DISSERTATION

PROMOTING PSYCHOSOCIAL HEALTH AND EMPOWERMENT AMONG FEMALE SEX

WORKERS IN NEPAL: A PILOT PEER EDUCATION INTERVENTION

Submitted by

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ABSTRACT

PROMOTING PSYCHOSOCIAL HEALTH AND EMPOWERMENT AMONG FEMALE SEX

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Across contexts, female sex workers (FSWs) may be exposed to varying degrees and combinations of risks in their work, including but not limited to long hours, poor working conditions, disease transmission, unplanned pregnancy, violence, drug and alcohol use and abuse, debt, and various forms of harassment, discrimination, and exploitation. It is likely that the risks associated with sex work are greater in developing countries where sex workers have a low and stigmatized status, minimal capacity to earn an adequate income, limited level of control regarding clients accepted and services rendered, and restricted access to sufficiently resourced health and other services and support structures. The sex industry in Nepal is synonymously referred to as the entertainment sector. Women in the entertainment sector (WES) in Nepal are vulnerable to an array of occupational risks, which compromise their psychosocial health and empowerment, in turn limiting their ability to thrive and engage in protective behaviors.

The present study involved the pilot test of a peer education intervention in collaboration with a non-governmental organization (NGO) to empower and promote the psychosocial and occupational health of WES in Kathmandu, Nepal. Ten WES were trained as peer educators (PEs) and, through formal and informal teaching opportunities, reached over 140 FSWs with psychosocial health promotion messages. In addition to a detailed literature review, method, and discussion, this dissertation comprises three manuscripts.

The first manuscript presents results from a quasi-experimental pre/post evaluation with 160 WES, including those who were ($n = 96$) and were not ($n = 64$) exposed to the PEs, to assess the impact of the program on psychosocial and occupational health and empowerment outcomes. Results indicate that WES who were exposed to the psychosocial health promotion messages of the PEs reported significantly improved psychosocial health knowledge and perceived self-efficacy, ability to access resources, happiness, and job control compared to WES who were not exposed to the PEs.

The second manuscript presents results from a mixed-methods evaluation to assess the feasibility of the program and its impact on the psychosocial and occupational health and empowerment of the 10 WES trained as PEs. PEs were surveyed at baseline, immediately post intervention, after 2-months, and after 10-months to evaluate psychosocial and occupational health, empowerment, and peer education efficacy. Upon completion of the program, one-on-one exit interviews were conducted with nine of the PEs and two field staff from the partner NGO to solicit more in-depth feedback about the program. PE survey results indicate the program had a significant impact on some aspects of psychosocial health and empowerment, with positive trends on many other variables. Exit interviews revealed additional positive impacts of the program, including enhanced confidence and communication skills and increased self-awareness and self-care behaviors. Overall, the findings presented in these two manuscripts suggest peer education is both a feasible and promising means to enhance the psychosocial and occupational health and empowerment of WES in Nepal.

The third manuscript details the processes implemented in this pilot study. Peer education methods have been established as a promising way to reach FSWs and other vulnerable and hard-to-reach populations with health promotion programming; however, there is scant published

information about how such programs are designed and implemented. This lack of process information contributes to poor clarity regarding how to effectively develop and execute peer education programs and increases the propensity for repetition among failed strategies. Using this pilot program as an example, this manuscript offers an in-depth vantage point into the black box of peer education by outlining the specific steps taken while designing, implementing, and evaluating the program. While considering each phase of the project, the challenges encountered along the way as well as the effective strategies implemented to overcome them are reviewed, with a focus on offering practical tips and strategies. Conclusions and a summary of recommendations for those interested in implementing similar programs are discussed.

These three manuscripts as a whole can be used to inform future interventions aiming to enhance the psychosocial and occupational well-being and empowerment of sex workers and other vulnerable and hard-to-reach working populations through peer education methods.

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CHAPTER 1: INTRODUCTION

Sex Work: History, Context, and Occupational Risks

Sex work or prostitution has been recognized in nearly every corner of the world. First

documented around 2000 BC, it has been referred to by some as the world's oldest profession

(Carr, 1995). The Joint United Nations Programme on Human Immunodeficiency

Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS; UNAIDS, 2006) maintains a broad

and inclusive definition of sex workers as "female, male and transgender adults and young

people who receive money or goods in exchange for sexual services, either regularly or

occasionally, and who may or may not consciously define such activity as income-generating"

(p. 8). Although some ancient traditions recognized sex work as the hereditary calling of certain

castes or subgroups, most current sex work is motivated by the economic objectives of sex

workers and/or other stakeholders (e.g., establishment owners, pimps) involved in the industry

(Aral et al., 2003).

Globally, a majority of those engaged in sex work are women or girls. Due to pervasive

gender inequalities in access to education, employment, and financial support outside of

marriage, some women and girls view sex work as one of the few available options to support

themselves (UNAIDS, 2002). The economic burden may be greater for women whose husbands

have died or abandoned them and therefore bear the primary responsibility to support their

children and/or other family members (UNAIDS, 2012).

The boundaries of what constitutes sex work are vague, spanning from erotic

performances with no physical contact to unprotected sexual intercourse (Harcourt & Donovan,

2005). Some individuals may occasionally exchange sexual favors for money or goods without

perceiving themselves as sex workers, while others may explicitly engage full-time in the commercial delivery of sexual services (Harcourt & Donovan, 2005). There is also great variation in terms of the structure of sex work. Some work under a controller, such as a manager or pimp, and others work independently. Some work in commercial establishments such as brothels or bars, and others work in public spaces such as in parks or on the street (Baral et al., 2012). Some are mobile and go where they can best earn, while others tend to stay in one place (UNAIDS, 2012). There is also dissimilarity in terms of clientele—some may cater to local communities while others are more focused on transient or migrant client populations (UNAIDS, 2012). Sex work also varies by level of choice—some freely choose sex work as their occupation while others are forced or coerced through various forms of trafficking (Ross, Crisp, Månsson, & Hawkes, 2012).

Due to the hidden and clandestine nature of sex work, the variation of opinions in terms of what constitutes sex work, and the high mobility of sex workers, it is difficult to estimate the absolute size of the sex worker population across the world or in any given country or city. Vandepitte et al. (2006) collected estimates of the proportion of female sex workers (FSWs) across different regions of the world, including Sub-Saharan Africa, Asia, Europe, Ex-Russian Federation, and Latin America, and found prevalence rates ranging between 0.4% and 7.4% of the total population across countries.

The nature of sex work varies considerably across different populations and regions of the world in terms of legality, visibility, and risk (Vandepitte et al., 2006). As stated by Harcourt and Donovan (2005), "every country, and every region within those countries, has a different composition to its sex industry—shaped by history, social and economic factors, legal framework, and policing practices" (p. 201). In some societies, sex work is legal and regulated,

sex workers are not economically impoverished or heavily stigmatized, and they are able to access health and other social services (Harcourt, Beek, Heslop, McMahon, & Donovan, 2001). In other societies, sex work takes the role of a survival tactic against the backdrop of severe poverty and desperation (UNAIDS, 1997). It is likely that the nature of sex work in many societies falls somewhere between these two extremes.

The extant variation in terms of who engages in sex work, their reasons for doing so, the sexual services provided, and the social context in which sex work takes place—in other words, variation in the who, why, what, and where of sex work—leads to a broad spectrum of health implications (Harcourt & Donovan, 2005). For instance, the health and well-being of FSWs in a country that has a well developed health infrastructure and laws protecting sex workers will differ significantly compared to a setting in which sex work is criminalized and basic health services are almost non-existent. Level of desperation is also a powerful factor that influences sex worker health outcomes. Given that women's primary motivation for engaging in sex work is often to support and provide a better life for their children (UNAIDS, 2002), even FSWs who are well educated about HIV and its transmission may forego using a condom if their child is sick, and they are desperate to earn money (Newman, 2003). It is necessary to understand the milieu within which sex work occurs, the power structures at play, and the broader social situation of FSWs when considering the health needs of FSWs (World Health Organization, [WHO], 2012b).

Although the hazards of sex work are context-specific, the profession is arguably a dangerous one. Across the diverse circumstances in which sex work takes place, sex workers may be exposed to different levels and combinations of hazards in their work, including but not limited to poor working conditions, long hours, disease transmission, violence, criminalization, drug and alcohol use, and various forms of discrimination, harassment, and exploitation (Rekart,

2005; Ross et al., 2012). Sex workers have been identified as a key population at risk for HIV infection (World Health Organization, 2016). Across 110 low- and middle-income countries, the HIV prevalence among sex workers is an average of 12 times higher than that of the general population, reaching as far as 50 times higher in some countries (UNAIDS, 2014). As a result of their high-risk status and the broader public health implications of disease transmission (i.e., given their potential role in serving as a bridge to the general population), the most commonly addressed risk among sex workers has been HIV and other sexually transmitted infections (STIs).

Psychosocial Health of FSWs

While substantial efforts and resources have been allotted to the prevention of HIV and other STIs, other occupational risks facing sex workers, including their psychosocial health, have largely been ignored. Psychosocial health is defined as "the mental, emotional, social, and spiritual dimensions of health" (Donatelle, 2009, p. 32). In other words, it refers to all aspects of health other than the physical or biological, including internal well-being as well as relationships with others.

The scant evidence available largely suggests poor psychosocial health among sex workers. For instance, Rössler et al. (2010) assessed the mental health of FSWs ($N = 193$) in Zurich, Switzerland and found that, compared to a non-sex worker sample, FSWs had higher one-year prevalence rates of mental disorders (50.3% vs. 12% respectively), as well as higher rates of mood disorders (30.1% vs. 5.6% respectively) and anxiety disorders (33.7% vs. 8.7% respectively). Gorry, Roen, and Reilly (2010) conducted a qualitative interview study exploring the emotional impacts of sex work, and found that FSWs from the UK reported a lack of self-respect and self-confidence, internalization of negative messages stemming from stigmatization,

fear of violence and abuse, lack of control and choice in their working lives, and feelings of guilt, shame, vulnerability, and stress. In a cross-cultural example, Farley (2003) interviewed 854 current or former sex workers (primarily females, but also including males and transgender individuals) from Canada, Colombia, Germany, Mexico, South Africa, Thailand, Turkey, the US, and Zambia, and reported that 68% met the criteria for post traumatic stress disorder (PTSD). In line with these findings, other studies have reported high rates of PTSD (Israel, Chudakov, Ilan, Belmaker, & Cwikel, 2002; US, Farley & Barkan, 1998), depression (China, Lau, Tsui, Ho, Wong, & Yang, 2010; Israel, Chudakov et al., 2002; Puerto Rico, Alegria et al., 1994; US, Farley & Barkan, 1998), substance use (China, Lau et al., 2010; UK, Gossop, Powis, Griffiths, & Strang, 1994, 1994; US, Kuhns, Heide, & Silverman, 1992, Young, Boyd, & Hubbell, 2000), self-harm tendencies (China, Lau et al., 2010; US, Kidd & Kral, 2002), and low self-esteem (China, Lau et al., 2010; UK, Harcourt et al., 2001; Zambia, Agha & Chulu Nchima, 2004), as well as a pessimistic future outlook (China, Lau et al., 2010; Singapore, Kok, Ho, Heng, & Ong, 1990), low life satisfaction (China, Wong, Holroyd, Gray, & Ling, 2006); US, Baker, Wilson, & Winebarger, 2004), and lack of perceived meaning in life (China, Wong et al., 2006) among FSWs.

A handful of studies have failed to establish a link between sex work and poor psychosocial health. For instance, Romans, Potter, Martin, and Herbison (2001) compared FSWs with an age-matched community sample of women in Australia and found no differences in mental health outcomes between the two groups. However, the sample of FSWs in this study was quite small (n = 29), and was therefore associated with an increased chance of a type two error (i.e., having insufficient statistical power to detect a difference even if one is actually present). In another example, Vanwesenbeeck (2005) examined levels of burnout, defined as a state of

mental, emotional, and physical exhaustion (Pines & Aronson, 1988), among FSWs in the

Netherlands. One of the most common measures of burnout, the Maslach Burnout Inventory

(Maslach, Jackson, & Leiter, 1996) is comprised of three dimensions: depersonalization (i.e.,

negative, detached, and cynical feelings towards other people), emotional exhaustion (i.e.,

feelings of being over-extended and depleted of emotional resources), and personal

accomplishment (reduced feelings of competence; Schutte, Toppinen, Kalimo, & Schaufeli,

2000). Vanwesenbeeck (2005) compared FSWs with two comparison groups (one consisting of

female nurses and the other a mixed-sex group of patients with "work-related psychological

problems") and found that only one of the three established dimensions of burnout,

depersonalization, was significantly higher among FSWs (p. 627). According to

(Vanwesenbeeck, 2005), negative social reactions, experiences of violence, lack of choice in

work situations, and lack of control in client interactions explained substantial variance in the

depersonalization aspect of burnout. It is important to keep in mind that both of these studies

were in countries with better infrastructure and laws protecting FSWs.

Poor psychosocial health, such as depression, anxiety, low self-confidence, low self-

esteem, and helplessness, contributes to a lack of motivation as well as a lack of perceived

agency or empowerment to engage in protective behaviors and pursue positive life changes.

Newman (2003) provided an eloquent explanation of the importance of psychosocial health in

the context of preventing HIV among FSWs as follows:

> Paramount in many HIV prevention models, most of which focus on the
> individual level of behavior change, is the underlying, but not always
> acknowledged, assumption that the individual has enough self-respect, feeling of
> self-worth, and will to live that she is motivated to implement efforts to protect
> herself from HIV (p. 170).

Of course, the promotion of psychosocial health among FSWs is important in terms of the general aim to promote health and well-being. But also, without a strong foundation of psychosocial health, programs targeting the physical health risks of FSWs, such as HIV and violence prevention programs, are likely to have minimal impact. In fact, there is evidence linking poor psychosocial health with higher HIV prevalence and lower rates of condom use among FSWs (Cournos, McKinnon, & Wainberg, 2005). For instance, Lau et al. (2010) investigated the associations between psychological problems and sexual health behaviors among Chinese FSWs and found those with suicidal ideation, poor mental health as assessed by the Mental Health Subscale SF-36, and a pessimistic future outlook were significantly more likely to report inconsistent condom use. Additionally, emotional instability and lack of social support were significantly associated with non-use of HIV prevention services. In another example, a study in Puerto Rico found a substantially higher HIV infection rate among sex workers with high levels of depressive symptoms compared to those with low levels (70% and 30% respectively; Alegria et al., 1994). Overall, these studies suggest there may be serious public health implications associated with poor psychosocial health among FSWs.

As a result of these findings, scholars involved in STI/HIV prevention among sex workers have argued for the importance of promoting psychosocial health in order to maximize the impact of prevention efforts (Chudakov et al., 2002; Lau et al., 2010; Rekart, 2005). For instance, Rekart (2005) advocated for interventions to move beyond the limited objective of HIV/STI prevention to enabling FSWs to move into "a more positive cycle of empowerment, supportive environment, harm prevention and mitigation, and improved quality of life" (Rekart, 2005, p. 2130). Gorry et al. (2010) laid out several recommendations for addressing emotional and psychological health issues with sex workers, one of which was to identify and overcome

FSWs' low self-worth and helplessness as well as other psychological barriers to adopting positive and healthy attitudes and behaviors. Some have even gone so far as to say that psychosocial health, particularly the promotion of empowerment or agency, is a necessary condition for successful prevention. In fact, 25 years ago Campbell (1991) asserted, "In order for any preventive approach to be effective, it will first have to empower prostitutes" (p. 1376). Despite these calls for action, there has been little research directly focused on understanding and promoting the psychosocial health and empowerment of sex workers.

Work and Non-Work Factors Related to Poor Psychosocial Health among FSWs

Workplace demands, including those related to the work itself, working conditions, the climate and culture of the organization, and relationships with others at work, are all likely contributors to the poor psychosocial health of FSWs. There is substantial research linking various work-related demands, often referred to as stressors, to various psychosocial health outcomes, often referred to as strains (Cooper & Marshall, 1976; Ganster & Rosen, 2013; Kornhauser, 1965). One of the most common models developed to explain the mechanisms underlying these stressor-strain relationships is the demand-control-support model. The demand-control-support model asserts that psychosocial strains will be experienced in jobs with high demands, low control, and low support (Karasek & Theorell, 1990). Bonde (2008) reviewed ten follow-up studies examining the causal relationship between the risk of experiencing major depressive disorder and the separate dimensions of the demands-control-support model. Results indicated elevated risk was associated with all three dimensions: odds ratio [OR] = 1.31, 95% confidence interval [CI] = 1.08, 1.59 for demands, OR = 1.20, CI = 1.08, 1.39 for control, and OR = 1.44, CI = 1.24, 1.68 for support (Bonde, 2008). Lack of control in the form of

participation in decision-making at work has also been linked with low self-esteem, motivation, and life satisfaction (Margolis, Kroes, & Quinn, 1974).

Although much of the theoretical work on stressors and strains has been conducted in traditional work settings, many of the established stressor-strain relationships find relevance in the context of sex work. For instance, Kornhauser (1965) found evidence linking poor mental health to unpleasant working conditions and excessive and inconvenient hours, both of which are characteristic of the sex industry. Sex work is associated with a unique set of cognitive and emotional demands that may contribute to elevated levels of psychosocial strain among FSWs. Sex work has been described as "emotion work" (Hochschild, 1979, 1988), in that FSWs are forced to fake their emotions and behaviors in order to satisfy the needs and expectations of their clients. Browne and Minichiello (1995) described this as "switching off the true self and going into 'remote control mode' or adopting a role" (p. 611). Sex workers are then tasked with the additional emotional burden of distancing themselves from this falsified persona in order to maintain their true identity (Brewis & Linstead, 2000). Another psychological burden of sex work is related to the need to stay vigilant, fully alert and attentive in order to protect themselves against potential dangers (Brewis & Linstead, 2000). Sex workers can never fully switch off, lest risking danger or slippage of their professional mask (Brewis & Linstead, 2000; Sanders, 2004). Although levels of demands, control, and support are likely to vary considerably across different sex worker populations, it is probable that demands are higher and control and support are lower in poverty-stricken societies where the industry is unregulated and sex workers are more vulnerable to exploitation and abuse.

There are also a number of factors outside of the work context, such as family problems and financial difficulties, which are likely to influence the psychosocial health of FSWs (Vanwesenbeeck, 2001). As stated by the WHO (2005):

> Sex workers often have a wide range of pressing concerns that affect their health, well-being, and capacity for action both directly and indirectly. These may include worries about children, police harassment, exploitative working conditions, housing problems, domestic violence, migration status, and HIV-related stigma (p. 16).

These non-work stressors are likely to act in a feedback loop in which problems outside of work affect the individual at work, which in turn exacerbate problems outside of work (Cooper & Marshall, 1976). For instance, as has already been noted, FSWs who are under financial duress may place their own health secondary to more immediate needs such as earning money to provide food, shelter, and education for their children (Basu & Dutta, 2009), making them more prone to tolerate heightened levels of risk.

Many have pointed to the role of social stigma in contributing to psychosocial distress (El-Bassel et al., 1997), mental disorders (Rössler et al., 2010), and negative self- and group-image (Evans, Jana, & Lambert, 2010) among sex workers. FSWs experience stigma and discrimination both within and outside of the context of sex work in response to the nature of their work and the defiance of social norms dictating the acceptability of having multiple partners for men but not for women (Fullilove, Fullilove III, Haynes, & Gross, 1990). Newman (2003) spoke to the influence of stigma as follows:

> Stigma is, in general, antithetical to HIV prevention, as it is precisely disempowering. Stigma acts as one deterrent to sex workers' (or any other stigmatized group's) meeting together in public, or advocating for themselves, as in so doing the sex workers call increased attention to themselves on that dimension in which they are stigmatized, in turn, garnering disapprobation, and sometimes violence, from others (p. 173).

Due to their stigmatized status, sex workers may feel they have to conceal their identity to friends and loved ones (Vanwesenbeeck, 2001). This situation not only diminishes social support structures, but also places an emotionally demanding burden on sex workers to maintain "double lives" (Vanwesenbeeck, 2001, p. 268).

In sum, there are numerous work- and non-work factors that contribute to the poor psychosocial health of FSWs. FSWs work under situations of high demands, such as long hours, emotional labor, and limited control and support. Outside of work, FSWs often face additional stressors, such as financial instability and family problems. Of course stigma and discrimination can be experienced both within and outside of the context of sex work. These multiple and diverse risks undoubtedly place the psychosocial health and overall well-being of FSWs at risk, which in turn has a negative impact on their ability to protect themselves from future risks as well as their receptivity to prevention programming.

In spite of the recognized importance of promoting psychosocial well-being among women working in the sex industry, there is a scarcity of support and care services for FSWs with psychosocial health problems (Dalla, 2006; Gorry et al., 2010; Sanders, O'Neill, & Pitcher, 2009), and there have been no published interventions to date exclusively targeting this issue. The present study marks an initial attempt to develop and pilot an intervention that specifically aims to promote psychosocial health among FSWs. Given the importance of developing new programs based on previous evidence, a review of risk reduction programs for FSWs with a focus on which program components have been most effective served as a starting point for developing the intervention.

Risk Reduction Programs for FSWs

Risk reduction programs for FSWs have focused on three levels of change: individual, community, and policy. Within these levels, many different strategies have been implemented, including education, prevention, care, occupational health and safety, and decriminalization initiatives (Rekart, 2005). The primary aim of risk reduction programs targeting sex workers has been on mitigating physical health risks, most commonly those related to HIV/STI prevention. In fact, it could be argued that in terms of risk reduction and health promotion, sex worker health is often equated with sexual health, while other facets of health are largely ignored.

A crucial aspect of all risk reduction programs is the stance that sex work is a profession, akin to any other, and that as workers, FSWs should be protected from all health and safety risks inherent in their profession (Newman, 2003). In other words, the goal of risk reduction is not to abolish sex work, but rather to reduce the hazards inherent in it. Newman (2003) articulated the importance of adopting this stance as follows:

> It seems disingenuous and incongruous to on the one hand tell these women [FSWs] that they are valued and cared for, and on the other hand that they are engaged in an ignominious and shameful means of making money, or to solely focus on ways to get out of sex work (p. 171).

Historically, the majority of HIV prevention programs have focused on promoting individual-level behavior change, primarily targeting sex workers' attitudes and behaviors related to safe sex (Gurnani et al., 2011; Newman, 2003). However, increased awareness of the limitations inherent in individual-level theories of behavior change has led some to argue for the importance of additionally focusing on structural and environmental influences (e.g., Gurnani et al., 2011). As a result, community empowerment, a strategy that has been used in many other settings to increase health and well-being, has been gaining recognition as a particularly effective risk reduction strategy for FSWs (Kerrigan, Fonner, Stromdahl, & Kennedy, 2013).

According to Karr, Pascual, and Chickering (1999) the aim of empowerment movements is "to enable the powerless to take proactive actions to prevent threats and to promote positive aspects of their lives" (p. 1433). Specifically, community empowerment approaches aim to challenge existing disenfranchising structures and promote increased collective and individual agency and control among sex workers both at work and in the broader society (Laverack & Wallerstein, 2001; Wallerstein, 1992). As opposed to a top-down approach, such as policy change, community empowerment approaches primarily rely on creating change from the bottom up through community mobilization (Evans et al., 2010). Community empowerment efforts typically focus on facilitating access to two broad domains of resources: material and relational (Ghose, Swendeman, George, & Chowdhury, 2008). Resource promotion strategies vary considerably from program to program; however, most interventions work to stimulate sex workers' individual and collective agency to challenge the inequitable social structures that negatively impact their health, well-being, and ability to protect themselves from HIV and other risks (Kerrigan et al., 2013). The International Labour Organization (ILO, n.d.) has highlighted a number of benefits of such community empowerment programs, including their capacity to leverage existing bonds among community members.

Kerrigan et al. (2013) conducted a meta-analysis of peer-reviewed articles published between 1990 and 2010 that evaluated the success of community empowerment interventions in preventing HIV/STI infection and promoting condom use among sex workers in low- and middle-income countries (LMICs). Overall, they reported positive effects of community empowerment programs on multiple HIV-related outcomes, including more consistent condom use with clients. The WHO (2012a) also conducted a systematic review of community empowerment programs for sex workers in LMICs and found positive trends in terms of reduced

HIV/STI prevalence and increased condom use. This review lauded community empowerment programs for having high benefits and no associated risks (WHO, 2012a).

One of the most well-known community empowerment interventions to target HIV/STI prevention among FSWs is the Sonagachi Project in Kolkata, India. Initiated in 1992, the Sonagachi Project is an ongoing, community-led intervention targeting both risk behaviors as well as broader structural factors that marginalize FSWs and increase their vulnerability to HIV. The intervention includes various components including peer education, HIV/STI testing and treatment, community organizing, and micro-credit programs, in addition to advocacy and anti-trafficking activities (Jana, Basu, Rotheram-Borus, & Newman, 2004). During implementation of the program, there were substantial increases in consistent condom use between FSWs and their clients along with significant decreases in STIs (Jana & Singh, 1994). A controlled trial replication of the original intervention model in two small urban communities in northeastern India was also associated with increased condom use among those in the intervention community (Jana et al., 2004). As a result of these successes, the Sonagachi Project has been recognized by the WHO as a model program for STI/HIV intervention (Nagelkerke et al., 2002).

A defining feature of the Sonagachi Project is its focus on empowering sex workers through individual, group, and structural level change (Newman, 2003). It is one of the few interventions that have specifically directed efforts toward helping FSWs build self-reliance, self-esteem, and self-respect (Newman, 2003). Developing trust and relationship building among sex workers and allowing them to assume greater responsibility and decision making power have been highlighted as key elements that have led to the success of the program (Newman, 2003).

In addition to adopting a community empowerment approach, a review of the risk reduction literature suggests a number of best practices that should be adopted when designing

and implementing health promotion interventions for FSWs. First, given the diversity in sex worker populations and the varied milieus in which sex work takes place, it is essential for interventions to be tailored to the specific social, behavioral, and professional heterogeneity of sex workers (Blanchard et al., 2005; Yadav et al., 2005). They should be culturally appropriate and guided by prevailing regional and local norms and conditions (Wechsberg & Luseno, 2010). In order to do so, active engagement with FSWs and the organizations working with them at all stages of the intervention process has been established as a crucial strategy to adopt when designing interventions for FSWs (Ross et al., 2012).

There are numerous benefits that come with engaging FSWs in the intervention process. First, it capitalizes on the extant knowledge and experience of FSWs in protecting themselves from the risks inherent in their profession. As elucidated by Rekart (2005), "For centuries, sex workers have faced the harms of sex work. They have developed strategies for understanding their options, modifying their risks, and coping with their situations" (p. 2125). Involving sex workers in the intervention process also allows for the customized tailoring of interventions to accommodate their distinctive culture, beliefs, and traditions and to enhance their leadership skills and capacity for self-determination, control, and autonomy (Hansen, Lopez-Iftikhar, & Alegria, 2002; Pauw & Brener, 2003; Vanwesenbeeck, 2001; Vanwesenbeeck, van Zessen, de Graaf, & Straver, 1994; Wallman, 2001; Wojcicki & Malala, 2001; Wolffers, 1999). A high level of engagement can also help to foster a sense of ownership and buy-in that cannot be achieved through top-down approaches (Rekart, 2005). The tendency for greater service uptake when the community defines the intervention goals as part of their own agenda, as opposed to when such goals are "imposed" upon them, has also been highlighted (ILO, n.d., p. 14). Engaging the organizations that work with sex worker populations, such as non-governmental organizations

(NGOs), comes with additional benefits. Such organizations have in-depth knowledge of and experience with sex workers that can aid in intervention tailoring. Furthermore, organization staff often have well developed rapport with FSWs that can assist in gaining access and building trust.

The WHO (2005) outlined a number of additional key strategies related to the development and implementation of effective and sustainable interventions in sex work settings. In addition to reaffirming the importance of actively engaging sex workers and the organizations working with them, the WHO (2005) also highlighted the importance of adopting a non-judgmental attitude, safeguarding sex worker rights to privacy, anonymity, and confidentiality, and taking precautions to ensure intervention activities do not have adverse effects. It is also essential to respect the human rights and basic dignity of sex workers, recognize the role of third parties (e.g., clients, establishment owners, the surrounding community), and appreciate the inherent motivation of sex workers to improve their own health and well-being.

In sum, community empowerment interventions have demonstrated promising results in terms of reducing risk among FSWs. However, a great majority of the interventions to date have focused on HIV/STI prevention while ignoring other dimensions of health and well-being. Although there are a few interventions that have targeted aspects of empowerment, such as the Sonagachi Project, sexual health outcomes remain the primary goal. A number of best practices have been identified, especially the recognition of sex work as work and the importance of engaging FSWs and the organizations working with them in all stages of the intervention process—from design and implementation to evaluation and dissemination. The present study adopted a peer education approach, a type of community empowerment intervention that

involves a high level of FSW engagement and has been found to be effective in reaching FSWs and other vulnerable and hard-to-reach populations.

