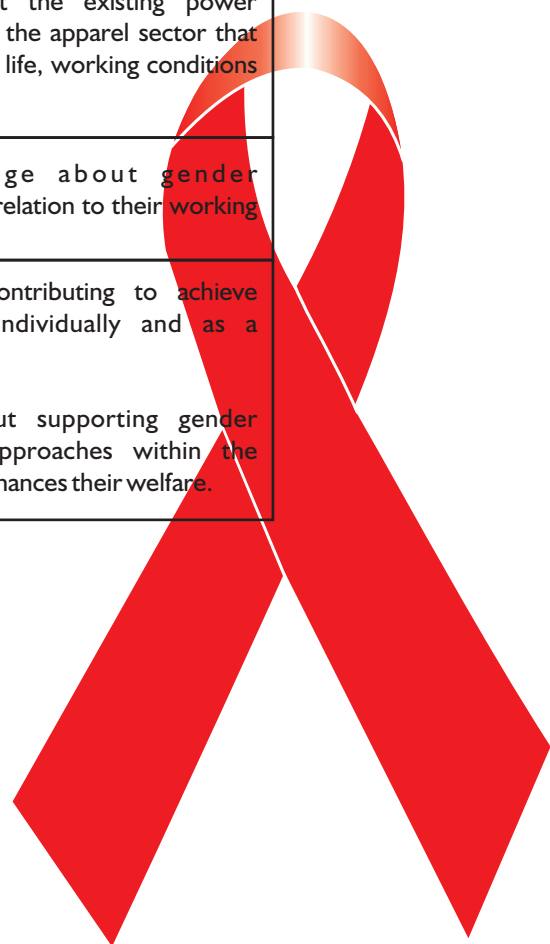
- Begin the session asking whether Sri Lankan society is “patriarchal” or “matriarchal”.
- When the colour of pens (that represent sex) is changed in the first exercise, there can be some comments and reluctance to accept that change. Participants would write words like beautiful, proud, weak, fashionable, cowardly etc. or names of birds and animals like peacock or even symbols to explain “Woman” and likewise words like strong, handsome, simple, fox, eel etc., to explain man. It can be shown that the words represent attitudes of society about either sex.
- If the group exercise is used, note that the symbols represent the attitudes. Those of the third sex should have the freedom to select the sex which they feel they belong to.
- Gender/Sex matrix can be shown using the PowerPoint presentation or using a flipchart paper with the matrix drawn on it. This is included in the reading materials.
- Make participants realize that roles attributed to males and females (gender roles) are observable in day to day life but average people do not attempt any classification of these. How gender roles are distributed between sexes is given in reading materials. Discuss disparities in this distribution that are disadvantageous to women.
- In the discussion about equity and equality, describe that equity is the process while equality is the product.
- Having distributed the drawing about the story of the Fox and the Stork after bringing groups together, get the participants explain what they get out of it. After considering a few responses, which reflect “Gender Equity and Gender Equality”, explain that equity need be maintained to reach equality, where disparities will be evened as far as possible.
- Remember that “tree” is the society where roots represent values and norms, trunk the institutions and branches the behaviour. Try to justify this simile.

Session 3

GENDER EMPOWERMENT AND MAINSTREAMING

Session Objectives:

Objective	Expected Result
Identifying the need for empowerment in general and in relation to the working environment in the apparel sector.	Participants, - know the need for empowerment of women to overcome power imbalances between females and males - are aware about the existing power imbalances within the apparel sector that affects their social life, working conditions and sexual life.
Identifying the role of gender mainstreaming to combat HIV infection at the workplace.	- gain knowledge about gender mainstreaming in relation to their working environment.
Focusing on skill development on empowerment and mainstreaming.	- gain skills on contributing to achieve empowerment individually and as a working group. - are aware about supporting gender mainstreaming approaches within the workplace that enhances their welfare.



Overview:

Women in Sri Lanka make sizeable contributions to Sri Lanka's economy. Working as migrant workers, labourers in export agriculture, and in garment factories, many women have made significant sacrifices in order to invest in the education of their children and the well being of their families and society.

When occupations both inside and outside the home are highly gender-determined (by sex, occupation etc.) women and girls are deprived of opportunity to develop and use their abilities to the full. Currently,

women's participation in the paid labour force is significant, although not evenly distributed, concentrated in professions such as nursing, teaching, export agriculture and garment industry.



Time: 01:15 hrs.



Materials:

Flipchart with models of empowerment, definitions etc.; PowerPoint presentation on “Gender”; demy paper, permanent marker pens, White/Blackboard, erasable markers and chalk



Activities:

- A role-play involving two women discussing about their predicaments due to lack of power to decide on their self employment ventures since their husbands and sometimes in-laws intervene.
- Relate this outcome to working situation in a discussion with participants.
- Recap the discussion with an introduction to the two concepts of empowerment of women and gender mainstreaming.

- Introduce simple means of making a gender analysis for gender responsive planning – especially of HIV prevention programmes. Also refer to gender blind, gender responsive and gender targeted programming.
- Divide participants into three groups and suggest to them to discuss what organizational changes are required to control HIV infection and safety of workers against HIV.
- Combine three outcomes and select salient steps that are practical.



Tips for Resource Persons:

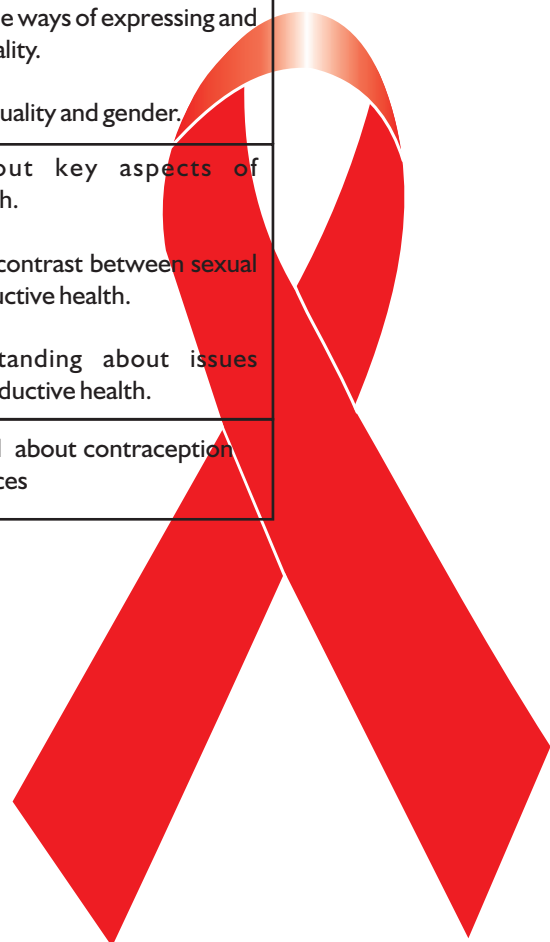
- Do not go to more detail than is necessary with these two concepts as too many facts could confuse the participants.
- Role play here is considering a scenario, which is external to the workplace environment. Involving the workplace can be sensitive to the management. However, the outcome of the role play could be related to a workplace, tactfully.
- Lay emphasis on safer sex.

Session 4

BASICS OF HUMAN SEXUALITY AND REPRODUCTIVE HEALTH

Session Objectives:

Objective	Expected Result
Introducing the basic concepts of human sexuality.	Participants, - know human sexuality from biological, cultural and social perspectives. - are aware about the ways of expressing and experiencing sexuality. - are clear about sexuality and gender.
Developing awareness about factors influencing sexuality and ways of expressing	- are aware about key aspects of reproductive health. - can compare and contrast between sexual health and reproductive health. - gain an understanding about issues surrounding reproductive health.
Developing awareness about contraception and safe health practices.	Awareness developed about contraception and safe health practices



Overview:

Sexuality is often seen through a gender perspective. Sexuality is distinct from gender but they are closely linked. An understanding of individual sexual behavior, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural, and economic forces that determine the distribution of power.

Knowledge of human reproduction is the basis for having healthy children, intimate relationships and happy families. Everybody has the right to reproductive health which ensures that each individual has access to safe, effective, affordable and acceptable methods of controlling fertility, access to appropriate health care

services that will enable women's safety during pregnancy and childbirth, and provides couples with the best chance of having a healthy infant.



Time: 01:30 hrs.



Materials:

Demy paper, permanent marker pens, flip chart, white board, outline drawings of a male and female drawn on demy paper, drawings of male and female genitals (external and internal), PowerPoint presentation or flipcharts on Human Sexuality, names of contraceptive methods written on pieces of hard paper, a PowerPoint presentation with diagrams of sex organs, reproductive process, specimens (contraceptive devices, materials, dildos)



Activities:

- Explain the aspects that are considered under human sexuality in brief. Differentiate between sexuality and gender.
- Emphasize characteristics of sex appeal and factors influencing sex urge.
- Use diagrams to discuss human sexual anatomy and their functions in relation to sex and reproduction. It is appropriate that participants are asked to explain the function of each part. Add only the missing facts.
- Ask if there is anything unnatural about different sexual orientations (masturbation, homosexuality, and heterosexuality). Emphasize that these are only means of appeasing the sex drive and each individual has the right to the preferred method. Get them to understand that diverse sexual preferences (not perversions) are a reality that cannot be challenged.
- Bring to focus the issue of masturbation and surrounding myths. Explain that masturbation is natural with many especially during adolescence, when one is growing in sexual inquisitiveness.
- Explain that sexual perversions are different from homosexuality, bisexuality or heterosexuality.
- Mention briefly that the multitude of publications that are available on newsstands near Export Promotion Zone do not cater to sex education.
- Define what reproductive health is. It is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.
- Discuss why reproductive health is important.
- Explain the reproductive cycle – puberty (physical and psychological changes of the body to enable reproduction), fertility, conception and gestation.
- Discuss in brief about abortion focusing on health, safety and legal implications.
- Explain the importance of ante-natal and post-natal care and services provided at Ante-natal Clinics (ANCs), Post-natal Clinics (PNCs), Well Woman Clinics and at the workplace.
- Begin this exercise by asking participants whether they are aware about contraception. Any married participants are likely to come up with what they know. Draw three concentric circles on the floor with chalk where innermost cycle is 1' in radius, next 2' and outermost 3'. Label the innermost "Most Effective", space between the innermost and the next "Effective" and space between the second and the outermost as "Less

Effective”; or the trainer can hatch the spaces with colour. Have names of contraceptive methods written on small cards and throw them up in order to make them fall on the circles. Ask the participants whether they agree with places where the cards have fallen. If they do not, invite them to make changes giving reasons for classifying them.

- Recap this with a discussion of advantages and disadvantages of specific methods. Pay attention to protection from unwanted pregnancies reminding the issue of teenage pregnancies now on the rise and its implications.
- Mention about the “morning after” pill in the event of an unplanned, casual sex encounter or rape. Emphasize that it is not a practice advised for repetition.
- Explain the objectives of family planning; i.e. assisting to overcome sub-fertility, delaying the first child and spacing births.
- Draw attention to personal hygiene in reproductive health.
- Recap with any questions answered.



Tips for Resource Persons:

- At the very outset, keep participants informed that certain things could be sensitive or embarrassing. Yet they are important to understand the relationship to HIV and sexuality. Also tell them that no personal issues, which could damage the dignity of any participant or his/her community should be highlighted and the purpose of the session is to clarify doubts for the benefit of everybody.
- Explain the social and biological risks associated with HIV. Individuals have a right to make their decisions on sexuality. Some individuals and some groups accept only sex between man and woman. Some cultures tolerate polyandry and polygamy.
- Do not add personal judgments to issues of sexuality. Try to emphasize that sexuality has a strong biological role and male and female bodies have evolved to enable that role. Also emphasize that a woman is not a sex toy and women can decide what they like to do with their bodies.
- Inform the participants not to write more than 10 – 12 words to define sexuality and tell them that they are not expected to give the exact definition. The responses could be biological, sociological or sometimes may not contain anything worthwhile.
- Based on the social, cultural and religious backgrounds, some might mention homosexuality as unnatural or bisexuality as unacceptable. Explain that none of these are unnatural. Also literary, historical and archaeological evidence prove that these practices existed in any society and has continued to exist.

- There are many myths about masturbation such as masturbation spoils sex life of marriage, produces erection and ejaculation problems, stuns the growth of the body, affects memory power, semen is a kind of “dhathu” that should not be wasted and so on.
- The exercise on reproduction is meant to remove any inhibitions in some of the participants.
- Effectiveness of contraceptives is given in a matrix. Refer reading materials. Mention success rates, advantages and disadvantages.
- It is advisable that you up-date your knowledge on reproductive health. You can seek information from medical services in the enterprise or from government public health services.

Session 5

BASICS OF HIV, AIDS AND STIs

Session Objectives:

Objective	Expected Result
Raising awareness on HIV and AIDS in particular and STIs in general.	While being able to differentiate between HIV and AIDS, participants can explain the mode of transmission, diagnostic process, window period, signs and symptoms of AIDS, treatment, prevention and myths surrounding HIV and AIDS. Participants, - are aware that Sri Lanka is highly vulnerable to the HIV infection; - are able to name most common STIs in Sri Lanka and their common signs and symptoms; - become knowledgeable about the sources for treatment, care and support and Post Exposure Prophylaxis (PEP) for HIV.
Drawing attention to the fact that STIs are a gateway to the transmission of HIV.	- are able to explain the reason for considering STI (s) as a gateway to HIV.
Instilling knowledge to enable understand HIV and AIDS from a gender perspective.	Participants, - are knowledgeable about basic biological aspects and sociological aspects of the relationship between gender and HIV and AIDS. - are able to list out reasons about the vulnerability of males and females to HIV. - are able to explain why females are more vulnerable. - are able to understand the reasons for feminization of the epidemic globally and locally. - become aware as to how gender issues at the workplace develop into sexual problems.



Overview:

Out of the estimated 33.3 million people living with HIV globally, in 2009, nearly 52 per cent were women (UNAIDS Report on the Global AIDS Epidemic 2010). While the ratio of women and men living with HIV remains stable globally, infection rates among women are rising in several countries as transmission patterns shift from high-risk groups to the general population, where more and more vulnerable women and girls are becoming infected. Women are more vulnerable to HIV due to biological, economic and social reasons. There are nearly 2.5 million children under 15 living with HIV and the number of children orphaned as deaths due AIDS continue to increase. In any country, the majority of individuals, who get infected, belong to the workforce thus threatening its economy. These statistics fluctuate with changing dimensions of the epidemic. Reader is reminded to obtain the latest statistics from www.unaids.org



Although Sri Lanka is a low prevalence country, many factors can lead to an acceleration of the epidemic. The cumulative number reported to be living with the infection in Sri Lanka since 1986 until end 2010 is about 1317. However, it is estimated that nearly 3000 people may be actually living with HIV.

Time: 01:30 hrs



Materials:

Demy paper; permanent marking pens, a PowerPoint presentation on HIV and AIDS with an introduction to common STIs in Sri Lanka, 04 cards with pictures of 02 women and 02 men, pictures of male and female genital anatomy (internal and external).



Activities:

- Use four pictures of individuals. See Tips for Trainers. Explain the pictures to the participants. Tell that one is HIV+.
- Give two minutes to identify, who has HIV out of them. Gather all the responses and make groups according to the answers.
- Allow 5 minutes to discuss further and give their reasons that justify the answer.
- If there is anybody, who wants to change the answer, allow that person to cross over to the relevant group. Ask for the reasons for changing the answer. These responses provide a base for the discussion to ensue.
- Commence discussion on HIV and AIDS building on their existing knowledge about HIV and AIDS. Present the meaning of acronyms, epidemiology (global and in Sri Lanka) of HIV, and explain the effects of HIV on the immune system.
- Make participants understand that HIV and AIDS are not the same.
- Explain the ways of HIV transmission. Use the Risk Chart to discuss transmission.
- Describe how HIV infection advances to AIDS and signs and symptoms of AIDS.
- Discuss about the methods of diagnosis, voluntary counselling, testing and where testing is available.
- Explain about the Window Period.
- Discuss about Anti Retroviral Therapy (ART), where it is obtainable and its importance in the prevention of mother to child transmission (PMTCT).
- Make aware of availability and the limitations of Post Exposure Prophylaxis (PEP) for accidental exposure to HIV
- Differentiate between risk and vulnerability related to HIV infection.
- Discuss the risk groups in Sri Lanka and ask if the participants or their peers are vulnerable. Recap with a PowerPoint or flipchart presentation.
- Present general facts regarding care and support required by people living with HIV and AIDS, barriers in general against the provision of care and support and barriers prevalent in Sri Lanka.
- Next discuss care and support for fellow workers, who are identified as HIV+ in the workplace.