Peer Education

Peer education is an approach whereby individuals who share demographic and/or experiential factors are trained to impart knowledge, increase awareness, and encourage behavior change among members of the same group (Medley, Kennedy, O'Reilly, & Sweat, 2009). Peer education has been speculated to date back to the times of Aristotle (Wagner, 1982) and has been used as an approach to address a multitude of topics in a variety of contexts (Turner & Shepherd, 1999). Within the context of sex work, peer educators (PEs) can be individuals who were formerly or are actively working in the industry and are aiming to educate and promote behavior change among other current or former sex workers (Vuylsteke & Jana, 2001).

The methods adopted through peer education interventions vary depending on the characteristics of the target population, context, available resources, and intended outcomes of the program. For instance, peer education can be informally delivered through everyday interactions or formally through structured (e.g., classroom) settings (Medley et al., 2009). In addition to providing educational information, PEs can also be utilized to identify common issues or difficulties experienced by FSWs, recruit new intervention participants, and facilitate access to resources and services (Ngugi, Wilson, Sebstad, Plummer, & Moses, 1996; Ramesh et al., 2010). PEs can also serve as resources to discuss difficult issues, such as how to negotiate with and manage difficult clients (Ngugi et al., 1996).

Some have criticized peer education programs for a lack of theoretical foundation. In fact, Turner and Shepherd (1999) referred to peer education as "a method in search of a theory" (p. 235). In the most basic sense, the theoretical underpinnings of peer education stem from

Rogers' (1983) diffusion of innovation (DOI) theory. DOI theory asserts that all community populations have popular and well-liked "opinion leaders" who have the ability to create new peer norms by endorsing and modeling behavior standards that diffuse throughout the population (Ross & Williams, 2002, p. 59). Because of their potential to diffuse healthier and more positive peer norms, peer education programs may be better able to help individuals develop and sustain behavior change compared to programs targeting individual behavior change in isolation (Ross & Williams, 2002).

Peer education programs have been suggested for use with sex worker populations for a variety of reasons (Turner & Shepherd, 1999). They utilize existing networks and communication structures (Finn, 1981) and can be used to educate those who are hard to reach (King, 1994). For a population such as sex workers who may be skeptical or untrusting of outsiders, peers are perceived as a trustworthy and credible source of information (Perry, 1989). PEs can thus provide an otherwise difficult if not impossible to establish link between practitioners and researchers involved in health promotion and the FSW community (International Labour Organization, n.d.). PEs can serve as role models by demonstrating that it is possible to gain respect and self-confidence and to protect and promote one's health (Jana et al., 2004; Perry & Sieving, 1991), and they can reinforce learning through ongoing contact. Involvement in peer education programs has also been shown to empower the PEs themselves through enhanced knowledge and self-esteem (e.g., Jackson, Bennett, Ryan, & Sowinski, 2001; Phelps, Mellanby, Crichton, & Tripp, 1994). The development of PE networks may also lead to an enhanced sense of solidarity within the community (World Health Organization, 2005). Another important benefit of peer education programs is that they are more cost-efficient than other intervention methods (Jones, 1992). Hutton, Wyss, and N'Diékhor (2003) conducted a cost-

effectiveness analysis of HIV/AIDS prevention programs in Chad, Central Africa, and found that peer education programs for sex workers cost an estimated $6-$16 per infection prevented, while other interventions, such as mass media and social marketing of condoms ($78-$534 per infection prevented) and voluntary counseling and testing for STIs ($906-$1,190 per infection prevented) were considerably more costly.

Despite these benefits, peer education has not gone without criticism. As previously noted, some have argued that peer education programs often lack an adequate theoretical base (Turner & Shepherd, 1999). Others have criticized peer education programs for failing to address relevant social and cultural factors (Milburn, 1995), contending that such limitations undermine our ability to understand the factors that contribute to past failures and successes (Campbell & Mzaidume, 2001).

Review of Peer Education Programs for FSWs.

Numerous peer education programs have been employed among FSWs for risk reduction, particularly STI/HIV prevention. A majority of programs have targeted FSWs in LMICs (Bali, Ford, Wirawan, Suastina, Reed, & Muliawan, 2000; Bangladesh, Sarafian, 2012; Dominican Republic, Welsh, Puello, Meade, Kome, & Nutley, 2001; Ghana, Asamoah-Adu et al., 1994; India, Ramesh et al., 2010; Kenya, Luchters et al., 2008, Ngugi et al., 1996; Thomsen et al., 2006; Malawi, Walden, Mwangulube, & Makhumula-Nkhoma, 1999; Phillipines, Morisky, Ang, Coly & Tiglao, 2006; Zimbabwe, Ngugi et al., 1996). However, evidence for their effectiveness is scant due to a lack of systematic outcome evaluations (Ford et al., 2000; Medley et al., 2009).

Medley et al. (2009) conducted the only meta-analytic review to date to assess the impact of peer education programs on HIV- and STI-related outcomes. Their review focused on studies in developing countries with a wide range of target populations, including youth, sex workers,

transport workers, heterosexual adults, prisoners, and minors. Across 30 peer-reviewed studies, peer education programs were significantly associated with increased HIV/STI knowledge (odds ratio [OR] = 2.28, 95% confidence interval [CI] = 1.88, 2.75), reduced equipment sharing among injection drug users (OR = 0.37, 95% CI = 0.20, 0.67) and increased condom use (OR = 1.92; 95% CI = 1.59, 2.33). However, peer education programs did not have an impact on decreasing rates of new sexually transmitted infections. Luchters et al. (2008) conducted a larger-scale longitudinal study to evaluate the impact of peer education programs on a sample of 503 Kenyan FSWs over a 5-year period (2000-2005) and found more promising results related to biological outcomes. Specifically, they reported lower HIV prevalence, as well as an increase in consistent condom use and greater likelihood to turn down clients who refused to wear condoms, among FSWs who were exposed to PEs as compared to those who were not exposed to PEs.

Although evidence suggests that peer education programs are an effective and cost efficient means of promoting sexual health among FSWs, it is important to acknowledge the possible difficulties associated with use of PEs. For instance, PEs promoting condom use in Honduras were accused by their peers of trying to steal clients who were willing to pay a higher price for unprotected sex (Vuylsteke & Jana, 2001). Another known challenge associated with peer education programs is retention. Past peer education interventions with FSWs have reported PE drop out rates as high as 50% between the first one to four months (Walden et al., 1999). This high drop out is likely due to high mobility among FSWs (WHO, 2005). Considerable efforts should be made to identify possible barriers or adverse reactions during the design process so the intervention can be tailored to prevent negative impacts and to maximize program effectiveness.

In sum, peer education programs have proven to be effective in promoting health behaviors, especially safer sexual practices, among FSWs across diverse geographic locations.

They are particularly well suited to target hard-to-reach populations, such as sex workers, and are notably more affordable than some of the alternative risk reduction interventions, a fact which has major implications for potential reach and impact. However, peer education programs often lack theoretical foundation and methodological rigor and have not previously been tested as a means to promote psychosocial health.

Best Practice Recommendations for Peer Education Programs with FSWs.

Peer education methods may be appropriately labeled as a "black box" due to the fact that reports often fail to include detailed program descriptions and instead focus only on program effectiveness (Backett-Milburn & Wilson, 2000). This has resulted in an overall lack of information regarding what does and does not work when implementing peer education programs. For instance, of the 30 studies included in the Medley et al. (2009) meta-analysis, only 14 reported how PEs were recruited and selected, only 20 reported information (although often limited) regarding how PEs were trained, only 19 reported process information related to supervision of PEs, only eight and 10 respectively discussed compensation and retention. The limited available information regarding best practices for implementing peer education programs with FSWs is reviewed below.

Recruitment and selection. The recruitment and selection of PEs is a key element of program success and should receive careful consideration (Medley et al., 2009). Some programs recruit self-nominated volunteers while others solicit the help of community leaders who are familiar with the target population to nominate candidates (Medley et al., 2009). Self-nominated volunteers may be more motivated, while other-nominated volunteers may be more skilled and experienced (Medley et al., 2009). Regardless of the approach taken, it is important that the selection process and criteria be made clear and transparent to all potential recruits (ILO, n.d.).

Also, even if community leaders are not part of the recruitment process, it is recommended to get their endorsement of selected candidates before making final selection decisions (Sethi & Jana, 2003).

There are a number of important considerations when it comes to selecting trainees for peer education programs. First and foremost, candidates should be selected based on their availability and commitment to attend the entire training and carry out their role as PE after the training concludes (ILO, n.d.). PEs should be empathic and comfortable with the sex worker community (Ross et al., 2012), demonstrate self-confidence, leadership potential, and the ability to be a strong role model for the health behaviors the program seeks to promote (ILO, n.d.). It is also highly important to select representatives of the target population who will be viewed as "true peers" (UNAIDS, 1999, p. 28). PEs who are from the same ethnic background and share similar experiences, language, and culture to the target population are better able to deliver more relevant and credible information (Overs & Hunter, 1996). Additionally, older PEs are thought to be more articulate and experienced and have more well-developed social skills compared to younger PEs (Jana et al., 2004). Key informants can provide useful information regarding communication networks, leadership patterns, and informal groupings that can aid in selection of PEs (Ngugi et al., 1996).

Training and supervision. The training and supervision of PEs are also key contributors to program effectiveness. Unfortunately, due to limited reporting, information regarding the optimal duration of training is not available. Of the 30 studies reviewed by Medley et al. (2009), 15 reported that PEs received "a onetime training course that ranged in length from a few days to 2 months" (p. 118), and only five studies reported provision of refresher training. Regardless of

training duration, it is essential to develop a flexible training schedule that accommodates the work schedules of the trainees (Sethi & Jana, 2003).

PE training should focus on program objectives and relevant content (i.e., depending on the topic/health risk of interest), as well as communication strategies and educational techniques (Ngugi et al., 1996). Training should ensure that trainees have a clear understanding of the goals of the program and their role and tasks as PEs, and should include ample opportunities to practice teaching and discuss key program content (UNAIDS, 1999). PEs should be familiar with various health and social services (e.g., legal services, domestic violence support) available in the community as well as how to access and refer others to those services (Borlone & Macchieralo, 2004). PEs should also be trained in interpersonal and communication skills, such as listening, asking questions, empathy, and problem-solving (Sarafian, 2012). Finally, PEs should be involved in developing outreach strategies, as they hold valuable insider knowledgeable regarding the most effective ways to communicate with their peers (Sethi & Jana, 2003).

In terms of teaching strategies, PEs should be encouraged to avoid traditional didactic approaches, which often treat learners as passive participants in the learning process, as such methods are contrary to fostering self-driven solutions, critical dialogue, and healthy debate (Campbell & MacPhail, 2002). Instead, PEs should be encouraged to adopt participatory, non-didactic educational techniques (e.g., role plays, songs, dramas; Campbell & Mzaidume, 2001; Sarafian, 2012). Given the low literacy of many sex worker populations (WHO, 2013), it is important to train PEs to use non-textual materials, such as visuals and diagrams, to convey messages (Sethi & Jana, 2003). PEs should also be encouraged to provide opportunities for participants to weigh the pros and cons of a range of behaviors and develop their own ideas

about alternative behaviors that reflect their unique ideologies, priorities, and capabilities

(Campbell & MacPhail, 2002). As explained by Campbell and MacPhail (2002):

> Peer education is supposed to be strictly non-directive, aiming to promote the
> empowerment of target audiences through providing them with contexts in which
> they can generate their own solutions to the health risk at hand, rather than
> through prescribing what the content of such discussions should be. (p. 337)

The ultimate goal of PEs should be to empower FSWs through internalized messages of self-

reliance, self-respect, and self-efficacy that will enable them to promote and protect their own

health (Jana et al., 2004).

If resources allow, other recommended elements of PE training include a kick-off

meeting so trainees can start developing relationships with one another and with program staff

(UNAIDS, 1999). Continued support in the form of regular individual and/or group meetings,

refresher trainings, provision of new or updated information and materials, and retreats can also

be valuable supplements to PE training (UNAIDS, 1999). In order to assess the effectiveness of

PE training, programs should build in written or oral tests of training knowledge, progress

reports, and evaluation of PEs by supervisory staff (UNAIDS, 1999). Additionally peer

educators should be observed while teaching to ensure fidelity of the messages delivered by peer

educators.

Retention and compensation. There is little evidence regarding the most effective

means of compensating and retaining PEs. Peer education programs vary widely in terms of

compensation—some provide no financial compensation, some provide small amounts of money

for transportation reimbursement, and others provide a salary to PEs (Medley et al., 2009). As

with other aspects of peer education programs, the effects of compensation on intervention

efficacy are unknown due to insufficient evidence. However, it is likely that retention will be

higher with greater compensation. In order to maintain PE motivation, the WHO (2005) suggests

holding regular meetings, offering various incentives, and providing opportunities for increased involvement in the project.

In conclusion, peer education has proven to be a promising approach for promoting health behaviors among FSWs and has been associated with increased condom use and other sexual health behaviors. However, it has not been previously tested as a means to promote psychological health. Additionally, a majority of peer education programs have lacked theoretical foundation and methodological rigor, and documentation regarding implementation best practices is scarce. More research is needed to unveil the potential of peer education to promote other, non-sexual aspects of health and to further understanding regarding the most effective means of recruiting, selecting, training, supervising, compensating, and retaining PEs.

Introduction to Present Study

The importance of promoting the psychosocial health and empowerment of FSWs is clear—without it, quality of life will remain low and other programs trying to protect FSWs from the various risks inherent in their work will likely be met with limited success. However, to date this aspect of sex worker health has been largely ignored. The present study was designed to fill this gap by pilot testing a brief peer education intervention to promote psychosocial health among FSWs in Kathmandu, Nepal. The intervention was designed and evaluated based on the Integrated Empowerment Theory (IET, Blanchard et al., 2013).

Integrated Empowerment Theory

The term empowerment is often mentioned in the HIV prevention and sex work literature; yet, it is rarely clearly defined and is often conflated with the construct self-efficacy. In citing Evans and Lambert (2008), Kerrigan et al. (2013) defined empowerment as "a social process, not focused on a given health or disease outcome, but rather one which seeks to

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challenge unequal power structures which inhibit the overall health and well-being of a given group" (p. 1927). Others have emphasized the multidimensional nature of empowerment and its relation to the promotion of numerous facets of psychosocial health, including self-efficacy, self-esteem, resilience, social participation, resource enhancement, and political awareness and participation (Olsen & Marger, 1993; Zimmerman, 1995). The lack of consistency and operationalization in definitions of empowerment across studies poses challenges to understanding the mechanisms through which empowerment leads to positive health outcomes and creates a barrier to replication of successful interventions (Blanchard et al., 2013).

The IET is an empowerment framework and corresponding measurement instrument that was developed by Blanchard et al. (2013) to assess the impact of a community mobilization intervention on the empowerment of FSWs in south India. The IET is unique in that it breaks down the mechanisms of empowerment into three distinct but inter-related domains: power *within*, power *with others*, and power *over resources*. Power *within* refers to internalized power in the form of self-esteem, self-efficacy, confidence, self-awareness, and consciousness of the factors that contribute to vulnerability. Power *with others* refers to the collective identity, mutual support, and trust required for collective empowerment and action. Finally, power *over resources* encapsulates the ability to exert power over resources in one's environment, such as educational opportunities, social entitlements (e.g., citizenship documentation, driver's license), financial credit, and legal and other social services. Blanchard et al. (2013) acknowledged other factors that influence FSWs' individual capability to benefit from empowerment programs, including socio-demographic characteristics (e.g., age, education level, caste, marital status), and the type of sex work practiced (e.g., number of clients per day, duration of time in industry).

Blanchard et al. (2013) examined these three inter-related domains of empowerment among a sample of 1,750 FSWs across five Districts in south India where an HIV/STI prevention and community mobilization intervention was being implemented as part of the Bill and Melinda Gates *Avahan* program. The program consisted of education, outreach, and other services to promote behavior change and increase access to services (see Gurnani et al., 2011 for a full program description). The program included a number of community-based mobilization activities focused on promoting the three types of empowerment—power *within*, power *with others,* and power *over resources*. Power *within* was promoted by fostering enhanced agency, confidence, and self-esteem among individual FSWs (Blanchard et al., 2013). Power *with others* was promoted by supporting the formation of FSW-owned community based organizations and by establishing drop-in centers, which provided a safe space and opportunity for FSWs to form a collective identity and work together to address challenges and meet their immediate needs (Blanchard et al., 2013; Gurnani et al., 2011). Finally, power *over resources* was promoted by providing micro-loans for self-employment opportunities and facilitating access to social entitlements, such as bank accounts, ration cards, and voter IDs (Blanchard et al., 2013).

Blanchard et al. (2013) examined the three types of empowerment as outcome variables (i.e., as predicted by level of exposure to the intervention) and as predictors of social and sexual health outcomes. When examined as outcome variables, level of exposure to the community mobilization intervention significantly predicted power *within* and *with others*, but not power *over resources*. When examined as predictor variables, power *within* and *with others* were found to be significant predictors of self-efficacy for service utilization and self-efficacy for condom use respectively. Blanchard et al. (2013) noted that the lack of significant findings related to

power *over resources* may be due to either the inadequacy of the questions asked or the overall high levels of this dimension of empowerment among FSWs in the study sample.

These findings provide evidence that different sub-domains of empowerment are predictive of different health and social outcomes for FSWs. Blanchard et al. (2013) called for future research to examine the effect of different interventions on the three domains of empowerment. Given that the aim of the present study is to promote psychosocial health and empowerment among FSWs through peer education, a form of community mobilization, the IET provides a well-suited framework for the design and evaluation of the intervention.

Context of the Present Study: Nepal

Nepal is a landlocked country in South Asia neighbored by India and China, and is home to over 30 million people, with approximately one million living in the capital city of Kathmandu (Central Intelligence Agency [CIA], 2016). Nepal is divided into three geological zones, ranging all the way from sea level to Mount Everest, the highest point in the world (Inter-Agency Standing Committee [IASC], 2015). In addition to its extant geographic diversity, Nepal is also diverse in terms of its people. Among the predominantly Hindu (81%) population, there are over 35 ethnic groups and more than 60 spoken languages (IASC, 2015). Nepal is an impoverished country with nearly a quarter of the population living below the poverty line (i.e., the level of income deemed adequate within a given country for survival; CIA, 2016). As of 2015, average life expectancy in Nepal was low (67.52 years) compared to other countries and slightly higher for women compared to men (68.92 and 66.18 respectively; CIA, 2016).

The economy of Nepal primarily revolves around agriculture, tourism, and remittances from migrant workers, most of whom are located in Gulf countries (CIA, 2016). The caste system, despite being illegal, has a strong influence over the distribution of social, economic, and

political capital in Nepal (IASC, 2015). Government healthcare is free, but most rely on traditional systems of healing (e.g., Ayurveda, shamans, Tibetan medicine) and seek medical treatment only as a last resort (IASC, 2015).

Although love marriages are becoming more common, arranged marriages are still the norm in Nepal (Ji, 2013). Sex is a taboo topic in Nepali society, especially for women (Menger, Kaufman, Harman, Tsang, & Shrestha, 2014). Therefore, sex work is viewed as being outside the norms of permissible female sexuality and is highly stigmatized (Basnyat, 2014).

Despite the end of the decade long "People's War" in 2006, which killed over 13,000 and displaced over 78,000 people, the political situation in Nepal has remained volatile (Brady, 2011). Political instability, in combination with pervasive patriarchal norms and extreme poverty, has contributed to low levels of education and few opportunities for women and girls in Nepal (Kaufman, Harman, & Shrestha, 2012). According to the most recent Nepal Demographic and Health Survey conducted by the Ministry of Health and Population (MOHP, 2012), women have substantially lower educational attainment (40% have no formal education) compared to men (14% have no formal education). Although literacy rates have increased for both sexes in recent years, in 2011 men still had substantially higher literacy rates (87%) compared to women (67%; MOHP, 2012). As a consequence, a growing number of women and girls—many of whom left their rural villages to escape conflict, domestic violence, and severe poverty—resort to sex work in massage parlors, dance bars, and other venues (Youth Partnership Project [YPP], 2010). Because a majority of FSWs in Nepal have fled small rural villages to seek a better life and a means of income generation in Kathmandu and other larger cities (National Centre for AIDS and STD Control [NCASC], 2011), they have left their families and friends and find themselves in a place where they have limited or no support systems.

Sex work and the sex industry in Nepal. Some early traditions in Nepal and India recognized prostitution as the hereditary calling of certain subgroups or castes (Bhatt, Gurubacharya, & Vadies, 1993; Brown et al., 1998). Although echoes of this practice remain, its ritual significance has since faded (Bhatt et al., 1993; Brown et al., 1998). Despite these ancient roots, the commercial sex industry in Nepal today is relatively new. The People's War contributed to the rise of Nepal's sex industry in several ways. It displaced many rural populations and drove them to migrate to urban centers seeking food and shelter (Frederick, Basynat, & Aguettant, 2010). It exacerbated poverty among rural and urban populations, leading the poor to consider jobs they would not have otherwise. It also led to the death and out-migration of thousands of men and boys, which placed increased pressure on girls and women to support impoverished families (Ministry of Women, Children, and Social Welfare, 2008). Another factor contributing to the development of Nepal's sex industry was the deterioration of the carpet, garment, and pashmina industries, resulting largely from the global economic downturn (Frederick et al., 2010). The rise of Nepal's sex industry is also linked to changing social norms, marked by increased prevalence of dating and premarital sex among adolescents and young adults and the rise of adultery among older, married men (Frederick et al., 2010). Sex for pleasure and having multiple sexual partners, particularly among males, is becoming increasingly normalized in Nepal. Cultural and societal changes such as increased migration, urbanization, and exposure to mass media are some of the factors that are likely contributing to changing sexual norms in Nepal (Adhikari & Tamang, 2009; Gubhaju, 2001; Menger et al., 2014).

In 2008 there were an estimated 25,000-34,000 sex workers in Nepal (World Bank, 2008). Nepal's sex industry is spread across the entire country but is concentrated in urban areas

and along major transportation routes (Frederick et al., 2010). According to Vandepitte et al. (2006), sex workers comprise approximately one percent of the population in Kathmandu. Due to the clandestine nature of sex work and the limitations of Nepal's population surveillance systems (World Bank, 2008), it is likely that this figure may underestimate the true number. Because the industry serves as a substantial component of Nepal's resource-poor economy— income generated from sex work is estimated to be as much as two percent to 14% of the gross domestic product (Pyle, 2001)—there is no foreseeable end in sight for the sex industry in Nepal.

Sex workers in Nepal represent a diverse group. The NCASC (2011) surveyed FSWs in Kathmandu ($N = 593$) to assess sexual health knowledge, behaviors, and status. Ages ranged from 16 to 48 years old, with a median age of 23 years. The majority (84%) were born outside of the Kathmandu Valley. Age at first marriage was young, with 85% married between the ages of 11-19 years ($M = 16.7$ years; NCASC, 2011), which is slightly younger compared to age at first marriage for Nepali women in the general population (M = 17.5 years; MOHP, 2012). Just over half (52.4%) of the respondents reported they were currently married at the time of the survey, and 81% had given birth to at least one child. Sixty-nine percent were literate, but only five percent had completed education beyond the 10th grade. Over three quarters of the sample reported consuming alcohol, nine percent reported consuming drugs in the past month, and less than two percent reported using injection drugs at some point during their lives.

According to the NCASC (2011) survey, a little over half ($n = 355$) of the sample was establishment-based FSWs (i.e., worked in the commercial sex industry) and the remainder were street-based. The FSWs reported entertaining one to six clients per day ($M = 1.6$). Clients represented a wide array of professions, most commonly businessmen, but also doctors, police/army men, transport workers, contractors, and "migrant/wage" workers (p. 28). Although

a high percentage (83%) reported using a condom with their last client, 10.7% admitted they sometimes agreed to sex without a condom if a client offered them more money for doing so. A large proportion (78.9%) said they had another job in addition to sex work, most commonly working in restaurants as waitresses.

The commercial sex industry in Nepal is synonymously referred to as the entertainment sector (Frederick et al., 2010). This term will be used throughout the remainder of this dissertation when referring to this industry and women working in this industry, except for when citing other studies that specifically used other terminology (e.g., FSWs) when describing their target population. As opposed to women and girls who sell sex from their home or on the street, women in the entertainment sector (WES) work in various establishments including massage parlors, dance bars, cabin restaurants (i.e., food and drink establishments with plywood cabins in which waitresses accompany customers), *dohoris* (i.e., nightlife establishments with traditional Nepali music as well as food and drinks) and *bhatti pasals* (i.e., small liquor and snack shops) (Frederick et al., 2010; NCASC, 2011). Whereas massage parlors are more explicit venues in which sexual services are provided, dance bars, cabin restaurants, *dohoris,* and *bhatti pasals* are considered sex access points, in which women and girls often make initial contact with clients and arrange to perform the agreed upon services at a nearby guest house (Frederick et al., 2010). Some guest houses or lodges have sex workers in residence, while others will arrange for sex workers upon request (Frederick et al., 2010).

It is important to note that not all WES actively engage in sex work (Frederick et al., 2010). Among those who do sell sex, some are willing adults; however, many do so unwillingly under coercion from customers and/or establishment owners (Frederick et al., 2010). Those who

enter by force, deception, or as children are defined as trafficking victims according to Nepali and international law (Frederick et al., 2010).

Forced prostitution is illegal in Nepal under the *Trafficking and Transportation (Control) Act, 2007* (Godwin, 2012), but Nepali law neither prohibits voluntary prostitution nor does it attempt to regulate sex workers' activities (Shrestha, 2006). Legalized status may be a prerequisite for improved social conditions of sex workers but does not guarantee them (Vanwesenbeeck, 2001). There is legislation in Nepali law that should protect WES from some of the aforementioned hazards and abuses. For instance, the Nepal Labour Act requires that workplaces have adequate light and fresh air and workers are paid one and a half times for overtime (Frederick et al., 2010). However, there has been a lack of adequate enforcement of these regulations in the entertainment sector (Frederick et al., 2010; Shrestha, 2006).

WES in Nepal are exposed to an array of risks to their health and well-being. Working hours are long, breaks and days off are few, and work environments may be noisy, dirty, dark, and smoky (Frederick et al., 2010). For those who do engage in sex work, risk of contracting HIV and other STIs, unwanted pregnancies, and other sexual and reproductive health risks are of concern (Frederick et al., 2010). HIV prevalence among FSWs in Nepal has been reported as high as 17.3% (UNAIDS, 2002) although more recent estimates suggest a lower prevalence (1.7%, NCASC, 2011), and high rates of other STIs have also been documented (NCASC, 2011; Shrestha & Gurubacharya, 1998). The higher FSW-client ratio in Nepal (1:20) compared to the average across South Asia (1:7.5) is associated with heightened risk of STI/HIV transmission (Ghimire, Smith, van Teijlingen, Dahal, & Luitel, 2011). Despite awareness of the importance of condom use to protect against such risks, FSWs have reported limited power to negotiate

condom use with clients (Ghimire et al., 2011; Kaufman, Harman, & Menger, 2015; Tamang, Nepal, Puri, & Shrestha, 2001).

WES are exposed to various forms of violence, abuse, and sexual harassment by clients and establishment owners, the latter of which are motivated to allow their customers to drink and harass the women in order to earn more money (Frederick et al., 2010). Individual and group rapes, sometimes by physical force and sometimes by threats to reveal their professional status to family members, have also been frequently reported (Frederick et al., 2010). Aside from these more severe forms of abuse, WES in Nepal also report facing various forms of verbal torture and abuse by clients and establishment owners (Frederick et al., 2010; NCASC, 2011). Intimate partner bonds with regular clients may further contribute to the vulnerability of FSWs. Driven by fear of losing the social security, emotional support, and feelings of inclusion provided by intimate partners, FSWs may engage in more risky sexual behaviors and/or endure various forms of physical and emotional abuse in an effort to protect their intimate bond (Singh, Malviya, Pandey, Sharma, & Sharma, 2016). Forced alcohol and drug use have also been reported (Kaufman et al., 2015).

Although non-sex workers in entertainment sector establishments may not be exposed to sexual health risks associated with work, they are still exposed to a myriad of other hazards. Because the primary source of profit for establishment owners (excluding massage parlors) and the primary source of commission for WES comes from selling food and alcohol, even those who do not sell sex may endure dangerous situations and abuse from clients so clients will stay longer and purchase more (Frederick et al., 2010). Additionally, regardless of sex work activity, all WES are subjected to social stigma and, as a result, may prefer to hide their job status from their families and the public eye (Frederick et al., 2010). This stigma influences the willingness

of WES to seek health services for diagnosis and treatment out of fear of being exposed by health workers or other authority figures (Evans & Lambert, 1997; Ghimire & Van Teijlingen, 2009; Mohebbi, 2015).