- Request participants to name STIs they know and write them on a flip chart.
- Ask if they know the signs and symptoms of any and await responses.
- Explain STIs in general and most common infections specifically in Sri Lanka using the PowerPoint presentation or flipchart. Correct any wrong information they had. Answer any relevant questions that follow.
- Ask for reasons to not seeking early treatment. List the reasons given. Clarify the complications if timely, appropriate treatment is not obtained.
- Draw attention to the facilities available for testing and treatment of STDs (please see Annexure I).
- Explain that contracting one or more STI(s) increase the risk of getting infected with HIV.
- Discuss about the relationship between gender, HIV and AIDS. Explain that HIV and AIDS are linked to gender using the reasons given in reading materials.
- Discuss vulnerability of women and men to HIV infection and related risks. Draw attention to the fact that women are more vulnerable thus leading to feminization of the infection.



Tips for Resource Persons:

- Remember that time management is very important. Use less time (without leaving out important facts) as possible on STIs.
- Go through the flipchart or PowerPoint presentation ahead of the session and update your knowledge about common STIs.
- Many participants may fail to respond to questions about STIs and they may need prompting to provide answers.
- Be conscious that discussions beyond the scope of objective are possible due to the interest in the subject.
- Have four pictures ready and induce character to them. Use familiar names but avoid those of participants.

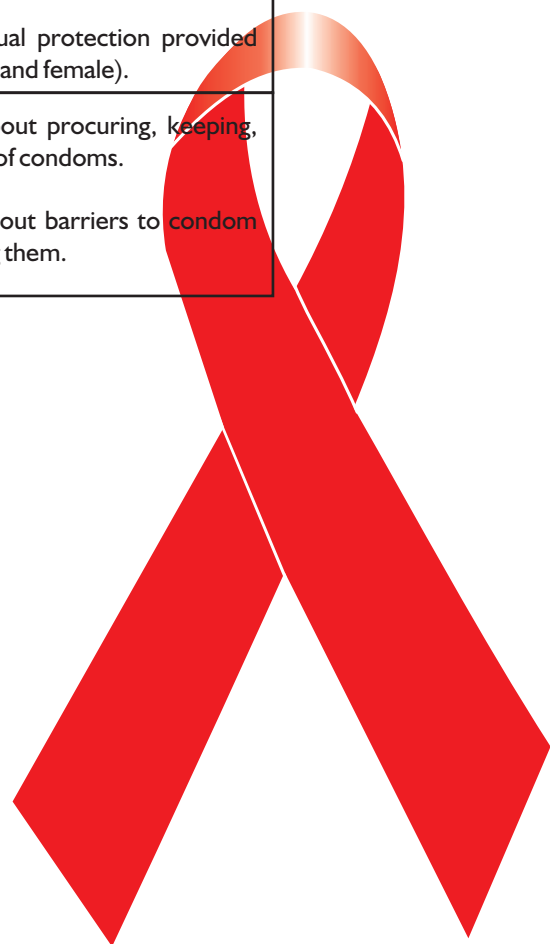
- *Saman is a 25 years old handsome youth employed as a technician in a factory. He visits his home once a month. In his village he is known as a carefree but dubious character. There are many stories afloat about his association with females.*
- *Priyani is about 23 years in age. She has a boyfriend in her village. She has changed her job twice now, each time to better prospects. Her present workplace is about 50 km away from her home and she is boarded near her workplace. Priyani's boyfriend is obsessed about this and suspects her now.*
- *Nandani is 35 years old and divorced. She has two children. In addition to alimony she receives, she gets piecemeal work from a tailoring shop. The owner of the tailoring shop, a man almost her age visits Nandani often.*
- *Fernando is a three wheeler driver operating from a vehicle park near a tourist hotel. He is used to drinking. He loves the company of his friends. His wife laments that he is not interested in her.*
- Refer reading materials for details about transmission of the infection.
- Discuss how the infection has progressed globally and locally. Both internal and external migration increases vulnerability to HIV.
- Discuss briefly regarding men having sex with me (MSM), sex trade and tourism in Sri Lanka and its relationship to spread of HIV infection.
- Remember that true and unreserved attitudes and knowledge of the group on HIV and AIDS would emerge during the session.

Session 6

PREVENTION OF STI/HIV AND CONDOM PROMOTION

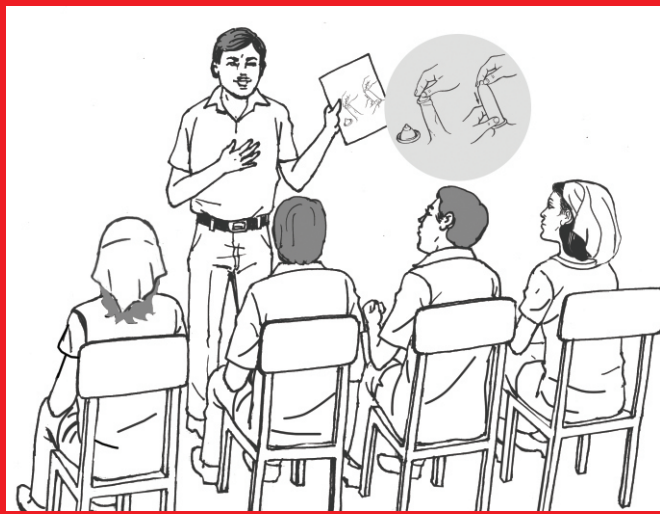
Session Objectives:

Objective	Expected Result
Developing knowledge about prevention of HIV and STIs.	Participants, - understand risky sexual behaviours in relation to transmission of HIV. - are knowledgeable about prevention of HIV. - understand the dual protection provided by condoms (male and female).
Developing knowledge and skills about using condoms for the prevention of HIV and STIs.	- knowledgeable about procuring, keeping, using and disposal of condoms. - knowledgeable about barriers to condom use and addressing them.



Overview:

There are challenges to the prevention activities against HIV infection. To date, a multitude of research has gained only limited success in finding a cure for HIV. As such, the education and the use of condoms are still in the forefront of prevention activities.



Time: 01:30 hours



Materials:

Demy paper, permanent marking pens, flip chart, white board, male and female condoms and dildos



Activities:

- Carry out the exercise on line up of risks. Different sex practices are written on cards and distributed among the participants. They are asked to rank the level of risk in the descending order after discussing among themselves. Thereafter, discuss to reach agreement if the order is correct. Sometimes, several corrections may be necessary.
- Discuss risk behaviour and challenges to prevention.
- Discuss the concept of safe sex and dual protection for the prevention of HIV infection and STIs.
- Discuss methods of prevention of HIV.
- Get the participants to respond to a quiz on condoms. The quiz is given with handouts for Session 5.
- Discuss about different kinds of condoms. Explain the advantages of using condoms and barriers to using them and about overcoming such barriers.

- Explain how these could be obtained and kept in possession (or stored), their use and proper disposal after use.
- Demonstrate how a condom should be worn properly and removed, using a dildo and condoms or flipchart (for female condoms). Also mention about the proper disposal after use.
- Ask participants to repeat the demonstration about correct use and removal.



Tips for Resource Persons:

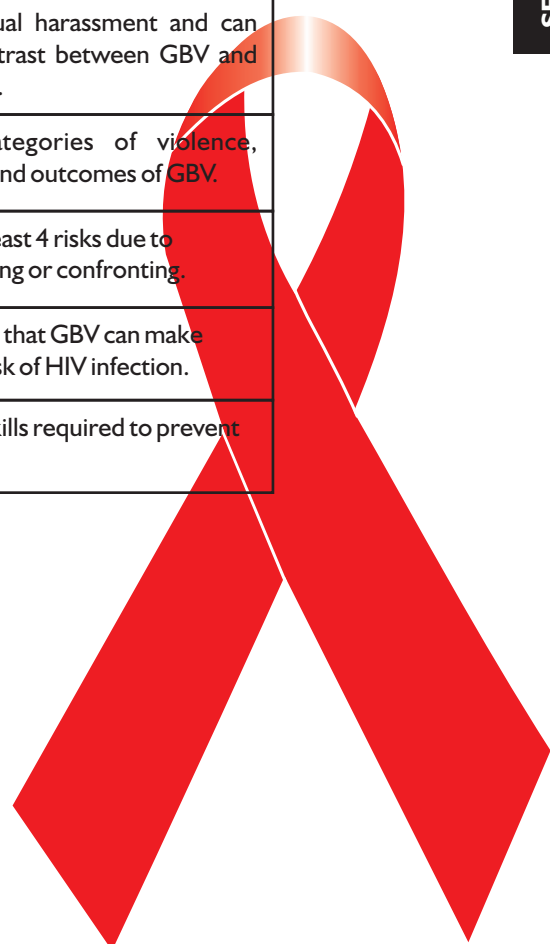
- Dual protection is a strategy to reducing risk of pregnancy and contracting sexually transmitted infections. It can be achieved by consistent use of condoms alone, both with other birth control method or by avoidance of penetrative sex.
- Ensure that dildos and male and female condoms are made available for practice of correct condom use. During the intervals, the participants can practice further.

Session 7

ADDRESSING GENDER BASED VIOLENCE AT HOME, SOCIETY AND THE WORKPLACE

Session Objectives:

Objective	Expected Result
Developing awareness about Gender Based Violence (GBV) at home/society and workplace.	Participants are : - aware about gender based violence taking place at home, society or workplace; - aware about sexual harassment and can compare and contrast between GBV and sexual harassment.
Enabling participants identify types of GBV.	- aware about categories of violence, common feelings and outcomes of GBV.
Identifying risks associated with workplace/casual sexual relationships.	- able to explain at least 4 risks due to declining, consenting or confronting.
Becoming aware of the relationship between GBV and HIV.	- able to understand that GBV can make women more at risk of HIV infection.
Empowering participants to take preventive measures against GBV.	- aware about the skills required to prevent GBV situations.



Overview:

Violence against women is a menacing social issue that plays a major role in increasing the risk of HIV infection among women. Women are more biologically vulnerable to HIV than men. Studies have shown that the risk of becoming infected with HIV during unprotected vaginal intercourse is higher for women than men. Semen has higher concentrations of HIV than women's vaginal secretions, and women have a larger surface area of mucosa exposed during sexual intercourse. In violent or forced-sex situations, forced penetration can cause abrasions that allow easy entry of HIV. This is especially true for young girls who are physiologically immature have even less of a barrier against HIV than mature women.



Fear of violence keeps some women from insisting on condom use. Fear of violence also keeps some women from seeking treatment. Women may delay being tested for HIV or fail to return for the results because they are afraid that sharing their HIV-positive status may result in physical violence.

Time: 01:30 hrs



Materials:

Demy paper; permanent marking pens; flip chart; white board; PowerPoint presentation / flipchart about women's rights



Activities:

- Divide the group into three and give the following case studies and ask the groups to identify and list the instances of Gender Based Violence (GBV) and sexual harassment with reasons. Invite groups to present. Leave presentation open for discussion for about 5 – 10 minutes.

Case Study 1

- Muktha, a pleasant young woman about 22 years of age, works in a factory with a majority of women workers. All of her friends appreciate her for being a sociable and humble person. One person in supervisory management expresses his ambition to start an affair, which she declines. This annoys him beyond measure. There are threats to take revenge indicating possible rape or dismissal from work. She is being scolded for the slightest delay, blamed for poor quality of finished work (whereas she is a very diligent worker), which agonizes her and causes immense mental pain. Although she has been praised several times as a committed and skilled worker, this situation prevents her from getting promoted as a line supervisor.

Case Study 2

- Suchara elopes with a native physician's helper, whom she meets during her visits to the physician for treatment. Their whereabouts were not known for sometime because the couple may have lived in some distant place. She returns to her boyfriend's place with him after a few weeks. She finds that her boyfriend's home is a crowded place with very poor facilities. The boy's father, who is the sole breadwinner, is a toddy tapper with no capacity to spend on improvements to the house. She suggests renting a house, but the boy rejects the idea being unable to afford it. Her repeated suggestions annoy the boyfriend, who assaults her. The boyfriend knows that she is discarded by her family owing to a cast problem. He takes advantage of this fact. In the meantime she conceives and husband induces an illegal abortion through a party known to him. She develops a depression for which no proper treatment was given.
- Explain what is meant by GBV, different forms of GBV and what sexual harassment is.
- Differentiate GBV in family, society and workplace in the Sri Lankan context. Pay attention to issues of dowry, ownership of property, forced marriages and prevention of marriages outside religious/ethnic/cast groups, harassment, intimidation, trafficking and the like that are present in Sri Lankan society.
- Draw attention to the relationship between GBV and HIV
- Draw the attention of participants to the persons and institutions, who can help.
- Involve participants to discuss preventive measures for GBV and sexual harassment in the family, society and workplace. This can be done as a group exercise as well by

the participants in three groups. After culling responses from participants expose them to the following facts.

- Mention about the legal instruments that preserve women's rights (Relevant clauses of the Constitution of Sri Lanka, Household Violence Act, CEDAW, Universal Declaration of Human Rights, Gender Focal Points, Police, and NGOs specializing on women's rights such as Centre for Women's Research (CENWOR), Women in Need (WIN) or similar Organisations.)



Tips for Resource Persons:

- Definition of GBV: Physical, mental or social abuse (including sexual violence,) which is directed against a person because of his or her sex or gender role in society or culture.
- Use the charts on GBV given in reading materials to explain types of violence. These can be written on a flipchart.
- Some useful definitions are given below:

Incest: sexual relations between blood-related persons (such as sex between father and daughter, father and son, mother and son, brother and sister, brother and brother or similar sexual relations.)

Rape: the use of physical force or threat in order to obtain sexual relations with penetration (vaginal and/or anal), i.e. sexual intercourse taking place without the other persons consent.

Sexual exploitation: taking advantage of, or involving in, the sexual satisfaction of adults, including activities such as child prostitution, pornography, trafficking, paedophilia, and sexual blackmail.

Sexual harassment: is manifested through indecent proposals, obscene words and pressure to have sexual relations, which are unwelcome, unwanted, marginal, verbal or non-verbal acts of a sexual nature.

Sexual violence: pressuring or forcing someone to perform sexual acts (can range from kissing to penetrative sex) against their will or making sexual comments that make someone feel humiliated or uncomfortable. It does not matter if there has been prior consenting sexual behavior between the individuals.

Emotional violence: is often the most difficult form of violence to identify. It is manifested through insults, humiliations, threats, lack of affection, etc. The consequences for men and women may be low self-esteem, distrust and emotional insecurity.

Physical violence:

Physical violence: is violence, which is expressed through punching, kicking, shoving and other acts which can provoke injury, endangering the health of a man or woman.

- Provide information on what to do and where to seek support if gender based violence is experienced, including information and contact details about of organizations such as Sri Lanka Sumithrayo, Women in Need or similar Organizations that offer advisory services to those affected to overcome distress. Also mention that Post Exposure Prophylaxis (PEP) can be obtained from National STI Clinics (Refer annexure 2)
- It is advisable to have a basic knowledge about the legal instruments in order to sensitize the participants regarding where they could reach, if a need arises.

Session 8

STIGMA AND DISCRIMINATION

Session Objectives:

Objective	Expected Result
Drawing attention to counteracting stigma and discrimination related to HIV and AIDS.	Participants, - understand the nature of stigma and discrimination surrounding persons living with HIV. - realize that stigma and discrimination and the threat of job loss experienced by persons living with HIV are barriers to knowing one's HIV status. - Understand how it increases vulnerability to HIV. - become aware of legal instruments available to counteract stigma and discrimination in the workplace.
Emphasizing the need for care and support to HIV and AIDS affected persons.	- become aware of the care and support they could give to enable persons living with HIV to lead a healthy life with dignity.

Overview:

AIDS related stigma and discrimination refer to prejudice, negative attitudes, abuse and maltreatment directed at persons living with HIV. They can result in being shunned by family, peers, employers', co-workers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of testing and treatment. Together, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. They discourage governments from acknowledging or taking timely action against AIDS. They deter individuals from finding out about their HIV status.