A common myth is that WES in Nepal are independent women who earn a lot of money (Frederick et al., 2010). Recent research suggests that the average monthly income for WES ranges anywhere from 500 to 6,000 Nepali rupees, which is equivalent to approximately $5-$60 USD (ActionAid Nepal, 2004; Frederick et al., 2010). Although, at the higher end this is generally more than they would earn in the few other jobs that young, unskilled, and uneducated women and girls are qualified for, such as factory work or domestic service, it is by no means highly lucrative work, and most WES spend a majority of their earnings supporting their families (Frederick et al., 2010). Additionally, instances of not being paid what they were promised, not being paid on time, and sometimes not being paid at all are not uncommon (Kaufman et al., 2015). Many have also reported assault and theft from clients as well as from men and boys on the street (Frederick et al., 2010). Job insecurity and extreme poverty may increase vulnerability to exploitation and abuse. Due to fear of being fired, WES may avoid asking for a higher salary, benefits, or better working conditions (Shakti Samuha, 2008). Some are also subject to forced labor through debt bondage and other policies enforced by establishment owners, such as not being allowed to quit until they bring in other women to replace them (Frederick et al., 2010).

Clients and establishment owners are not the only abusers of sex workers in Nepal. Despite its legal status, in practice, sex workers in Nepal are often treated as criminals (McNeill, 2008) and commonly arrested, detained, and harassed by police (Frederick et al., 2010). Police are known to use the *Public Offences and Penalties Act* of 1970, which prohibits violating the peace or demonstrating obscenity in public spaces, to raid establishments where sex work is

suspected, such as dance bars and massage parlors ("Raids alone," 2010). In fact, police are allowed by Nepali law to enter homes and workplaces if they are suspicious that "immoral acts" may be taking place inside (Frederick et al., 2010, p. 52). Police harassment ranges from unjustified arrest to various forms of abuse and extortion (Sarkar et al., 2008). As a result, many sex workers are under the impression that prostitution is illegal in Nepal and have expressed desires for legalization and decriminalization in order to gain protection from client abuse, police harassment, and other forms of discrimination (Shrestha, 2006). Sex workers in Nepal are also at risk of being trafficked to other countries. In fact, Frederick et al. (2010) noted that Kathmandu's sex industry is perceived by traffickers as a "training ground" to prepare women and girls for transfer into the sex work industries in Gulf countries and other destinations (p. 21).

Unfortunately, due to pervasive gender inequalities and culturally-based ideas related to male dominance and female submissiveness, WES have little power or agency to protect themselves from the many hazards inherent in their work (Poudel & Carryer, 2000). Eller and Mahat (2003) elaborated on the powerlessness of Nepali women as follows:

> Nepali women tend to have an attitude of resigned acceptance to the difficulties in life. In part, this attitude might be a result of powerlessness of women in the culture or a belief system that people must deal with whatever life presents. (p. 58)

Given their particularly low and stigmatized status, the traditional role expectations that Nepali women are to be obedient, passive, and self-sacrificing in relationships, renders WES defenseless in harmful and abusive situations (Poudel & Carryer, 2000, p. 77).

Psychosocial health of WES in Nepal. The psychological and social impact of sex work in Nepal is profound (Blanchet, 1996; Terre des hommes, 2005). Although there have been very few studies to date, reports from counselors and psychologists who have worked with WES in Nepal suggest high rates of depression, anxiety, guilt, anger, hopelessness, isolation, insecurity,

and fear (Frederick et al., 2010). The ways in which poor psychosocial health status manifests in WES are varied. Some may express their feelings in behavior that is abusive or impulsive, while others may become reclusive and withdrawn. In extreme cases, the psychological burden of their lifestyle may lead to self-destructive behavior, including excessive use of drugs or alcohol, self-inflicted harm, or even attempted suicide (Frederick et al., 2010). The psychological and social impact on the children of FSWs, who often receive inadequate attention because their mothers must work long hours, is not known but is of concern.

Ghimire et al. (2011) conducted field observations and interviews with 15 FSWs in Nepal and found low self-efficacy to be the main predictor of not using condoms with clients and intimate partners, highlighting the broader public health implications underlying the importance of empowerment programs. In another study, Eller and Mahat (2003) examined the psychological health of former Nepali FSWs ($N = 98$) and found similar levels of stress, anxiety, and depression to a sample of women from the general Nepali population. However, findings may have been different had their sample consisted of women who were currently rather than formerly engaged in sex work.

Of course the stigma attached to sex work plays an influential role in the psychosocial health of WES in Nepal. Even if a woman exits the industry, her stigmatized status may last a lifetime. While citing Blanchet (1996), Frederick et al. (2010) explained, "once branded with derogatory words such as *randi* or *bhalu* (the equivalents of the English words "prostitute" or "whore") the stigma is often not removable even in older age, and is passed on to the children" (p. 49). Stemming from this pervasive stigma are many forms of discrimination, such as unkind remarks from shopkeepers and other community members, refusal to rent rooms from landlords, and malicious gossip in their neighborhoods and home villages (Frederick et al., 2010). When

asked about dissatisfaction with their occupation, WES often state stigma and negative societal

attitudes as a reason (ActionAid Nepal, 2004; Menger et al., 2014).

Risk reduction among WES in Nepal. There are numerous anti-trafficking

interventions in Nepal, primarily implemented by NGOs and INGOs, which are focused on

prevention (e.g., intercepting suspected victims at border checkpoints, educating police,

increasing opportunities for livelihood) as well as providing care and support for trafficking

victims (Kaufman & Crawford, 2011). However, many of these organizations are focused on

trafficking outside of Nepal. There are a growing number of smaller, less established NGOs that

focus on promoting the health and well-being of WES within the borders of Nepal. These

organizations largely focus on advocacy and awareness raising, as well as provision of

vocational training, childcare, healthcare (primarily focused on HIV/STI prevention and

reproductive health) and legal support (see Frederick et al., 2010 for a list of organizations and

services provided). A few of these organizations offer group and/or individual counseling

services for WES; however, these services are typically reserved for women and girls who have

been through particularly traumatic experiences, and the counselors tend to have minimal

training (J. Maharjan, personal communication, December 13, 2013). Overall, programs to

promote the health and well-being of WES in Nepal suffer from a lack of program evaluation

(Kaufman & Crawford, 2011). Kaufman and Crawford (2011) conducted a review of anti-

trafficking programs conducted by NGOs in Nepal and pointed to the problems associated with a

lack of impact evaluation:

> Without proper evaluations and outcome measures, the impact and cost-
> effectiveness of these programs is unknown. It is easy to list the number of girls
> and women who have participated in the various programs or to specify the
> districts where awareness-raising campaigns have taken place. However, without
> measures of attitude change or increases in knowledge, it is unknown whether
> these programs are really worth the time, effort, and money they require.

Implementing expensive programs despite a lack of evidence for program effectiveness would be problematic anywhere in the world, but in Nepal, where resources are extremely limited, it is particularly distressing. (p. 660)

To date, there have been no published interventions aiming to promote psychosocial health and empowerment among WES in Nepal.

In sum, there is a great need for interventions designed to promote the psychosocial well-being and empowerment of WES in Nepal. Without a strong foundation of psychological and social well-being, it is likely that other programs targeting FSWs, such as HIV and violence prevention programs, will have minimal impact. Overall, it is important for programs to be theoretically-based, methodologically rigorous, and comprehensively evaluated.

Summary and Rationale

The present study sought to determine the feasibility and effectiveness of a brief peer education intervention to promote the psychosocial health and empowerment of WES in Kathmandu, Nepal. The intervention was designed based on the IET (Blanchard et al., 2013) and evaluated through a quasi-experimental pre/post design, in which WES who were and were not exposed to the PEs were surveyed on key psychosocial health and empowerment outcomes before and after the program. The survey also examined if exposure to the intervention was associated with improved occupational health, in the form of increased job control, decreased burnout, and decreased workplace bullying. Job control is defined as the extent to which an individual has control over her tasks and conduct during the working day (Karasek Jr, 1979). As previously mentioned, burnout is a state of mental, physical, and emotional exhaustion resulting from prolonged exposures to stressors on the job (Pines & Aronson, 1988). Finally, workplace bullying refers to persistent exposure to mistreatment and aggression from others at work, including colleagues, superiors, and subordinates (Einarsen, Hoel, & Notelaers, 2009). These

occupational health constructs have rarely been examined, despite their potential influence on psychosocial health and well-being (e.g., job control, Stansfeld & Candy, 2006; burnout, Maslach, Schaufeli, & Leiter, 2001; workplace bullying, Cortina, Magley, Williams, & Langhout, 2001). The same survey, with additional items to assess efficacy related to being a PE (i.e., efficacy related to teaching, communication, leadership, and helping others), was administered to the trained PEs at four time points—baseline, immediately post intervention, 2-months post intervention, and 10-months post intervention.

All aspects of this pilot study—including the design, implementation, and evaluation—were conducted in close collaboration with a Kathmandu-based NGO that has been working to educate and empower WES since 2004. The study sample consisted of an existing community empowerment network that the partner NGO established in 2010 in order to foster social support and solidarity among WES in the Kathmandu Valley.

This study aimed to test four hypotheses as follows:

Hypothesis 1

Women who are exposed to psychosocial health promotion messages via the PEs will report improved psychosocial and occupational health and empowerment post intervention compared to women who are not exposed to the PEs.

Hypothesis 2

Given that the participants in the present study were part of an existing community empowerment network, it is likely that those who had been involved in the network for more time were able to develop stronger and more trusting relationships with one another compared to those who had been a part of the network for a shorter period of time [Newman, 2003]. Therefore, it was hypothesized that length of time as a member of the community empowerment

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network will moderate the effect of the intervention on psychosocial and occupational health and empowerment. Specifically, improvements in all outcomes at post intervention will be greater for participants who have been a member of the network for a longer period of time compared to participants who have been a member of the network for a shorter period of time.

Hypothesis 3

PEs will report significantly improved psychosocial and occupational health and empowerment at post intervention and follow-up compared to baseline.

Hypothesis 4

PEs will report higher efficacy related to communication, leadership, teaching, and helping others at post intervention and follow-up compared to baseline.

CHAPTER 2: METHOD

In close collaboration with a local non-governmental organization (NGO), a brief peer education intervention was developed, piloted and evaluated through quantitative and qualitative methods for its effectiveness in promoting psychosocial health and empowerment among WES in Kathmandu. The Colorado State University Institutional Review Board and the Nepal Health Research Council approved all study procedures and evaluation materials prior to implementation.

Partner NGO

The partner NGO has been working to educate and empower WES in Kathmandu since 2004. Their headquarters is located in Lainchaur, a neighborhood in the northwest region of Kathmandu next to Thamel, the well-known commercial tourist mecca and home to many entertainment sector establishments. The NGO provides an array of programs and services to educate and empower WES, including a women's school to teach literacy and basic education, a temporary children's shelter for women who cannot adequately provide for their children, a health clinic for check-ups and education, a cooperative savings program, and various training programs to promote skill enhancement, income generation, and leadership development. The NGO provides pro-bono psychosocial and trauma counseling and legal assistance for those in need. They also actively engage in advocacy and raising awareness through various events and media outlets, including a weekly radio program.

Community-Based Participatory Research Approach

A community-based participatory research (CBPR) framework was used to guide the design and implementation of the project through a highly collaborative relationship with the

partner NGO and active engagement with the target population. There is growing interest in and support for the use of CBPR approaches in health promotion research (Israel, Eng, Schulz, & Parker, 2013). In fact, the Institute of Medicine considers CBPR a critically important approach to public health education in the 21st Century (Gebbie, Rosenstock, & Hernandez, 2003).

According to Israel et al. (2013), the aim of CBPR is to bring together communities and researchers in order to "establish trust, share power, foster co-learning, enhance strengths and resources, build capacity, and examine and address community-identified needs and health problems" (p. 14). Some of the core aspects of the CBPR approach include adopting an ecological perspective with a focus on multiple determinants of health; recognizing that all partners bring different expertise, perspectives and experiences to the partnership; balancing knowledge generation with intervention for community benefit; and maintaining a commitment to sustainability (Israel et al., 2013). Although there is a great deal of variation in CBPR approaches, they all aim to conduct research that engages, shares power with, and is beneficial to community members (Israel et al., 2013). When taking a CBPR approach, researchers aim to relinquish the role of expert in order to fully engage community members in the learning and decision-making process (Israel et al., 2013). Through this practice, community members are empowered to bring about desired changes within their communities (Hagey, 1997).

In the present study, the partner NGO played a prominent role throughout all stages of the project. During the design phase, NGO leadership and staff steered the direction of the intervention in terms of both aims and execution. They also played a critical role in the evaluation process, informing both the content and administration of the surveys. Finally, they were instrumental in the reporting and dissemination of study findings. To encourage active participation throughout the project, I continuously emphasized the importance of their

familiarity with the culture and their invaluable knowledge of and expertise working with the target population. Although nearly all of the NGO's staff played a role in the project at some point in time, two field staff, whose primary job was to visit the entertainment sector establishments to help the women with day-to-day problems (e.g., police harassment and arrest) and educate them about the NGO's programs and services, were the most actively engaged in the project. From here on out, these two staff members will be referred to as "the two key field staff."

Women from the target population were also actively engaged throughout the project. They helped to guide the direction and design of the project through a voting session and focus group interview. They were also engaged in implementation of the program through their role as PEs. The key roles of the partner NGO and women from the target population will be detailed below.

Participants

Participants were all members of an existing community empowerment network called the "Women's Watch Network" that the partner NGO began working to establish in 2011. The goal of establishing this network was to foster greater solidarity, social support, and empowerment among WES in Kathmandu. The NGO President had a vision to eventually help this network of women achieve official status as a registered trade union in order to further promote the collective voice and empowerment of its members.

At the time of the study, the network consisted of 20 groups formed based on establishment type and geographic location with approximately 16-28 women in each group ($M = 20.65$, $SD = 3.79$). Five groups were predominantly cabin restaurant workers, one was predominantly dance bar workers, six were predominantly *bhatti pasal* workers, seven were

predominantly massage parlor workers, and one was a mobile group (see Figure 2.1 for a map representing group type and approximate geographic location for all 20 network groups). All groups had an elected leadership structure consisting of a Chairperson, Vice Chairperson, Secretary, and Treasurer. In meetings coordinated by the NGO field staff, groups convened biweekly and group Chairpersons convened bimonthly to discuss the issues faced by their respective members. At least one of the two key field staff was present at each meeting in order to moderate the discussion, keep attendance records, and take meeting minutes. Each group had a cooperative savings account, in which all members were required to invest a minimum of 100 Nepali rupees (equivalent to approximately one US dollar) during each biweekly group meeting. A review of attendance records indicated that meetings were generally well attended. An examination of a sample of translated meeting minutes revealed that the topics discussed during biweekly group meetings primarily focused on issues related to cooperative savings accounts. For instance, translated minutes from a number of meetings described situations in which a member was advocating for the group to provide her with a small loan and the group discussed whether the loan should be granted and under what conditions (e.g., by when the member would need to pay the loan back and at what interest rate). Challenges related to police harassment were also commonly discussed.

The partner NGO requested that women from these network groups be selected and trained as peer educators (PEs). The trained PEs would then teach the lessons learned to their group members during regularly scheduled biweekly meetings. Although the partner NGO requested that one member of each of the 20 network groups be selected and trained, the decision was made to limit this pilot training to 10 PEs due to limited financial resources and suggestions made by previous peer education program manuals to limit the number of trainees per class to

10-15 (Mongard, Brussa, & de Jong, 1997; Smith, Karsh, Carayon, & Conway, 2003). Training in small groups allows for the high level of student-instructor interaction needed to foster motivation, monitor progress, and determine the comprehension level of each learner (Smith et al., 2003).

Procedures

Determine Program Focus

As previously noted, WES in Kathmandu are exposed to numerous occupational hazards. Although the partner NGO expressed immediate interest in developing a peer education program, leadership was not clear on which hazards they would like to address through the program. When there is uncertainty or flexibility in the research plan, it is important to first develop and prioritize research questions based on community needs, concerns, resources, and strengths (Israel et al., 2013).

A multi-step process was conducted to determine the focus on the program. First a literature review helped to identify an initial list of the occupational hazards faced by WES in Kathmandu. In order to ensure the comprehensiveness of this list and to better understand the programs and services currently being offered, representatives from six NGOs (including the partner NGO) and two International NGOs (INGOs) targeting WES in Kathmandu were interviewed between September-December 2013. Interviews were conducted with one or more staff members from each of the eight organizations. Psychosocial counselors affiliated with two of the NGOs were also interviewed. All interviews were conducted in person at the NGO/INGO offices in Kathmandu. Participants were asked to describe their target population(s), programs and services provided, challenges faced and effective strategies related to program implementation (particularly with regard to the use of PEs), and perceived gaps in programs and

services for WES in Kathmandu. Participating organizations were provided with a summary report of the findings (see Appendix A).

Based on the literature review and NGO interviews, eight possible program topics were identified as follows: sexual health; reproductive health; violence and exploitation; trafficking and safe migration; labor relations; laws and rights; psychosocial health; and substance use/abuse. A meeting was convened with the two key field staff in order to review and discuss all possible topics. The field staff were asked to remove possible topics from the list if they felt the issue was already being adequately addressed by their own or other NGOs or if they did not want to focus on the topic for other reasons. For instance, they quickly removed sexual health from the list as they felt strongly that there were numerous other NGOs focusing on this topic, some through peer education programs. I was able to contribute to this conversation with the knowledge gained through the NGO interviews. The final list included five topics, which the two key field staff felt would be beneficial for WES in Kathmandu: women's health (other than sexual health); violence and exploitation; trafficking and safe migration; laws and rights; and psychosocial health.

In the next step, the partner NGO called a meeting with the group Chairpersons from the Women's Watch Network (15 of 20 Chairpersons attended). During this meeting, held at the headquarters of the partner NGO and facilitated by the two key field staff under my guidance, the Chairpersons were asked to vote on which topics they would be most interested in learning about. First, the overall goal of the project—to promote the health, safety, and well-being of WES in Kathmandu—was briefly described. Next, the specific project goal—to develop a peer education training program to teach a small subset of women from the network groups how to educate, raise awareness among, and empower their peers through teaching—was described. The

field staff then reviewed each of the five possible training topics, discussing the overall topic as well as possible subtopics that could be addressed through the training. The Chairpersons were encouraged to ask questions and weigh in with their opinions throughout this part of the meeting. Once all topics had been reviewed, the Chairpersons were then asked to vote on which topics they would be most interested in learning about. Each topic was assigned a color on a piece of chart paper taped to the wall. Participants were given a simple voting sheet with three boxes, labeled one, two, and three in Nepali. They were also given five stickers, one for each topic color. They were asked to place the sticker corresponding with the color of the topic they were most interested in learning about in the box labeled one and so on to indicate their top three choices. The NGO staff facilitated this voting process. The Chairpersons' top three choices in order from most interested to least interested were: 1) laws and rights; 2) psychosocial health; and 3) women's health (other than sexual health).

Next, a project advisory board was assembled including key leadership and staff from the partner NGO and other individuals who served as advisors to the partner NGO (e.g., a lawyer and psychosocial counselor who already advised and worked with the partner NGO) and met to review the training topics and the voting outcomes from the Chairperson meeting. Overall, the advisory board members stressed the importance of psychosocial health above the other topics. During this meeting, two possibilities were discussed: 1) focus the entire training on psychosocial health, or 2) select three of the five topics to focus on in less depth. The President of the partner NGO was asked to make the final decision in order to foster a sense of ownership and control over the direction of the project. She made the final decision to focus the entire training on psychosocial health.

Focus Group on Psychosocial Health

In order to gain insights into the psychosocial health conceptualizations and status of WES in Nepal, an informal focus group was conducted with a convenience sample of five WES recruited by the President of the partner NGO. I facilitated the session, and the President attended to translate and help guide the discussion. Participants were asked to define what psychosocial health means to them and why they perceived it as important; describe some of the common psychosocial health problems faced by, as well as the factors that influence psychosocial health of, WES; brainstorm strategies that are helpful in dealing with psychosocial health problems; and suggest which topics they would be interested in receiving training about related to psychosocial health. Given the sensitivity of the topic, participants were told that they were not expected to share personal experiences or concerns, but rather to focus on the psychosocial health of WES in general, in order to make them feel they could share as much or as little of their personal experiences as they felt comfortable. See Appendix B for the questions asked during the focus group guide.

When asked to define the psychological and social aspects of psychosocial health, participants equated psychological health with stress, tension, worries, loneliness, sadness, and depression, and equated social health with social work (e.g., serving those who are less fortunate). Many participants reported that when they experience stress or tension, they tended to keep it to themselves and find solutions on their own. This may be due to the stigma associated with mental illness in Nepal (Kohrt & Harper, 2008). Some associated the tendency to keep their feelings inside with negative health consequences, such as headaches, sleep disturbances, and eating problems. The participants explained that the well-being of their children was their number one concern and was often prioritized above their own health and well-being.

Participants were highly interested in learning better ways to deal with stress and improve their psychosocial health and expressed a strong interest in participating in the training program. This focus group provided valuable insights into the psychosocial health status and concerns of WES in Kathmandu.

Training Design and Overview

The training consisted of six 3-hour sessions broken into two phases. The length of the overall training and the training sessions was determined based on the limited resources available as well as recommendations made by the two key field staff that it should be kept short so as not to be perceived as overwhelming by the target population. During the design phase, I asked the two key field staff to help come up with a name for the program, and they suggested "*Haamro Raksha*," which means "Our Protection." A graphic designer developed a logo for the program pro bono, which was similar to the NGO's logo and was used on all recruitment and training materials.

Phase one. The first phase of the training (i.e., Phase 1) consisted of three sessions focused on basic peer education skills. The aims of this part of the training were to establish a baseline understanding of what peer education is and why it is important and to develop the leadership, communication, and teaching skills the trainees would need to be successful in their role as PEs. I facilitated this phase of the training with assistance from a female Nepali research assistant. At the time, the research assistant had been working at another Kathmandu-based NGO with programs targeting WES for four years and had extensive experience working with and training members of the target population.

The Phase 1 training content and activities were designed based on training manuals from previous peer education programs, primarily those targeting HIV prevention among FSWs (e.g.,

Family Health International, 2006). A draft of the training materials was thoroughly reviewed in two face-to-face meetings—one with two Nepali women who had experience designing anti-trafficking training materials and one with the female Nepali research assistant who was recruited to help facilitate the training. Edits were made based on their feedback. The final training manual and corresponding materials can be found in Appendix C.

Phase two. The second phase of the training (Phase 2) consisted of three sessions focused on different topics related to psychosocial health. The goal of this phase was to establish a baseline understanding of what psychosocial health is, why it is important, and how to promote it in daily life. In order to ensure culturally relevant training on psychosocial health, the Phase 2 training sessions were facilitated by three local Nepali experts, including a psychosocial counselor who had been providing pro-bono trauma counseling for WES via the partner NGO for six years (and was also a member of the project advisory board), a spiritual leader from an international meditation organization, and a "life skills"[1] trainer from another NGO that works with WES in Kathmandu. The psychosocial counselor was recruited through the partner NGO, and the other two trainers were recruited through my personal network. Face-to-face meetings were held with each of the three Phase 2 trainees to develop an outline for their training content (see Appendix D for the three outlines). Because the spiritual leader had no previous experience with WES, a pilot of his training was conducted with staff from the partner NGO to ensure appropriateness of the proposed content and activities. This trainer modified his plan based on the feedback provided by the partner NGO staff during this pilot session.

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[1] This trainer typically provides a 36-hour training that her NGO refers to as a "life skills" training. Upon reviewing the full training manual, this training covers a variety of topics to help women in the entertainment industry foster the personal and relational knowledge and skills to be happy and successful in life, such as communication skills, positive thinking, and self awareness.

Each Phase 2 session consisted of two hours of new training content provided by the expert trainers followed by a one-hour debrief session. During the debrief sessions, which I facilitated with the assistance of the female Nepali research assistant and staff from the partner, participants were asked to discuss the key lessons they had learned in the training that they wanted to share with their peers. Two female artists who were recruited from an online Kathmandu expatriate community listserv, one Canadian and the other Israeli, attended these debrief sessions in order to create visual teaching aids for the PEs. One of the artists sketched visual representations of the lessons learned on a piece of chart paper on the wall, allowing the trainees to view, react to, and interpret the drawings in an interactive fashion. The other artist simultaneously copied down the final drawings onto an electronic drawing tablet. At the end of each Phase 2 debrief session, a copy of the final drawing from the tablet was printed and distributed to the PEs (see Appendix D for the final drawings for each of the three phase two trainings).

The trainees were asked to use the customized visual teaching aids to teach the lessons learned to their peers both formally during their next network group meeting and informally while at work. They were encouraged to adopt participatory, non-didactic educational techniques during their practice teaching and to encourage their peers to generate their own ideas and strategies for incorporating the lessons learned into their daily lives (e.g., through activities and discussion). In order to give ample teaching time for each topic, there was a two-week gap between each of the Phase 2 trainings. The hope was that, through completing three rounds of attending the training and practicing teaching different topics, the PEs would develop teaching confidence and competency so they could receive training on other topics in the future and know how to disseminate their new knowledge and skills to their peers.

Training approach/strategies. The entire program was designed to be in line with the previously mentioned best practices (see Chapter 1). The training content was highly interactive, strengths-based, and tailored for a low-education, low-literacy population. All trainers were encouraged to adopt a participatory non-classroom style of teaching, to promote critical thinking, and to help the trainees come up with their own solutions and strategies. Given the focus group participants' prioritization of their children as well as the meta-analysis findings of Karr et al. (1999) that women in empowerment programs are often motivated by a "deep commitment to protect and promote the wellbeing of their children and families" (p. 1452), the potential of the knowledge and skills learned during training to help WES excel in their role as mothers was continuously emphasized.

The training was also designed based on training transfer best practices. Training transfer refers to the extent to which the knowledge and skills learned in training get transferred to work and life outside of training (Grossman & Salas, 2011). Some of the key factors that have been found to foster the transfer of training include behavioral modeling, error management, and opportunities for practice (Grossman & Salas, 2011). Behavioral modeling was promoted by providing participants with positive and negative models of training concepts as well as opportunities to practice new skills through role playing activities. Error management was simulated by encouraging participants to anticipate challenges they might face while teaching their peers and potential strategies to overcome the identified challenges. Finally, through the visual teaching aids and built in teaching opportunities, participants were provided with resources and opportunities to apply their new skills and abilities outside of the training context.

Inspired by the IET (Blanchard et al., 2013), the training was also designed to promote the three types of empowerment—*within*, *with others*, and *over resources*. In order to promote

power *within*, the program aimed to foster self-awareness, self-esteem, and self-confidence and focused on positive topics such as the importance of self-care and the value of women in Nepali society. Power *with others* was promoted by providing opportunities for the women to discuss and reflect on the lessons learned with one another—both in the training and during their practice teaching. Finally, power *over resources* was promoted by enhancing PE awareness of community resources, as well as how to access and refer others to them.

Staff Orientation

Prior to beginning the training, a half-day orientation meeting was held with all NGO staff involved in the project to ensure a common understanding of the aims and steps of the program and what assistance would be required of the staff throughout the implementation process. The meeting was conducted in Nepali and co-facilitated by the psychosocial counselor and myself. The female Nepali research assistant who was recruited to help facilitate the PE training also attended in order to translate my portion of the session, although the psychosocial counselor also spoke English and was able to aid in translation. The meeting was held off-site at the Nepal Fulbright program offices in order to ensure the staff from the partner NGO would be able to give their full attention and not be distracted by the day-to-day demands at the NGO headquarters. The meeting was well attended but, unfortunately, the NGO President was not able to attend due to a family emergency.

During the first half of the meeting, the psychosocial counselor provided an interactive training on psychosocial health—what it is, why it is important, and how it affects WES. The second half of the meeting was spent reviewing the program goals and steps in detail. The NGO staff were encouraged to ask questions and offer suggestions for how to improve the implementation plan. A number of useful insights were provided, including valuable information

regarding the scheduling of program activities in order to maximize trainee participation. This orientation meeting not only ensured that all NGO staff understood the project, why it was important, and what their roles would be in it, but it also served to make them feel valued and highlighted their role as influential members of the project team, thus increasing their ownership of and commitment to the project.

Recruitment and Selection of PEs

To ensure a high level of motivation, the 10 PEs were recruited through a self-nomination process (Medley et al., 2009). The NGO field staff were asked to announce the training opportunity to women from all 20 network groups during the biweekly network group meetings as well as during their regular establishment visits. Recruitment was limited to members of the Women's Watch Network who were 18 years of age or older. Again, older PEs are thought to be more articulate and experienced and have more well-developed social skills compared to younger PEs (Jana et al., 2004). All who were interested in the training were invited to attend a one-hour information session at the partner NGO headquarters to learn more about the opportunity and to apply. Attendance at this session served as a way to eliminate potential candidates who may have expressed an interest in the training but, in reality, were not able to take the time to attend a meeting to get more information. The two key field staff were given simple recruitment flyers in Nepali that advertised limited spaces available for a free training in peer education and psychosocial health and provided the time and location of the information session.