Time: 01:00 hour



Materials:

Demy paper, permanent marking pens, flip chart, white board, video, power point presentation or a flipchart with necessary information for the session



Activities:

- Show a video of a person/s living with HIV sharing his/her story to prepare the environment for the session.
- Request participants to recollect any direct experience or anything they have read or heard regarding stigma.
- Play the following game:

- Ask participants to stand in a circle. Make them assume that they are a group of workers, who have undergone a HIV screening test. Tell them that the laboratory has sent the results, which will be made known.
- Have a number of small chits equivalent to the number of participants ready, of which some are marked with “+” and others with “-” and folded in double. Those marked “+” need to be around 1/4th of the number in the group.
- Now distribute the chits among the participants after shuffling them in a box.
- Request participants to open what they have picked. Inform that those with “+” are HIV positive.
- Get each “positive” one to explain the feelings he/she had immediately as he/she saw the result even though this is a contrived situation.
- Using the outcome of the exercise conduct a short discussion about stigma and discrimination attached to HIV and AIDS. Widely accepted reasons for stigma given in reading materials can be used here. Also explain the possible consequences.
- Explain the settings, where those living with HIV and AIDS are discriminated against, such as, e.g., family, workplace, community, school, health care etc. Use information in the handout.
- Emphasize that stigma and discrimination needs elimination. Human rights in general and workers rights in particular should be safeguarded. The ILO Code of Practice on HIV/AIDS and the world of work, the Recommendation concerning HIV and AIDS and the World of Work, 2010, (No. 200) and the Sri Lanka National Policy on HIV and AIDS in the World of Work are key instruments that address workplace discrimination.
- Discuss the levels of care and support required and what is available for the affected persons in Sri Lanka.



Tips for Resource Persons:

- Factors that contribute to HIV and AIDS-related stigma are included in the handout.
- Research by the International Centre for Research on Women (ICRW) found the possible consequences of HIV-related stigma to be:
 - Loss of income/livelihood.
 - Loss of marriage and childbearing options.
 - Poor care within the health sector.

- 
- Withdrawal of care given at home.
 - Loss of hope & feelings of worthlessness.
 - Loss of reputation.
 - Blame.
 - Care of persons living with AIDS.
 - Discuss the disadvantaged position of women such as, having to bear the burden of a family, being blamed (where men are excused) for getting infected, unfavourable social environment that prevents women from seeking treatment.
 - Discuss the impact of HIV and AIDS on children. (no. living with HIV, no. orphaned and child labour issues).
 - Use the chart given in the handout to summarize the needs for care and support.
 - Attention is drawn to the Session 9 regarding workplace action for eliminating stigma and discrimination

Session 9

INTEGRATING HIV AND AIDS EDUCATION IN TO WORKPLACE PROGRAMMES

Session Objectives:

Objective	Expected Result
Analyzing the existing HIV and AIDS programmes/ services for workers.	If HIV and AIDS workplace programmes are available, participants will find strengths and weaknesses of the programme from a gender perspective and suggest modifications. If unavailable, they will make suggestions for a future programme.
Emphasizing the ILO Recommendation 200, the Code of Practice on HIV and AIDS and the Sri Lanka National Policy on HIV and AIDS in the world of work.	Participants know the purpose and key areas of ILO Code of Practice and other instruments and Policies and use them for developing a workplace HIV and AIDS education programme.



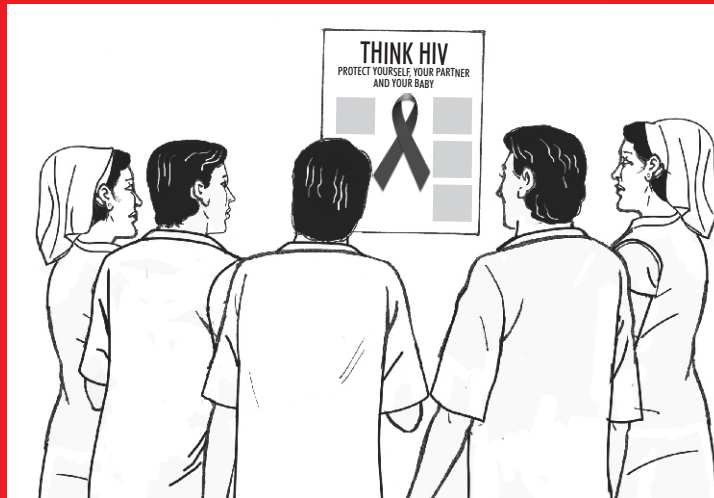
Overview:

A majority of people living with HIV worldwide are working and are in their most productive years. They generate much-needed income to support their families, and their skills and experience make a massive contribution to their workplace and the try. However, despite major advances in attitudes and knowledge about HIV, many women and men workers still face discrimination, stigma and fear of losing their job. The workplace can be one of the most effective settings for responding to HIV as it is a community where people come together to discuss and learn from one another. Existing structures and facilities

such as occupational health services can also be used for HIV prevention, care and support services.

The ILO Code of Practice (CoP) on HIV/AIDS and the world of work, the Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200) and the Sri Lanka National Policy on HIV and AIDS in the World of Work provides a framework for action related to the workplace,

contains principles for policy development and practical guidelines for programmes at enterprise, community and national levels with particular emphasis on the prevention of HIV, management and mitigation of the impact of HIV and AIDS on the world of work, care and support of workers infected and affected by HIV and AIDS and elimination of stigma and discrimination on the basis of real or perceived HIV status.



Time: 01:45 hrs



Materials:

Demy paper, permanent marking pens, flip chart, white board, ILO Code of Practice for HIV/AIDS and Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200), copy of the Sri Lanka National Policy on HIV and AIDS in the World of Work



Activities:

- Discuss as to why HIV and AIDS are workplace issues and how it affects workers (from a gender perspective). Having noted the responses, rectify any wrong impressions in a short discussion.
- Inquire from the participants about any HIV and AIDS programmes linked to workplace committees in their workplaces and policies that create an enabling environment. Ask about any corporate social responsibility (CSR) activities of the enterprise. Record responses on the white board and assess the gender participation.
- Introduce the 10 key principles of the ILO Code of Practice and components of a workplace HIV programme. (See reading materials.)
- Draw attention to the ILO Recommendation 200, the Sri Lanka National Policy on HIV and AIDS and the world of work
- Discuss the features of a peer education programme: how a peer education programme could be established at the workplace, how peer educators could be selected, the characteristics of a peer educator to be considered in selecting, and common problems encountered in selecting peer educators.
- Call for ideas about activities that can be included in a workplace HIV and AIDS education programme or to enrich an existing one. Draw upon the skills of participants.
- Emphasize the need for monitoring and evaluation of workplace HIV and AIDS education programmes. A monitoring tool is introduced.

Involve participants to develop a HIV prevention programme with particular focus on gender issues for implementation in their workplaces. Suggest to them to be innovative as far as possible and to design it in a manner that does not interrupt production schedules. They can work in random groups or having grouped according to their workplaces.



Tips for Resource Persons:

- HIV and AIDS are workplace issues because of the impact on workers due to loss of income and employee benefits, stigma and discrimination and pressure on families and the problem of orphans, child labour etc.
- Encourage the participants to integrate gender in workplace HIV prevention programmes.
- The ILO Code of Practice, the Recommendation 200 and the National Policy on HIV and AIDS in the world of work considers HIV and AIDS as a workplace issue and that there should not be discrimination and dismissal based on a person's HIV status. It advocates maintaining confidentiality, providing care and support, establishing a social dialogue, gender equality, no screening for purpose of recruitment, training, promotions and maintaining a healthy working environment. It also emphasize that “health” is not only being treated for diseases but a state of physical, mental and social well-being. The key components are given in the reading materials.
- Through the programme to be designed, try to promote safe sex and empowerment of both women and men to reduce transmission of HIV and STI.

Session 10

BEHAVIOUR CHANGE COMMUNICATION (BCC)

Session Objectives:

Objective	Expected Result
Developing knowledge of the basics of communication.	Participants will, - be able mention components of the communication model.
Developing awareness on BCC.	- be able to define BCC and its role.
Generating inspiration out of documented experiences on BCC.	- learn from the experiences of others. - develop their skills in message design.
Guiding participants to engage in a productive discussion to find ways and means to exercise BCC efforts in their workplace.	- be able to prepare a list of ways to exercise a BCC campaign at their workplace.
Enhancing understanding about peer education.	- be able to prepare a list to show how peer educators could be used.

Overview:

Behaviour change communication (BCC) is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviours. BCC has evolved from information, education and communication (IEC) programmes to promote more tailored messages, greater dialogue and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behaviour change programs to ensure sustainable change in attitudes and behaviour.



Time: 01:45hrs



Materials:

Demy paper, permanent marking pens, flip chart, white board, a power point presentation on BCC, video on a BCC experience



Activities:

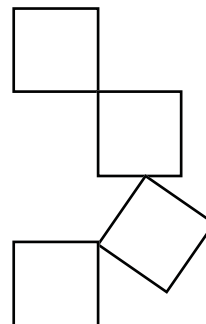
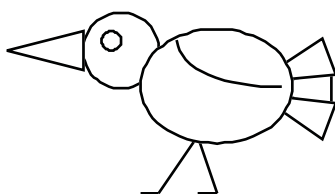
- Begin the session with an exercise involving the whole group to prove that different people perceive a single message in several different ways. Resource person describes a simple picture requesting participants to respond or displays a picture and ask participants to explain. At the end they compare resource person's version of explanation with their versions. Explain the reasons and introduce components of a communication model.
- Inquire if the participants know how a behaviour change would take place and sum up responses. Present the behaviour change model. Creative messages are capable of generating motivation.

- Explain definition of Behaviour Change Communication and what BCC can achieve. Also stages of individual behaviour adoption.
- Divide participants to four groups and ask them to develop messages about safe sex. Explain that effective messages: command attention; are clearly stated; communicate a benefit; are consistently repeated; reach the heart and the head; create trust; and call for action.
- Invite groups to present and assess through constructive criticism as to how effective the messages are. One example is given under the Tips for Resource Persons below. They can compare with what they witnessed in the video.
- Discuss about the delivery of messages and use of media for this purpose. Provide examples.
- Engage the participants in a productive discussion to find ways and means to exercise BCC efforts in their workplaces.
- Explain the role of peer educators at the workplace for results oriented, sustainable and cost effective BCC.
- Discuss good qualities of peer educators and process of selection of peer educators for behaviour change communication.



Tips for Resource Persons:

- Explain a picture of a bird or 4 -5 squares drawn in some random order. Have these ready beforehand. For example:



- Behaviour Change Communication (BCC) is an interactive process that helps develop tailored messages and approaches with communities using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and social behaviour change; and maintain appropriate behaviours. (ILO/FHI Toolkit for workplaces)
- Results that can be generated by effective behaviour change communication are given in the Handout 10

Session 11

DEVELOPING PROGRAMMING AND TRAINING SKILLS

Session Objectives:

Objective	Expected Result
Presentation of peer education programme plan by participants.	Strengths and weaknesses are assessed with consensus from the whole group. One single programme is structured out of individual presentations. Necessary training aids are identified.
Developing training skills for integrating HIV education in the workplace.	Participants gain practical experience on training methodology.



Overview:

Peer education is a widely used tool in the response to HIV and typically involves training and supporting members of a given group to effect change among members of the same group. Among the advantages of peer education is the ability to access people infected with HIV or vulnerable to the infection. This access is both physical and socio-cultural (UNAIDS 1999), with peer educators able to communicate effectively because they understand the language and patterns of communication of those whom they seek to influence. Small groups selected at random or according to workplaces are able to design individual programmes, the content of which can be shared with each other to streamline into a single programme.



Time: 01:30 hours



Activities:

- The participants hand in the programmes designed by them according to the instructions provided during the previous session. One programme is randomly selected and discussed. Invite suggestions to improve the one discussed.
- Request others to examine their work plans and note suitable changes. Draw their attention to see if their plans comply with the settings prevailing in respective institutions.
- Encourage them to raise questions to clear their doubts.
- Give an overview of training methods and involve participants in a lecture discussion, role play and a small group discussion. Carry out one demonstration each for each method and invite peer trainers' views.
- Compare and contrast training methods briefly with the methods of interpersonal communication. The focus should be on the application of communication methods in training.

- Make decisions on training aids depending on the resources available in respective enterprises.



Tips for Resource Persons:

- Electronic hardware such as multimedia may not be available at all the participating enterprises. As such, peer trainers should be asked to use graphic media provided with the module.
- Peer trainers would find it convenient if arrangements are made to provide them further guidance where required especially when they encounter problems during the implementation of their programmes. This is possible over the telephone and all peer trainers may not require such assistance.
- It may not be possible to conduct the training programme at a stretch for two days. Under such circumstances, the resource person has to see if peer trainers have organized to impart training by dividing the programme into several parts consisting two or three sessions at a time. It is important to recap the sessions in the previous parts to maintain continuity, at the beginning of each part. For this 15 - 20 minutes may be sufficient.
- Note the details in the handout.

Session 12

FINAL SESSION

Session Objectives:

Objective	Expected Result
Conducting Post-test and workshop evaluation	Ascertainment of the knowledge gained by participants from the whole programme. Decisions made on implementing the designed programme in respective enterprises.



Overview:

The participants reminisce on the sessions preceded. They are made to be mindful about the voluntary commitment expected of them for the welfare of their peers. A feedback is given about what they have gained from the programme.



Time: 01:00 hours



Materials:

Post-test questionnaire



Activities:

- Sum up the whole programme and administer the post-test.
- A short address by a representative of the management.
- A participant proposes the vote of thanks.



Tips for Resource Persons:

- Any further guidance to peer trainers can be provided during the course of this session.

HANDOUTS

Session 2: Handout A Basic Concepts of Gender and Sex

Gender:

refers to the socially constructed roles and relations between women and men, girls and boys in a given society. These come with a set of beliefs, expectations, symbols and institutional arrangements around female and male “identities” and expected behaviours. Gender roles and relations change over time, and there are wide variations both within and between age groups, socio-economic classes, races, religions, societies and cultures. Gender relations are also relations of power which affect who can access and control resources. These relations have an effect on every aspect of education, employment, working conditions, social protection, representation and voice at work.

- Social/Cultural
- Learned through socialization
- Therefore, can be changed
e.g. women and men can work as teachers, doctors, engineers, etc
e.g. women and men can take care of children, the elderly, etc.

Sex:

refers to characteristics of women and men that are biological and universal

- Biological
- Given by birth
- Therefore, cannot be changed

e.g. only women can give birth and only men can impregnate.

Gender Roles – Who does what?

- By mapping the gender division of labour, we can identify the different gender roles of women and men.

- They are about the way resources are allocated and about the way men and women are valued in a given society.
- Gender relations are context-specific – They vary overtime and between different groups of people
- They vary according to other social relations such as class, ethnicity, area, disability and the like.

Gender Roles	Women	Men
Productive roles and responsibilities	Manual, professional labour, remuneration. Subsidiary activities: Part-time, casual, producing for consumption and sale.	Economic, employment, earn a living remuneration, manual labour, professional, subsidiary work, part-time, casual but they are identified in relation to these roles.
Reproductive roles	Bearing, nurturing and rearing children, cooking, cleaning other household work.	Family security/protection- personnel and property, travelling, breadwinner of the family.
Community Roles	Ceremonies, religious work, maintaining kinship and good relations with neighbours, social interactions, share and care activities.	Public roles, powerful positions- management and control, decision making, external links and community work, political activism.

Gender Equity

- The process of being fair to women and men. Equity measures are strategies to achieve gender equality. Equity measures compensate for historical, economic and/or social disadvantages of groups which prevent a level playing field. They may include equal treatment or treatment that is different because it responds to different needs and interests but is considered equivalent in terms of rights, benefits, obligations and opportunities.

Gender Equality

- The equal value given by society to both the similarities and differences between women and men and the varying roles they play.
- Women and men should enjoy the same status, have equal conditions to realize their full human rights and develop their full potential. They should be free to make choices about their behaviour and aspirations, and define their needs
- They should be able to contribute to national political, economic, social and cultural development and to benefit from the results.

- Because of existing social conditions, the position and status of men and women are different – therefore, different treatment of women and men is necessary. This means
- Gender equality in the world of work means equality of opportunity and treatment, equality of remuneration, equal access to safe and healthy working environments, equality in association and collective bargaining, equality in obtaining meaningful career development, maternity protection, and balance between work and home life that is fair to both women and men.

Gender Balance

- Gender Roles are learned behaviours in a society and conditions women and men about the activities, tasks and responsibilities considered to be masculine and feminine.
- Analyzing the roles of women and men in a given context shows the existing gender imbalance in society, is caused by:
 - The Gender Division of Labour for Productive & Reproductive activities
 - Gender stereotypes
 - Women's subordination

Session 2: Handout B

Instruments that establish gender equality

International Labour Organization (ILO) Convention C 111: Discrimination (Employment and Occupation) 1958

- Defines discrimination.
- Promotes equality of opportunity and treatment in employment and occupation.
- Suggests member countries to devise methods to eliminate discrimination.

Universal Declaration of Human Rights (UDHR) : Article 23 – Right to Work under Favourable Conditions.