Approximately three weeks in advance of the information session, the two key field staff were asked to announce the opportunity and distribute the flyers. In visits to the NGO during this time, it was evident that the field staff had not been distributing the recruitment flyers provided

(perhaps because they forgot or were too busy); however, they assured me that they were announcing the training and that plenty of interested recruits would come to the information session. Also during this time, the President of the NGO arranged for me to be interviewed on a weekly radio program in order to announce the training opportunity.[2] The radio interview lasted approximately one hour and focused primarily on the mental health and empowerment of WES in Nepal. The interview was conducted in English, and the interviewer summarized approximately every 10-15 minutes of the interview in Nepali in the final edited version that was aired. At the end of the interview, logistical details for the information session were provided in Nepali.

A couple of days in advance of the originally scheduled date, the partner NGO postponed the information session by one day due to a scheduling conflict. The two key field staff assured me that they informed all potential recruits of the change; however, it is possible that the women who attended the rescheduled information session were those who the field staff knew well and personally wanted to be selected as PEs. I expressed concerns that interested women would show up on the date that was initially announced. However, only a couple of women arrived on the originally scheduled date, upon which they were informed of the schedule change and encouraged to return the next day.

The information session was held at the partner NGO headquarters. At the beginning of the session, I introduced myself and briefly described the training opportunity with the female Nepali research assistant who was recruited to help facilitate the training aiding as a translator. The NGO President and the psychosocial counselor attended the initial part of the information session to further elaborate on psychosocial health and to give their endorsement for the training.

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[2] The NGO held a regular Sunday evening spot on a local Nepali radio program aired across the Kathmandu Valley on which they covered various topics relevant to WES.

I then gave an in-depth overview of the training, including a description of the content, the schedule, all evaluation components, eligibility requirements (i.e., member of Women's Watch Network, 18 or older, commitment to complete the entire training program, practice teaching requirements, and all components of the evaluation), and incentives (i.e., transportation reimbursement, lunch, closing ceremony, completion certificates). I also informed the recruits that we would only select 10 women to train. One of the NGO staff stressed that the 10 women who took the training would be sharing what they learned with others so the knowledge would be passed on to many women, even those who were not able to take the training. It was emphasized that the PEs would only receive a completion certificate if they completed all six training sessions and participated in all evaluation activities, including an exit interview. Recruits were encouraged to ask questions throughout the session. Finally, those who felt confident they could complete all program requirements were encouraged to see one of the NGO staff or the research assistant in order to complete a screening survey.

The screening survey was in Nepali and included a number of fill-in-the-blank and multiple choice questions to assess demographics, previous trainings taken, exposure to PEs in the previous year, capacity to lead group discussions with and offer advice to others, and days and hours they were available for the training. A brief personality measure was included to assess conscientiousness and emotional stability, both of which have been associated with performance across a variety of jobs (Barrick & Mount, 2005). The screening survey also asked a number of open-ended questions to assess personal strengths and weaknesses, whether they viewed themselves as leaders, and reasons for wanting to be a PE. The goal of the screening survey was to determine if their motivations, work history, background experiences, and other characteristics would make them a good candidate (see Appendix F for the screening survey).

The initial plan was to administer the screening survey immediately after the information session. However, the psychosocial counselor instead facilitated a trust building activity on the roof of the NGO, lunch was served, and the recruits left. The NGO field staff followed up with each interested recruit over three days to verbally administer the screening surveys to accomodate low levels of education and literacy. Thirty women, representing 16 of the 20 network groups, completed the screening survey.

The NGO President volunteered to help with translation while entering the data from the screening surveys. Through this process, she noted that some of the recruits reported a false caste status on the survey.[3] Specifically, some of the women from a lower caste reported being from a higher caste, but the NGO President was aware of their true caste status. She explained these women were likely motivated to lie out of fear that divulging their true caste would decrease their chance of being selected for the training. The NGO President assured me that this tendency to lie was likely higher on the screening survey than the baseline survey, as the women were particularly motivated to make a good impression during the recruitment session.

Two separate groups of recruits were selected to be final candidates—I selected one group and the two key field staff selected the other group. Once the screening survey data were entered, a scoring system was developed with higher scores reflecting greater probability of being successful as a PE, and each potential recruit was assigned a final sum score. Demographic characteristics were also considered during this process, with a preference for older women (Jana et al., 2004), and those with more diverse work experience (i.e., in terms of types of work establishments) and more years of experience working in the entertainment sector (Overs & Hunter, 1996). For instance, if two recruits from the same group had the same score, preference

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[3] Caste was inquired about to ensure the selected PEs represented a range of caste groups.

would be given to the older of the two with more experience in the entertainment sector and/or who had worked across a variety of establishment types. The top 10 scoring recruits from 10 different groups comprised my final selected candidates. In a separate process and without knowledge of the screening survey results, the two key field staff were asked to select their top 10 candidates based on who they thought would be most successful in the role of PE and who would best be able to commit to the program.

After the two separate lists were constructed, I met with the two key field staff to compare lists. We agreed on four of our initial selections. Although the field staff had not included her on their list, I convinced them to select the highest scoring candidate from the screening survey process. For the remaining five, I deferred to the field staff's suggestions. When asked to explain why we should select their lower scoring candidates instead of some of my higher scoring candidates, the most common response was that the women who scored higher on the screening survey had busy schedules, family obligations, or other issues that would prevent them from being able to fully commit to the program. One of their selections was a woman who had not attended the information session or completed a screening survey, but they felt strongly that she take the training. As can be seen in Figure 2.2, the women selected to be trained as PEs (which dictated which groups were in the experimental condition) were all from network groups that were clustered inside of Kathmandu proper (i.e., inside of Ring Road) in close proximity to Thamel and the headquarters of the partner NGO. The groups located outside of Kathmandu proper and further away from the headquarters of the partner NGO did not have PEs and were therefore designated as control groups.

Training Implementation

The training was conducted between February 4, 2014 and March 21, 2014. The first four sessions (i.e., all three Phase 1 sessions and the first Phase 2 session) were conducted on four consecutive days (February 4-7). To allow for a two-week break for the PEs to practice teaching after each of the Phase 2 trainings, the fifth training took place on February 21, the sixth and final training took place on March 7, and the final round of practice teaching concluded on March 21. All 10 trainees attended the first four sessions, nine attended the fifth session, and seven attended the final session. The PEs completed the formal practice teaching requirement in their next biweekly network group meeting for each Phase 2 training attended (i.e., 10 completed practice teaching based on the first Phase 2 training, nine completed practice teaching based on the second Phase 2 training, and seven completed practice teaching based on the final Phase 2 training).

All trainings took place in a small, private room at the headquarters of the partner NGO from 10am to 1pm. Each session had a brief (5-10 minute) break in the middle during which tea and biscuits were served, and lunch was provided after each training. During Phase 2, serving lunch at the end of each training allowed time to go to a nearby print shop to print copies of the visual teaching aids in order to give them to the trainees before leaving for the day.[4] The two key field staff attended all training sessions and took an active role in facilitating some of the activities. They also helped to administer one-page post training reaction surveys to each PE after each of the six trainings to gain their feedback and reactions to each session (see Appendix G for the post training reaction survey and Chapter 4 for a descriptive summary of post training reaction survey responses).

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[4] It was not possible to print the visual teaching aids at the NGO headquarters due to regularly scheduled power outages.

During Phase 1, I reviewed the training plan in detail with the female Nepali research assistant the day before or morning of each training to ensure she was familiar with and understood the plan for each day. At the beginning of the first session, each trainee was provided with a nametag, notebook, pen, and a binder in which to keep their training materials. The binders were stored at the NGO during Phase 1 of the training, and the PEs took their binders home during Phase 2 so they could use them to store the visual teaching aids. At the beginning of sessions five and six, the PEs were asked to report back about their practice teaching, with a focus on the challenges faced and effective strategies implemented. In this way, the PEs were able to learn from one another's experiences. The expectation that all PEs would have to report on their teaching experiences also helped to promote accountability. The two key field staff attended all group meetings and were encouraged to take an active role coaching and assisting the PEs during their practice teaching. They were also asked to complete an observational rating form of the PE's teaching performance during each practice teaching session (see "Program Evaluation" section below for more details about the observational rating form and Chapter 4 for a descriptive summary of observational rating form results). The expectation for the field staff to complete an observational rating form for each practice teaching session served as a way to increase their accountability for assuring the practice teaching took place as well as ensure fidelity of the messages delivered by the peer educators. In order to ensure fulfillment of the post intervention evaluation components, the completion certificates were withheld until all PEs completed a post intervention survey and an exit interview. Completion certificates were awarded during a closing ceremony held at a nearby restaurant, at which lunch and cake were served, as a way to formally celebrate the accomplishments of the PEs.

Evaluation

The evaluation consisted of two main components: 1) a quasi-experimental impact evaluation comprised of baseline and post intervention surveys to assess psychosocial and occupational health and empowerment outcomes among members of the Women's Watch Network who were and were not exposed to the PEs, and 2) a mixed-methods evaluation to assess the impact of the program on the 10 WES trained as PEs and the feasibility of the program. For the impact evaluation, surveys were administered to WES representing members of all 20 network groups of the Women's Watch Network during the two key field staff's regular establishment visits and biweekly network group meetings. The women from the 10 groups with PEs comprised the experimental condition (including five massage parlor groups, one cabin restaurant group, three *bhatti pasal* groups, and the one mobile group) and the women from the 10 groups without PEs comprised the control condition (including two massage parlor groups, four cabin restaurant groups, the one dance bar group, and three *bhatti pasal* groups). For the mixed-methods PE evaluation, PEs completed the same baseline and post intervention surveys as the impact evaluation participations, as well as some additional questions to assess PE efficacy (i.e., efficacy related to teaching, communication, leadership, and helping others). The PEs also completed the same survey at two additional time points—2-months post intervention and 10-months post intervention. The observational rating forms completed by the NGO staff served as a measure of teaching competency. Finally, one-on-one exit interviews were conducted with PEs and the two key field staff to collect more in-depth feedback about the training and practice teaching experiences.

Survey Development

An initial survey was drafted to assess all demographics and outcome variables of interest. Although a majority of survey items came from previously existing scales, many items were reworded to accommodate the low levels of education and literacy among the target population. To reduce respondent burden, two, four-point Likert scales were used for a majority of the items—a level of agreement scale and a frequency scale. Therefore, many of the items were also reworded in order to correspond with one of these rating scales.

The survey was translated into Nepali by the female Nepali research assistant who was recruited to help facilitate the training and then back-translated into English by a bilingual staff member from the partner NGO. Based on the wording issues identified during the back-translation process, the survey was modified to optimize accuracy and clarity. A Nepali language instructor then carefully reviewed the survey and additional fine-tuning was conducted based on her input. The inclusion of both insider and outsider perspectives have been advocated as best practices for ensuring semantic equivalence in survey translation (Schaffer & Riordan, 2003). Finally, cognitive interviewing was conducted with a bilingual staff member from the partner NGO to ensure the survey items were being interpreted in Nepali in the intended way. Cognitive interviewing is a technique commonly used to identify potential sources of response error by asking the respondent to provide a detailed description of their thought processes when considering how to respond to survey questions (Fujishiro et al., 2010). Throughout the translation process, a decentering approach was adopted in which both the English and Nepali versions of the survey remained subject to revisions until appropriate grammatical structures and conceptual clarity were achieved (Brunette, 2004). Decentering has been suggested as a superior approach to simple back-translation when conceptual equivalence is the primary goal (Behling &

Law, 2000; Werner & Campbell, 1970) because decentering deems both languages as equally important, whereas back translation places more importance on the original language as the standard for comparison (Moure-Eraso & Friedman-Jimenez, 2005).

During an in-person meeting, the two key field staff reviewed all survey items and requested elimination or re-wording of items they believed would cause discomfort among participants. For instance, they did not want to ask the women questions pertaining to sex work or refer to the women as sex workers or even as WES, as they did not want to make participants feel uncomfortable or stigmatized. The initial version of the survey included 90 items using both numerical and visual rating scales (see Appendix H).

The initial version of the survey was pilot tested with 12 WES recruited by the two key field staff. The pilot test was conducted in one of the NGO's satellite meeting spaces and was carried out to reflect the intended administration procedures for the actual survey. The two key field staff facilitated the pilot test, and the female Nepali research assistant who was recruited to help facilitate the training and I attended to observe and to address questions or concerns that arose.

During the pilot test, the field staff attempted to administer the surveys in a group format (i.e., in which a staff member read the survey items and response options and the participants selected their own responses). However, it was clear that some of the participants were copying responses from other participants (perhaps those with lower literacy were copying from those with higher literacy). Based on this observation, we determined the surveys would have to be administered verbally, one-on-one, and filled out by the field staff rather than the participants.

Based on the pilot test, it was evident that: 1) the survey needed to be shortened; 2) the participants were frustrated by questions perceived as redundant; and 3) the participants found

the visual ratings scales to be confusing. The survey was shortened and edited based on the pilot feedback. In trying to reduce redundancy, items with simple language were given preference, while attempting to maintain enough items to capture the full breath of each construct.

Measures

The baseline survey (Appendix I) assessed demographic and background information and social desirability. Outcomes were assessed at baseline and post intervention. The post intervention survey (Appendix J) additionally assessed exposure to PEs and a couple of questions related to career aspirations and suggestions for reducing harassment in the entertainment sector at the request of the President of the partner NGO. PE surveys included additional questions to assess efficacy related to being a PE (i.e., teaching, communication, leadership, helping others). See Appendices H-J for the final baseline and post intervention surveys and additional PE efficacy questions.

Demographic and background information. Demographic and background information included age, home district, caste/ethnic group, length of time living in Kathmandu, reason for leaving home village, marital status, whether or not husband provides financial support, number of children, religion, years of education completed, length of time in network group, previous training in psychosocial health and life skills, length of time working in the ES, current workplace type/s, reason/s for working in the ES, alcohol and drug consumption at work in the last month, and whether or not they had a citizenship card, savings (in their network group cooperative savings account and/or other account), or a voter ID. All participants were also asked

to indicate the name of the network group they were a member of at baseline and whether or not they had switched group membership at post intervention.[5]

Outcomes. Outcome measures included burnout, the three types of empowerment from the IET (i.e., power *within*, power *with others*, and power *over resources*), happiness, job control, overall health, psychosocial health knowledge, stress, and workplace bullying.

Burnout. Burnout was assessed with four items from the 10-item short version of the Malach-Pines Burnout Measure (BMS-10; Malach-Pines, 2005). The BMS assesses three aspects of burnout—physical, emotional, and mental. Questions related to physical burnout were not included. Participants were asked to indicate how often they felt tired, depressed, helpless, and "I've had it" regarding their work during the last month on a four-point Likert scale ranging from never to always. Reliability and construct validity of the BMS-10 has been established with Jewish ($\alpha = .87$) and Arab ($\alpha = .85$) samples in Israel (Malach-Pines, 2005), and has demonstrated high face (Pines, 2000a, 2000b, 2002) and construct (Malach-Pines, 2005) validity.

Empowerment. With permission, modified items from the Blanchard et al. (2013) IET measure were combined with additional items to assess the three types of empowerment. Power *within* was assessed with a total of eight items: four items from the IET, three modified items from the General Self-Efficacy (GSE) scale (Schwarzer & Jerusalem, 1995), and a single-item written by the research team. The GSE is a 10-item scale designed to assess perceived self-efficacy, which is defined as an optimistic self-belief related to one's ability to cope with a broad range of challenging or stressful demands. Criterion validity and internal reliability ($\alpha = .75$-$.94$) of the GSE have been validated cross-culturally (Luszczynska, Scholz, & Schwarzer, 2005; Scholz, Doña, Sud, & Schwarzer, 2002). One newly constructed item, "I have the power inside

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[5] The field staff explained that WES occasionally change network groups due to a change in the geographic location or establishment type of a their primary work location.

me to be happy and strong despite my problems," was also included as a global measure of power *within* specifically relevant to the type of empowerment *within* the training aimed to foster. Power *with others* was assessed with six items from the IET. Finally, empowerment *over resources* was assessed with six items asking about perceived access to different types of community services. Blanchard et al. (2013) assessed power *over resources* by asking about access to social entitlements, such as a citizenship card or driver's license. However, given the brevity of the present study (i.e., the intervention was implemented across 6 weeks as opposed to across several years in the Blanchard et al. (2013) study, it was not likely that access to social entitlements would improve between the baseline and post intervention surveys. However, it was more likely that educating the PEs about various community services and how to access and refer others to them could enhance perceptions regarding access to community services. Therefore, power *over resources* was assessed through five newly constructed items related to perceived ability to access community resources (e.g., counseling/mental health services, sexual health services, legal advice and services). All empowerment items were assessed on a four-point Likert scale ranging from disagree a lot to agree a lot.

　　Happiness. Happiness was assessed by a single-item on a visual analog scale in which participants were asked to mark a '□' to show how happy they have been in the last month on a line with a smiley face on one end and a sad face on the other. Similar single-item measures have been proven as valid and reliable measures of happiness (Abdel-Khalek, 2006). Scores were translated to a 13-item scale, as the full length of the response line was 13 centimeters.

　　Job control. Job control, defined as "the working individual's potential control over his tasks and his conduct during the working day" (Karasek Jr, 1979, pp. 289-90), was assessed by a

single, newly-constructed item "How often do you feel you could decide what you do at work and how you do your work?" on a four-point Likert scale ranging from never to always.

      Overall health. Overall health was assessed by a single-item asking participants to rate "How is your current health?" on a four-point Likert scale ranging from poor to excellent. There are over 25 years of research to support such single-item measures as robust predictors of subsequent mortality (DeSalvo et al., 2006; Ganster, 2008).

      Psychosocial health knowledge. Psychosocial health knowledge was assessed with two items rated on a four-point Likert scale ranging from disagree a lot to agree a lot. These items were written based on the content covered during the training.

      Stress. Stress was assessed with two items on a four-point Likert scale ranging from never to always. One item was from the Perceived Stress Scale (PSS), a scale developed to assess "the degree to which individuals appraise situations in their lives as stressful" (Cohen, Kamarck, & Mermelstein, 1983, p. 385). The PSS has been used extensively cross-culturally and translated into numerous languages (Lee, 2012). Eller and Mahat (2003) used the original 14-item version (PSS-14) on a sample of former Nepali commercial sex workers who were HIV positive and found acceptable internal reliability ($\alpha = .72$). The item used (i.e., "How often do you feel that difficulties are piling up so high that you can not overcome them?") was selected from the PSS-4, the shortest form of the PSS (Cohen & Williamson, 1988). This item was selected because it best reflected the psychosocial health strains reported by the five WES during the focus group interview. The other item, "How much have you had worries, sadness, or thoughts playing in your heart-mind?" was included based on advice from Dr. Brandon Kohrt, a medical anthropologist with extensive experience conducting research related to mental health in Nepal. Kohrt and Harper (2008) identified five elements of the self that are central to

understanding Nepali conceptualizations of mental health and psychological well-being, namely the *man* (heart-mind), *dimaag* (brain-mind), *jiu* (the physical body), *saato* (spirit), and *ijjat* (social status). Kohrt (personal communication, December 9, 2013) recommended inclusion of a question related to the heart-mind (*man*) as a measure of psychosocial stress.

Workplace bullying. Workplace bullying was assessed with three items from the Negative Acts Questionnaire-Revised (NAR-Q; Einarsen et al., 2009). The NAR-Q was confirmed as a valid instrument for the assessment of workplace bullying in a study with over 5,000 employees in the UK (Einarsen et al., 2009). The NAQ-R is comprised of three inter-related factors—person-related bullying (e.g., slander, social isolation), physically intimidated bullying (e.g., physical aggression, threats of physical violence), and work-related bullying (e.g., criticizing someone's work, Einarsen et al., 2009). The items selected included two items from the person-related dimension and one from the physically intimidating dimension. None of the items from the work-related dimension were included as they were not relevant to work in Nepal's ES. Participants were asked to indicate how often they experienced each type of workplace bullying from their coworkers during the last month on a four-point Likert scale ranging from never to always.

Social desirability. Social desirability was assessed with four modified true/false items (coded as 0 for false and 1 for true) from the Reynolds Short Form of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982). The short form comprised of 11-items demonstrated accepted reliability ($\alpha = .74$; Reynolds, 1982). Two of the items indicated socially desirable responding if the participant answered in the affirmative and two of the items indicated socially desirable responding if answered negatively. There is evidence of similarities in reporting

behaviors and ratings of social desirability items across cultures, supporting the notion of social desirability as a universal concept (Johnson & Van de Vijver, 2003).

PE efficacy. PE efficacy was assessed with 13 items (see Appendix K). Four items were modified from the Leadership and Personal Development Inventory (LPDI; Carter, 1989), which measures perceptions of personal and leadership life skills. The LPDI has been used previously to assess the impact of peer education programs on PEs (Sawyer, Pinciaro, & Bedwell, 1997) and includes three subscales: group achievement, attitude toward group work, and personal development. Two items came from the attitude toward group work subscale (e.g., "I feel comfortable as a group leader"), and two items came from the personal development subscale (e.g., "I can explain difficult things to others."). Group achievement items were not relevant to the present study. Additional items were written to supplement the four LPDI items as follows: three items to assess efficacy in helping others (e.g., "If someone comes to me with a problem, I am confident that I can help them"), four items to assess communication confidence (e.g., "I can facilitate group discussions."), one item to assess teaching confidence, and one item directly asking about perceived leadership skills. Participants were asked to rate their level of agreement with each item on a four-point Likert scale ranging from disagree a lot to agree a lot. One of the communication items was removed from the analysis because, in retrospect, it was not worded in a way to represent efficacy ("I am interested to hear others' thoughts and ideas").

PE exposure. PE exposure was assessed at post intervention by asking participants to indicate if they had heard of the Haamro Raksha program and if their group had a PE from the program. If they reported that their group had a PE from the program, they were also asked to recall how many times she shared her training knowledge with them during their biweekly group meetings (between 0-3), and three open-ended questions—which topic(s) were covered, what

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their favorite topic was, and what other topics they would be interested in learning about related to psychosocial health.

Power Analysis

A power analysis was conducted to determine the sample size required to detect an effect. Medley et al. (2009) conducted a meta-analysis of peer education interventions for HIV prevention in developing countries that included 12 interventions with commercial sex workers. The pooled effects odds ratio for the effects of these 12 interventions on condom use was 2.31, 95% CI [1.66, 3.23]. Given that there are no previously published peer education programs targeting the outcomes psychosocial health and empowerment among sex workers, it was necessary to calculate power based on condom use as an outcome. According to the conversion formula proposed by Chinn (2000), this odds ratio is equivalent to a Cohen's d of .46 (i.e., a medium effect size). A priori power analyses indicated that approximately 80 participants were required for each condition (experimental and control) in order to achieve adequate statistical power to detect an effect size of .46. However, the research team aimed to recruit an additional 20 participants per condition in order to account for possible attrition between baseline and post intervention surveys. A recently published evaluation study of a peer education sexual health intervention with FSWs in India reported a 70% dropout rate between baseline and follow-up surveys that were administered after approximately 23 weeks (Sarafian, 2012). However, since the proposed study 1) administered post intervention surveys only 4 weeks after baseline (as opposed to 23 weeks); 2) had the assistance of the two key field staff to retain participants; and 3) paid participants to complete the post intervention surveys, a much lower (20%) dropout rate between the two surveys was anticipated.

Survey Recruitment

Three field staff (the two key field staff and one part time field staff) recruited women from the Women's Watch Network to take the surveys. Recruitment and administration of the baseline survey was conducted during the field staff's regular establishment visits and during biweekly network group meetings at the same time as announcement of the PE training opportunity. The field staff were asked to survey a total of 200 women with an equal number from each of the 20 network groups (i.e., approximately 10 women from each group). Inclusion criteria were that the women were currently working in the entertainment sector and at least 18 years of age. Minors were not included as it was not feasible to obtain parental consent given that a majority of WES originate from outside of Kathmandu (NCASC, 2011) and communication channels with parents are limited (M. Thapa, personal communication, October 1, 2013). Furthermore, because it is illegal for women under the age of 18 to work in the entertainment sector in Nepal, asking minors to complete a survey in which they have to identify their age and identify as working in the entertainment sector would place them in a position of increased risk.

Training of Survey Administrators

The field staff were trained in survey administration in a meeting the Nepali research assistant, who was recruited to help facilitate the training, and myself. First, we reviewed a survey administration protocol that was created in English and Nepali. This document covered: 1) what materials to bring with them during survey administration (e.g., consent forms, survey copies, compensation); 2) steps for administering the survey; 3) information about recruitment to the PE training program and; 4) logistical details for the informational session. After reviewing the survey administration protocol, the field staff were asked to practice giving the survey to one another while the research assistant and I observed and ensured they were following all

instructions. Each field staff was given a laminated copy of the survey administration protocol to serve as a reference during administration (see Appendix L for the survey administration protocol).

Survey Administration

The two key field staff and an additional field staff administered the baseline survey between January 10-24, 2014. All surveys (baseline and post intervention) were administered one-on-one, verbally in Nepali. Upon engaging with a potential participant, the field staff first confirmed that the woman was a member of the Women's Watch Network and that she was 18 or older. Next, they read the consent form, ensured comprehension, and asked the individual to sign the form if they agreed to participate. Participants were given my Nepal phone number and encouraged to contact me if they had any questions or concerns about participating. After obtaining written consent, the field staff assigned the participant an ID number from a list they had been provided and wrote the participant's name on the ID number sheet. This number was written at the top of the survey in lieu of the participant's name. They then administered the survey, reading all instructions and questions out loud to the participant, and filling in all participant responses. The administration process took between 30-45 minutes to complete. After the survey was completed, the field staff gave the participant her compensation (100 Nepali rupees) and asked her to sign the ID number sheet with her name to confirm receipt. According to the field staff, most (~90%) of the surveys were administered at the participants' workplaces, and the rest were given during biweekly network group meetings. The field staff reported challenges in delivering some of the surveys due to the distracting nature of the workplace environments. For instance, there were often other people (e.g., clients, establishment owners, coworkers) in the room, and there were times when the participant had to go into another room

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with a client mid-survey, upon which the field staff waited, and the participant finished

completing the survey after concluding her interaction with the client.

Upon receiving the baseline surveys, it was evident that there was a significant amount of

missing data. It was also clear that the field staff were not always careful to clearly check the

response options (i.e., sometimes the check was between two response options, and it was

unclear which option was intended). Prior to administration of the post intervention survey, I met

with the field staff to emphasize the importance of completing all questions (i.e., unless the

participant asked to skip the question) and clearly checking response options. The two key field

staff administered the post intervention survey between March 27-April 16, 2014, again during

their regular establishment visits and the biweekly network meetings. The field staff experienced

a great deal of hardship while attempting to track down the participants at post intervention due

to the high levels of mobility among WES.

PE Survey Administration

The PEs completed the same surveys as the experimental and control participants, with

13 additional questions to assess PE efficacy, at four time points: baseline, post intervention,

two-months post intervention (2-month follow-up), and 10-months post intervention (10-month

follow-up). Upon selection of the 10 PEs, it was determined that four had not taken the baseline

survey as part of the broader impact evaluation. Therefore, the baseline survey was administered

to these four PEs at the beginning of the first training session. The field staff delivered the

remaining surveys (i.e., the post intervention, 2-month follow-up, and 10-month follow-up

surveys) to the PEs at their workplaces or during the regularly scheduled network group

meetings. The PEs also received 100 Nepali rupees for each survey completed.

Observational Rating Forms

The two key field staff were asked to fill out an observational rating form, adopted (with permission) from a community lay health worker intervention targeting Mexican Americans with diabetes (Swider, Martin, Lynas, & Rothschild, 2010), to rate PE teaching performance during each group meeting. Specifically, the form was designed to collect an overall performance rating and level of skill across seven categories: clarity of content; openness to questions; encouraging active participation and helping participants; asking questions to check for understanding; discussing practical application of topics; confidence; and managing participants who went off topic. At the end of each Phase 2 training session, I sat with a bilingual staff member of the partner NGO to create bullet points of the four to five main sub-topics covered during the training. These topics were translated into Nepali and included on the observational rating forms and the field staff were asked to indicate which sub-topics were or were not covered by the PEs during each practice teaching session. There was also a section for the field staff to provide open-ended comments or suggestions for the PE. See Appendix M for a sample observational rating form. Again, asking the field staff to complete the observational rating forms served as another way to increase accountability for the practice teaching.

Exit Interviews

Upon completion of the program, the PEs and the two key field staff were asked to participate in 30-60 minute individual exit interviews in order to gather more in-depth feedback regarding the training and PE practice teaching experiences. I conducted the interviews using a structured guide (see Appendix N). A bilingual administrative-level staff member from the NGO (the one with the best English) attended the interviews and aided with translation. Written consent and permission to record the interviews was obtained from all participants. Interviews

were transcribed verbatim and translated into English by a Nepali research assistant. The PEs were each compensated with 100 Nepali rupees for participating in an exit interview. PEs were told they would not receive a completion certificate until after completing an exit interview as another strategy to encourage participation.