- (1) Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
- (2) Everyone, without any discrimination, has the right to equal pay for equal work.
- (3) Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
- (4) Everyone has the right to form and to join trade unions for the protection of his interests.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

- Art. 1 - Discrimination.
- Art 2-6 - Member States' duty to create laws, regulations to ensure gender equality.
- Art 7 - Political participation.
- Art 8 - Represent country at international level.
- Art 10 - Right to education, continuing education.
- Art 11 - Right to:
 - employment
 - work
 - same salary
 - same opportunity
 - choose profession
 - retirement & job security
 - health provisions
 - maternity, childbirth

NATIONAL LAW

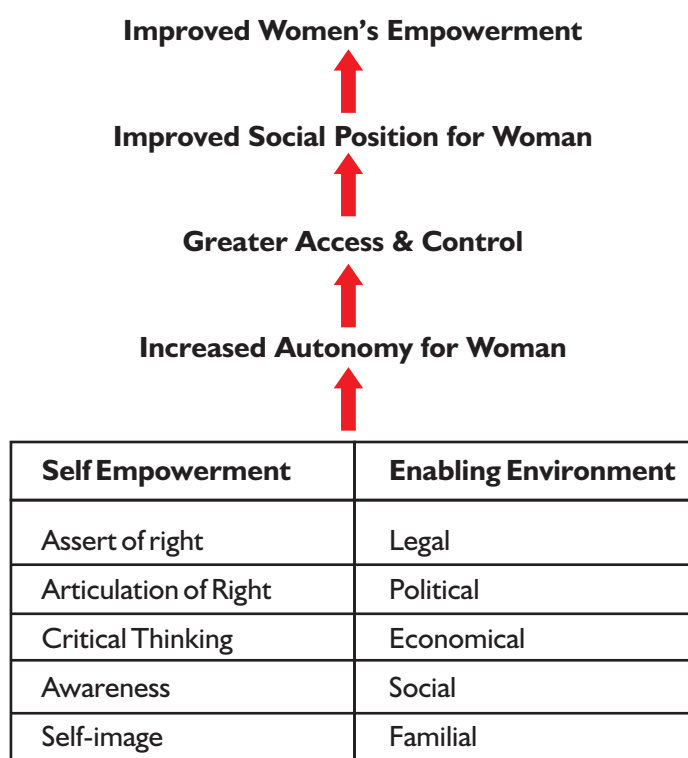
- Constitution of Sri Lanka.
- Shop and Office Act.
- Wages Boards Ordinance.
- Factories Ordinance.
- Employment of Women, Young Persons and Children Act.
- Penal Code -Sexual Harassment

Session 3: Handout

Women's empowerment

Empowering women means supporting a process by which women and men become aware of their unequal power relationships and are provided with the information and skills to speak out against inequality in their homes, communities and workplaces. This process also implies promoting change in the socio-economic conditions that often subordinate women to men. Moreover, it means helping men become aware of the benefits of gender equality for their families, communities, businesses and national economies. Meaningful participation in formal decision-making structures (such as governments, employers' organizations and trade unions) is seen as a key aspect of their empowerment, as are the development of life skills to help them assert their rights.

Equality & Empowerment



Gender Mainstreaming

- Background
 - During the UN Women's Decade – the Women in Development (WID) approach was adopted to deal with the unequal relations between women and men in the family, in economic activities and in society.

- This approach aimed to give women economic independence.
 - It 'added' women to existing development processes and activities.
 - It did not lead to fundamental changes in the role and position of women.
- The critique of the WID approach led to the development of the Gender and Development (GAD) approach.
 - Gender – 'feminine' and masculine' – was seen as the socially defined roles for women and men.
 - Gender subordination was identified as the key issue in this approach, which addresses the situations of both women and men in society.
 - Gender subordination meant an unequal situation between women and men.
 - Since the mid-1980s, 'mainstreaming' has been the strategy to address problems of gender inequality.

Definitions

- “Taking account of gender equality concerns in all policy, programme, administrative and financial activities and in organizational procedures, thereby contributing to a profound organizational transformation” UNDP [1998].
- “Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies, programmes, in any area and at all levels. ECOSOC [1997].
- It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of the policies and programmes in all political, economic and societal spheres so that women and men benefit equally, and inequality is not perpetuated.
- “The ultimate goal is to achieve gender equality.”

Gender analysis and planning

Gender analysis is a tool to identify the specific needs and concerns of women and men, girls and boys regarding their specific conditions, needs, access to/control over resources, attitudes and activities, and their access to development benefits and decision-making. It studies the links between these and other factors in the larger social, economic, political and environmental context.

- gender analysis is the first step in gender-responsive strategic and development planning. It entails:

- collecting sex-disaggregated data and information about the population being addressed;
- identifying the sexual division of labour (that is, the division of reproductive tasks such as preparing food and cleaning in the home between women and men and access to/control over productive resources and benefits by women and men respectively);
- understanding the practical and strategic needs;
- reviewing capacities of relevant organizations to mainstream gender in order to promote gender equality

Gender planning may be broadly defined as planning that is based on this analysis, integrating → gender equality and → women's empowerment aims, into all stages of the design, implementation, monitoring and evaluation of a programme or project. This includes the setting of goals and objectives, the definition of strategies and indicators, the selection of methodologies and tools for integrating a gender perspective, gender-related activities and the allocation of resources to carry them out.

Through an initial gender analysis and needs assessment, you may find the need for →gender-targeted action (targeting women and/or men separately or together) which will then be operationalized through gender planning. In any case, the first step for a →gender responsive project is always to undertake a gender analysis.

Session 4: Handout

Basics of Human Sexuality

Human sexuality is how people experience the erotic and express themselves as sexual beings. Frequently driven by the desire for sexual pleasure, human sexuality has biological, physical, and emotional aspects.

Biologically, it refers to the reproductive mechanism as well as the basic biological drive that exists in all species and can encompass sexual intercourse and sexual contact in all its forms. It is a powerful source to bring people together. Emotional aspects deal with the intense emotions relating to sexual acts and associated social bonds. Physical issues around sexuality range from purely medical considerations to concerns about the physiological or even psychological and sociological aspects of sexual behaviour.

Therefore, human sexuality includes:

- Human body and reproductive anatomy.
- Biological sex – male, female or intersex.
- Gender – girl, boy, woman, man or transgender (Transgender person -these are persons, who physically are of one sex i.e. female or male but psychologically feel themselves to be of the opposite sex. In other words, it's a woman inside a man's body or a man inside a woman's body. The difference between the psychological and physical states causes stress. Intense psychotherapy and surgery to change the physical appearance to match the psychological state may bring relief to such persons.)

Transvestite – this is a person (woman or man,) who enjoys dressing up in clothes of the opposite sex. (There is no wish to change the sexual orientation.)

- Gender identities – feelings about gender.
- Sexual orientations – homosexual, heterosexual, bisexual.
- Sex drives – desire to have sex as well as different aspects of sex arousal.
- Sexual identity – how individuals identify their own sexual characteristics. This is different from sexual orientation but closely related to sexual behaviour.
- *Sexual health* is an important part of sexuality. Positive sexual health means not only being free of disease, but also being able to enjoy sex that is safe, pleasurable, and free of violence. The use of violence during sex, for example, in rape causes injury and bleeding that increases the risk of being infected with HIV.
- The sexual choices a person makes will determine whether or not he or she is sexually healthy or at risk of sex-based problems such as HIV, STI, rape, unwanted pregnancy, and abortion, among others.

Sex appeal

Sexual attractiveness or sex appeal refers to a person's ability to attract in a sexual or erotic manner the interest of another person. The attraction may be to a physical quality of a person, or to any other, more amoral qualities of that person.

About sexual feelings

The sex hormones may cause one to have sexual feelings. Sometimes they make one feel sexy. A young person may begin to explore parts of her/his body that give these feelings when touched, especially the genital area.

Sometimes an individual may have a crush on somebody. 'Crushes' are when an individual finds that s/he is thinking about somebody most of her/his time and s/he may even believe that s/he is 'in love' with her or him. A crush could be -

- between a boy and a girl
- on someone known of the same or opposite sex
- a really strong feeling about a movie star or pop star
- with somebody in the class or school; may even be a teacher or with somebody in one's family

Sexual perversions

Perversions are sexual desires or activities that lie outside the cultural norm, and under some conditions are considered mental disorders. What constitutes "perversion" or "deviation" varies from society to society. Some perversions have been (and are) crimes in some jurisdictions. Others are viewed as harmless eccentricities by many people. Some perversions are defined as potential mental disorders in medical indexes. Professional treatment is usually indicated only when such conditions lead to involvement of non-consenting sexual partners, or are clearly damaging to the physical or mental well-being of the pervert.

Although homosexuality was once considered to be a perversion, it is not usually regarded as such any longer. Paragraph 14 of the HIV and AIDS Recommendation, 2010 (No. 200) provides that: Measures should be taken in or through the workplace to reduce the transmission of HIV and alleviate its impact by:(e) promoting the active involvement and empowerment of all workers regardless of their sexual orientation and whether or not they belong to a vulnerable group;

Identified perversions constitute a long list. However, pedophilia (sexual attraction to children) and frotteurism – colloquially “jacking” (sexual arousal through rubbing one's external genitals against a non-consenting stranger in public) are mostly reported in Sri Lanka. These acts are punishable by law.

What are sexual problems?

A sexual problem means that sex is not satisfying or positive for somebody.

In women, sexual problems can include:

- Having less desire for sex.
- Having trouble feeling aroused.
- Not being able to have an orgasm.
- Having pain during intercourse.

Sexual problems in men include:

- Erection Problems (Erectile dysfunction – ED).
- Loss of Sexual Interest.
- Low Testosterone.
- Male Infertility.

Sexual problems such as under-arousal or premature ejaculation can occur at any age and for any number of reasons. A general state of under arousal is often accompanied by other issues in life such as overwork, stress and/or relationship problems. Men are often fairly poor at recognizing or acknowledging psychological issues or they see it as a sign of weakness. Stress is often viewed as something that affects other people but many men simply aren't tuned in to reading the signs in themselves.

Loss of interest in sex: A lack of libido can sometimes be accompanied by erection problems. Rejecting love-making, or finding reasons to avoid sexual contact such as picking a fight or staying up to watch the late movie, can easily be interpreted by a partner as rejection.

Sexual myths (a false belief) are common in all societies. Myths are important as they influence a person's sexual behaviour.

Three common myths are that:

- A single act of sex cannot cause a pregnancy.
- Use of condoms during sex reduces sexual pleasure for the man.
- Sexual pleasure is not necessary for a woman.

Session 4: Handout B

Reproductive Health

“It is a state of complete physical, mental and social well-being, and not merely absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”.

Puberty

Puberty is the time when sexual reproductive organs mature in order to enable giving birth to babies. Long before any outward changes happen, special hormones begin to be produced inside the bodies of both girls and boys. Hormones are substances that affect the working of many different parts of the body, including sexual development and growth.

Puberty often begins at about 10 years of age, but any outward signs are not obvious then. Physical changes become more obvious at about 13 -16 years for most boys and about 11 -14 for most girls. Along with the physical changes come emotional changes. The youth at puberty also start to think differently. All in all, there are quite a few major changes to deal with during puberty. Girls start to have their periods (to menstruate) around the age of 13, usually about 2 years after breasts first start to develop, and continue having periods until menopause, which occurs, on average, at about the age of 51.

During the reproductive cycle, a woman's body releases an egg, prepares itself for fertilization of the egg by sperm and creates an environment in the uterus in which the fertilized egg could implant and form a developing embryo (ultimately, a baby). If the egg is not fertilized, the lining of the womb is discharged from the body, which is known as menstruation (period).

What is menopause?

Menopause is a normal condition that all women experience as they age. The term "menopause" is commonly used to describe any of the changes a woman experiences either just before or after she stops menstruating, marking the end of her reproductive period.

Sexual reproduction

When girls and boys reach puberty, their bodies start to change and become more mature. From this time, if a male and a female have sexual intercourse, a conception is possible. Sperm are the male 'seeds' that contribute to starting a new life - living sperm look a lot like tadpoles (under a microscope).

When sperm are ejaculated by the male during sexual intercourse, they get deposited in the vagina. They reach the uterus through the cervix, and into the fallopian tubes of the female. These sperm are looking for an ovum (or egg) to fertilize.

When a female is born she carries thousands of ova or eggs ready to use when she becomes adult. If an ovum has been released, a sperm can unite with it, fertilize it and make the first cell of a new baby. Once one sperm has fertilized the ovum, no other sperm can get in - the female is now pregnant.

Reproductive health care

Both the expectant mother and the baby (called embryo during the 1st trimester and foetus thereafter until birth) are likely to encounter situations that pose risks to their health. Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, sexually transmitted diseases including HIV, gender based violence and other problems related to their reproductive system and sexual behaviour.

These require attention from qualified health personnel. Ante-natal Clinics, Post-natal Clinics and Well-woman Clinics are meant to provide health care and medical attention practically on all aspects of reproductive health as required for the expectant mothers, post-partum mothers and newborns. These clinics are regularly held by field health teams headed by Medical Officers of Health. The Family Health Bureau monitors these activities at the national level.

Abortion

While forced abortion is treated as a criminal offence, women's access to legal abortions is restricted by law in most countries in the world. These laws are diverse and religious, moral and cultural aspects continue to influence abortion laws in the world. Only a small number of countries prohibit abortion in all cases and in most countries and jurisdictions, abortion is allowed to save the pregnant woman's life, where the pregnancy is the result of rape or incest or with limitations as in before which trimester the abortion must take place. However, many women only have limited access to safe abortion services. In Sri Lanka except when the mother's life is in danger all other forms of abortions and attempted abortions are offences punishable under the penal code.

Session 4: Handout C

Contraception

What is contraception?

Contraception, are techniques and methods used to prevent human fertilization.

What are some methods of contraception?

There are several general methods of contraception, including (but not limited to):

Barrier methods, such as condoms, the diaphragm, and the cervical cap, designed to prevent the sperm from entering the uterus.

Intrauterine device, or IUD, is a small device that is inserted into the uterus by a healthcare provider. The IUD is more than 99 percent effective at preventing pregnancy. An IUD can stay in the uterus for up to 10 years. It has to be removed by a health care provider.

Hormonal contraceptives, such as oral pills, injections, skin patches, vaginal rings, and implants release hormones into a woman's body that interfere with fertility by prevent ovulation.

Sterilization is a method that permanently prevents a woman from getting pregnant or a man from being able to get a woman pregnant. Female sterilization is referred to as Tubectomy and male sterilisation as Vasectomy. Sterilization involves surgical procedures that must be done by a healthcare provider and usually cannot be reversed.

Behavioural and natural controls such as abstinence, withdrawal method, breast feeding, rhythm method of which success rate is low.

The choice depends on factors such as user's health, frequency of having sex, how many partners one has, and when it is necessary to have children in the future. By contacting field health workers or a medical officer, necessary advice could be obtained.

Emergency contraception - This pill, referred to as “morning after pill” has to be taken as soon as possible after an unprotected intercourse. It is effective when taken within 72 hrs after unprotected intercourse.

Most Effective	Effective	Less Effective
IUD Implant Injectables Sterilization	Correct and constant use of oral birth control pills Correct and consistent use of Condom	Withdrawal Periodic abstinence / Rhythm method

Session 5: Handout

Basics of HIV, AIDS and STIs

HIV stands for **Human Immunodeficiency Virus**. AIDS was first clinically observed between late 1980 and early 1981. The virus was discovered in 1983 by two separate research groups led by Robert Gallo and Luc Montagnier. HIV is different from most other viruses because it attacks the immune system. The immune system gives our bodies the ability to fight infections. HIV finds and destroys a type of white blood cell (T cells or CD4 cells) that the immune system must have to fight disease.

AIDS stands for **Acquired Immunodeficiency Syndrome** and describes a collection of symptoms and infections (i.e. syndrome) associated with acquired deficiency of the immune system. The level of HIV in the body and the appearance of certain infections are used as indicators that HIV infection has progressed to AIDS.

Transmission of HIV

Modes of transmission of HIV – blood, sexual, vertical (mother to child).

Blood

- Blood transfusion.
- Blood products (before 1985).
- Organ/tissue transplantation.
- Sharing needles/syringes for injecting drugs.
- Needle stick injury.
- Contamination of open cuts/mucous membranes (rare).

Sexual

- Unprotected anal sex - high risk.
- Unprotected vaginal sex - high risk.
- Unprotected oro-genital sex - low risk.

Mother to child

- During delivery.
- Breastfeeding.
- In womb (across the placenta).

Essential factors for HIV transmission to occur:

- there must be a source of infection.
- there must be a means for it to be transmitted.
- there must be a route of entry to the host organism and target cells.
- there must be a sufficient concentration of HIV.

Body fluids which can transmit HIV.

- blood - including menstrual blood.
- Semen.
- vaginal secretions/fluids.

- breast milk (to a baby).
- cerebrospinal fluid.
- wound drainage.

Note- HIV is present in saliva in some people with HIV. However it is not considered to be a risk for transmission.