Data Entry and Cleaning

A Nepali research assistant conducted double data entry of all impact evaluation and PE data to ensure all responses were accurately recorded. The two sets of data were compared, and discrepancies were resolved by referring back to the raw data. For example, if one dataset showed a response value of "2" for a participant for one of the items and the other dataset showed a response value of "3" for the same participant, the correct value was confirmed in the raw data. Seventeen participants reported "basic" or "non-formal" for years of education. A professor from the Department of Education at Tribhuvan University advised that this response was likely equivalent to between one and two years of completed education. Therefore a "1.5" was imputed for these 17 participants (S. Acharya, personal communication, June 5, 2014).

Of the 193 participants who completed a survey (experimental $n = 100$, control $n = 93$), 32 cases were deleted for various reasons. Four cases were deleted due to having only baseline responses. Three cases were deleted due to the participant reporting different group membership at baseline and post intervention. Finally, group membership (i.e., whether the individual identified as a member of an experimental or control group) was checked against the question assessing exposure to PEs at post intervention, and 26 cases were deleted due to reporting incorrect exposure to PEs. Specifically, four experimental participants who reported no exposure to PEs and 22 control participants (representing nine of the 10 control groups) who reported exposure to PEs were deleted. The reason for these cases of incorrect exposure is unclear.

However, it is possible that these individuals switched groups between the baseline and post intervention surveys (although none reported switching groups when asked at post intervention) or attended group meetings for more than one group. See Figure 2.3 for a figure depicting deleted cases. After these deletions, the final number of participants was 160 (experimental $n = 96$, control $n = 64$).

A binary variable was created in which the 33 cases that were deleted were assigned a "1" and the 160 retained cases were assigned a "0." Chi-square and independent samples t-tests were run to determine if there were significant differences between the two groups (i.e., deleted and retained cases) on any of the 22 demographic and background variables or social desirability. A Bonferroni correction was applied to account for multiple comparisons, $p = .05/23 = .002$. No significant differences on any of the 23 demographic and background variables were found between deleted and retained cases.

For the baseline and post intervention survey responses that were accidentally checked between boxes by the field staff, the average of the two responses was imputed. For example, if the field staff checked between strongly agree (a value of four) and agree (a value of three) a "3.5" was imputed.

<div align="center">

Data Analysis

</div>

The data analysis procedures are described in two main sections: 1) data analysis for the impact evaluation to determine if those exposed to the PEs reported improved psychosocial and occupational health and empowerment at post intervention compared to those who were not exposed to the PEs as well as whether or not length of time in network groups moderated the treatment effects, and 2) data analysis for the PE data, including the four surveys (baseline, post intervention, 2-month follow-up, and 10-month follow-up), observational rating forms completed

by the two key field staff, and exit interviews in order to assess the feasibility of the program and its impact on the 10 WES trained as PEs.

Impact Evaluation

Data analysis for the impact evaluation consisted of four main components: 1) assessment and handling of missing data, 2) factor analysis and scale construction, 3) descriptive statistics for all demographic and outcome variables, and 4) hierarchical linear modeling to assess the impact of the program on all outcomes of interest and length of time in network group as a potential moderator of the treatment effects. Analysis and handling of missing data, creation of scale scores, and descriptive statistics were conducted using SPSS V23, and confirmatory factor analysis and hierarchical linear models were conducted using Mplus V6 (Muthén & Muthén, 2007). Impact evaluation results are reported in Chapter 3. Full results from the first two steps—handling and factor analysis and scale construction—are reported here.

Assessment and handling of missing data. At baseline, across all demographic and outcome variables, 3.3% of the data were missing. Missing data were spread across the dataset (i.e., only five out of 59 variables had no missing values). Of the 54 variables with missing data, the percentage of missing values ranged from 0.6% missing to 30% ($M = 3.6\%$, $SD = 4.7\%$). There were two demographic variables and two dependent variables that had more than five percent missing at baseline. The two demographic variables were number of children (30% missing) and number of years working in the entertainment sector (10% missing), and the two dependent variables were one of the power *within* questions (15% missing) and the single-item used to assess happiness (7.5% missing). The field staff informed me that the reason for the large amount of missing data on the number of children was because they left it blank if the women

said they had 0 children. However, I was unable to confirm if the response was left blank (i.e., actually missing) or intended to be 0.

At post intervention, there was considerably less missing data (1.4%) across the entire data set. This suggests that the greater amount of missing data at baseline was likely due to error on behalf of the survey administrators (i.e., the field staff) as opposed to participant unwillingness to answer questions. Again the missing data were spread across the dataset (i.e., only 15 out of 39 variables had no missing values). Of the 24 variables with missing data, the percentage of missing values ranged from 0.6% missing to 13.1% missing ($M = 2.3\%$, $SD = 2.7\%$). There was only one variable that had more than five percent missing, which was one of the ancillary variables assessing exposure to PEs. However, this variable was only used for descriptive purposes and was not included in any of the inferential analyses. Therefore, associations between demographic variables and social desirability and missing data on outcomes at post intervention were not examined.

Because traditional data analysis techniques such as multiple regression rely on estimated covariance matrices, cases with missing data are typically eliminated through listwise deletion. Due to the distribution of missing data across the baseline and post intervention datasets (see "Missing data analysis" in the Results section below for more details), such approaches would result in deletion of a substantial proportion of the sample. Full information maximum likelihood (FIML) is an approach based on raw, individual-level data, rather than the sample covariance matrix. FIML specifies different covariance matrices for individuals based on the number of observations present (Mehta & Neale, 2005) and therefore takes advantage of all available data, including cases with only partial data (Heck & Thomas, 2015).

One important assumption that must be met when implementing FIML is that the data are missing at random (MAR), meaning the reason data are missing is not related to the missing values themselves but could be related to other observed scores. In other words, when data are MAR, the scores for individuals with missing data would not have differed significantly from the scores of those with data present (Heck & Thomas, 2015). Given the missing data in this study were likely due to administrator error and the finding that time working in the entertainment sector and social desirability were significantly associated with missing data on items with large percentages of missing values, the MAR assumption seems plausible. Nonetheless, it is important to note that it is impossible to confirm MAR with 100% certainty due to the fact that the missing values themselves cannot be known (Newman, 2014).

Multiple imputation (MI) is another approach to handle missing data that was considered. MI is a more time intensive procedure in which unbiased values are imputed over and over again for all missing values creating multiple data sets, and subsequent models are run to generate parameter estimates across all imputed datasets (Newman, 2014). Hypothesis tests based on MI are considered unbiased because they account for the level of uncertainty associated with each parameter estimated. However, statisticians have found that FIML and MI data routines often result in nearly identical results because both are designed to provide unbiased estimates under the MAR assumption. Furthermore, when such a small percentage of missing data are randomly missing, the method used to handle missing data is considered less important. As stated by Tabachnick, Fidell, and Osterlind (2001), "if only a few data points, say, 5% or less, are missing in a random pattern from a large data set, the problems are less serious and almost any procedure for handling missing values yields similar results" (p. 59). Therefore, the more simple and efficient approach of FIML was selected over the more arduous MI approach.

Logistic regression models were specified to determine if missing data on the two dependent variables at baseline (i.e., the power *within* question and self-rated happiness) was significantly associated with any of the demographic variables or social desirability. A total of 31 variables were tested for association with missing data as follows: age; home district region (Far West, Midwest, West, Central, Eastern); caste (Brahmin, Chhetri, Janajati, Dalit); number of years living in Kathmandu; marital status (Y/N); financial support provided by husband (Y/N); number of children; religion (Hindu, Buddhist, Other, Hindu and Buddhist); time in network group; previous psychosocial health training (Y/N); time working in the ES; workplace type (massage parlor, cabin restaurant, dance bar, guest house, *bhatti pasal* [snack shop], other); alcohol use at work during last month (Y/N); drug use at work during last month (Y/N); number of social entitlements (citizenship certificate, savings in network group cooperative savings account, other savings, voter ID); and social desirability. The two social desirability items that indicated socially desirable responding if answered negatively (i.e., 0) were reverse-coded, and a sum score comprised of the four social desirability items was created (scores ranging from 0-4), with high scores reflecting high levels of social desirability. A sum score for total number of social entitlements (ranging from 0-4) was also created. The only demographic variables that were not tested were reasons for leaving their home village and reasons for working in the ES, as these variables were only included in the surveys at the request of the President of the partner NGO and were not intended for use in future analyses. Variables associated with missing data were not examined for the two demographic variables with a high percentage of missing data since these variables were not necessary for inclusion in the explanatory models in order to examine the hypotheses of interest.

First, a binary variable was created to represent the missing values for each of the dependent variables with a high percentage of missing values for each demographic variable (i.e., the power *within* question and self-rated happiness). This variable was assigned a "1" if the value was missing and a "0" if the value was present. Demographic variables and social desirability were examined individually for association with this binary variable using logistic regression. A Bonferroni correction was applied to account for multiple comparisons ($p = .05/31 = .002$). Time working in the entertainment sector was the only variable that was significantly associated with missing data for happiness ($b = .46$, $SE = .15$, $p = .002$). Time working in the entertainment sector and one workplace type (massage parlor) were significantly associated with missing data for the one power *within* item. Therefore, a multiple logistic regression model was specified including these two variables to determine which variables were still significantly associated with missing data on the one power *within* after controlling for the others. Time working in the entertainment sector ($b = .63$, $SE = .17$, $p < .001$) remained significantly associated with missing data on the power *within* item after controlling for working in a massage parlor, but working in a massage parlor was no longer significant when controlling for time in the entertainment sector ($b = -2.14$, $SE = .87$, $p = .014$). Time working in the entertainment sector was included in the hierarchical linear models for the scale including this power *within* item (see factor analysis and scale construction below for details as to why this item was considered as a measure of shame) and happiness as covariates (see section below titled "Hierarchical linear modeling"). If the data are not missing at random (i.e., the reason for the missing data is related to the values themselves), inclusion of this variable in these models will aid in converting a NMAR to a MAR missingness mechanism to meet the MAR prerequisite of FIML (Newman, 2014).

Factor analysis and scale construction. Confirmatory factor analyses (CFA) were conducted on the three dimensions of empowerment—*within*, *with others*, and *over resources*—in order to confirm the factor structure of these dimensions for future analysis. First, items were reverse-coded as needed so all items were scored in a way such that a high score reflected a high amount of the construct (e.g., a high score on a burnout item reflected a high amount of burnout). A three-factor structure was hypothesized for power *within*. Using principal components analysis Blanchard et al. (2013) found a two-factor structure for their measure of power *within*, and two items from each of these factors were used in the present study. Therefore, it was hypothesized that two factors would come from the four Blanchard et al. (2013) items and a third factor would come from the GSE scale (Schwarzer & Jerusalem, 1995). The newly constructed global measure of power *within* relevant to psychosocial health was hypothesized to belong to this third factor given the similarity of its wording to the GSE items. Although Blanchard et al. (2013) found two factors for power *with others*, just one of the six items included in the present study was from one of the factors and the remaining five were from the other factor. Therefore, power *with others* was hypothesized to consist of just one factor in the present study. Power *over resources*, which consisted of six newly generated items, was also hypothesized to comprise one factor. Upon reconsideration, one item from this domain was removed because it asked about ability to get help "from anyone anywhere" in the event of experiencing violence but not specifically related to accessing community resources.

The hypothesized three factor structure for power *within*, with two 2-item factors and one 4-item factor, demonstrated poor fit, $\chi^2(17) = 41.04$, comparative fit index (CFI) = .86, root-mean-square error of approximation (RMSEA) = .09, standardized root mean square residual (SRMR) = .06. One of the 2-item Blanchard et al. (2013) factors for power *within* was dropped

for two reasons: 1) it was negatively correlated with the other two power *within* factors, and 2) only one of the items demonstrated an acceptable factor loading (> .4). Instead of dropping these items ("It is difficult for me to tell others where I work," and "I feel ashamed to go to [the partner NGO] and other NGOs") from the analysis entirely, they were instead considered as a measure of shame related to working in the entertainment sector and analyzed as a psychosocial health outcome rather than an empowerment outcome. A two-factor model for power *within* was specified and resulted in acceptable fit, $\chi^2(8) = 9.53$, CFI = .99, RMSEA = .04, SRMR = .03. The factor that included items from the IET is hereafter referred to the confidence component of power *within*, and the factor comprised of GSE and the newly constructed item is referred to as the efficacy component of power *within*. Another model was approximated to determine if a single factor structure would provide a better fit to the data; however, this model demonstrated poor fit, $\chi^2(9) = 26.25$, CFI = .87, RMSEA = .11, SRMR = .06.

The hypothesized 6-item, one factor structure for power *with others* demonstrated poor fit, $\chi^2(9) = 35.06$, CFI = .82, RMSEA = .14, SRMR = .06. One item was removed due to having a negative factor loading. However, the model still demonstrated poor fit, $\chi^2(5) = 25.96$, CFI = .84, RMSEA = .16, SRMR = .06. The item with the lowest standardized factor loading (.512), highest standardized residual variance (.738), and highest modification indices was then removed, resulting in a 4-item model with acceptable fit, $\chi^2(2) = 2.86$, RMSEA = .05, CFI = .99, SRMR = .03. Finally, the hypothesized one factor, 5-item structure for power *over resources* resulted in acceptable model fit, $\chi^2(5) = 12.66$, CFI = .98, RMSEA = .09, SRMR = .03. Therefore, no modifications were required for this factor.

Scales scores were constructed for each dimension of empowerment based on the final CFA models described above. To assess internal consistency, Cronbach's alpha was computed

for each empowerment scale with more than two items (α range = .67-.84). Scale scores were

also computed for psychosocial health knowledge, stress, shame, burnout, and person-related

workplace bullying, and Cronbach's alpha was computed for burnout (α = .86), because it had

more than two items. Scale scores were calculated using all available data points for each

participant. See Table 2.1 for a summary of all outcome measures, including number of items,

Cronbach's alpha (or correlations for constructs with only two items), and a sample item for each

construct.

Descriptive statistics. Descriptive statistics were conducted to summarize demographic

and background information for all study participants (see Table 22.) and to assess baseline and

post intervention means and standard deviations for experimental and control participants for all

outcome variables (see Table 2.3). *T*-tests were conducted to determine if there were significant

differences between experimental and control participants on time in network group (i.e., the

moderator), time working in the entertainment sector, and baseline outcomes. To account for

multiple comparisons, a Bonferroni correction (p = .05/13 = .004) was applied. Correlations were

also calculated for treatment status and all outcome variables (see Table 2.4). Finally, Q-Q Plots

and histograms were also examined for all variables to assess normality. No highly skewed

distributions were identified.

Hierarchical linear modeling. Given the hierarchical or clustered nature of the data,

with participants nested within network groups, the assumption of traditional statistical tests that

the observations are independent of one another was violated (Baldwin, Imel, Braithwaite, &

Atkins, 2014). In other words, it is likely that members of one network group were more similar

to one another than they were to members of other network groups, simply because they had

spent more time with one another and were exposed to the same PE. Use of traditional statistical

tests (e.g., multiple regression) in this situation could lead to biased p-values, confidence intervals, and effect sizes (Baldwin, Murray, & Shadish, 2005; Crits-Christoph & Mintz, 1991; Wampold & Serlin, 2000). HLM techniques accommodate for the correlations among observations by modeling the variability between clusters or groups (Raudenbush & Bryk, 2002; Singer & Willet, 2003).

Using the scale scores, a series of hierarchical linear models (HLMs) was specified to determine the impact of the intervention on all psychosocial health, empowerment, and occupational health outcomes at post intervention while controlling for baseline scores on each outcome (see Table 2.5 for results). First, basic two-level models were run to calculate the intra-class correlation (ICC) for each outcome variable. ICCs represent the proportion of variance that lies within groups. Then, a HLM multiple regression model was specified for each of the 13 outcomes. Baseline outcomes were grand-mean centered to aid in interpretation of the model intercept. When baseline scores grand-mean centered, the intercept represents the average score for a participant in the control group (i.e., TX = 0) with the average baseline score on the outcome across all participants. To account for multiple comparisons, a Bonferroni correction ($p = .05/13 = p = .004$) was applied.

A number of the measured demographic variables are likely to influence the psychosocial health and empowerment of FSWs. For instance, Blanchard et al. (2013) found that older FSWs had higher scores across all three dimensions of empowerment compared to younger FSWs, and Boyle et al. (1997) found comparably worse psychosocial health among FSWs who had children, a history of injection drug use, and had worked in the sex industry for more than four years. However, because baseline outcomes were included in all models, it was not necessary to include these additional covariates since the variation in outcomes as a result of these covariates would

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be accounted for in the baseline scores (J. zumBrunnen, personal communication, September 22, 2015). For instance, although FSWs with more education are likely to feel a greater sense of empowerment within, any resulting differences would be reflected in baseline empowerment scores. Other than baseline outcomes, time working in the entertainment sector was included in the models for happiness and shame (which includes the one power *within* item with a large percentage of missing data) because it was found to be significantly associated with missing data on these variables.

To test the hypothesis that the effect of the intervention would be stronger for participants who had been members of their network group for a longer amount of time, length of time in network group was examined as a potential moderator of the effect of the intervention on all outcomes. An interaction term was created for this variable and treatment condition (i.e., treatment*time). Both the time in network group variable and the interaction term were added to the models for each outcome variable to examine whether duration of group membership moderated the effect of the intervention. Again, to account for multiple comparisons, a Bonferroni correction ($p = .05/13 = .004$) was applied. After adding the interaction term to the models, all treatment effects became insignificant, and none of the interaction terms were significant. Therefore, the results of these models (see Table 2.6) are not reported in the results section of Chapter 3.

Given that there was no significant treatment effect on shame, and the fact that the two items used to measure shame were originally intended to measure power within, this outcome variable was removed from Chapter 3 for the sake of parsimony. The Bonferroni correction minus this outcome variable results in the same p-value ($p = .05/12 = .004$). Baseline and post intervention means and standard deviations for shame for experimental and control participants

are reported in Table 2.3, and the results of the HLM and moderated HLM for shame are

reported in Tables 2.5 and 2.6 respectively.

Thematic analysis of PE exposure data. A thematic analysis was conducted on the

three open-ended questions related to PE exposure.

PE Data

Three different types of data were analyzed to assess the impact of the program on the

PEs: 1) survey results (baseline, post intervention, 2-month follow-up and 10-month follow-up),

including analysis and handling of missing data; 2) observational rating forms completed by the

two key field staff; and 3) exit interviews. All analyses were conducted using SPSS V23. Results

from these analyses are reported in Chapter 4.

Data analysis for the PE survey data—collected at baseline, post intervention, 2-month

follow-up, and 10-month follow-up—consisted of three main components: 1) assessment and

handling of missing data, 2) descriptive statistics for all demographics and outcome variables,

and 3) repeated measures analysis of variance (ANOVA) to assess the impact of the program on

all outcomes of interest. The same scales that were constructed for the larger impact evaluation

were used for the PE data analysis. Scale scores were created for the four aspects of PE

efficacy—teaching efficacy ($\alpha = .59$), communication efficacy ($\alpha = .48$), leadership efficacy ($\alpha =$

.80), and efficacy for helping others ($\alpha = .46$).

Assessment and handling of missing data. At baseline, across all demographic and

outcome variables, less than one percent of the PE data were missing. The missing data was

spread across the dataset (i.e., seven out of 72 variables had missing values). At post

intervention, 3.6% of the PE data were missing. Again, the missing data was spread across the

dataset (i.e., 15 out of 47 variables had missing values). At the 2-month follow-up, there was

1.1% missing (missing on 5 out of 47 variables), and at the 10-month follow-up there was 0.6% missing (missing on 3 out of 47 variables). Given the small percentage of missing data across all time points, mean imputation was used. Although mean imputation has been criticized for reducing variability (Newman, 2014), it will allow for analyses to be conducted by traditional data analysis techniques without losing cases through listwise deletion. Again, if only 5% or less of the data are missing in a random pattern, almost any procedure for handling missing values will yield similar results (Tabachnick et al., 2001).

Descriptive statistics. Descriptive statistics were conducted to summarize all PE demographics (see Table 2.7).

Repeated measures ANOVA. In order to assess the impact of the program on PE psychosocial and occupational health, empowerment, and peer education self-efficacy, repeated measures ANOVA tests were run to compare scores across the four survey time points (baseline, post intervention, 2-month follow-up, and 10-month follow-up). To account for multiple comparisons, a Bonferroni correction ($p = .05/17 = .003$) was applied. If an overall significant difference in means was detected across time points, pairwise comparisons (using a Bonferroni confidence interval adjustment) were examined to identify which means were significantly different from one another.

As with the impact evaluation, there was also no significant change in shame for the 10 PEs, and therefore this outcome variable was removed from Chapter 4 for the sake of parsimony. The Bonferroni correction minus this outcome variable resulted in the same p-value ($p = .05/16 = .003$). The results of the repeated measures ANOVA for shame (along with the results for the rest of the outcome variables) are reported in Table 2.8.

Observational rating forms. Basic descriptive statistics were conducted to describe the quantitative data from the observational rating forms, and overall themes and highlights were extracted from open-ended comments made by the field staff.

Exit interviews. Data analysis of the exit interview transcripts was conducted in two stages guided by the framework outlined by Braun and Clarke (2006). First, an American undergraduate research assistant and I independently completed open-coding of each transcript and met to discuss discrepancies and to generate an initial list of themes. Each theme was operationally defined and, when necessary, assigned example quotes from the transcripts to demonstrate the nature of the category for the coders. Next, two American undergraduate research assistants (not including the assistant that helped with the initial open-coding) independently applied the list of codes to a blank set of transcripts using Atlas.ti V6 (Muhr & Friese, 2004) qualitative data analysis software. The two sets of coded transcripts were then compared using the Atlas.ti add on, Coding Analysis Toolkit (CAT). CAT was used to generate a summary of all coding that did and did not match across the two independent sets of transcripts. The codes that did not match (e.g., one research assistant applied a code to a section of text but the other did not) were reviewed, and coders were encouraged to add a code if they felt it should have been applied in the first place. During this process, the coders were not told that the other member of the coding team had applied the code. Instead, they were just asked to review each section of text and decide if they either agreed or disagreed that the code be added. If they were unsure, they were instructed to not add the code and move on to the next quote. After additional codes were added through this checking process, CAT was then used to calculate Cohen's kappa, a measure of inter-rater reliability ranging from 0 (no agreement) to one (perfect agreement). When interpreting Kappa, a value of 0-.20 is considered as none to slight, .21-.41 is interpreted

as fair, .41-.60 is considered as moderate, .61-.80 is substantial, and .81-1.00 is interpreted as

almost perfect (McHugh, 2012).

Synopsis

The sex industry in Nepal is synonymously referred to as the entertainment sector. Women in the entertainment sector (WES) in Kathmandu are vulnerable to an array of occupational risks, which compromise their psychosocial health and empowerment, in turn restricting their ability to protect themselves from the many hazards they face as part of their work. The present study is a pilot test of a peer education intervention conducted in collaboration with a non-governmental organization (NGO) to empower and promote the psychosocial health of WES in Kathmandu, Nepal. Ten WES were trained as peer educators and, through formal and informal teaching opportunities, reached over 140 WES with psychosocial health promotion messages. Based on a quasi-experimental pre/post evaluation with 160 WES, including those who were ($n = 96$) and were not ($n = 64$) exposed to the peer educators, the program was found to have a significant positive effect on psychosocial health knowledge and perceived self-efficacy, perceived ability to access resources, happiness, and job control. Overall, findings suggest that peer education methods are a feasible and promising means to enhance the psychosocial health and empowerment of WES in Nepal.

Introduction

Sex work or prostitution has been recognized in nearly every corner of the world. Although the hazards associated with sex work vary depending on the nature of the work itself (e.g., types of sexual activities performed), sex worker to client ratio, and context (e.g., venue of sex work, legal framework, sociocultural norms pertaining to sex and gendered power dynamics), the profession is arguably a dangerous one. Across the different circumstances in which sex work takes place, female sex workers (FSWs) may be exposed to varying degrees and combinations of risks in their work, including but not limited to long hours, poor working conditions, disease transmission, unplanned pregnancy, violence, drug and alcohol use and abuse, debt, and various forms of harassment, discrimination, and exploitation (Rekart, 2005; Ross, Crisp, Månsson, & Hawkes, 2012). These numerous work-related risks place a tremendous burden on the psychosocial health (i.e., the mental, emotional, spiritual and social aspects of health; Donatelle, 2009) of FSWs, which in turn compromises their ability to engage in protective behaviors. FSWs are also at risk of psychological strains stemming from their need to stay vigilant, fully alert, and attentive in order to protect themselves against potential dangers. (Brewis & Linstead, 2000). FSWs are sometimes forced to fake their emotions and behaviors in order to satisfy the needs and expectations of their clients and can never fully switch off, lest risking danger or slippage of their professional mask (Brewis & Linstead, 2000; Sanders, 2004).

There are also a number of non-work factors, such as financial difficulties and family problems, which are likely to influence the psychosocial health of FSWs (Vanwesenbeeck, 2001). These extra-organizational stressors are thought to act in a feedback loop in which problems outside of work affect the individual at work, which in turn exacerbate problems outside of work (Cooper & Marshall, 1976). For example, FSWs who are under financial duress

may place their own health secondary to more immediate needs such as earning money to provide food, shelter, and education for their children by, for instance, not using a condom in order to earn more money (Basu & Dutta, 2009). This, in turn, may lead to HIV/STI infection, which may then contribute to greater financial duress due to increased health care costs and the inability to work as a result of poor health. Many have also pointed to the role of social stigma in contributing to psychosocial distress (El-Bassel et al., 1997), mental disorders (Rössler et al., 2010), and negative self- and group image (Evans, Jana, & Lambert, 2010) among sex workers. Due to their stigmatized status, FSWs may feel they have to conceal their identity to friends and loved ones, which not only diminishes social support structures, but also places an emotionally demanding burden on FSWs to maintain "double lives" (Vanwesenbeeck, 2001, p. 268).

The scant evidence available suggests FSWs have poor psychosocial health, including high rates of depression (Alegria et al., 1994; Chudakov, Ilan, Belmaker, & Cwikel, 2002; Farley & Barkan, 1998; Lau, Tsui, Ho, Wong, & Yang, 2010); PTSD (Chudakov et al., 2002; Farley & Barkan, 1998), self-harm tendencies (Kidd & Kral, 2002; Lau et al., 2010); substance use (Gossop, Powis, Griffiths, & Strang, 1994; Kuhns, Heide, & Silverman, 1992; Lau et al., 2010; Young, Boyd, & Hubbell, 2000), as well as low self-esteem (Agha & Chulu Nchima, 2004; Harcourt, Beek, Heslop, McMahon, & Donovan, 2001; Lau et al., 2010), 2001; and low life satisfaction (Baker, Wilson, & Winebarger, 2004; Wong, Holroyd, Gray, & Ling, 2006); lack of perceived meaning in life (Wong et al., 2006), and a pessimistic future outlook (Kok, Ho, Heng, & Ong, 1990; Lau et al., 2010). Despite these findings, there have been no published interventions worldwide that have directly aimed to promote the psychosocial health of FSWs.

Poor psychosocial health, such as depression, anxiety, low self-esteem, and low self-efficacy, contributes to a lack of motivation as well as a lack of perceived empowerment or

agency to engage in protective behaviors and pursue positive life changes. Of course, the promotion of psychosocial health among FSWs is important in terms of the general aim to promote health and well-being. But also, without a strong foundation of psychosocial health, programs targeting the physical health risks of FSWs, such as HIV and violence prevention programs, are likely to have minimal impact (Lau et al., 2010). Scholars involved in STI/HIV prevention among FSWs have argued for the importance of promoting psychosocial health in order to maximize the impact of prevention efforts (e.g., Chudakov et al., 2002; Lau et al., 2010; Rekart, 2005). Some have even gone so far as to say that psychosocial health, particularly the promotion of empowerment or agency, is a *necessary* condition for successful prevention (Lau et al., 2010). The goal of the present study was to pilot test an intervention to promote the psychosocial health and empowerment of FSWs in Kathmandu, Nepal.

Context: Sex Work in Nepal

Nepal is an impoverished country in South Asia adjacent to China and India. The predominantly Hindu (81%) population is comprised of over 35 ethnic groups and more than 60 spoken languages (Inter-Agency Standing Committee [IASC], 2015). Despite the end of the decade long internal conflict in 2006, which killed over 13,000 and displaced over 78,000 people, the political situation in Nepal has remained volatile (Brady, 2011). Political instability, in combination with extreme poverty and pervasive patriarchal norms, has contributed to a lack of education and limited job opportunities for women and girls in Nepal (Kaufman, Harman, & Shrestha, 2012). As a consequence, a growing number—many of whom fled their villages to escape conflict, domestic violence, and severe poverty—resort to sex work in the pursuit of economic survival (Youth Partnership Project, 2010). Because a majority of FSWs in Nepal have fled small rural villages to seek a better life in Kathmandu and other cities (National Centre for

AIDS and STD Control [NCASC], 2011), they have left their families and friends and find themselves in a place where they have limited support.

The commercial sex industry in Nepal is referred to synonymously as the entertainment sector (Frederick, Basynat, & Aguettant, 2010). This term will be used from here on out when referring to this industry and women working in this industry, except for when citing other studies that specifically used other terminology (e.g., FSWs) when describing their target population. In contrast to women who engage in sex work from their home or on the street, women in the entertainment sector (WES) work in various commercial establishments including massage parlors, cabin restaurants (i.e., establishments serving food and drinks with private plywood cabins in which women accompany customers), dance bars, *dohoris* (i.e., nightlife establishments with traditional Nepali music as well as food and drinks), and *bhatti pasals* (i.e., small liquor and snack shops; Frederick et al., 2010; NCASC, 2011). It is important to note that not all WES actively engage in sex work (Frederick et al., 2010). Among those who do sell sex, some are willing adults; however, many do so unwillingly under coercion from customers and/or establishment owners (Frederick et al., 2010).

WES in Nepal are exposed to an array of risks to their health and well-being. Working hours are long, breaks and days off are few, and work environments may be noisy, dirty, dark, and smoky (Frederick et al., 2010). For those who do engage in sex work, risk of contracting HIV and other STIs and unwanted pregnancies are concerns (Frederick et al., 2010). Although women who do not engage in sex work in the entertainment sector may not be at risk in terms of their sexual health, they are still exposed to numerous other risks at work, including violence, abuse, and sexual harassment by clients and establishment owners (Frederick et al., 2010).

Individual and group rapes, sometimes by physical force and sometimes by threats to reveal their professional status to family members, are frequently reported (Frederick et al., 2010).

In addition to these more severe forms of abuse, WES also report being humiliated, insulted and treated like commodities by clients and establishment owners (ActionAid Nepal, 2004; Shakti Samuha, 2008). Forced alcohol and drug use, as well as instances of not being paid what they were promised, not being paid on time, and sometimes not being paid at all, are not uncommon (Kaufman, Harman, & Menger, 2015). Many have also reported assault and theft from clients as well as from men and boys on the street (Frederick et al., 2010). Some WES are also subject to forced labor through debt bondage by establishment owners (Frederick et al., 2010). Due to fear of being fired, WES may avoid asking for a higher salary, benefits, or better working conditions (Kaufman et al., 2015; Shakti Samuha, 2008).

Forced prostitution is illegal in Nepal under the *Trafficking and Transportation (Control) Act, 2007* (Godwin, 2012), but Nepali law neither prohibits voluntary prostitution nor does it attempt to regulate the activities of sex workers (Shrestha, 2006). However, despite its legal status, in practice sex workers in Nepal are often treated as criminals and are commonly arrested, detained, and harassed by police (Frederick et al., 2010; McNeill, 2008). Police are known to use the *Public Offences and Penalties Act* of 1970, which prohibits violating the peace or demonstrating obscenity in public spaces, to raid establishments where sex work is suspected ("Raids alone," 2010). Police harassment ranges from unjustified arrest to various forms of abuse and extortion (Sarkar et al., 2008).

Regardless of sex work activity, all WES are subject to social stigma and, as a result, may prefer to hide their job status from their families and the public eye (Frederick et al., 2010). Stemming from this pervasive stigma are many forms of discrimination, such as unkind remarks

from shopkeepers and other community members, refusal to rent rooms from landlords, and malicious gossip in their home villages (Frederick et al., 2010). The particularly low and stigmatized status of WES, combined with the traditional role expectations that Nepali women are to be obedient, passive, and self-sacrificing in relationships (Poudel & Carryer, 2000), renders them defenseless in harmful and abusive situations.

The psychological and social impact of sex work in Nepal is profound (Blanchet, 1996; Terre des hommes, 2005). Although there have been few studies to date, reports from counselors and psychologists who have worked with WES in Nepal suggest high rates of depression, anxiety, isolation, guilt, anger, hopelessness, fear, and insecurity (Frederick et al., 2010). Ghimire, Smith, van Teijlingen, Dahal, and Luitel (2011) conducted interviews and field observations with 15 FSWs in Nepal and found low self-efficacy to be a primary predictor of not using condoms, highlighting the broader public health implications underlying the importance of empowerment programs.

There are a handful of non-governmental organizations (NGOs) offering programs and services for WES in Nepal. However, these organizations give minimal focus to promoting psychosocial health (J. Maharjan, personal communication, December 13, 2013) and do little in terms of program evaluation (Kaufman & Crawford, 2011).

Overall, there is a great need for interventions designed to promote the psychosocial health and empowerment of WES in Nepal. Without a strong foundation of psychological and social well-being, it is likely that other programs targeting WES, such as HIV and violence prevention programs, will have minimal impact. Overall, it is important for programs to be theoretically-based, methodologically rigorous, and comprehensively evaluated.

The Present Study

The present study sought to determine the feasibility and effectiveness of a brief peer education intervention to promote the psychosocial health and empowerment of WES who were members of an existing community empowerment network in Kathmandu, Nepal. Peer education (i.e., an approach whereby individuals similar in demographic and/or experiential factors are selected and trained to impart knowledge, increase awareness, and encourage positive behavior change among individuals from the same group) is a promising approach for promoting sexual health behaviors among FSWs (Luchters et al., 2008; Medley, Kennedy, O'Reilly, & Sweat, 2009) but it has yet not been tested as a means of promoting psychological health.

In terms of psychosocial health, the intervention aimed to decrease stress and promote enhanced psychosocial health knowledge, overall health, and happiness among WES. The program also aimed to promote three types of empowerment in line with the Integrated Empowerment Theory (IET; Blanchard et al., 2013). The IET is an empowerment framework and corresponding measurement instrument that was originally developed to assess the impact of a community mobilization intervention on the empowerment of FSWs in south India (Blanchard et al., 2013). The IET breaks down the mechanisms of empowerment into three distinct but inter-related domains: power *within*, power *with others*, and power *over resources*. Power *within* refers to internalized power in the form of self-esteem, self-efficacy, self-awareness, and consciousness of the factors that contribute to vulnerability. Power *with others* refers to the collective identity, mutual support, and trust required for collective empowerment and action. Finally, power *over resources* encapsulates the ability to exert power over resources in one's environment, such as educational opportunities, social entitlements (e.g., citizenship documentation, driver's license), financial credit, and other social services. Given the aim of the

present study is to promote psychosocial health and empowerment among WES through peer education, a form of community mobilization, the IET provides a well-suited framework for the design and evaluation of the intervention.

This study also aimed to assess the impact of the intervention on the occupational health of WES in the form of increased perceived job control, decreased burnout, and decreased bullying in the workplace. Job control is defined as the extent to which an individual has control over her tasks and conduct during the working day (Karasek Jr, 1979). Burnout is a state of mental, physical, and emotional exhaustion resulting from prolonged exposures to stressors on the job (Pines & Aronson, 1988). Finally, workplace bullying refers to persistent exposure to mistreatment and aggression from others at work, including colleagues, superiors, and subordinates (Einarsen, Hoel, & Notelaers, 2009). All three of these constructs have been associated with psychosocial health outcomes (e.g., job control, Stansfeld & Candy, 2006; burnout, Maslach, Schaufeli, & Leiter, 2001; bullying, Cortina, Magley, Williams, & Langhout, 2001), but have been minimally examined among FSWs.

Summary and Hypotheses

WES in Nepal, and FSWs worldwide, are in great need of programs to promote psychosocial and occupational health and empowerment. Without a strong foundation of psychological and social well-being, their quality of life will remain poor, and it is likely that other programs aiming to improve their health and well-being, such as those focused on HIV prevention, will have minimal impact. Peer education has proven to be a promising approach for promoting sexual health behaviors among FSWs but has not been pilot tested as a means of promoting psychological health. The primary aim of the present study was to assess the impact

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of a brief peer education program on psychosocial and occupational health and empowerment of WES in Kathmandu, Nepal. In line with this goal, the first hypothesis was as follows:

> **Hypothesis 1.** Women who are exposed to psychosocial health promotion messages via the PEs will report significantly improved psychosocial and occupational health and empowerment post intervention compared to women who are not exposed to the PEs.

Given that the WES in the present study were part of an existing community empowerment network, it is likely that those who had been involved in the network for more time were able to develop stronger and more trusting relationships with one another compared to those who had been a part of the network for a shorter period of time (Newman, 2003). Therefore, it is likely the impact of the intervention on all outcomes will be moderated by duration of network involvement. Specifically it was hypothesized that:

> **Hypothesis 2.** Length of time as a member of the community empowerment network will moderate the effect of the intervention on psychosocial and occupational health and empowerment. Specifically, improvements at post intervention will be greater for participants who have been a member of the network for a longer period of time compared to participants who have been a member of the network for a shorter period of time.

This hypothesis was supported by the findings of Blanchard et al. (2013) that duration of exposure to the community mobilization program was associated with higher levels of empowerment.

Method

In partnership with a Kathmandu-based non-governmental organization (NGO), a brief peer education intervention was designed, implemented, and evaluated for its effectiveness in promoting psychosocial and occupational health and empowerment outcomes among WES. A community-based participatory research (CBPR) framework was used to guide the design and implementation of the project. The aim of CBPR is to bring together communities and researchers in order to establish trust, foster co-learning, build capacity, enhance strengths and resources, and examine and address community-identified needs and health problems (Israel, Eng, Schulz, & Parker, 2013). Although there is a great deal of variation in CBPR approaches, they all aim to conduct research that engages, shares power with, and is beneficial to community members (Israel et al., 2013). In the present study, all members of the partner NGO and especially two key field staff, as well as women from the target population, held a prominent role throughout the project. See (Chapter 5) for a more in-depth description of the engagement of these stakeholders across program design, implementation, and evaluation as well as additional details regarding the methodological challenges faced and effective strategies implemented throughout the project.

Participants

Participants were all members of an existing community empowerment network that the partner NGO began establishing in 2011 in order to foster greater solidarity, social support, and empowerment among WES in Kathmandu. At the time of the present study, the network consisted of 20 groups formed based on establishment type and geographic location with 16-28 women in each group ($M = 20.65$, $SD = 3.79$). Five groups were comprised of cabin restaurant workers, one was dance bar workers, six were *bhatti pasal* workers, seven were massage parlor

workers, and one was a mobile group. All groups had an elected leadership structure and a cooperative savings account and convened bimonthly in meetings coordinated and attended by the two key field staff to discuss the issues faced by their respective group members.

Procedures

      Training overview. The peer educator training program was developed in close collaboration with the partner NGO and guided by insights gained during an informal focus group with five WES in which they were asked to discuss their psychosocial health conceptualizations and status. The training, given the name "Haamro Raksha" (which means "our protection") by one of the key field staff, consisted of six 3-hour sessions broken into two phases. The first phase of the training (Phase 1) was facilitated by the first author with the aid of a female Nepali research assistant/translator and consisted of three sessions aiming to establish a foundational understanding of what peer education is and to develop the leadership, communication, and teaching skills the trainees would need to be successful as PEs. The second phase of the training (Phase 2) consisted of three sessions aiming to instill knowledge regarding what psychosocial health is and why it is important and skills for how it can be promoted in daily life. In order to ensure culturally congruent training, Phase 2 was facilitated by three local Nepali experts, including a psychologist, a spiritual leader from an international meditation organization, and a "life skills"[7] trainer from another NGO that provides programming for WES in Kathmandu. Each Phase 2 session consisted of two hours of new content provided by one of the expert trainers followed by a one-hour debrief session. Two female artists—one Israeli and one Canadian—volunteered to attend these debrief sessions in order to create visual teaching

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[7] This trainer typically provides a 36-hour training that her NGO refers to as a "life skills" training covering a variety of topics to help WES foster the personal and relational knowledge and skills to be happy and successful in life, such as communication skills, positive thinking, and self awareness.

aids representing the lessons learned. The PEs were asked to use the customized visual teaching aids to teach the lessons learned both formally during their next network group meeting and informally while at work, and were encouraged to use interactive and discussion-based teaching strategies.

The training content was highly interactive, strengths-based, and tailored for a low-education, low-literacy population. Inspired by the IET (Blanchard et al., 2013), the training was designed to promote power *within*, power *with others*, and power *over resources*. To promote power *within*, the program aimed to foster self-awareness, self-esteem, and self-confidence and focused on positive topics such as the importance of self-care and the value of women in Nepali society. Power *with others* was promoted by providing opportunities for the women to discuss and reflect on the lessons learned with one another during the PEs' practice teaching sessions. Finally, power *over resources* was promoted by enhancing the PEs' awareness of community resources, as well as how to access and refer others to them. The training was also designed to promote training transfer, which is the extent to which the content and skills learned through the training are applied to work and life outside of training (Grossman & Salas, 2011). Specifically, training transfer was promoted through behavioral modeling, discussion of error management strategies, and opportunities to practice teaching (Grossman & Salas, 2011).

Recruitment and selection of PEs. The NGO field staff were asked to announce the training opportunity to women from all 20 network groups during their regular establishment visits and biweekly network group meetings. Recruitment was limited to members of the network who were 18 years of age or older because older PEs are likely to be more articulate and experienced and have more well-developed social skills compared to younger PEs (Jana, Basu, Rotheram-Borus, & Newman, 2004). All WES who met the inclusion criteria and were interested

in the training were invited to attend an information session at the partner NGO headquarters to learn more about the opportunity and to apply. Details about the training and information session were also announced by the first author on a weekly radio program targeting WES in Kathmandu (an opportunity that was facilitated by the partner NGO).

The information session covered an overview of the training, including a description of the content, schedule, logistics, evaluation components, and incentives. Those who felt confident they could complete all training and evaluation components were encouraged to complete an application, which was designed to determine if their motivations, work history, background experiences, and other characteristics would make them effective in the role of PE. Thirty women, representing 16 of the 20 network groups, completed the application, which was administered verbally, one-on-one, by the two key field staff.

Two separate sets of 10 recruits representing 10 different network groups were selected to be final candidates—one set was selected by the first author based on application scores (calculated to reflect probability of being successful as a PE), and the other set was selected by the two key field staff based on who they thought would be most successful in and able to commit to the role of PE. The first author and two key field staff then met to compare lists and select the final candidates. The women selected to be trained as PEs were all from network groups that were clustered inside of Kathmandu proper (i.e., inside of Ring Road) in close proximity to Thamel and the headquarters of the partner NGO. Five of the 10 network groups that did not have PEs (and therefore comprised the control condition) were located outside of Kathmandu proper and further away from the headquarters of the partner NGO.

Training implementation. All trainings took place in a small, private room at the headquarters of the partner NGO. The first four sessions (i.e., all three Phase 1 sessions and the

first Phase 2 session) were conducted on four consecutive days. In order to allow each PE the opportunity practice teaching each topic during their next bimonthly network group meeting, there was a two-week gap between each of the Phase 2 sessions. All 10 trainees attended the first four sessions, nine attended the fifth session, and seven attended the final session. The trainees completed the formal practice teaching requirement in their next biweekly network group meeting for each Phase 2 training attended. The two key field staff attended all training sessions and were encouraged to assist the PEs with their practice teaching.

Evaluation

A quasi-experimental pre/post impact evaluation was conducted to assess the psychosocial and occupational health and empowerment of network members who were and were not exposed to the PEs. Surveys were administered to women representing members of all 20 network groups during the two key field staff's regular establishment visits and the biweekly network group meetings. Again, network members from the 10 groups with PEs comprised the experimental condition, while those from the 10 groups without PEs comprised the control condition. The PEs also completed the same survey at baseline and post intervention as well as at two additional time points—two-months post intervention and 10-months post intervention. Results from the PE surveys as well as one-on-one exit interviews conducted with the PEs and the two key field staff and other aspects of the process evaluation are reported elsewhere (Chapter 4).

Survey development. A survey was drafted, translated into Nepali by a Nepali research assistant, and then back-translated into English by a bilingual staff member from the partner NGO. A number of best practices related to survey translation were adopted, such as including insider and outsider perspectives (Schaffer & Riordan, 2003), conducting cognitive interviewing

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(i.e., a technique commonly used to identify potential sources of response error) with a bilingual staff member of the partner NGO (Fujishiro et al., 2010), and implementing a decentering approach in which both the English and Nepali versions of the survey remained subject to revisions until conceptual clarity was achieved (Brunette, 2004). The initial version of the survey was piloted with 12 WES in one of the partner NGO's satellite meeting spaces. The survey content and administration protocol were modified based on the pilot feedback.

Measures. The baseline survey assessed demographic and background information and social desirability. Demographics measured included Outcomes were assessed at baseline and post intervention. The post intervention survey additionally assessed exposure to PEs.

Demographic and background information. Demographic and background information assessed included age, home region, caste/ethnic group, length of time living in Kathmandu, marital status, whether or not husband provides financial support, number of children, religion, years of education completed, length of time in network group, previous training in psychosocial health and life skills, length of time working in the entertainment sector, current workplace type/s, alcohol and drug consumption at work in the last month, and number of social entitlements (i.e., whether they had a citizenship card, savings in their network group cooperative savings account, other savings account, or a voter ID). All participants were also asked to indicate the name of the network group they were a member of at baseline and whether or not they had switched group membership at post intervention.

Outcomes. Burnout, job control, stress, and workplace bullying were assessed on a four-point frequency Likert scale ranging from never to always. Participants were asked to consider their experiences in the previous month when answering these questions. Empowerment and psychosocial health knowledge were assessed on a four-point level of agreement Likert scale

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ranging from disagree a lot to agree a lot with no retrospective time period specified. Scales for the remaining constructs are described below.

Burnout. Burnout was assessed with four items from the 10-item short version of the Malach-Pines Burnout Measure (BMS-10; Malach-Pines, 2005). The BMS measures three aspects of burnout—physical, emotional, and mental. Questions related to physical burnout were not included. Reliability and construct validity of the BMS-10 has been established with Jewish (α = .87) and Arab (α = .85) samples in Israel (Malach-Pines, 2005), and has demonstrated high face (e.g., Pines, 2000a, 2000b, 2002) and construct (Malach-Pines, 2005) validity.

Empowerment. Modified items from the IET measure (Blanchard et al., 2013) were combined with additional items to assess the three types of empowerment. Power *within* was assessed with four items from the Blanchard et al. (2013) measure, a newly constructed item to measure power *within* specific to the type of empowerment within the training aimed to foster (i.e., related to psychosocial health), and three modified items from the General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995). The GSE is a 10-item scale designed to assess perceived self-efficacy, defined as an optimistic self-belief related to one's ability to cope with a broad range of challenging or stressful demands. Criterion validity and internal reliability (α = .75-.94) of the GSE have been validated cross-culturally (Luszczynska, Scholz, & Schwarzer, 2005; Scholz, Doña, Sud, & Schwarzer, 2002). Power *with others* was assessed with six items from the IET. Finally, power *over resources* was assessed through five newly constructed items related to perceived ability to access community resources (e.g., counseling/mental health services, sexual health services, legal advice and services).

Happiness. Happiness was assessed by a single-item on a visual analog scale in which participants were asked to mark a check mark (□) to show how happy they had been in their life

in the last month on a line with a smiley face on one end and a sad face on the other. Similar single-item measures have proven to be valid and reliable measures of happiness (e.g., Abdel-Khalek, 2006). Scores were translated to a 13-item scale by measuring the placement of the check mark on the line, which was 13 centimeters.

Job control. Job control was assessed with a single newly-constructed item (i.e., "How often do you feel you could decide what you do at work and how you do your work?").

Overall health. Overall health was assessed with a single-item asking participants to rate "How is your current health?" on a four-point Likert scale ranging from poor to excellent. Similar single-item measures have been proven as valid and reliable measures of global health (DeSalvo et al., 2006; Ganster, 2008).

Psychosocial health knowledge. Psychosocial health knowledge was assessed with two items written based on the training content.

Stress. Stress was assessed with two items. One item was from the short form of the Perceived Stress Scale (PSS-4), a scale developed to assess "the degree to which individuals appraise situations in their lives as stressful" (Cohen, Kamarck, & Mermelstein, 1983, p. 385). The PSS has been used extensively cross-culturally (Lee, 2012) as well as in Nepal (Eller & Mahat, 2003). The item used (i.e., "How often do you feel that difficulties are piling up so high that you can not overcome them?"), selected from the PSS-4 (Cohen & Williamson, 1988), was selected because it best reflected the psychosocial health strains reported by the five WES during the focus group interview. The other item used to measure stress (i.e., "How much have you had worries, sadness, or thoughts playing in your heart-mind?") was included based on advice from a medical anthropologist with extensive experience conducting mental health research in Nepal (B. Kohrt, personal communication, December 9, 2013).

Workplace bullying. Three items from the Negative Acts Questionnaire-Revised (NAQ-R; Einarsen et al., 2009) were used to assess workplace bullying. The NAQ-R has been proposed as a valid and standardized instrument for the assessment of workplace bullying (Einarsen et al., 2009). The NAQ-R is comprised of three inter-related factors—person-related bullying (e.g., slander, social isolation), physically intimidated bullying (e.g., physical aggression, threats of physical violence), and work-related bullying (e.g., criticizing someone's work; Einarsen et al., 2009). The items selected included two items from the person-related dimension and one from the physically intimidating dimension.

PE exposure. PE exposure was assessed post intervention by asking participants to indicate if their network group had a PE from the "Haamro Raksha" program. If a participant reported that their group had a PE from the program, they were also asked to recall how many times she shared her training knowledge with them during their biweekly group meetings (between 0-3), and three open-ended questions—which topic(s) were covered, what their favorite topic was, and what other topics they would be interested in learning about related to psychosocial health.

Social desirability. Social desirability was assessed with four modified true/false items from the Reynolds Short Form of the Marlowe-Crowne Social Desirability Scale (Reynolds, 1982). There is evidence of similarities in reporting behaviors and ratings of social desirability items across cultures, supporting the notion of social desirability as a universal concept (Johnson & Van de Vijver, 2003).

Power analysis. A power analysis was conducted to determine the sample size required to detect an effect. Medley et al. (2009) conducted a meta-analysis of peer education interventions for HIV prevention in developing countries including 12 programs with sex

workers and found the pooled effects odds ratio for the effects on condom use was 2.31, 95% CI [1.66, 3.23], which is equivalent to a Cohen's d of .46 (Chinn, 2000). Given that there are no previously published peer education programs targeting psychosocial and occupational health and empowerment outcomes among sex workers, it was necessary to calculate power based on condom use as an outcome. A priori power analyses indicated that approximately 80 participants were required for each condition (i.e., experimental and control) in order to achieve adequate statistical power to detect an effect size of .46. The research team aimed to recruit an additional 20 participants per condition in order to account for possible attrition between baseline and post intervention surveys.

Recruitment and survey administration. Three field staff from the partner NGO (i.e., the two key field staff and one part time field staff) recruited women from the network to take the surveys during their regular establishment visits and during biweekly network group meetings. The field staff were asked to survey a total of 200 women with an equal number from each of the 20 network groups at baseline and follow up with the same women post intervention. Inclusion criteria were that the women were currently working in the entertainment sector, network members, and at least 18 years of age. Minors were not included as it was not feasible to obtain parental consent given that a majority of WES originate from outside of Kathmandu (NCASC, 2011) and communication channels with parents are limited (M. Thapa, personal communication, October 1, 2013). Furthermore, because it is illegal for women under the age of 18 to work in the entertainment sector in Nepal, asking minors to complete a survey in which they have to identify their age and identify as working in the entertainment sector would place them in a position of increased risk.

After obtaining written consent, the field staff administered all surveys one-on-one, verbally, in Nepali. Each survey took between 30-45 minutes to complete. Participants were given 100 Nepali rupees for each survey taken (equivalent to approximately $1 US). All study procedures and evaluation materials were approved by the Nepal Health Research Council and the Colorado State University Institutional Review Board and the prior to implementation.

Data Analysis

Data analysis for the impact evaluation consisted of six main components: data cleaning, assessment and handling of missing data, factor analysis and scale construction, descriptive statistics for all demographics and outcome variables, thematic analysis of PE exposure data, and hierarchical linear modeling to assess the impact of the program on all outcomes of interest and to examine time in network group as a potential moderator of the treatment effects. Analysis and handling of missing data, creation of scale scores, and descriptive statistics were conducted using SPSS V23, and confirmatory factor analysis and hierarchical linear models were conducted using Mplus V6 (Muthén & Muthén, 2007).

Data cleaning. Of the 193 participants who completed a survey (experimental $n = 100$, control $n = 93$), 33 cases were deleted for various reasons. Four cases were deleted due to having only baseline responses. Three cases were deleted due to the participant reporting different group membership at baseline and post intervention. Finally, group membership (i.e., whether the individual identified as a member of an experimental or control group) was checked against the question assessing exposure to PEs at post intervention, and 26 cases were deleted due to reporting incorrect exposure to PEs. Specifically, four experimental participants who reported no exposure to PEs and 22 control participants who reported exposure to PEs were deleted. The reason for these cases of incorrect exposure is unclear. However, it is possible that these

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individuals switched groups between the baseline and post intervention surveys (although none reported switching groups when asked at post intervention) or attended group meetings for more than one group. After these deletions, the final number of participants was 160 (experimental $n = 96$, control $n = 64$).

Assessment and handling of missing data. The extent of missing data among the 160 participants in the final sample was assessed. Traditional data analysis techniques, such as multiple regression, rely on estimated covariance matrices, and cases with missing data are eliminated through listwise deletion. Due to the distribution of missing data across the baseline and post intervention datasets (see "Missing data analysis" section under Results for details), such approaches would require deletion of a substantial proportion of the sample. Therefore, full-information maximum likelihood (FIML) was used to handle missing data. FIML is an approach based on raw, individual-level data, rather than the sample covariance matrix. FIML specifies different covariance matrices for individuals based on the number of observations present (Mehta & Neale, 2005) and therefore, takes advantage of all available data, including cases with only partial data (Heck & Thomas, 2015).

Factor analysis and scale construction. Confirmatory factor analyses (CFA) were conducted on the three dimensions of empowerment—*within*, *with others*, and *over resources*—in order to confirm the factor structure of these constructs for future analysis. First, items were reverse-coded as needed so all items were scored in a way such that a high score reflected a high amount of the construct (e.g., a high score on a burnout item reflected a high amount of burnout). A three-factor structure was hypothesized for power *within*. Blanchard et al. (2013) found a two-factor structure for their measure of power *within*, and two items from each of these factors were used in the present study. Therefore, it was hypothesized that two factors would come from the

four Blanchard et al. (2013) items and a third factor would come from the GSE items (Schwarzer & Jerusalem, 1995). The newly constructed global measure of power *within* relevant to psychosocial health was hypothesized to belong to this third factor given the similarity of its wording to the GSE items. Although Blanchard et al. (2013) found two factors for power *with others*, just one of the six items included in the present study was from one of the factors and the remaining five were from the other factor. Therefore, power *with others* was hypothesized to consist of just one factor in the present study. Power *over resources*, which again consisted of five newly generated items, was also hypothesized to comprise one factor.

Scale scores were calculated for each outcome that was measured with more than one item using all available data points for each participant. Cronbach's alpha was computed to determine the internal consistency of scales with more than two items.

Descriptive statistics. Descriptive statistics were conducted to summarize demographic and background information for all study participants and to assess baseline and post intervention means and standard deviations for experimental and control participants for all outcome variables. *T*-tests were conducted to determine if there were significant differences between experimental and control participants on all variables to be included in the hierarchical linear models. A Bonferroni correction ($p = .05/12 = .004$) was applied to correct for multiple comparisons.

PE exposure data. Percentages were calculated on responses to the item asking how many times a PE taught during participants' last three network group meetings, and a thematic analysis was conducted on the three open-ended questions related to PE exposure.

Hierarchical linear modeling. Using the scale scores, separate hierarchical linear models (HLMs) were specified to determine the impact of the intervention on each of the 12

outcomes at post intervention while controlling for baseline scores. Given the hierarchical or clustered nature of the data with participants nested within groups, the assumption of traditional statistical tests that the observations are independent of one another is violated (Baldwin, Imel, Braithwaite, & Atkins, 2014). Use of traditional statistical tests in this situation could lead to biased p-values, confidence intervals, and effect sizes (Baldwin, Murray, & Shadish, 2005; Crits-Christoph & Mintz, 1991; Wampold & Serlin, 2000). HLM techniques accommodate for the correlations among observations by modeling the variability between clusters or groups (Raudenbush & Bryk, 2002; Singer & Willet, 2003).

In order to test the hypothesis that the effect of the intervention would be stronger for participants who had been members of their network group for a longer length of time, another series of hierarchical linear models was specified to examine time in network group as a potential moderator of the effect of the intervention on each of the 12 outcomes.