Diagnosis of HIV

HIV is detected by an HIV antibody test called ELISA or EIA (Enzyme Linked Immunosorbent Assay)

It is -

- a screening test,
- sensitive but not specific,
- cheap and simple.
- available in government and private hospitals

Positive ELISA Test needs further testing for confirmation of HIV infection. The confirmatory test is called Western Blot.

It is -

- diagnostic,
- very specific for HIV,
- more expensive,
- skilled reading and
- done by reference laboratories only

Elisa and Western Blot tests both screen for antibodies to the virus, not for the virus itself.

Behaviours that do not transmit HIV

- Shaking hands, hugging, kissing.
- Sharing equipment such as the telephone, machinery.
- Using the same toilet, towels and cutlery and crockery.
- Using the same swimming pool, washing machine.
- Caring for people living with HIV and AIDS.
- Mosquito and insect bites.

Progression from HIV infection to AIDS

Normal Healthy Individual



Infected with HIV
WINDOW PERIOD (12 weeks or even 6 months)

After the original infection, it takes between two weeks and six months for antibodies to HIV to appear in the blood. The period between becoming infected with HIV and the point at which antibodies to HIV can be detected in the blood is called the “WINDOW PERIOD”. During this period, an HIV-infected person can still spread the disease, even though a test will not detect any antibodies in his or her blood.



HIV Positive (Antibodies can be detected by a blood test)
No symptoms



May take around 10 years to develop into full blown AIDS

Prevention of transmission

Sexual	Blood	Mother to child
• Postponing sexual debut • Being faithful to one's partner. • Correct and consistent condom use.	• Following universal precautions • Ensuring safety of donated blood before transfusion and organ transplantation • Use of disposable syringes	• Primary prevention of HIV in women of child bearing age and specially young women • Prevention of unintended pregnancies in HIV infected women • Making aware women with HIV of the choices available regarding childbearing • Linking HIV positive women to sexual and reproductive health services • Providing antiretroviral therapy to pregnant women living with HIV to reduce HIV transmission risk to the baby • Implementation of safe delivery practices and safe breastfeeding

Treatment

- No cure discovered to date.
- Antiretroviral Therapy (ART).
 - reduces spread of HIV.
 - reduces opportunistic infections.
 - prolongs sero-conversion from HIV to AIDS.
 - reduces mother to child transmission.

Post Exposure Prophylaxis

- It is potentially life saving if given appropriately and correctly. Treatment should be started as soon as possible (less than 72 hours of exposure). The course is of four weeks duration.

Global summary of the AIDS epidemic at the end of 2009 an estimated:

33.3 million [31.4 million–35.3 million] people globally were living with HIV
2.6 million [2.3 million–2.9 million] people became newly infected with HIV
1.8 million [1.6 million–2.1 million] people died from AIDS-related causes
(Source: UNAIDS Global Report 2010)

Following figures reflect the situation regarding HIV and AIDS in Sri Lanka as at end 2010:

HIV and AIDS Prevalence - <0.1%

Estimated number of HIV+ cases (Adults > 15 years) - 3,000

Estimated number of HIV+ cases Children < 15 years - 35

Cumulative HIV positive cases reported – 1317

Cumulative AIDS Cases-340

Cumulative AIDS Deaths-221

Cumulative Vertically Transmitted cases reported (Mother-to-child) of HIV-47

Male: Female Ratio- 1.5:1

Reported new infections in 2010 – 121

Reported AIDS deaths in 2010 - 19

(Source: National STD/ AIDS Control Programme)

Reasons for increased risks and vulnerabilities of women to HIV infection

Women are more at risk of HIV infection and carry the burden of HIV than men due to the following reasons:

- Biologically more at risk of HIV infection than men.
- Sexual subordination, in marriages or relationships.
- Violence against women and girls.
- Economic and social dependency.
- Burden of caring for HIV-infected family and community members.
- Poverty.
- Majority of migrants and refugees in many countries are women
- Most women have limited access to education and have higher rates of illiteracy.
- Discriminatory property, inheritance, custody and support laws affect women.
- HIV-related stigma and discrimination towards women is more often than men.

- Subordination to male colleagues or superiors in the workplace.
- Lack of social security or other occupational benefits.
- Many men having sex with men have female partners or wives.
- Women are more likely to wait longer before seeking services and treatment

Men and boys: key risks and vulnerabilities

- Norms, stereotypes and expectations about “masculine” behaviour.
- Male-dominated sectors of activity where working conditions may increase exposure to risk.
- Sexual relations between men are criminalized or surrounded by stigma, discrimination and taboos.

Session 5: Handout B

Sexually Transmitted Infections

STIs constitute a number of infections caused by bacteria ,viruses or parasites transmitted through unprotected sexual contact. Namely:

- Chancroid
- Chlamydia
- Cytomegalovirus
- Genital Warts
- Gonorrhoea
- Hepatitis B
- Herpes
- HIV
- Human Papilloma Virus
- Intestinal Parasites
- Molluscum Contagiosum
- Pelvic Inflammatory Disease
- Pubic Lice
- Scabies
- Syphilis
- Trichomoniasis

Usual mode of spread is through sexual contact due to unsafe sex with an infected person. South East Asia, which includes Sri Lanka as well, is the region where the largest number of infections occurs. In addition to transmission by unprotected sex, some infections (HIV, Syphilis etc.) can be transmitted through blood.

Commonly occurring STIs in Sri Lanka are: Genital Herpes, Genital Warts, Syphilis and Gonorrhoea. Complete cure is possible for the diseases such as Syphilis, Gonorrhoea, Non Gonococcal Urethritis/ Cervicitis and Trichomoniasis provided full course of treatment as well as treatment of the contact/partners is followed as advised by the physician. The diseases of viral origin can reappear causing a family and a social issue.

Following symptoms are common in STIs:

- small blisters in external genital area.
- wounds, pustules or rashes in the genital region.
- discharge of pus from vagina or penis.
- pain or burning sensation during urination.
- unusual itching in genital areas.
- pain during sexual intercourse.
- pain in lower abdomen and oedema or pain in testicles.

Therefore, it is vital to obtain medical advice and treatment at the earliest, if these symptoms appear after a casual sexual contact. It is also important that all sexual contacts of an identified patient are treated even if the contacts (in many cases the spouse or a regular sex mate other than the spouse) are free of clinical manifestations. The treatment is free at government clinics. The information and identity of patients are kept confidential.

Session 5: Handout C

Women and girls: key risks and vulnerabilities

- Women are **biologically more at risk of HIV infection** than men and twice as likely to contract the virus through unprotected sex, particularly when they suffer (small or large) injuries due to friction during intercourse or have a sexually transmitted infection (STI).
- **Sexual subordination**, in marriages or relationships, where women are often expected to be ignorant about sexual practices and passive in sexual interactions; this makes it difficult if not impossible for women to negotiate condom use for safer sex or refuse unsafe sex, particularly if they fear violence and/or abandonment.
- **Violence against women and girls**, whether by family members or close acquaintances, partners or by strangers, has been shown to increase women's risk of becoming infected with HIV. Violence or fear of violence prevents many women from negotiating safe sex, getting tested for HIV, disclosing their HIV status, and seeking treatment and support.
- **Economic and social dependency** on men affects many women's bargaining power related to safer sex, and may also prevent women from seeking counselling and adhering to antiretroviral treatment (ART). Such dependency may mean that women lack money to pay for health services or transportation, and/or have to ask permission from their husbands or other male family members to access such services.
- In most countries, women and girls are traditionally the principal care-givers within families and communities. They are therefore more heavily impacted by the **burden of caring for HIV-infected family and community members** than men and boys. This increases their workload and diminishes their capacity to access schooling and/ or engage in income-generating activities.
- The burden of HIV and AIDS on women and girls is compounded by **poverty**, as women are over-represented among the poor in all regions of the world. During times of economic hardship, families may allocate resources to men and boys first, and to women and girls later or not at all, with consequences for the latter's health and access to basic services. Girls are more likely to be taken out of school and engage in **child labour** than boys, including in the worst forms of child labour. Women may be forced to make a living through paid sex or exchanging sex for food, shelter and protection.
- A significant proportion of **migrants and refugees** in many countries are women, and in some settings such as domestic work, this puts them at a higher risk of gender-based violence and hence HIV infection.
- **Limited access to education and higher rates of illiteracy** disproportionately affect women and girls and make it more difficult to access HIV prevention and treatment information.

- **Discriminatory property, inheritance, custody and support laws** deprive many women of financial security and income-generating activities if they have lost their partners or have been abandoned because they themselves are living with HIV. Many HIV-positive women and girls are forced into commercial sexual exploitation (“survival sex”) where they have little to no negotiating power with regards to condom use.
- **HIV-related stigma and discrimination** often affects women more than men. This in turn marginalizes women living with from society and from economic activity.
- **Subordination to male colleagues or superiors in the workplace** may place women at risk of sexual harassment and abuse.
- Many women work in sectors where their activities are **not covered by social security or other occupational benefits** such as in their homes, in subsistence farming, domestic work and in the informal economy.
- Because of the taboos and stigma that surround **men having sex with men**, many have female partners or wives. These women's HIV infection risk is particularly high because their male partners often lack access to HIV prevention services.
- Women are more likely to **wait longer before seeking services and treatment**, and are therefore more likely to be at an advanced stage of infection.

Men and boys: key risks and vulnerabilities

- **Norms, stereotypes and expectations about “masculine” behaviour** can affect knowledge and confidence about sex, domination in sexual relationships with women, as well as alcohol and substance use. They can lead men and boys to practice unsafe and/or non-consensual sex, including sex within casual and/or multiple sexual partnerships. They can also discourage men and boys from seeking HIV-related information and services.
- In many countries, there are male-dominated **sectors of activity** where working conditions may increase exposure to risk, for example the transport or construction sector. Here workers are separated from homes and families and often housed in men-only living arrangements where relationships with sex workers are a common practice.
- **Sexual relations between men are outlawed or surrounded by stigma, discrimination and taboos**, as in many countries expectations of “masculinity” emphasize men's sexual domination over women as a defining characteristic of manhood. As a consequence, men who have sex with men are exposed to HIV risk because they are less likely to have access to or actively seek available HIV prevention information and treatment services.
- Whether heterosexual or homosexual, **unprotected receptive anal sex poses** a much higher risk than unprotected receptive vaginal risk, thus putting men who have sex with men at particular risk of acquiring HIV.

- In many countries HIV and AIDS services are provided primarily in family planning, prenatal and child health clinics, which are based on the **assumption that only women have reproductive responsibilities**. Thus, they are designed to reach women and meet women's needs, thereby making it difficult for men to benefit from such services.
- Boys from families affected by HIV and AIDS, and orphans in particular, may be taken out of school and forced into **child labour**, including the worst forms of child labour.

Session 6: Handout A

Prevention of STD/HIV and the use of condoms

Prevention challenges

Women have some unique issues with regard to HIV.

- **Mother-to-child HIV transmission.** Women can pass HIV to their babies during pregnancy, delivery or breast-feeding.
- **Biological differences** The lining of the vagina provides a large area of contact for potential exposure to HIV-infected semen.
- Some diseases or disorders of the female reproductive tract make HIV more serious:
 - Vaginal infections (yeast, bacterial vaginosis).
 - Other sexually transmitted diseases (gonorrhea, chlamydia, trichomoniasis).
 - Pelvic inflammatory disease.
 - Human papillomavirus infections.
- **Social differences.** Women may lack power in sexual relationships and may:
 - have sex against their will.
 - have sex without a condom, against their will.
 - have sex with a man without knowing whether he has high-risk behaviors.
 - trade sex for money or other benefits
 - be unable to talk to their partners about abstinence, faithfulness, and condom use.

Prevention of HIV

Steps for prevention of HIV infection includes

- Having non- penetrative sex
- Correct and consistent use of condoms
- Maintaining a mutually faithful sexual partnership
- Postponing sexual début
- Infection control in the workplace

- Practicing standard universal precautions
- Safe needle use
- Using only sterile skin piercing equipment

Condoms do not provide complete protection against HIV. The only sure protection is abstinence.

Dual protection or **dual method** is a strategy for reducing risk of pregnancy and prevention of sexually transmitted infections. Dual protection can be achieved by consistent use of condoms alone, both with other birth control methods or by avoidance of penetrative sex.

Session 6: Handout B

Condoms at a Glance

Condoms are the only form of protection that can both help to stop the transmission of STDs such as HIV, and also prevent pregnancy.

Condoms are:

- latex or plastic sheaths for the penis (or female condoms for insertion into the vagina).
- prevent pregnancy and sexually transmitted infection.
- can be used for vaginal, anal, or oral sex.
- are safe, effective, and convenient.
- are easy to get and no prescription is required.
- cost less, but sometimes welfare organizations make them available free.
- are needed only when having sex unlike other contraceptives.
- are lightweight and disposable.
- can help relieve premature ejaculation.
- may help a man stay erect longer.
- can be put on as part of sex play.
- can be used with other birth control methods for dual protection.
- cause no medical side effects.
- are available in various shapes, colours, flavours, textures and sizes that increase the fun of having sex with condoms.

Effectiveness

Against pregnancy:

- 98% (perfect use); 85% (typical use)

Against HIV -if used consistently and correctly:

- Male condom 80–95% effective.
- Female condom 94–97% effective.

Choosing a condom

- Ensure good quality.
- Ensure that it complies with standards.
- Check expiry date.
- Use appropriate type
 - size, thickness, lubrication, flavor, texture, colour
- Choose appropriate lubricant
 - water based

Storing condoms

- Ensure cool dry place.
- Ensure that it is not kept in heat, pocket, wallet or glove box
- Ensure it is not crinkled or folded

Putting on a condom

- Put the condom on before penis touches the vulva. Men leak fluids from their penises before and after ejaculation. This fluid can carry enough germs to pass sexually transmitted infections and possibly cause pregnancy.
- Use a condom only once. Use a fresh one for each erection. Have a good supply on hand.
- Condoms usually come rolled into a ring shape and are sealed in an aluminum foil or plastic cover. Take care not to damage the condom while unwrapping. If it is torn, brittle, stiff, or sticky, throw it away and use another one.
- Pull back the foreskin, unless circumcised, before rolling on the condom.
- Place the rolled condom over the tip of the hard penis.
- Leave the half inch space, in the form of a nipple, at the tip to collect semen.
- Pinch the air out of the tip with one hand while placing it on the penis.
- Unroll the condom over the penis, all the way down to the base, with the other hand.
- Smooth out any air bubbles. (Friction against air bubbles can cause the condom to break.)

For increasing pleasure

- Make condom part of foreplay
- Have partner put it on.
- Use extra lubricant inside.
- For some men condoms can sustain the pleasure.

Removal of a condom after use

- Pull out while penis is erect.
- Hold the condom against the base of the penis while pulling out to avoid spilling.
- Discard the condom.
- Wash the penis with soap and water before having sex play again.

If the Condom Breaks ...

- If the condom breaks during intercourse, pull out quickly and replace it. Men should be able to tell if a condom breaks during intercourse. To learn what it feels like, men can break condoms on purpose while masturbating.
- If the condom breaks and semen leaks out, wash the semen away from the vulva or penis with soap and water.
- Emergency contraception can prevent pregnancy if started within 72 hrs after unprotected intercourse. The sooner you start it, the better it will work.