A number of demographic variables are likely to influence the psychosocial health and empowerment of WES. For instance, Blanchard et al. (2013) found that older FSWs had higher scores across all three dimensions of empowerment compared to younger FSWs, and Boyle et al. (1997) found comparably worse psychosocial health among FSWs who had children, a history of injection drug use, and had worked in the sex industry for more than four years. However, because baseline outcomes were included in all models, it was not necessary to include these additional covariates since the variation in outcomes as a result of these covariates would be accounted for in the baseline scores. Other than baseline outcomes, time in the entertainment sector was included only in the models for happiness, given its significant association with missing data on this variable at baseline (see results from Missing data analysis below).

Results

The 160 participants included in the final analyses (experimental $n = 96$, control $n = 64$) represented WES from all 20 network groups (*Range* = 1-17 women per group, *M* = 8.00, *SD* = 4.42).

Missing Data Analysis

At baseline, across all variables, 3.3% of the data were missing. The missing data were spread across the dataset (i.e., only five out of 59 variables had no missing values). Only one outcome variable, self-rated happiness (7.5% missing), had more than five percent missing. Logistic regression models were conducted to determine if any of the demographic variables or the social desirability scores were significantly associated with missing data on happiness. Time working in the entertainment sector was the only significantly associated variable ($b = .46$, *SE* = .15, $p = .002$) and was therefore included in the hierarchical linear model for happiness as a covariate. At post intervention, only 1.4% of the data was missing across the entire data set, and none of the outcome variables had more than five percent missing. Therefore, associations between demographic variables and missing data were not examined for the post intervention data.

Factor Analysis and Scale Construction

The hypothesized three factor structure for power *within* demonstrated poor fit, $\chi^2(17) = 41.04$, comparative fit index (CFI) = .86, root-mean-square error of approximation (RMSEA) = .09, standardized root mean square residual (SRMR) = .06. Two items comprising one of the factors from the Blanchard et al. (2013) measure of power *within* were dropped because they were negatively correlated with the other two power *within* factors, and only one of the items demonstrated an acceptable factor loading (i.e., > .4). A two-factor model for power *within* was

specified and resulted in acceptable fit, $\chi^2(8) = 9.53$, CFI = .99, RMSEA = .04, SRMR = .03.

Another model was approximated to determine if a single factor structure would provide a better

fit to the data; however, this model demonstrated poor fit, $\chi^2(9) = 26.25$, CFI = .87, RMSEA =

.11, SRMR = .06. The factor that includes items from the IET is hereafter referred to the

confidence component of power *within*, and the factor comprised of GSE and the newly

constructed item is referred to as the efficacy component of power *within*.

The hypothesized 6-item, one factor structure for power *with others* demonstrated poor

fit, $\chi^2(9) = 35.06$, CFI = .82, RMSEA = .14, SRMR = .06. One item was removed due to having

a negative factor loading. However, the model still demonstrated poor fit, $\chi^2(5) = 25.96$, CFI =

.84, RMSEA = .16, SRMR = .06. The item with the lowest factor loading (.512), highest residual

variance (.738), and highest modification indices was then removed, resulting in a 4-item model

with acceptable fit, $\chi^2(2) = 2.86$, RMSEA = .05, CFI = .99, SRMR = .03. Finally, the

hypothesized one factor, 5-item model for power *over resources* resulted in acceptable fit, $\chi^2(5)$

= 12.66, CFI = .98, RMSEA = .09, SRMR = .03. Cronbach's alpha for the efficacy component of

power *within*, power *with others*, power *over resources*, and burnout ranged between α = .67-.86.

Correlations for two-item scales (i.e., the confidence component of power *within*, psychosocial

health knowledge, stress, and the personal dimension of workplace bullying) ranged from r =

.44-.61.

Descriptive Statistics

See Table 3.1 for a summary of demographic and background information and Table 3.2

for baseline and post intervention means and standard deviations for experimental and control

participants for all outcome 12 variables, time working in the entertainment sector, and time in

network group (i.e., the moderator). *T*-test results indicated significant differences between

experimental and control participants on three baseline outcomes: the confidence component of power *within* $t(158) = -2.43$, $p = .016$ stress $t(155) = -2.46$, $p = .016$, and burnout $t(154) = -2.55$, $p = .012$. However, after applying the Bonferroni correction ($p = .05/12 = .004$), these differences were rendered not significant. *T*-tests also revealed there were no significant differences between experimental and control participants on time in network group $t(153) = -.492$, $p = .624$ or time working in the entertainment sector $t(142) = -1.16$, $p = .249$.

PE Exposure

Of the 96 experimental participants, 94 responded to the open-ended questions regarding PE exposure. Of them, only 2 participants (2.1%) reported a PE taught during two of their last three network meetings and the remainder (97.9%) reported a PE taught during all three. A thematic analysis was conducted on these responses. When asked to recall the topics covered during the PE practice teaching sessions, the main responses included psychosocial skills (86.2%), spiritual knowledge/religion (85.1%), life skills (83%), and communication (41.5%). Most participants (58.5%) reported they liked all topics equally, while others specified life skills (16%), psychosocial skills (12.8%), or spiritual knowledge/religion (11.7%) as their favorite topics. Participants suggested other psychosocial health topics they would be interested in learning more about. The most common responses were: "things that are important and useful in my life" (40.4%) and "making time/caring for myself" (24.5%).

Hierarchical Linear Models

Intra-class correlations, representing the proportion of between group variance, ranged from .04 to .24 across outcome variables ($M = .16$, $SD = .05$). In other words, between 4% and 24% of the variance in outcomes was between groups, as opposed to within groups.

Holding baseline scores constant, experimental participants were found to have significantly higher post intervention scores on the efficacy component of power *within*, $b = .48$, $SE = .10$, $p < .001$, 95% CI [.32, .66], power *over resources*, $b = .40$, $SE = .11$, $p = .003$, 95% CI [.22, .58], psychosocial health knowledge, $b = .46$, $SE = .15$, $p = .003$, 95% CI [.21, .71], happiness, $b = 1.36$, $SE = .39$, $p < .001$, 95% CI [.73, 2.00], job control, $b = .60$, $SE = .11$, $p < .001$, 95% CI [.41, .79], and the personal dimension of workplace bullying, $b = .46$, $SE = .11$, $p < .001$, 95% CI [.27, .64] compared to control participants. All significant changes were in the expected direction with the exception of workplace bullying, which was expected to decrease after exposure to the PEs. Again, statistical significance was determined using a Bonferroni correction ($p = .05/12 = .004$) to account for multiple comparisons. See Table 3.3 for a summary of all HLM results. Time in network group was not found to be a significant moderator of the effects of the intervention on any of the 12 outcome variables, and therefore results are not reported for these models.

Discussion

Overall, this pilot program revealed that peer education is a feasible and promising approach to improving psychosocial and occupational health and empowerment outcomes among WES in Nepal. WES who were exposed to the psychosocial health promotion messages of the PEs reported significantly higher scores on the efficacy component of power *within*, power *over resources*, psychosocial health knowledge, happiness, and job control post intervention compared to participants who were not exposed to the PEs. Exposure to the PEs did not have a significant effect on the confidence component of power *within*, power *with*, health, stress, burnout, or the physical dimension of workplace bullying. These findings are partially congruent with the finding that participation in the community empowerment program in south India

evaluated by Blanchard et al. (2013) was associated with significant increases in power *within* and power *with others*, but not power *over resources*. This is likely due, in part, to the discrepancies in the measures used to assess empowerment constructs across the two studies as well as the substantial differences in the nature of the two programs (e.g., duration, context, program type).

Contrary to the hypothesis, WES who were exposed to the PEs reported significantly higher scores on the personal dimension of workplace bullying post intervention compared to control participants. This finding may be due in part to increased awareness of the bullying they experienced resulting from a general heightened awareness of their psychosocial health status as opposed to an actual increase in experienced bullying. It is also possible that increased self-efficacy and perceptions of control led to an increase in confrontational behaviors that could result in more perceived bullying.

Given that no peer-reviewed published studies worldwide have attempted to improve the psychosocial health of FSWs through peer education methods, we were unsure if the WES would completely reject or generally show a lack of interest in the program. To the contrary, the program had low rates of attrition compared to other programs targeting FSWs (Medley et al., 2009). The incredible efforts of the two key field staff to ensure that all PEs attended the training sessions and conducted their practice teaching during the network group meetings, as well as their commitment to ensure that all participants who took the survey at baseline also took the survey post intervention, contributed significantly to the low attrition. In a parallel mixed-methods evaluation (Chapter 4) the PEs reported that their peers were generally interested in and engaged with the training content during their practice teaching sessions. The findings of this parallel evaluation also revealed that the program also had a positive effect on many

psychosocial and occupational health and empowerment outcomes among the 10 WES trained as PEs.

Limitations

There are a number of limitations that should be considered when interpreting the findings of this pilot study. Of course, the ability to detect an effect was limited by the reduced statistical power after deleting over 30 cases, resulting in a final sample with an unequal number of participants in the experimental and control groups. It is likely that additional significant effects would have been observed if a larger sample size had been maintained. The generalizability of the findings is restricted given that the participants were part of an existing community empowerment network. It is possible that program acceptance, impact, and attrition rates would have looked different if the program had been pilot tested with WES who were not already so heavily engaged in such a network. Furthermore, as previously mentioned, the women selected to be trained as PEs were all from network groups that were clustered inside of Kathmandu proper in close proximity to Thamel (and the headquarters of the partner NGO). Half of the control groups were located outside of Kathmandu proper and further away from the headquarters of the partner NGO. This may have influenced the findings, as perhaps members of groups located inside Kathmandu proper had more interaction with and involvement in the programs of the partner NGO (as well as other NGOs with programs targeting WES) compared to members of groups that are located outside of Kathmandu proper.

There are also limitations related to program evaluation. Due to restrictions enforced by the partner NGO, the survey was brief and did not measure sex work activity. As a result, many constructs were assessed with just a few or, in some cases, even a single-item, and the extent to which participants engaged in sex work is unknown. Furthermore, given the scant psychological

research conducted in Nepal, particularly with WES, there were no previously validated measures related to the constructs of interest. Future research is needed to validate measures to assess psychosocial and occupational health and empowerment among FSWs in Nepal and elsewhere. Also, it is possible that participants reported better psychosocial health and empowerment due to self-preservation bias and the stigma surrounding poor mental health (Kessler & Underwood, 1993). Given that the surveys were administered one-on-one verbally by the NGO field staff, participants may have been more inclined to respond in a socially desirable way (Hochstim, 1967) and to agree or acquiesce than to disagree (Javeline, 1999). Finally, the fact that data were only collected at baseline and post intervention renders the longer-term effects of the program unknown. However, many interventions targeting FSWs only survey at one time point, do not include a control group, and/or have high attrition rates (Shahmanesh, Patel, Mabey, & Cowan, 2008), so this study is certainly a step in the right direction in terms of methodological rigor and retention.

Future Research

There are a number of important directions for future research. First and foremost, these results provide support for conducting a larger scale trial. Although a randomized controlled trial (RCT) study is likely not feasible or ethical (i.e., considering this pilot demonstrated primarily positive intervention effects), a wait-list control or stepped-wedge design (Brown & Lilford, 2006) may be suitable alternatives. The brevity of this pilot program certainly has its benefits in terms of requiring minimal time, money, and other resources, it is likely that enhanced impact would be associated with an intervention that is longer in duration. Forsman, Nordmyr, and Wahlbeck (2011) reviewed the effectiveness of psychosocial health interventions targeting older adults and found more positive effects associated with interventions lasting for three or more

months compared to shorter interventions. Future programs should also measure change at multiple occasions post intervention to assess longer-term impact. It is also important to examine the potential of pairing psychosocial health promotion interventions with other types of health promotion interventions targeting FSWs, such as HIV and violence prevention programs, to enhance the effectiveness of such programs. Given the growing global investment in HIV prevention initiatives targeting FSWs (United Nations Joint Programme on HIV/AIDS, 2015), there may be a window of opportunity to integrate psychosocial health approaches into new programming (Cournos, McKinnon, & Wainberg, 2005).

The feasibility and impact of peer education to promote psychosocial health and empowerment of FSWs should also be examined in other contexts (e.g., rural areas of Nepal, in other countries) and with other sex worker populations (e.g., younger FSWs, street-based FSWs, male and transgender sex workers). Given that street-based or other public place-based sex work is the most widespread type of sex work globally, programs are especially needed to target this group (Harcourt & Donovan, 2005). Given the disparate needs that different communities of sex workers in different, and even in the same, countries may have, it is likely that a psychosocial health promotion peer education program would have to look quite different in order to be effective for a different population of sex workers (Newman, 2003). Nonetheless, many of the methodological features of this pilot study, namely the high level of participation of the partner NGO and WES and the use of native trainers to provide culturally congruent training on psychosocial health, apply across contexts. The creation of the customized teaching aids through the interactive debrief sessions seems to be a particularly beneficial element that should be adopted by future programs, especially when the target population is characterized by low levels of education and literacy.

In addition to extending the length of the program, there are a number of additional ways in which future programs could enhance the PE training program and practice teaching experiences. There are many other topics related to psychosocial health and empowerment that may be beneficial to cover, such as healthy relationships, stress management, mindfulness, positive thinking, substance use/abuse, and mental health first aid. Future research should place more emphasis on training PEs in the provision of social support. Sarafian (2012) evaluated the presence of and outcomes related to different types of social support in a peer education program targeting hotel-based sex workers in Dhaka, Bangladesh. Exposure to PEs high in informational support (i.e., the provision of information and advice to help solve problems) was associated with higher self-efficacy and more self-reported condom use at follow-up, and exposure to PEs high in emotional support (i.e., the provision of caring and empathic support) was associated with greater STI treatment seeking at follow-up. These findings suggest that informational and emotional support may make differential contributions to health outcomes and thus should both be emphasized in PE training.

As suggested by the Joint United Nations Programme on HIV/AIDS (2003), program impact could also be enhanced by including goal-setting elements for PEs (e.g., number of peers to teach each day). Similarly, it may also be beneficial to include goal-setting elements for those receiving the lessons from the PEs (i.e., the peers). In line with best practices, goals should be aligned with the SMART acronym: Specific, Measurable, Attainable, Realistic, and Time-bound (Williams, 2012). Furthermore, feedback on goals should be provided, given the importance of performance feedback in fostering motivation (Locke, 1968). Goal-setting may lead to an increased impact on psychosocial and occupational health and empowerment outcomes.

In addition to programs aiming to enhance the psychosocial and occupational health and empowerment of FSWs, it is also important to develop programs to promote psychosocial health knowledge and supportive behaviors of gatekeepers (e.g., owners, managers, and staff of sex work establishments; Ross et al., 2012). Yang et al. (2005) found perceived gatekeeper support to be associated with an increase in a number of outcomes related to sexual health among sex workers, including increased condom use communication with sexual partners, condom use frequency and intention to use condoms, and self-efficacy to use condoms. Health professionals and others who provide services to FSWs (e.g., NGO staff) are another important gatekeeper population (Wong et al., 2006).

There are many important directions for future research with regards to program evaluation. For instance, additional psychosocial health outcomes (e.g., quality of life, depression, anxiety) and additional occupational health outcomes (e.g., job satisfaction, work stress) that may also be affected by such programs should be assessed. It is also important to track the impact of the program on behavioral outcomes (e.g., self-care behaviors) and longer-term impacts, such as whether WES who wish to exit the sex industry are successful in doing so.

Future research should also focus on how to promote program sustainability. With limited resources and other priorities, the partner NGO was not able to continue the program. If they had access to funding mechanisms that would allow them to hire someone (perhaps even a graduate of the training) to run the program, sustainability may have been more feasible. A series of reports was prepared for the partner NGO with hopes they can use the findings from this pilot study to apply for funding to continue the program by training more WES as PEs and/or providing refresher training for the 10 WES trained through this pilot program. Future research should examine additional ways to streamline the program and reduce the burden on NGO staff

in order to promote sustainability. Finally, in order to fully promote psychosocial and occupational health and empowerment among WES in Nepal, more efforts are needed to help them gain access to education, vocational skills, and job opportunities.

Conclusion

Overall, the findings from this pilot study indicate the methods of peer education methods as a feasible and promising means of enhancing the psychosocial and occupational health and empowerment of WES in an existing community empowerment network in Kathmandu, Nepal. This study reinforces the value of using community-based participatory research methods when piloting new programs with FSWs. This pilot study can inform future programs aiming to promote the psychosocial and occupational well-being and empowerment of FSWs as well as other vulnerable and hard-to-reach working populations.

CHAPTER 4: PEER EDUCATOR MIXED-METHODS MANUSCRIPT[8]

Synopsis

In Nepal, the sex industry is synonymously referred to as the entertainment sector. Women in the entertainment sector (WES) in Nepal are exposed to many dangers as part of their work, including exploitation, violence, and disease transmission. These challenging circumstances compromise the psychosocial health and agency of WES, which in turn diminishes their ability to protect themselves from the many hazards inherent in their work. In collaboration with a local non-governmental organization (NGO), a brief peer education intervention was piloted to promote the psychosocial health and empowerment among WES in Kathmandu, Nepal. Ten WES were trained as peer educators (PEs), and a mixed-methods evaluation was conducted to assess the feasibility and impact of the program on the PEs. The PEs were surveyed at baseline, immediately post intervention, after 2-months, and after 10-months to evaluate psychosocial and occupational health, empowerment, and peer education efficacy. Upon completion of the program, one-on-one exit interviews were conducted with nine of the PEs and two field staff from the partner NGO to solicit more in-depth feedback. Survey results indicate the program had a significant impact on some aspects of psychosocial health and empowerment, with positive trends on many other outcomes. Exit interviews revealed additional positive impacts of the program, including enhanced confidence and communication skills and

increased self-awareness and self-care behaviors. Overall, peer education was found to be a feasible and promising means of enhancing the psychosocial health and empowerment of WES in Nepal. These findings can inform future peer education programs targeting sex workers and other vulnerable and hard-to-reach working populations.

Introduction

Sex work, defined as the provision of sexual services in exchange for money, goods or other benefits, has been documented in nearly every corner of the world (Vandepitte et al., 2006). The faces of sex work vary considerably across different populations in terms of level of visibility, organization, legal status, and risk (Harcourt & Donovan, 2005). Although the risks associated with sex work vary across situations, the profession is arguably a dangerous one. Across the diverse circumstances in which sex work takes place, female sex workers (FSWs) may be exposed to different levels and combinations of hazards in their work, including but not limited to poor working conditions, long hours, disease transmission, violence, criminalization, drug and alcohol use, debt bondage, and various forms of discrimination and exploitation (Rekart, 2005; Ross, Crisp, Månsson, & Hawkes, 2012).

As a result of their high-risk status and the broader public health implications of disease transmission, the most commonly addressed risk among FSWs has been the transmission of human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). However, scholars have highlighted the need for interventions to move beyond the limited objective of HIV/STI prevention to also focus on promoting the psychosocial health (i.e., the mental, emotional, social, and spiritual aspects of health; Donatelle, 2009) of FSWs (Chudakov, Ilan, Belmaker, & Cwikel, 2002; Donatelle, 2009; Lau, Tsui, Ho, Wong, & Yang, 2010; Rekart, 2005). For instance, Rekart (2005) encouraged the development of interventions to help FSWs

move into a positive cycle of empowerment, improved quality of life, and a more supportive environment. Despite these calls for action, there has been relatively little research directly focused on understanding and promoting the psychosocial health of FSWs.

Psychosocial Health of FSWs

The scant evidence available largely suggests poor psychosocial health among FSWs. For instance, past studies have reported high rates depression (e.g., Lau et al., 2010); substance use (e.g., Young, Boyd, & Hubbell, 2000); self-harm tendencies (e.g., Kidd & Kral, 2002); post-traumatic stress disorder (e.g., Farley, 2003); and poor self-esteem (e.g., Harcourt, Beek, Heslop, McMahon, & Donovan, 2001); as well as a pessimistic future outlook (e.g., Kok, Ho, Heng, & Ong, 1990), low life satisfaction (e.g., Baker, Wilson, & Winebarger, 2004); and lack of perceived meaning in life (e.g., Wong, Holroyd, Gray, & Ling, 2006).

There are many factors that are likely to contribute to poor psychosocial health among FSWs. As previously mentioned, FSWs are exposed to numerous workplace stressors, including various forms of violence, harassment, exploitation, and abuse. Sex work is also emotionally demanding in that FSWs are often forced to assume a falsified persona in order to satisfy the needs and expectations of their clients (Browne & Minichiello, 1995). There are also a number of stressors FSWs may face outside of the work context, such as family problems, financial difficulties, and experiences of stigma that are likely to influence their psychosocial health (Vanwesenbeeck, 2001). All of these work and non-work stressors may act in a feedback loop in which problems at work affect the individual outside of work, which in turn exacerbate problems at work (Cooper & Marshall, 1976).

Poor psychosocial health among FSWs contributes to a lack of motivation as well as a lack of empowerment to engage in protective behaviors and pursue positive life changes. It is of

course important to promote the psychosocial health of FSWs in order to enhance their overall well-being and quality of life. But also, without a strong foundation of psychosocial health, programs targeting the physical health risks of FSWs, such as those focused on HIV and violence prevention, are likely to have minimal impact. The present study is an initial step to pilot an intervention designed to promote the psychosocial health of FSWs.

Risk Reduction among FSWs

A number of best practices have been identified for developing risk reduction programs for FSWs. One key aspect of effective programming is engaging FSWs and the organizations working with them in all stages of the intervention process (Ross et al., 2012). Such participatory approaches not only capitalize on the extant knowledge FSWs possess related to protecting themselves from the risks inherent in their profession, but they can also allow for the customized tailoring of interventions to accommodate distinctive needs and preferences, and enhance FSWs' leadership skills and capacity for self-determination, control, and autonomy (Hansen, Lopez-Iftikhar, & Alegria, 2002; Pauw & Brener, 2003; Vanwesenbeeck, 2001; Vanwesenbeeck, van Zessen, de Graaf, & Straver, 1994; Wallman, 2001; Wojcicki & Malala, 2001; Wolffers, 1999). Participatory approaches can also help to establish a sense of ownership and buy-in among both FSWs and the organizations aiming to serve them that cannot be achieved through top-down approaches (Rekart, 2005). The present study utilized the methods of peer education, a community empowerment approach that involves a high level of FSW engagement.

Peer education programs train individuals who share experiential and/or demographic factors to educate and encourage behavior change among same group members (Medley, Kennedy, O'Reilly, & Sweat, 2009). Peer education programs have been recommended for use with sex workers and other hard-to-reach populations for a number of reasons. Peer educators

(PEs) may be perceived by FSWs as a more trustworthy and credible source of information compared to outsiders (e.g., Perry, 1989), can serve as role models in protecting and promoting health (Jana, Basu, Rotheram-Borus, & Newman, 2004) and can reinforce learning through ongoing contact.

Numerous peer education programs have been employed among FSWs for risk reduction, most of which have focused on STI/HIV prevention. These programs have been found to be effective in improving attitudinal and behavioral outcomes related to sexual health (Medley et al., 2009). Peer education programs have been found to be more cost-efficient compared to other intervention methods (e.g., Jones, 1992). Hutton, Wyss, and N'Diékhor (2003) conducted a cost-effectiveness analysis of HIV/AIDS prevention programs in Chad, Central Africa, and found that peer education programs for sex workers cost an estimated $6-$16 per infection prevented, while other interventions, such as mass media and social marketing of condoms ($78-$534 per infection prevented) and voluntary counseling and testing for STIs ($906-$1,190 per infection prevented) were considerably more costly. Despite these benefits and promising findings, peer education has not previously been directly tested as a way to promote psychosocial health among FSWs.

The present study was designed to fill this gap by pilot testing a brief peer education intervention to promote psychosocial health and particularly empowerment, among women working in the sex industry. The intervention was designed and evaluated based on the Integrated Empowerment Theory (IET) (Blanchard et al., 2013). The IET is an empowerment framework that considers three distinct but inter-related domains of empowerment: power *within*, power *with others*, and power *over resources*. Power *within* refers to confidence, self-efficacy, and awareness of the factors that contribute to vulnerability. Power *with others* refers to social

support, solidarity, and perceived ability to take collective action. Finally, power *over resources* encapsulates the ability to access and exert control over resources in one's environment. The intervention was designed to promote psychosocial health and these three aspects of empowerment among women working in the sex industry in Kathmandu, Nepal.

Context: Nepal and Sex Work

Nepal is an impoverished country in South Asia located between India and China. Political instability, in combination with pervasive patriarchal norms and extreme poverty, has contributed to low levels of education and few opportunities for women and girls in Nepal (Kaufman, Harman, & Shrestha, 2012). As a result, a growing number of women and girls (many of whom left their rural villages to escape domestic violence, political conflict, and severe poverty) resort to sex work in bigger cities, such as Kathmandu, in pursuit of economic survival (National Centre for AIDS and STD Control [NCASC], 2010).

The commercial sex industry in Nepal is synonymously referred to as the entertainment sector (Frederick, Basynat, & Aguettant, 2010). As opposed to women and girls who sell sex on the street or from their home, women in the entertainment sector (WES) work in various establishments including dance bars, massage parlors, cabin restaurants (i.e., food and drink establishments with plywood cabins in which waitresses accompany customers), and *bhatti pasals* (i.e., small shops selling liquor and snacks; Frederick et al., 2010; NCASC, 2011). Frederick et al. (2010) estimated there are 11,000 to 13,000 WES in Kathmandu alone.

Despite the fact that sex work is legal in Nepal, WES are afforded few protections under Nepali law (Shrestha, 2006). As a result, they are exposed to an array of risks to their health and well-being, including poor working conditions, sexual and reproductive health risks, and various forms of harassment, violence, and exploitation by clients, establishment owners, and even law

enforcement officers (Frederick et al., 2010). Not all WES actively engage in sex work; however, WES who do not engage in sex work are still exposed to a myriad of other hazards inside these establishments (Frederick et al., 2010). Job insecurity and extreme poverty may increase vulnerability to exploitation and abuse. Additionally, all WES are subject to social stigma and, as a result, may prefer to hide their job status from their families and the public (Frederick et al., 2010).

The psychosocial impact of working in the entertainment sector is profound (Frederick et al., 2010). The few published studies to date suggest high rates of anxiety, depression, hopelessness, isolation, insecurity, and fear and low self-efficacy and sense of agency among WES in Nepal (Frederick et al., 2010; Ghimire, Smith, van Teijlingen, Dahal, & Luitel, 2011). To date, there have been no published interventions aiming to promote psychosocial health and empowerment among WES in Nepal.

Summary and Rationale

The importance of promoting the psychosocial health and empowerment of FSWs is clear—without it, other programs aiming to protect them from the various risks inherent in their work will likely be limited in success. Nonetheless, to date this aspect of sex worker health has been largely ignored. The primary aim of this study was to assess the feasibility of using a brief peer education intervention to promote psychosocial health and empowerment among WES in Kathmandu, Nepal as well as the impact of the program on the psychosocial health and empowerment of the trained PEs through a mixed-methods evaluation. The broader impact evaluation of this study has been reported elsewhere (Chapter 3).

Another aim of this study was to determine the potential of the program to enhance the occupational health of WES in the form of increased job control (i.e., the level of control an

individual has over tasks and conduct during the working day, Karasek Jr, 1979), decreased

burnout (i.e., a state of physical, mental and emotional exhaustion resulting from prolonged

exposures to workplace stressors, Pines & Aronson, 1988), and decreased bullying in the

workplace (i.e., persistent exposure to aggression and mistreatment from supervisors and

colleagues at work, Einarsen, Hoel, & Notelaers, 2009). These occupational health variables

have been linked with psychosocial health outcomes (e.g., job control, Stansfeld & Candy, 2006;

burnout, Maslach, Schaufeli, & Leiter, 2001; bullying, Cortina, Magley, Williams, & Langhout,

2001), but have been minimally examined among FSWs.

Method

In close collaboration with a local non-governmental organization (NGO), a brief peer

education intervention was developed, pilot tested, and evaluated through quantitative and

qualitative methods for its effectiveness in promoting psychosocial and occupational health and

empowerment among WES in Kathmandu. Guided by a community-based participatory research

(CBPR) approach (Israel, Eng, Schulz, & Parker, 2013), the partner NGO played a prominent

role throughout all stages of the project. Leadership and staff from the NGO steered the direction

of the intervention in terms of both the aims and execution and played a critical role in the

evaluation process, informing both the content and administration of the surveys. Two key field

staff, who coordinated the network group meetings and made frequent visits to the entertainment

sector establishments, were the most heavily involved in the project. Women from the target

population were also actively engaged throughout the project. They helped to guide the direction

and design of the project through a voting session and focus group interview, and they were also

engaged in implementation of the program through their role as PEs. The involvement of the

partner NGO and WES in the design, implementation, and evaluation of the program has been

detailed elsewhere (Chapter 5). All study procedures and evaluation materials were approved by the Colorado State University Institutional Review Board and the Nepal Health Research Council prior to implementation.