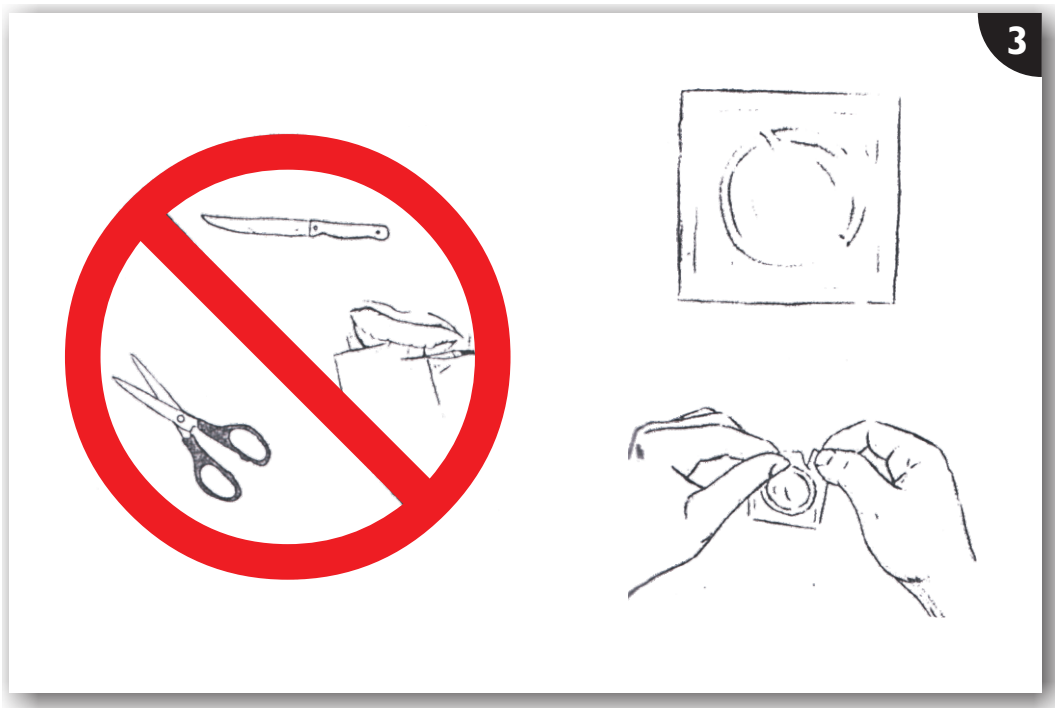
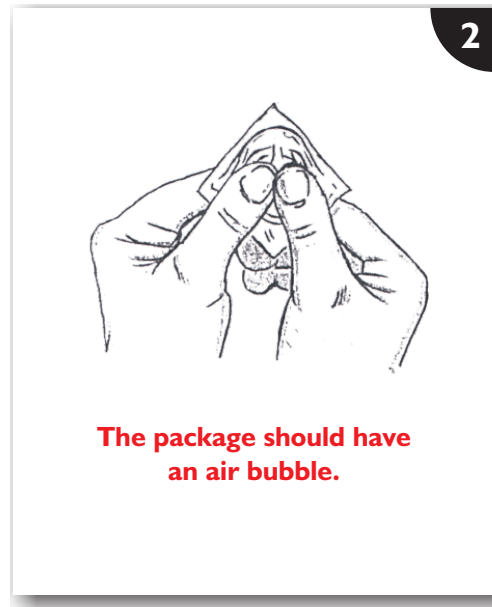
Barriers to use of condoms

- Non-availability and inaccessibility to condoms.
- Lack of knowledge and skills about using a condom properly.
- The common myths that condoms reduce sexual pleasure.
- Stigma associated with condoms – i.e. a person who uses condoms is engaging in illicit sex.
- A belief that condoms do not provide protection against HIV and STIs.
- A fear that a condom may slip off inside the vagina.
- A fear that the condom may tear inside the vagina.

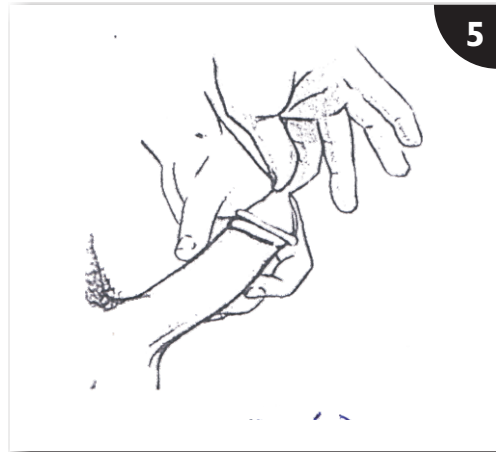
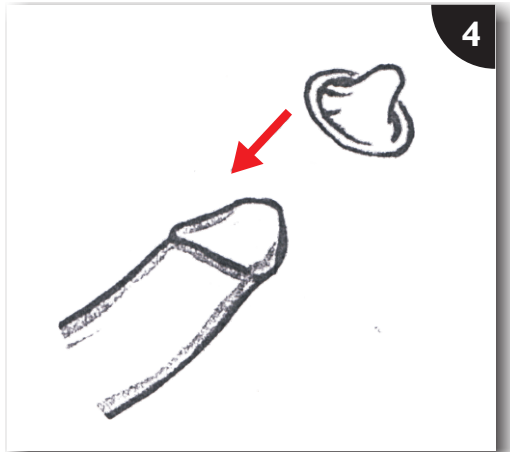
The benefits of using female condoms

- Opportunity for women to share the responsibility for the condoms with their partners.
- A woman may be able to use the female condom if her partner refuses to use the male condom.
- The female condom will protect against most STDs and pregnancy if used correctly.

Steps in wearing a male condom



Steps in wearing a male condom



Session 6: Handout C

Condom Quiz

(Please tick off the correct answer).

01. How many sizes of condoms are there?

- a. Regular and large
- b. Many different sizes
- c. One size

02. How many varieties of condoms are there?

- a. Male and female.
- b. Male only.
- c. No idea.

03. Why are condoms ribbed?

- a. Ribbed condoms are cheaper.
- b. Ribbed condoms can increase sensation for both partners.
- c. Ribbed condoms are used for oral sex only.

04. Do condoms provide total protection against all STIs?

- a. No.
- b. Yes.

05. How many condoms should be worn by a man to avoid pregnancy and transmission of STIs?

- a. One.
- b. Two.
- c. As many as comfortable.

06. How often should a male condom be used?

- a. More than once, if they are washable.
- b. Only once.
- c. More than once if it is with the same person.

07. How often should a female condom be used?

- a. More than once, if it is with the same person.
- b. More than once, if they are washable.
- c. Only once.

08. At what point during sexual intercourse should the male condom be put on the penis?

- a. Before the penis is erect.
- b. Just before the point of ejaculation to catch the semen.
- c. Once erect and before any contact with the partner's body.

09. At what point during sexual intercourse should the female condom be inserted ?

- a. Well before the intercourse (up to 8 hours) to avoid interference with the moment.
- b. Once the woman feels the urge.
- c. Immediately before the intercourse.

10. Which is the most effective at preventing pregnancy, HIV and STIs?

- a. Oral contraceptives
- b. Withdrawal
- c. Condoms.

11. After sex, when should the condom be removed off the penis?

- a. Soon after ejaculation
- b. Before the penis gets too soft
- c. At least ten hours later

As soon as the penis is no longer erect

12. Which is the correct expression out of the following?

Friction may cause condom to break.

It is a man's responsibility to wear the condom during sex.

It is bad luck to wear two condoms.

Answers:

01. b; 02. a; 03. b; 04. a; 05. a; 06. b; 07. c; 08. c; 09. a; 10. c; 11. a; 12. a

Session 7: Handout A

Addressing Gender Based Violence (GBV) at Home, Society and the Workplace

GBV can be defined as “violence involving men and women, in which the female is usually the victim and which arises from unequal power relationships between women and men”.

Violence against women and girls is often referred to as “gender based violence” because it evolves in part from women's subordinate gender status in society. In most cultures, traditional beliefs, norms and social institutions legitimize and, therefore, perpetuate violence against women.

Violence against women has been called "the most pervasive, yet, least recognized human rights abuse in the world." Accordingly, the Vienna Human Rights Conference and the Fourth World Conference on Women gave priority to this issue, which jeopardizes women's lives, bodies, psychological integrity and freedom. Violence may have profound effects – direct and indirect – on a woman's reproductive health, including:

- Unwanted pregnancies and restricted access to family planning information and contraceptives.
- Unsafe abortion or injuries sustained during a legal abortion after an unwanted pregnancy.
- Complications from frequent, high-risk pregnancies and lack of follow-up care.
- Sexually transmitted infections, including HIV.
- Persistent gynaecological problems.
- Psychological problems.

Gender discrimination throughout a woman's life

Phase	Type
Prenatal	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape during war).
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care.
Childhood	Genital cutting; incest and sexual abuse; differential access to food, medical care, and education; child prostitution.
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution.
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities. (In some jurisdictions rape does not necessarily include penetration, but the use of sexual organs of either the perpetrator or the victim – the perpetrator can use their hand to stimulate genitals and it would still be considered as rape. Also note that in many countries marriage does not constitute implied consent to sexual intercourse.)
Old Age	Abuse of widows, elder abuse (which affects mostly women).

Source: Heise, L. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank Discussion Paper. Washington, D.C., The World Bank.

Violence at home

Most domestic violence involves male anger directed against their women partners. This gender difference appears to be rooted in the way boys and men are socialized -- biological factors do not seem to account for the dramatic differences in behaviour in this regard between men and women.

Pregnant women are particularly vulnerable to gender-based violence. Some husbands become more violent during the wife's pregnancy, even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage and four times the risk of having a low birth-weight baby.

Gender and violence

The prevalence of domestic violence in a given society, therefore, is the result of tacit acceptance by that society. The way men view themselves as men, and the way they view women, will determine whether they use violence or coercion against women.

UNFPA recognizes that ending gender-based violence will mean changing cultural concepts about masculinity, and that process must actively engage men, whether they be policy makers, parents, spouses or young boys.

Sexual assault

The majority of sexual assault victims are young. Women in positions of abject dependence on male authorities are also particularly subject to unwanted sexual coercion. Rape in time of war is still common. It has been extensively documented in recent civil conflicts, and has been used systematically as an instrument of torture or ethnic domination.

Sexual harassment

There are several definitions and two are given below.

“Sexual Harassment is any unwanted sexual attention women experience. It can include leering, pinching, repeated comments, jokes and insults, lewd gestures of a sexual nature, the display of pornographic material, pressure for sexual favours and bribes. It can take the form of attempted and actual rape.”

“Sexual Harassment is any unwelcome physical contact and advances, demand on request for sexual favours, sexually coloured remarks, display of pornography, any other unwelcome physical, verbal or non-verbal conduct of a sexual nature.”

Session 7: Handout B

Life Skills

Life skills are essentially those abilities that help promote mental well-being and competence in young people as they face the realities of life. They can be utilized in many content areas: prevention of drug use, sexual violence, teenage pregnancy, HIV/AIDS prevention and suicide prevention. Life skills empower young people to take positive action to protect them and promote health and positive social relationships.

- (1) Decision making: the decision-making process should be dealt with constructively. When individuals have to make a decision concerning their health, they should be able to evaluate the choices and think about the respective consequences before making positive, healthy decisions.
- (2) Problem solving: Following steps are applicable in solving problems: A. Defining the problem. B. Listing any ideas, which are possible solutions. C. Evaluating the options. D. Picking the optimum solution and E. making a plan to put it into action.
- (3) Creative thinking: Creative thinking involves learning to be innovative in looking for all kinds of possible choices and then evaluating their respective value as solutions.
- (4) Critical thinking: Critical thinking entails objective analysis of information and experience. Personal values, peer pressure, and mass media can influence individual attitudes and these influences, when they have to face them.
- (5) Effective communication: Effective communication means expressing oneself through language and other means. Means of expression should be consistent with one's cultural background, and be specific to a particular situation.
- (6) Interpersonal relationship skills: Forming and maintaining friendships with other people is very important for mental health and constructive participation in society. Individuals should have good relationships with family members. They should also learn how to break off personal relationships that are harmful or negative influences.
- (7) Self-awareness: Self-awareness is the realization of one's own special characteristics, strengths, weaknesses and desires. This training helps to cope with stressful situations by looking inwards. More often than not, self-awareness is a communication and creative thinking.
- (8) Empathy: Empathy refers to understanding others' life situations. It leads to acceptance of others who are different from oneself, which fosters cross-communication. It also encourages caring, helping and looking after those in need.
- (9) Coping with emotions: is realizing how emotions can affect action and help maintain a peace of mind.

- (10) Coping with stress: When coping with stress it is necessary to understand where stress may come from and how it can affect people. Taking precautions to reduce tension and learning to relax by changing the environment and the ways of living is important when coping with stress.

Session 8: Handout

Stigma and Discrimination of Persons Living with HIV

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. They can result in being shunned by family, peers and the wider community; poor treatment in healthcare and education settings; an erosion of rights; psychological damage; and can negatively affect the success of testing and treatment.

AIDS stigma and discrimination exist worldwide, although they manifest themselves differently across countries, communities, religious groups and individuals. They occur alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be directed towards those involved in what are considered socially unacceptable activities such as prostitution and drug use.

Why is there stigma related to HIV and AIDS?

Fear of infection coupled with negative, value-based assumptions about people, who are infected, leads to high levels of stigma surrounding HIV and AIDS.

Factors that contribute to HIV and AIDS-related stigma:

- AIDS is a life-threatening disease, and therefore people react to it in strong ways.
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatized in many societies.
- Most people become infected with HIV through sex, which often carries moral baggage.
- There is a lot of inaccurate information about how HIV is transmitted, creating irrational behaviour and misperceptions of personal risk.
- HIV infection is often thought to be the result of personal irresponsibility.
- Religious or moral convictions lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

Activists protest against HIV-related discrimination, in India research conducted by the International Centre for Research on Women (ICRW) found the possible consequences of HIV-related stigma to be:

- Loss of income/livelihood.
- Loss of marriage & childbearing options.
- Poor care within the health sector.

- Withdrawal of care giving in the home.
- Loss of hope & feelings of worthlessness.
- Loss of reputation.

Discrimination

Discrimination consists of actions or omissions that are derived from stigma and directed towards those who are stigmatized. AIDS-related discrimination may occur at many levels. There is discrimination in family and community settings and in institutional settings such as in hospitals, workplace, educational institutions, prisons and social welfare settings. Some examples of discrimination in the various settings are given here.

Care and Support

A community's reaction to somebody living with HIV and AIDS can have a huge effect on that person's life. If the reaction is hostile a person may be ostracized and discriminated against and may be forced to leave her/his home, or change her/his daily activities such as shopping, socializing or schooling.

Early stage	Later stages	End of life stage
HIV testing	Prevention and treatment of Opportunistic Infections	End of life care
Counselling & psychosocial support	Managing nutritional effects	Preparing for death
Prevention of onward transmission	Palliative care (includes clinical services, social care, psychological services, spiritual care and positive preventive care involving the entire family)	Support for surviving family and orphans
Protection from stigma and discrimination	Antiretroviral therapy Complementary and alternative medicine	

Session 9: Handout A

Integrating gender into workplace HIV and AIDS Programmes

HIV and AIDS is a workplace issue because of its impact on workers described below;

- Loss of income and employee benefits.
- Stigma and discrimination.
- Pressure on families and the problem of orphans.

Gender segregated statistics of infected persons attached to workplaces are not available. However, workplaces are not free from risk factors. Among the risk factors noted by UNICEF, the following are present at the workplaces:

- Age of marriage getting delayed. Herein, employment is a good reason for delaying because workers tend to have a reserve of money saved before marriage on the one hand and geographical location of the workplace also could be a reason. This is especially so in garment factories located in Industrial Promotion Zone. Many workers come from far away places. Some jobs may have a restriction on marriage.
- Changes in social and cultural norms contribute to the practice of risky sexual behaviours. This applies both to life inside and outside the workplace.
- Increasing evidence of adolescents engaging in commercial sex, both heterosexual and homosexual. Police raids have found garment workers also involved in commercial sex.

Adolescents comprise nearly one fifth of Sri Lanka's total population of 19.3 million. 28% of the population is between 10-24 years old and 19.7 per cent are in the 10-19 age group. Since Sri Lanka is still in the beginning of the HIV epidemic, successful control will to a large extent depend on the knowledge, attitude and practices of the country's adolescents and youth.

- High risk behaviours such as low condom use.
- Apart from the above, coercion from individuals in supervisory grades is often reported by workers.

Availability of workplace specific gender policies is rare; however, due to legal coverage assuring welfare of workers, gender issues are addressed to a certain extent. Nevertheless, HIV and AIDS policies have to be introduced and in that regard attention to the following would enable the integration of the gender component into those programmes:

- Expanding the scope of HIV and AIDS programmes beyond focusing merely on sex education. Such programmes should consider social and mental aspects as well.
- All information and inputs imparted in these programmes should be gender sensitive.

- Introducing measures to prevent patients of either sex from being treated differently. HIV and AIDS is not an issue for sexual harassment and sexual discrimination because there is no apparent reason as to why one is more at fault for contracting the infection.
- Infected persons should not be isolated from their former work teams.
- Inclusion of rights issues: Sickness whatsoever in general and HIV and AIDS in particular is not a reason for refraining from enjoying one's rights. Individuals infected while being employed should be allowed to continue until they are debilitated to continue and infection should not be a barrier at recruitment.
- Supporting and encouraging individuals to continue treatment without interruption.
- Use any infected person as a peer educator provided such involvement is no cause for stigma. Any desire of a person wanting to remain unidentified should be respected.
- HIV and AIDS programmes should require intimating laboratory findings related to HIV and AIDS screening of a person to the Human Resource Department of the workplace or any person in charge of human resource responsibilities. In turn, human resource personnel should maintain the information confidential.
- Introducing a befriender for the welfare of infected persons. Mental health services can play an important role for women with HIV and AIDS.

Concerns to be addressed in developing peer education programs

- Creating awareness on HIV and AIDS.
- Condom promotion.
- Treatment for STIs,
- Care and support.
- Adopting a workplace HIV and AIDS Policy

Session 9: Handout B

The ILO Code of Practice

The ILO Code of Practice is introduced recognizing HIV and AIDS as a workplace issue and that there should not be discrimination and dismissal over the disease. It advocates maintaining confidentiality, care and support, social dialogue, gender equality, facilities for screening and a healthy working environment. It also emphasizes the fact that “health” is not only about being treated for diseases but a state of physical, mental and social well-being.

4.1 Recognition of HIV and AIDS as a workplace issue

HIV and AIDS is a workplace issue, not only because it affects the workforce, but also because the workplace can play a vital role in limiting the spread and effects of the epidemic.

4.2 Non-discrimination

There should be no discrimination or stigmatization of workers on the basis of real or perceived HIV status.

4.3 Gender equality

More equal gender relations and the empowerment of women are vital to successfully preventing the spread of HIV infection and enabling women to cope with HIV and AIDS.

4.4 Healthy work environment

The work environment should be healthy and safe, and adapted to the state of health and capabilities of workers.

4.5 Social dialogue

A successful HIV and AIDS policy and programme requires cooperation and trust between employers, workers, and governments.

4.6 Screening for purposes of employment

HIV and AIDS screening should not be required of job applicants or persons in employment and testing for HIV should not be carried out at the workplace except as specified in this code.

4.7 Confidentiality

Access to personal data relating to a worker's HIV status should be bound by the rules of confidentiality consistent with existing ILO codes of practice.

4.8 Continuing the employment relationship

HIV infection is not a cause for termination of employment. Persons with HIV-related illnesses should be able to work for as long as medically fit in appropriate conditions.

4.9 Prevention

The social partners are in a unique position to promote prevention efforts through information and education, and support changes in attitudes and behaviour.

4.10 Care and support

Solidarity, care and support should guide the response to AIDS at the workplace. All workers are entitled to affordable health services and to benefits from statutory and occupational schemes.

Session 10: Handout A

Behaviour Change Communication (BCC)

Behaviour change communication is an interactive process that helps develop tailored messages and approaches with communities using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and social behaviour change; and maintain appropriate behaviours. (ILO Toolkit)

Communicative challenges to HIV and AIDS exist because:

- A. HIV is invisible (for several years); silent (for several years); non-debilitating (for several years); infectious; has multiple transmission modes; and is non-discriminating. (e.g. in terms of age, gender, geography.)
- B. HIV and AIDS deals with human behaviours,
- C. Efficacious responses to HIV and AIDS involve adoption of behaviours,
- D. HIV and AIDS deals with populations.

Effective behaviour change communication can:

Increase knowledge of HIV and AIDS;

Stimulate social and community dialogue;

Promote essential attitude change;

Improve skills and sense of self-effectiveness;

Reduce stigma and discrimination against people living with HIV and AIDS

Create a demand for information and services;

Advocate an effective response to the epidemic; and

Promote services for prevention, care and support of vulnerable populations.

Stages of Individual Behaviour Adoption and BCC Approaches

Stage	BCC Approach
Pre-contemplation (Unaware) <i>How can I get AIDS?</i>	Encourage awareness and value change. <i>How can I get HIV infection?</i>
Early contemplation (Aware) <i>HIV can be transmitted by unprotected sex.</i>	Promote benefits of the new behaviour. <i>HIV infection can be prevented.</i>
Late contemplation (Concerned) <i>I feel like using condoms.</i>	Reduce the costs involved in adopting new behaviour (including financial costs and barriers to access), foster social support, and teach relevant skills necessary for the required behaviour change. <i>I'm determined to use condoms.</i>
Preparation for Action (Knowledgeable and motivated to change) <i>With condoms, no infection and more pleasure</i>	Personalize risks and benefits, deliberate decision-making, increase self-efficacy and self-esteem and perception of positive change among peer group. <i>I'm trying to keep up. The condom is no barrier to enjoy sex.</i>
Action (Modifying behaviour) <i>Use condoms every time in unprepared casual sex.</i>	Reward and support change. <i>Condoms offer dual protection.</i>
Maintenance (Practicing sustained behaviour change) <i>I'll continue to use condoms.</i>	Continue support of the behaviour change. <i>More pleasure, no fear, no infection.</i>

Session 11: Handout

Involvement of Peer Educators

Young people listen more attentively and more readily to what respected peers say. This is especially true when talking about issues of life skills, safety and sexuality. This powerful and effective influence is called "peers' influence." Peer Education takes advantage of the positive aspects of peer influence to educate young people. It usually begins with training of peer educators.

Peer education programmes at the workplaces could be an integral part of HIV and AIDS workplace programmes. Services such as HIV counselling, testing and treatment, STI control, and condom distribution can be provided through workplace medical services. If such services are not available persons can be referred to Government STI Clinics. Either way, peer educators have an important role to play in linking workers and services.

Peer educator is a person who shares common characteristics with the peer group on whom the programme is focused (age, sex, economic status and position).

Selecting peer educators

Recruiting and training peer educators should be a major component of any workplace peer education programme. Management and workers' representatives should work together to identify and train a pool of peer educators for each workplace. Groups of workers can also be asked to nominate individuals as peer educators or even vote for those that they prefer. The peer educators should possess necessary credibility and there will be inhibitions to talk freely. Some other factors to consider in selecting peer educators are as follows:

- Well-rounded workers -not necessarily the persons with best academic talents
- Gender balance where ever possible
- Perhaps older workers
- Perhaps sexually active (if this information is available)

Characteristics of a peer educator

Desirable characteristics in a peer educator include:

- being part of the workers.
- being motivated by concern for the health of their colleagues.
- being available and accessible to workers at all times.
- having effective interpersonal skills.

- having natural leadership skills.
- possessing good organizational skills.
- being respected by the colleagues.
- the ability to listen to other peers without bias or assumptions.
- the ability to speak the language spoken at the workplace, and
- the ability to keep sensitive information confidential.

Common problems encountered in selecting peer educators

- Not being really the peers of the target population.
- Difficulties in communication if educators have a higher level of education, income or employee status than those of the target population.
- Being busy at their work and having little time to be involved in a peer education programme.

Some guidelines to conduct peer educator sessions in small groups

When involved in small groups, use the following group rules to encourage discussion and participation:

- Do not allow negative comments (put-downs).
- Allow everybody equal opportunity to talk.
- Do not allow interruption by others while one person talks.
- Respect everybody's right to decline to discuss a personal issue.
- Stay on the topic; no side discussions or 'buzz sessions' on other topics, and
- Maintain information confidential.

Dealing with problem situations in groups

In small groups, individual member behaviour may vary. Trainer should be prepared to help solve minor communication problems that might arise in small groups, e.g. when a member of the group:

- Dominates the conversation
- Is critical of others: puts other people down, usually to make herself/himself feel superior

- Tells others what to do all the time
- Often interrupts other people
- Does not participate in the group activity
- Chats about things not related to the activity

Ways of dealing with problems in groups

- If there are disruptions, politely remind the group that there is a problem or task to solve, as well as a time limit.
- Talk privately to the person causing the problem. Review the basic group rules and how the person's behaviour is negatively affecting the group. Request her/his support and cooperation the next time the group meets.
- Respond to those who interrupt by saying, "Excuse me, just a reminder that everyone in the group has the right to speak without being interrupted".
- If the behaviour is so disturbing that it cannot be ignored, deal with it in the group. Criticize what is being said or done (rather than criticizing the person responsible for the disruption or making disruptive statements). Point out how the behavior blocks the group from functioning well.
- At the end of a group session, lead a discussion about how the group is doing. Try to do this in such a way that feelings are not hurt.

Communication skills

Since a peer educator will be working with her/his peers, it is important that s/he has good communication skills. Some may already have many of these skills to some extent which formed the basis for selection as a peer educator.

However, the three skills most people need for continual improvement are :

- Listening actively and well.
- Using positive body language to show empathy (to show that peer educator understands how the other person feels or what her/his point of view is):
 - Focusing on the person with direct eye contact (looking into people's eyes)
 - Refraining from interrupting
 - Avoiding interrupting to describe peer educator's own experiences

- Refraining from giving attention to outside disruptions (other people or events) and
- Being comfortable with silence.

Giving feedback

To give feedback to another person means commenting on that person's statements, behaviour or performance. When doing this, the other person must feel that the educator is listening and cares about what s/she has said or done.

Do

- Ask questions to show interest in the person (How do you feel about that?)
- Be sincere, caring and understanding.
- Use verbal encouragement (such as 'What happened then?').
- Use nonverbal encouragement (such as nodding your head).
- Ask questions to make the situation clearer (if necessary).
- Summarize the person's points and feelings.

Do not

- Judge the person.
- Comment on things that cannot be changed.
- Interrupt too early to give feedback.

If the venue is a workplace building, obtaining prior permission to use the venue from the administration is always useful.

Conducting training sessions by peer educators

Selecting participants

- Have a schedule ready for a stipulated period. Decide the number, taking the physical space available into account.
- Seek permission from managers of respective departments.
- Consider their risk levels, if possible and give priority to those at high risk.
- Include peers from both sexes in proportion to numbers available from each sex.

Venue

- Usual physical space available for training purposes can be selected. If not improvise a place free from distractions.
- Ensure adequate seating facilities.
- If the venue is a workplace building, obtaining prior permission to use the venue from the administration is always useful.

Duration

- Make a decision about the number of sessions that can be conducted during the time available. It will be more practical to conduct two or three sessions at a time. In other words, whole workshop is divided into two or more parts considering time constraints.

Announcing

- Inform well in advance. This can be done in several ways: i.e. displaying notices in conspicuous places; informing individuals as and when they meet; using meetings; requesting peer educators to spread the news etc.
- In the same vein, announce well in advance if a programme had to be postponed. Avoid postponing halfway through the proceedings.
- If participants are expected from another section, which is located away from the main complex, it is very necessary to select a contact point for these announcements.

Resource material and resource persons

- Refer to the manual and have all necessary materials ready. This includes duplication of handouts as well.
- If it had been planned to invite a resource person, do so well in advance. Provide details about the nature of services expected of her or him.
- Ask for some background information about the resource person to be used in the introduction. The resource person's correct name and designation is very important since an introduction with incorrect information would inconvenience that person. An introduction for two or three minutes is quite sufficient. Remember one minute of talking amounts to 100 – 125 words!
- Organize refreshments if possible.

Beginning a workshop

- Plan an inauguration for the first session but no such formalities are required in subsequent sessions if the whole workshop is divided into two or more parts.
- Managing time is of utmost importance to maintain pace. If there had been a delay in commencing, try to be brief with the inauguration formalities but do not rush. Think of some strategies beforehand to handle such situations.

Draft Schedule for a Peer Educator training programme

Day I

Time	Topic	Objective	Methodology
8.30-9.00am	Pre test and Registration.	- Assess the existing knowledge of Participants.	Pre test questionnaire
9.00-9.30am	Inauguration and introduction of participants.	- Welcome Explain the objective and the strategy of programme Familiarization among participants and resource persons.	Game
10.30-10.45am	TEA		
10.45- 12.30pm	Basics of HIV/AIDS/STI.	- Enhance the knowledge of symptoms and signs of common STIs.	Presentations and discussion
12.30-1.15pm	LUNCH		
1.15-2.15pm	Gender, Sex and sexuality.	- Understand the concept of gender and its relationship to HIV. - Create positive attitudes towards individual sexual behaviours. - Enable participants to openly discuss on issues related to sex and sexuality.	
2.15- 3.15pm	Line up of sexual behaviours.	- Understand the risk of HIV in relation to different sexual practices and safe sex.	Group work.
3.15- 3.30pm	TEA		
3.30 - 4.30pm	Stigma and Discrimination.	- Create positive attitudes towards people living with HIV/AIDS.	Case study analysis and game.

Time	Topic	Objective	Methodology
8.30-9.00am	Recap	- Recapitulate the sessions of Day I	Brainstorming.
9.00-10.15am	All about condoms.	- Develop skills on correct and consistent use of condoms. - Develop capacity in overcoming barriers for condom use.	Group work.
10.15-10.30am	TEA		
10.30- 12.30	Effective Communication	- Understand the basics of effective Communication. Identify the barriers of communication and ways to overcome them. - Basics of Behaviour Change.	
12.30-1.15pm	LUNCH		
1.15-2.00pm	Roles of Peer Educators	- Create understanding on the role of peer educators in the prevention of HIV/AIDS and STIs in the Workplace.	Group work.
2.00- 3.00pm	Role play on Peer Education	- Develop skills in peer education techniques. Motivate the participants to discuss on sex and related issues openly.	Role play
3.00- 3.15pm	TEA		
3.15 - 4.15pm	Develop Work plan	- Identify opportunities within the workplace to integrate HIV/AIDS education and design a work plan.	
4.15- 4.30pm	Post Test	- Assess the improvement of knowledge and attitudes of the Participants as a result of the training programme.	Administration of test.
4.30-5.00pm	Closing Session	- Reading the PE pledge and Wrap up.	

Annex I: Games

(There are some games included here for the convenience of the trainers. Some are directly linked to the subjects and some are only ice-breakers. Opportunity for introducing new games is limitless and depends on the creativity of the trainers. It is reminded that these games should not take too much time. Otherwise, the time allocated for the session will be unnecessarily consumed..)

Distribute a sheet of paper and pen to each participant. Ask each participant to create a list of all the different types of work done by different individuals in their respective families, including themselves. Ask the participants to think about the types of work done by male relatives in comparison to the types of work done by female relatives. Have each participant read aloud a few examples from her list, specifying whether the activity is male, female, or for either gender. On the board, write the different types of work mentioned, creating a list of those done by men, a list of those done by women, and a list of those that can be performed by either sex.

Non-writing alternative: Rather than have each participant make a written list, divide the participants into pairs and ask them to discuss the different types of work done by different individuals in their respective families, including themselves.

Discuss reasons for categorizing these types of work as men's work or women's work and the absurdity of such classification.

1.1 Fruit salad

Fruit salad is ideal after lunch. All the participants stand in a circle. Resource person shows them the way to make fruit salad. He mentions four fruits; for example, pineapple, apple, bananas, and guava. In fact, each of these names of fruits, represent a direction. When the resource person says 'pineapple' all have to bend forwards. Accordingly they bend backwards when 'apple' is called out, bend to the left when 'bananas' is called out, and bend to the right when the call is for 'guava'. If the resource person says 'fruit salad', the participant's make a churning movement, turning the body above the waist with hands on the hip. The game is continued changing the fruit and calling out fruit salad in between. This freshens up those who were drowsy after the lunch.

1.2 Guess

One of the participants is sent out of the room. The others think of a subject out of items available in the room for her/him to guess such as, for example, a sun flower, which is seen physically in a vase of flowers or in a picture hanging on the wall. Or else, this subject can be an item of furniture in the room. When asked, the guesser returns to the room and begins to inquire, trying to guess the subject by its characteristics. The other players answer the questions briefly with “yes” or “no”. The guesser must formulate questions in a precise manner, so that it is possible to answer briefly, for example:

- Is it animate?
- Is it a piece of furniture?
- Is it yellow in colour? or similar questions..

With every question, the guesser must try to move from general to specific. The person, who guesses the subject with the help of the least number of questions, wins the game. A reward can be on offer, such as, for example, a packet of candies, which all could share.

Since the group is large, the game can be played in two rounds. About three guessers can be selected in the first round (may be using lots) and then continue with the game.

1.3 Filling the bottle

Place a bottle, a cup of water, and a teaspoon each on two stools. Each respective item should be similar in size. Divide participants into two teams of equal number and ask them to line up with each stool in front of them at the start line marked on the floor. When the signal is given to start the game, the player standing at the head of the line runs to the stool, takes a spoon, pours a spoonful of water from the cup to the bottle. Once done, the player runs back to the team and stands at the end of the line as the last person. This should continue and the team which fills their bottle first wins.

1.4 Who is it?

Everybody takes a sheet of paper and draws a head and neck, either of a man, an animal or a bird at the top of it. Then, the sheet is folded so that the drawn head cannot be seen, except a little part of the neck. Once everybody is finished, the drawing is passed to the next player. Now, every player has a new sheet with the picture s/he has not seen as yet. Now, everybody draws the body and then folds the paper and passes to the next player. The third player has no idea what the two players before her/him have drawn because the paper is folded in such a manner that only a last part of the body is seen. The third player completes the low extremities of the body. Once finished, unfold the picture. Outcome could be quite laughable!

1.5 Candy

Pass around a bag containing at least four different types of toffees. Ask each participant to take one toffee out of the bag. The Resource Person has one piece each in a box. After all the participants have selected their toffees, the Resource Person selects one toffee at random and announces that this toffee signifies that s/he has HIV or another toffee STD or that yet another toffee indicates an unplanned pregnancy. All participants with the respective types of toffee should stand as they have either HIV or STD or are involved with an unplanned pregnancy. The fourth kind of toffee is selected next. These participants now stand. These people have had sex with or shared drugs with the first group. Now they must worry about HIV/STDs or parenthood.

This continues until only one group remains seated. This group of participants has not been involved with any risky activity.

In summarizing, discuss the following questions:

- Why is this group left?
- How did you feel when you were told what your candy or toffee represented?
- Who made the choice?
- Look at another person in your group. Can you tell what kind of candy/toffee they have?
- Did anyone choose not to choose?
- How was luck involved?

Emphasize that in making choices regarding sex and drugs, “you can't tell by looking.”; that looks can be deceptive.

I.6 Harassment hurts

A shopping bag filled with water and tied well and some sharpened pencils are required. Keep the shopping bag in a tray. Tell the participants that the bag represents a person. The pencils will be insults, putdowns and the like . that we have heard throughout our life. Hold the bag up for all to see and ask a participant to shout an insult, while at the same time inserting a pencil into the bag. (Pencil must completely go through both sides of the bag). Ask another participant to do the same with another pencil and another shopping bag filled with water.

Discussion: How is this example represented in real life? The pencils (insults) stay in the bag (the person). As you pull out the pencils (apologies), the person is wounded, and what was once a vibrant, fulfilled human being becomes scarred, empty and worthless. . All these insults become a part of who you are.

Annex 2: National STD/AIDS Control Programme and Main STD Clinics

Services provided by the National STD/AIDS Control Programme

The National STD/AIDS Control Programme of the Ministry of Healthcare & Nutrition comprising the Central Clinic and National Reference Laboratory (in Colombo) and limited to a network of STI clinics and branch clinics across the country, provide free services for persons affected with sexually transmitted infections and HIV and AIDS. The aims of the NSACP are to

- 1 prevent HIV and other STIs in Sri Lanka
- 2 improve the quality of life of people living with /affected by HIV and AIDS by minimizing stigma and discrimination and providing them quality healthcare.

The NSACP works closely with the National Blood Transfusion Service and the National Programme for TB control and Respiratory Diseases.

The following services are available at the Central Clinic:

- Clinical management of sexually transmitted infections.
- Clinical management of HIV and AIDS.
- Free Antiretroviral therapy.
- Voluntary counselling & testing facilities (VCT).
- Institutionalized care at the IDH Hospital, Angoda for HIV/AIDS affected persons.
- PMCT services.
- National Reference Laboratory – laboratory based diagnostic services for sexually transmitted infections and HIV.
- Referral for related medical management, contraception & family planning services and medico-legal services.
- Pap smear testing.
- Referral for colposcopy.
- Outreach programmes on HIV and AIDS and STIs for the general public and targeted groups aimed at supporting behaviour change.
- Condom social marketing and free condoms.
- Hotline (Central Clinic, Colombo).
- Issue of medical certificates on Blood Test for Syphilis (VDRL- Venereal Diseases Research Laboratory Test) status for migrant workers.
- Teaching/training in Venereology for medical undergraduate and postgraduate students.
- Teaching/training of other health cadres, NGOs, CBOs.
- Pre-Employment medical screening for government officers.
- HIV Sero- surveillance / Behavioural surveillance.

Main STD clinics

STD clinic	Address	Telephone number
1	Ampara District General Hospital, Ampara	0602 -636301
2	Anuradhapura Teaching Hospital, Anuradhapura	0252 -236461
3	Badulla Provincial General Hospital, Badulla	0552 -222578
4	Balapitiya Base Hospital, Balapitiya	0912 -255447
5	Batticaloa Teaching Hospital, Baitticaloa	0652 -222261
6	Colombo Central Clinic National STD / AIDS Control Programme, 29, De Saram Place, Colombo 10	0112 - 667163 0112 - 667029
7	Chilaw General Hospital, Chilaw.	0322 -220750
8	Embilipitiya Base Hospital, Embilipitiya.	0452 -230141
9	Gampaha Base Hospital, Gampaha.	0332 -234383
10	Hambantota Base Hospital, Hambantota.	0472 -222247
11	Jaffna Teaching Hospital, Jaffna.	0212 -222261
12	Kalmunai Base Hospital, Kalmunai.	0672 -223660
13	Kalutara District General Hospital, Kalutara.	0342 -236937
14	Kalubowila Teaching Hospital, Kalubowila.	0114 -891055
15	Kegalle District General Hospital, Kegalle.	0352 -231222
16	Kandy Teaching Hospital, Kandy.	0812 -203622
17	Kurunegala Teaching Hospital, Kurunegala.	0372 -224339
18	Mannar District General Hospital, Mannar.	0232 -250573
19	Matale District General Hospital, Matale.	0663 -664387
20	Matara District General Hospital, Matara.	0412 -232302
21	Monaragala District General Hospital, Monaragala.	0552 -276261
22	Mahiyanganaya Base Hospital, Mahiyanganaya.	0552 -257261
23	Mahamodara (Galle) Teaching Hospital, Mahamodara (Galle).	0912 -245998
24	Negombo Base Hospital, Negombo.	0312 -224156
25	Nuwara Eliya District General Hospital, Nuwara Eliya.	0522 -234393
26	Polonnaruwa District General Hospital, Polonnaruwa.	0272 -225787
27	Ragama Teaching Hospital, Ragama.	0112 -960224
28	Ratnapura Provincial General Hospital, Ratnapura.	0452 -226561
29	Trincomalee District General Hospital, Trincomalee.	0262 -222261
30	Vavuniya District General Hospital, Vavuniya.	0242 -224575

Hotline (Central STD Clinic, Colombo) - 011 2667162

Branch clinics (operating as of 1st January 2010)

Branch Clinic Conducted By Chilaw STD Clinic

Contact No - 0322 - 220750

Clinic	Address	Days and Time of Functioning
1 Putatlam	Base Hospital Putatlam	Tuesday. 10.00 - 14.00
2 Dankotuwa	District Hospital Dankotuwa	2nd and 4th Thursday of the Month
3 Kalpitiya	District Hospital Kalpitiya`	1st and 3rd Wednesday of the Month

Branch Clinic Conducted By Kaluthara STD Clinic Contact No -0342 -236937

1 Panadura	Base Hospital Panadura	Tuesday 8.30 - 10.00 2
2 Horana	Base Hospital Horana	Friday 8.30 - 12.00

Branch Clinic Conducted By Kandy STD Clinic Contact No - 0812 - 203622

1 Nawalapitiya	District Hospital Nawalapitiya	1st and 3rd Wednesday of the Month
2 Bogambara	Prison Hospital Bogambara	1st and 3rd Tuesday of the Month
3 Pallekele	Open Prison Pallekele	4th Wednesday of the Month

Branch Clinic Conducted By Kurunegala STD Clinic Contact t No - 0372 - 224339

1 Kuliapitiya	Base Hospital Kuliapitiya	Monday 11.00-14.00
2 Nikaweratiya	Base Hospital Nikaweratiya	Thursday 11.00-14.00

Branch Clinic Conducted By Polonnaruwa STD Clinic Contact No - 0272 - 225787

1 Bakamuna	Peripheral Unit Bakamuna	1st Friday of the Month.
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Annex 3:

TIPS FOR ORGANIZING A TRAINING PROGRAMME

This is a checklist to support peer educators or trainers organizing training activities.

Pre-training

- Need Assessment (It is obvious in this instance – HIV prevention in workplace environments.)
- Curriculum and Lesson Plans (Module is provided.)
- Participants, their background and the level of their awareness of the .subject.
- Venue – space and facilities (In a suitable place within the workplace.)
- Resources
 - Person
 - Budget
 - Training Material (should match with the equipment available)
 - Training Equipment (check them if they are in working condition)
- Detailed Lesson Plan.

Training

Physical facilities:

- Stationery (Handouts, writing paper)
- Facilities – furniture, toilets, electricity and water and other relevant facilities.
- Atmosphere free from distractions.
- Timing: Aiming to suit time available without disrupting work, with the consent of the management.
- Food or refreshments.
- Rest.
- Payments for refreshments, stationery and other facilities..
- Follow-up.
- Keeping Records. (It is advisable to keep a record of proceedings for future reference.)

Participant assessment:

- Pre-test
- Post-test

Post Training

- Follow-up/Monitor (A format is provided.)
- Evaluation
- Records
 - Course-end Report
 - Expenditure Statement
 - Proceedings

Responsibilities of Participants

- Express willingness to learn.
- Express expectations.
- Be part of a group.
- Share experiences.
- Cooperate in learning activities.
- Confront / Clarify
 - Self
 - Facilitator
 - Fellow participants
- Provide feedback.

Process

- Meeting venue / Its preparedness.
- Physical facilities.
- Warm social atmosphere.
- Suitable methodology -Non-threatening climate. -Allowance for personal discovery. - Theory building rather than theory imposing. -Reassurance.

Responsibilities of Facilitator

- Openness to learn.
- Clarify learning direction.
- Preparedness / Readiness.
- Facilitate
 - Conductive learning.
 - Experience sharing.
 - Identifying mind-sets.
- Observe -Quality of participation. -Facilitating or obstructing behaviour. -Symptoms of withdrawal.
- Counselling

Annex 4

The Peer Educators' Pledge

As Peer Educators of the HIV/AIDS Workplace Education Programme of the ----- Company, we pledge, with dignity and honour, to commit ourselves to always disseminate correct & necessary information on prevention of HIV to our co-workers, to provide them with guidance, care and support and to maintain strict confidentiality at all times.

Name	Signature
.....	
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.....	
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.....	

Date:

Annexure 5

Suggestions for PRE/POST TEST questionnaire

01. What is HIV?

02. What is AIDS?

03. Name 3 body secretions that could contain a high concentration of HIV?

I

ii

iii

04. Write three main modes of HIV transmission?

I

ii

iii

05. Explain the “window period” in brief.

06. Answer Yes or No to the following questions

i. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner, who has no other partners?

ii. Can a person reduce the risk of getting HIV by using a condom every time s/he has sex?

iii. Can a healthy-looking person have HIV?

iv. Can a person get HIV from mosquito bites?

v. Can a person get HIV by sharing food with someone, who is infected?

07. Mention three important steps you would take if you learn that one of your peers is HIV+.

i

ii

iii

08. Write three possible measures for prevention of HIV infection.

- i.
- ii.
- iii.

09. Write 04 Sexually Transmitted Infections (STIs) common in Sri Lanka.

- i. ii. iii. iv.

10. What do you understand by the terms “gender” and “sex”.

11. Identify three barriers that prevent women from entering non-traditional jobs?

- i.
- ii.
- iii.

12. Equal opportunity is (circle the correct answer):

- i Providing facilities to generate equal outcomes by men and women.
- ii The process of being fair to men and women.
- iii Equality of opportunity and treatment irrespective of a person's sex.

13. Explain in a few words the general changes that occur when either a boy or a girl reaches puberty.

14. What is not an objective of family planning out of the following?

- i Assisting to overcome sub-fertility.
- ii Terminating unwanted pregnancies.
- iii Delaying the arrival of first child.
- iv Spacing births.

15. Give two ways in which condoms provide protection.

- i
ii

16. Are condoms effective against all STIs? Circle the correct answer. Yes / No

17. Identify the permanent (marking “P”) and temporary (marking “T”) contraceptive methods out of the following:

Loop (IUD)		Vasectomy	
Tablets		Implants (Norplant)	
Condoms (Male & Female)		Injectables (Depo-Provera)	
Tubectomy		Withdrawal	
Abstinence		Rhythm	

18. What is meant by gender based violence (GBV) in your understanding?

19. Are there any laws specifically against GBV? Yes / No.
If possible, name one or more in case the answer is “Yes”.

20. Mention three organizations that provide solace to victims of GBV.

21. What is the relationship between HIV and GBV?

22. Mention ways in which People Living with HIV are subjected to stigma and discrimination

23. Write 05 consequences of discrimination against a person with HIV.

- i
- ii
- iii
- iv
- v

24. Out of men and women who are more at risk and how?

25. What are the pre-requisites for behaviour change?

26. Who is a peer educator?

27. Write 05 qualities necessary for a peer educator.

- i
- ii
- iii
- iv
- v

Answers:

01. Human Immunodeficiency Virus.

02. Acquired Immunodeficiency Syndrome.

03. - Blood (including menstrual blood).

- I. Semen.
- II. Vaginal secretions/fluids.
- III. Breast milk (to a baby).
- IV. Cerebrospinal fluid.
- V. Wound drainage.

04. i. Unprotected sex.

- ii. Blood.
- iii. Mother to child

05. The period between becoming infected with HIV and the point at which antibodies to HIV can be detected in the blood is called the “WINDOW PERIOD”.

06. i. Yes. ii. Yes. iii. Yes. iv. No. v. No.

07. i. Treating the person with empathy but not sympathy.

- ii. Make the person feel his or her condition is not a barrier to maintain sound normal relationships.
- iii. Intervene at times when others treat him/her harshly
- iv. Provide guidance regarding the steps to be taken such as regular visit to the clinic.
- v. Maintain confidentiality.
- vi. Helping to plan the future.

08. i. Abstinence.

- ii. Being faithful to one mutually faithful partner for sexual relationships.
- iii. Correct and consistent condom use.

09. i. Syphilis.
- ii. Gonorrhea.
- iii. Genital warts.
- iv. Trichomoniasis.
- v. Genital herpes.

10. Gender” is a social construct whereas “sex” is a biological construct.

11. i. Traditional ideas that some jobs are not appropriate for women.
- ii. Attitude of the community demeaning women in non-traditional jobs.
- iii. Barriers in the job market.
- iv. Family members or close relatives making decisions on behalf of women.
- v. Feeling that women's output levels are low.

12. Equality of opportunity and treatment irrespective of a person's sex.

13. Onset of adult features; Change in preferences; Attraction to the opposite sex.

14. Terminating unwanted pregnancies.

15. i. Prevention from STIs.
- ii. Preventing unwanted pregnancies.

16. No. Condoms are effective only for some sexually transmitted infections. A greater level of protection is provided for the diseases transmitted by genital secretions. A lesser degree of protection is provided for genital ulcer diseases or HPV (human papilloma viruses) because these infections also may be transmitted by exposure to areas (e.g., infected skin or mucosal surfaces) that are not covered or protected by the condom.

17. Identify the permanent (marking “P”) and temporary (marking “T”) contraceptive methods out of the following:

Loop (IUD)	T	Vasectomy	P
Tablets	T	Implants (Norplant)	T
Condoms (Male & Female)	T	Injectables (Depo-Provera)	T
Tubectomy	P	Withdrawal	T
Abstinence	T	Rhythm	T

18. Acts of violence involving women and men, in which the female is usually the victim and which arises from unequal power relationships between women and men.

19. The Prevention of Domestic Violence Act-2005 ; CEDAW; Criminal Law.

20. The Police (Women's Desks); Women's NGOs; Organizations like Sri Lanka Sumithrayo;
21. Women in positions of abject dependence on male authorities are particularly subject to unwanted sexual coercion by violent means and in a majority of instances, they are deprived of making decisions on safe sex .
22. Answers such as “treating as an outcast”, “injuring the person's prestige”; “victimizing women”; “humiliation”; “treating as a black sheep” are acceptable.
23. i. Prevention of access to employment.
 ii. Discontinuance of employment.
 iii. Distancing by previously near and dear
 iv. Being considered as a burden by family members
 v. Excommunication at various levels of the community.
24. Women are more at risk because:-
- they are biologically more at risk of HIV infection than men.
 - there is sexual subordination in marriages or relationships.
 - there is violence perpetrated against women and girls.
 - of their economic and social dependency.
 - of the burden of caring for HIV-infected family and community members.
 - of Poverty.
 - migrants and refugees in many countries are women.
 - most women have limited access to education and higher rates of illiteracy.
 - discriminatory property, inheritance, custody and support laws affect women.
 - HIV-related stigma and discrimination is more towards women more often than men.
 - of their subordination to male colleagues or superiors at the workplace.
 - of lack of social security or other occupational benefits.
 - many men having sex with men, have female partners or wives.
25. Motivation based on knowledge and attitude.
26. Peer educator is a person, who shares common characteristics with the peer group on whom the programme is focused (age, sex, economic status and position).
27. Any five of the following -
- being part of the workers.
 - being motivated by concern for the health of their colleagues.
 - being available and accessible to workers at all times.
 - having effective interpersonal skills.
 - having natural leadership skills.
 - possessing good organizational skills.
 - being respected by the colleagues.
 - the ability to listen to other peers without bias or assumptions.
 - the ability to speak the language spoken at the workplace, and
 - the ability to keep sensitive information confidential.