Participants

Participants were all members of an existing community empowerment network that was established by the partner NGO to promote social support and solidarity among WES in Kathmandu. At the start of the present study (January 2014), the network consisted of 20 groups with 16-28 members in each group. Each group had a cooperative savings account and convened in biweekly meetings coordinated by the partner NGO to discuss the issues faced by their respective group members. At least one of the two key field staff was present at each meeting in order to moderate the discussion, keep attendance records, and take meeting minutes. Ten WES from 10 different network groups were selected and trained as PEs. Approximately 200 women from this network, including those who were and were not exposed to the PEs, were surveyed as part of a larger impact evaluation (Chapter 3).

Recruitment and Selection

The training was announced to women from all 20 network groups by the NGO field staff during biweekly network group meetings as well as during their regular establishment visits. The first author also announced the training during a local radio program targeting WES in Kathmandu. Recruitment targeted network members who were 18 years of age or older. Those who were interested in the training were encouraged to attend an information session at the office of the partner NGO to learn more about the opportunity and to apply. Recruitment started three weeks prior to the information session. Thirty women, representing 16 of the 20 network groups, completed an application.

Of the 30 WES who completed an application, two separate groups of 10 recruits from 10 different network groups were selected to be final candidates. The first author scored the applications so higher scores reflected greater probability of being successful as a PE and selected one group based on these scores, and selected 10 candidates based on these scores. The two key field staff selected the other group based on who they thought would be most successful in the role of PE. The first author and field staff then met to compare lists, and the field staff were asked to make the final selection decisions based on who they felt would be most committed to and well-suited for the role of PE.

The Intervention

Training design and overview. The training included six, 3-hour sessions broken into two main phases. The training content was designed to be strengths-based, highly interactive, and tailored for a low-education, low-literacy population. The training was also designed to promote training transfer (i.e., the extent to which the lessons and skills learned in training are transferred outside of the training context) by including behavioral modeling and error management strategies and opportunities to practice new skills [Grossman & Salas, 2011].

The first phase of the training consisted of three sessions focused on providing trainees with a baseline understanding of what peer education is and why it is important and to help them develop the skills they would need to be successful as PEs (e.g., communication skills, teaching strategies). The first author facilitated this phase of the training with assistance from a female Nepali research assistant/translator. The second phase of the training consisted of three sessions focused on different topics related to psychosocial health. In order to ensure provision of culturally relevant training, three Nepali experts—including a psychologist, a meditation guru,

and a "life skills"[9] trainer from another Kathmandu-based NGO targeting WES—were recruited to facilitate these sessions. Each session during the second phase of the training included two hours of new training content provided by one of the expert trainers and a one-hour debrief session. During the debrief sessions, participants were asked to discuss the key lessons they had learned in the training that they wanted to share with their peers. Two female artists (one Israeli and one Canadian) attended these debrief sessions to help create drawings to serve as customized visual teaching aids for the PEs. See Figure 4.1 for an example visual teaching aid (i.e., the one created during the session facilitated by the psychologist).

Practice teaching. After each of phase two training session, the PEs were given two weeks to use the customized visual teaching aids to teach the lessons learned formally during their next biweekly network group meeting as well as informally while at work.

Implementation. The entire training was conducted in a small, private room at the headquarters of the partner NGO. The first four sessions were conducted four consecutive days in a row. In order to give ample time to practice teaching each topic, there was a two-week gap between each of the phase two trainings. The two key field staff were encouraged to take an active role in coaching and assisting the PEs during their practice teaching. All 10 trainees attended the first four sessions, nine attended the fifth session, and seven attended the final session. The PEs completed the formal practice teaching requirement in their next biweekly network group meeting for each Phase 2 training attended. After the final practice teaching session concluded, completion certificates were administered to the PEs.

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[9] This trainer typically provides a 36-hour training that her NGO refers to as a "life skills" training. Upon reviewing the full training manual, this training covers a variety of topics to help WES foster the personal and relational knowledge and skills to be happy and successful in life, such as communication skills, positive thinking, and self awareness.

Program Evaluation

The feasibility and impact of the program on the 10 PEs was evaluated through a mixed-methods design. Mixed-methods designs have been suggested when study goals include triangulation of findings and provision of process details that may be useful to practitioners (Bryman, 2006). The PEs completed surveys at four time points—baseline, immediately post intervention, after 2 months, and after 10 months—to determine the impact of the program on psychosocial and occupational health, empowerment, and efficacy related to being a PE. The PEs also completed a brief, one-page reaction survey after each of the six training sessions. To assess teaching competency, the field staff were asked to complete an observational rating form during each formal practice teaching session (i.e., each time a PE taught during a network group meeting). Finally, one-on-one exit interviews were conducted with the PEs and the two key field staff after the close of the program to collect more in-depth feedback about the training, the practice teaching experiences, and the impact of the program.

Survey measures. Demographics were assessed at baseline and outcome measures were assessed at all four time points. See Chapter 3 for a more in-depth description of the survey development processes.

Psychosocial health. Five constructs were measured related to psychosocial health. Overall health was assessed with a single-item on a four-point Likert scale ranging from poor to excellent. Psychosocial health knowledge was assessed with two newly constructed items on a four-point Likert scale ranging from disagree a lot to agree a lot. Stress was assessed with two items—one item from the short form of the Perceived Stress Scale (PSS-4; Cohen & Williamson, 1988) and one item written by a medical anthropologist to assess psychological well-being in Nepal—on a four-point Likert scale ranging from never to always. Finally, a single-item on a

sliding scale from 1-13 was used to assess happiness. A retrospective period of one month was specified for items pertaining to stress and happiness.

Empowerment. Newly constructed items and modified items from other previously developed scales were combined with modified items from the Integrated Empowerment Theory (IET) measure (Blanchard et al., 2013) to assess the three types of empowerment. Six items were used to assess power *within* including two items from the IET, three items from the General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995), and a newly constructed item specifically designed to assess power *within* related to psychosocial health. Power *with others* was assessed with four modified items from the IET, and power *over resources* was assessed with five newly constructed items designed to gage perceived access to different types of community resources and services (e.g., mental and sexual health services, legal advice and services). All empowerment items were assessed on a four-point Likert scale ranging from disagree a lot to agree a lot with no specified retrospective period. According to results of a confirmatory factor analysis reported elsewhere (Chapter 3), power *within* consisted of two factors (labeled "confidence" and "efficacy"), and power *with others* and power *over resources* each consisted of a single factor.

Occupational health. Job control was assessed with a single, newly-constructed item. Burnout was assessed with four items from the short version of the Malach-Pines Burnout Measure (BMS-10; Malach-Pines, 2005). Workplace bullying was assessed with three items from the Negative Acts Questionnaire-Revised (NAQ-R; Einarsen et al., 2009) Specifically, two items were from the personal dimension of the NAQ-R and one was from the physical dimension. All three occupational health variables were assessed on a four-point Likert scale ranging from never to always with a retrospective period of one month.

Peer education efficacy. Peer education efficacy was assessed with 12 items on a four-point Likert scale ranging from disagree a lot to agree a lot. Four items were modified from the Leadership and Personal Development Inventory (LPDI; Carter, 1989), which measures perceptions of personal and leadership life skills. The other eight items were newly constructed to assess efficacy in helping others (3 items), communication (3 items), teaching (1 item), and perceived leadership skills (1 item). Four, 3-item scales were created from these 12 items to represent different types of peer education efficacy: communication efficacy, teaching efficacy, leadership efficacy, and efficacy to help others.

Survey administration. The two key field staff administered all four surveys (baseline, post, 2-month follow-up, and 10-month follow-up) verbally in Nepali, one-on-one during their regular establishment visits and during biweekly network group meetings. Written consent was obtained and participants were compensated with 100 Nepali rupees (equivalent to approximately $1 US) for each survey completed. An additional part-time field staff aided in administration of the baseline surveys, which took place during the same time as PE recruitment. Upon selection of the 10 PEs, it was determined that four had not taken the baseline survey as part of the broader impact evaluation, so this survey was administered to these four individuals at the beginning of the first training session.

Other measures. In addition to the main survey, the PEs completed post-training reaction surveys designed to gain their feedback and reactions to each training session. All reaction surveys were administered by the NGO staff one-on-one in Nepali. The field staff were also asked to fill out an observational rating form, adopted from a community lay health worker intervention targeting Mexican Americans with diabetes (Swider, Martin, Lynas, & Rothschild, 2010), to rate PE performance during each formal practice teaching session conducted during the

network group meetings. The form solicited ratings on seven categories (i.e., clarity of content; openness to questions; encouraging active participation and helping participants; asking questions to check for understanding; discussing practical application of topics; confidence; and managing participants who went off topic) on a 5-point Likert rating scale ranging from "low, needs a lot of additional training and practice" to "excellent, an outstanding role model for her peers." The form also asked the field staff to indicate which of the main sub-topics from each training were or were not covered during each practice teaching session and included a place to record open-ended comments or suggestions regarding the teaching performance of the PE. Finally, attendance records were examined for all network group meetings during which practice teaching took place in order to calculate the number of WES that received teaching from the PEs.

Exit interviews. Upon completion of the program, the PEs were asked to participate in a 30-60 minute exit interview at the NGO headquarters in order to gather more in-depth feedback regarding the training and their practice teaching experiences. The first author conducted all exit interviews using a structured interview guide, and a bilingual, administrative-level staff from the partner NGO aided with translation. Written consent and permission to record the interviews was obtained from all participants. The PEs were each compensated with 100 Nepali rupees for their time. Exit interviews were also conducted with the two key field staff to gain their feedback about the training and the practice teaching experience of the PEs. Interviews were transcribed verbatim and translated into English by a bilingual Nepali research assistant.

Data Analysis

Quantitative analysis. Quantitative data analysis was conducted using SPSS V23. Basic descriptive statistics were computed to summarize demographic information from the baseline survey and results from the post training reaction surveys, observational rating forms, and

attendance records. In order to assess the impact of the program on psychosocial and

occupational health, empowerment, and peer education efficacy, repeated measures ANOVA

tests were run to compare scores across the four survey time points. To account for multiple

comparisons, a Bonferroni correction ($p = .05/16 = p = .003$) was applied. If an overall

significant difference in means was detected, pairwise comparisons were conducted (using a

Bonferroni confidence interval adjustment) to determine which time points were significantly

different from one another. Given the small amount of missing data across all time points (1.1%

at baseline, 3.6% at post, 1.1% at the 2-month follow-up, and 0.6% at the 10-month follow-up),

mean imputation was used to avoid listwise deletion.

Qualitative analysis. A thematic analysis of the exit interview transcripts was conducted

in two stages guided by the framework outlined by Braun and Clarke (2006). First, two members

of the research team independently completed open-coding of each transcript and met to discuss

discrepancies and to generate an initial list of themes. Each theme was operationally defined and,

when necessary, assigned example quotes from the transcripts to demonstrate the nature of the

category for all coders. Next, two additional members of the research team independently

applied the list of codes to the transcripts using the software program Atlas.ti. The two sets of

coded transcripts were then compared using the Atlas.ti add on, Coding Analysis Toolkit (CAT).

CAT provided a summary of all coding that did and did not match across the two sets of

independently coded transcripts. The codes that did not match (i.e., one coder applied a code to a

section of text but the other did not) were reviewed and coders were encouraged to add a code if

they felt they should have applied it in the first place. During this process, the coders were not

told that the other member of the coding team had applied the code. Instead, they were just asked

to review each section of text and decide if they either agreed or disagreed that the code be

added. If they were unsure, they were instructed to not add the code and move on to the next quote. After additional codes were added through this checking process, Cohen's kappa (κ) was calculated in CAT to assess inter-rater reliability. Across all themes, there was a high level of agreement between the two coders (Mean $\kappa = .84$, Range of κ across constructs $= .64$-1.00). A basic thematic analysis was conducted on responses to open-ended questions on the post training reaction surveys and the observational rating forms.

Results

Quantitative Results

Demographics. The PEs ranged in age from 24 to 48 years ($M = 34$, $SD = 7.07$) and represented all major caste groups: Brahmin ($n = 2$), Chhetri ($n = 2$), Janajati ($n = 4$), Dalit ($n = 1$), and one did not respond. They had lived in Kathmandu between 8-25 years ($M = 12.70$, $SD = 4.88$) and were originally from different regions: Western Nepal ($n = 2$), Central Nepal ($n = 6$), and Eastern Nepal ($n = 2$). Nine of the PEs were married, only one of which reported receiving financial support from her husband. All of the PEs reported having children; number of children ranged between one and five ($M = 2.80$, $SD = 1.23$). The majority ($n = 6$) identified as Hindu, and the others identified as Buddhist ($n = 2$), Christian ($n = 1$), and both Hindu and Buddhist ($n = 1$). Years of education ranged from 0-8 ($M = 2.15$, $SD = 2.93$); four PEs reported having completed no years of education. All ten PEs reported having a citizenship certificate and savings in their network group's cooperative savings account, and nine reported having savings elsewhere. Only one PE had received training related to psychosocial well-being or life skills in the previous year (one PE did not respond to this question).

The PEs had been working in the entertainment sector between 4-20 years ($M = 9.05$, $SD = 4.40$) and had been members of their network group between 1-3 years ($M = 2.23$, $SD = .70$).

They represented a range of entertainment sector establishments, including massage parlors (n = 4), cabin restaurants (n = 2), *bhatti pasals* (n = 3), and other types of establishments (n = 2). Seven PEs only worked at one type of establishment, and the other three worked at two types of establishments. All of the PEs cited the need to pay for living expenses and for their children's education as reasons for starting to work in the entertainment sector. Other reasons included: no other means of earning income (n = 7), a friend or relative was doing it (n = 2), deserted by husband (n = 5), and became a widow (n = 1). When asked about alcohol and drug use at work in the last month, four reported using alcohol and one reported using drugs.

Repeated measures ANOVA tests. Results from repeated measures ANOVA and post hoc tests are summarized in Table 4.1. According to Mauchly's Test, the assumption of sphericity had been violated for the efficacy component of power *within* ($\chi^2(5) = 13.36$, p = .021), power *over resources* ($\chi^2(5) = 17.99$, p = .003), burnout ($\chi^2(5) = 15.88$, p = .008), communication efficacy ($\chi^2(5) = 29.93$, $p < .001$), and leadership efficacy ($\chi^2(5) = 12.68$, p = .028); therefore, degrees of freedom were corrected using Greenhouse Geisser estimates for these variables. For all other variables, Mauchly's Test indicated the assumption of sphericity had not been violated, so sphericity was assumed.

Post training reaction surveys. On a scale of one to five, the PEs rated the training very highly (M = 4.80, SD = .23) and felt the trainers clearly stated the goals and objectives of the training (M = 4.82, SD = .12), presented the materials at an appropriate level and pace (M = 4.72, SD = .20), and were responsive to questions (M = 4.74, SD = .24). On a scale of one to four, the PEs perceived the lessons learned as applicable to their daily lives (M = 3.86/4.00, SD = .20). The majority of the PEs rated the length of the training sessions as "just right." Sum scores for each training session (based on average ratings for each category across all participants) ranged

from 22.5 to 24 out of 24. The session facilitated by the psychologist was the only session to receive a perfect score (i.e., 24 out of 24).

Observational rating forms. Of the three formal practice teaching sessions expected of each PE, seven PEs completed all three, two PEs completed two, and one PE completed one. Therefore, the field staff completed a total of 26 observational rating forms. Across all 26 forms, the lowest rated performance category (on a scale of one to five) was "effectively managed participants who went off topic" ($M = 2.92$, $SD = .69$). Two categories were tied with the highest ratings: "answered questions and encouraged participants to ask questions" ($M = 3.19$, $SD = .63$) and "asked questions to make sure participants understand" ($M = 3.19$, $SD = .75$). Average performance ratings (i.e., across all seven categories) were calculated for each practice session. The overall performance ratings were highest for the first topic (i.e., covering the content from the session facilitated by the psychologist, $M = 3.23$, $SD = .35$, $N = 10$), followed by the third topic (i.e., covering the content from the session facilitated by the life skills trainer, $M = 2.98$, $SD = .38$, $n = 9$), and lowest for the second topic (i.e., covering the content from the session facilitated by the meditation guru, $M = 2.92$, $SD = .27$, $n = 7$). The field staff reported that each PE covered all bulleted sub-topics during each practice teaching session, indicating that none of the key points were missed during the formal practice teaching sessions.

Attendance records. According to attendance records from the 26 network meetings in which practice teaching took place, it was estimated that the PEs delivered psychosocial health promotion messages to 140 WES. Given the PEs also taught their peers informally at work, it is likely they were able to reach well over this number.

Qualitative Results

 Exit interviews. Nine of the 10 PEs and the two key field staff completed one-on-one exit interviews (the tenth PE was unresponsive to requests to schedule an interview). Their comments fell into four categories: 1) training reactions, 2) teaching experiences, 3) program impact, and 4) suggestions for improvement. Pseudonyms are used to label quotes to protect the anonymity of the PEs.

 Training reactions. Overall, the PEs and the field staff had positive reactions to the training. They felt the duration of the training sessions (3 hours) and the amount of content covered during each session were appropriate, although some PEs suggested increasing the length of the training sessions to allow time for content to be covered in more detail. A majority of the PEs expressed a desire to receive additional training in the future. When asked to comment on their favorite topics, the most often mentioned topics were the roles and qualities of a PE and the importance of self-care. For instance, one participant commented: "I liked the part about making time for myself, taking care of myself and not just others" (Kali, age 40).

 Many PEs reported that busy schedules and time constraints posed difficulties in attending the training. One PE expressed that she did not feel comfortable sharing with others at the beginning of the training and suggested more group activities and discussions to help trainees feel more comfortable with one another. A number of PEs and the two key field staff highlighted role-playing exercises as a particularly effective training strategy. Some also commented that the provision of incentives—namely lunch after each session, transportation reimbursement, and program completion certificates—was an effective strategy for motivating PEs to attend the training sessions. The PEs enjoyed the experience of having artists draw their ideas during the post training debrief sessions.

Teaching experiences. The PEs generally felt positive about and enjoyed their practice teaching experiences, and many expressed a desire to teach more in the future. They reported feeling confident and well prepared to teach as a result of the training. When teaching outside of their network group meetings, some PEs arranged a time and place to meet with their peers ahead of time while others taught impromptu when opportunities arose. They taught one-on-one and in small (three to six) and large (10-20) groups for between 15-30 minutes. In addition to teaching their peers, some reported sharing the lessons learned with friends, family, and neighbors.

The PEs reported a number of challenges associated with the practice teaching. As with the training, time limitations were mentioned as a challenge. Many also pointed to low levels of education and literacy, both their own and that of their peers, as a challenge. Another difficulty noted by one of the field staff was teaching in distracting contexts (e.g., in entertainment sector establishments with owners, clients, and coworkers around).

The PEs described their peers' reactions to the training as generally positive. They reported that peers listened carefully, asked questions, and exhibited curiosity about the customized visual teaching aids. Some peers expressed a desire to attend the training themselves. A couple of the PEs described situations in which their peers expressed a lack of interest in the content or concerns about losing money while attending the lessons. Some PEs reported using persuasive arguments and providing tea as strategies to get their peers to stay and listen.

The PEs also emphasized aspects of the program that helped facilitate their practice teaching experiences, especially the customized visual teaching aids. They emphasized the utility of these aids in helping them remember the training content and in overcoming educational and literacy deficiencies. For example, one PE noted: "My mind does not work that well as I have a

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lot of burden in there. When I look at the picture [teaching aid], I can understand...and I can teach others as well easily" (Shobha, age 40). Some PEs said they carried the teaching aids with them in a binder provided during the training, and one PE reported hanging the drawings on a wall in her workplace in order to spark teaching opportunities. Another PE reported feeling as though her peers would not have taken her as seriously if she had not had the teaching aids. A number of PEs also mentioned the assistance and coaching provided by the field staff as being particularly helpful.

Program impact. The PEs and two key field staff mentioned a number of ways in which they felt the program had a positive impact, both on the PEs as well as the individuals they taught. All of the PEs reported increased knowledge, confidence, curiosity, and desire to learn more. Many also reported increased communication and teaching efficacy. For instance, one PE explained: "Earlier I could not talk in front of people. I used to get very nervous…Now it is all different. I feel very satisfied that I can speak without any hesitation" (Sushan, age 37). A few PEs claimed that the training taught them to be more calm and polite in situations in which they used to get easily angered and upset. This dispositional shift was validated by the two key field staff who reported noticing improved relations with and communication between the PEs and others. For instance, one of the field staff commented: "The way the women talk to their clients and the police has changed significantly…They followed [the trainer's] lesson, how to treat others, how to behave with different people."

A number of PEs also felt their relationships with friends and loved ones had improved, citing examples of their own observations as well as positive feedback they had received from others. Many PEs also reported enhanced self-awareness and self-care behaviors as a result of participating in the program, as well as increased happiness and a more positive outlook on life.

For instance, one PE exclaimed: "I feel very happy. I nowadays feel I can do something for myself in life. Earlier even small things used to bother me. I felt helpless and used to cry. But now I look at problems from a different perspective" (Ashika, age 30). Finally, a number of PEs noticed positive changes in their peers, such as improved communication skills and increased self-care behaviors.

Suggestions. When asked, a majority of the PEs said they did not have any recommendations for how the program could be improved. The most common suggestion was to provide more training on the topics already covered (e.g., teaching strategies, communication, self-care), but a few called for training on additional topics (e.g., future planning). Many PEs thought it would be beneficial if the NGO coordinated regular (e.g., monthly or bimonthly) meetings for the PEs to receive additional training, practice new skills, and share teaching strategies. The PEs and the two key field staff called for additional incentives for PEs, such as extra transportation costs and ID cards as well as a designated space for teaching. The field staff suggested the importance of ensuring PEs have access to other trainings offered by the partner NGO so they could continue using their teaching skills to inform their peers about other topics.

Training reaction forms. When asked what they liked most about the trainings, the trainees often mentioned specific topics covered during the training, particularly the topics covered by the psychologist (e.g., self-care). The role-playing activities and artist sessions were also mentioned. Common suggestions for how the training could be improved included having longer sessions and ensuring all trainees arrived at the training on time.

Observational rating forms. In their open-ended comments, the field staff noted increased teaching competency and leadership qualities among the PEs across time. They commented that some of the PEs experienced difficulties trying to make the subject matter clear

due to their lack of education and literacy skills and frequently mentioned the utility of the visual

teaching aids in helping to overcome these difficulties. The field staff also observed positive

benefits of the practice teaching on the members of the network groups. For instance, they

commented on how the practice teaching sessions gave the members a unique chance to speak up

and put their opinions forward on topics not usually discussed during the biweekly group

meetings.

Discussion

Overall, findings from this pilot study indicate a brief peer education program is both

feasible and a promising means of promoting psychosocial and occupational health and

empowerment among WES. Compared to baseline, the PEs reported a significant increase in the

confidence component of power *within* at the two-month follow-up, and this effect remained

significant at the 10-month follow-up. The PEs also reported a significant increase in happiness

and overall health at the two-month follow-up compared to baseline, and, for the former, this

effect remained significant at the 10-month follow-up. There was a significant increase in

psychosocial health knowledge between the post intervention and the 2-month follow-up;

however, this effect did not remain significant at the 10-month follow-up. These findings are

aligned with previous studies demonstrating that involvement in peer education programs can

empower PEs through enhanced knowledge and self-esteem (Jackson, Bennett, Ryan, &

Sowinski, 2001; Phelps, Mellanby, Crichton, & Tripp, 1994).

The intervention did not have a significant effect on the PEs power *with others*, power

over resources, stress, job control, workplace bullying, or any aspects of peer education efficacy;

however, many of these variables showed positive trends with small to medium effect sizes. The

finding that many of the positive trends in outcomes had diminished by the 10-month follow-up

survey suggests that it may be valuable to provide refresher training to PEs sometime between two and 10 months after the initial training.

During the exit interviews, the PEs expressed positive reactions to the training and pointed to the role-playing exercises and incentives as particularly effective strategies to promote learning and motivation, respectively. These comments were echoed on the post training reaction surveys. The PEs also reported positive feelings about their practice teaching experiences. They felt confident and well-prepared as a result of the training received and highlighted the customized teaching aids and coaching provided by the two key field staff as particularly helpful. In line with the survey findings, nearly all of the PEs reported an enhanced sense of confidence, efficacy, psychosocial health knowledge, and happiness during the exit interviews. Many also reported positive social impacts, including improved communication skills and a positive influence on their relationships with others, as well as increased happiness and a generally more positive outlook on life. A number of PEs reported noticing some of these positive changes in their peers as well. These comments were corroborated during interviews with the two field staff.

Despite the lack of significant survey findings related to peer education efficacy, the field staff reported increased teaching efficacy and ability across time in the observational rating forms. They reported that the PEs were generally better at facilitating discussion and asking and answering questions related to training content, but struggled a bit more when trying to keep the discussion on topic. Future programs should incorporate opportunities for PEs to practice keeping the discussion on topic. For instance, future programs could include a role-playing exercise in which one trainee acts as a PE trying to teach and the others act as peers and purposefully try to derail the conversation.

The success of this program can be attributed to a number of factors, especially the strong collaborative role assumed by the partner NGO and WES. As previously mentioned, active engagement with FSWs and the organizations working with them at all stages of the intervention process has been established as a crucial strategy to adopt when designing interventions for FSWs (Rekart, 2005; Ross et al., 2012). Other factors that likely contributed to the success of the program include the provision of incentives, the use of local trainers to deliver the psychosocial health training content, the built-in opportunities for practice teaching, the customized visual teaching aids, and the coaching and support for PEs provided by the NGO field staff.

Limitations and Future Research

Despite the aforementioned strengths of this pilot study, there are a number of limitations that should be considered when interpreting the findings. Of course, the ability to detect an effect was limited by the very small sample size. Larger trials should be conducted, both to assess effects with adequate statistical power and to determine the feasibility of rolling out this type of program on a larger scale. Furthermore, the generalizability of the findings is restricted given that the participants were part of an existing community empowerment network. Finally, the fact that the process data (i.e., the post training reaction surveys, observational rating forms, and exit interviews) were only collected from those directly involved and invested in the program likely impacted the results. Future research should additionally use more objective raters to collect process data.

There are a number of additional important directions for future research. Future studies should collect more detailed observational data to learn more about effective PE teaching strategies and challenges faced and tailor training programs accordingly. The potential of such programs to enhance psychosocial health and empowerment among other sex worker populations

(e.g., street-based FSWs, FSWs in other countries, male sex workers, FSWs who are not part of a preexisting community empowerment network) should also be examined. Given the disparate needs that different communities of sex workers in different, and even in the same, countries may have, it is likely that a psychosocial health promotion peer education program would have to look quite different in order to be effective for a different population of sex workers (Newman, 2003). However, many of the methodological features of this pilot study, namely the high level of participation of the partner NGO and target population and the use of native trainers, apply across contexts.

Conclusion

Overall, findings suggest that PE methods are a feasible and promising means of enhancing the psychosocial and occupational health and empowerment of FSWs in Kathmandu, Nepal. This study reinforces the value of using mixed-methods design to assess such programming. This pilot study can inform future programs aiming to promote the psychosocial well-being and empowerment of FSWs as well as other vulnerable and hard-to-reach working populations.

Synopsis

Peer education methods have been established as a promising way to reach female sex

workers (FSWs) and other vulnerable and hard-to-reach populations with health promotion

programming. Although there is evidence to support the effectiveness of peer education

programs targeting sex workers, there is scant information about how such programs are

designed and implemented, and program evaluation strategies are often lacking in

methodological rigor. This lack of process information and rigor contributes to poor clarity

regarding how to effectively develop and execute peer education programs and increases the

propensity for repetition among failed strategies. In close collaboration with a non-governmental

organization in Kathmandu, Nepal, a brief peer education program was pilot tested with the goal

of promoting psychosocial health and empowerment among women working in the commercial

sex industry (commonly referred to in Nepal as the entertainment sector). Using this pilot

program as an example, this paper will offer an in-depth vantage point into the black box of peer

education programs by outlining the specific steps taken while designing, implementing, and

evaluating the program. While considering each phase of the project, the challenges encountered

along the way as well as the effective strategies implemented to overcome them are reviewed,

with a focus on offering practical tips and strategies. Conclusions and a summary of

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recommendations for those interested in implementing similar programs are discussed. The process information, challenges, and strategies highlighted can be used to inform future interventions aiming to enhance the health and well-being of sex workers and other vulnerable and hard-to-reach working populations through peer education methods.

Introduction

Peer education is an approach whereby individuals who share similar demographic characteristics and life experiences are trained to convey knowledge, increase awareness, and encourage positive attitude and behavior change among members of the same group (Medley, Kennedy, O'Reilly, & Sweat, 2009). Peer education methods have been used to address a multitude of topics with diverse populations across a variety of contexts (Turner & Shepherd, 1999). The techniques implemented through peer education programs vary widely depending on the characteristics of the target population and context, the resources available, and the intended outcomes of the program.

Peer education programs have been suggested for use with hard-to-reach populations, including female sex workers (FSWs), for a variety of reasons (King, 1994; Turner & Shepherd, 1999). They utilize existing networks and communication structures (Finn, 1981) and have relatively low implementation costs compared to other types of health promotion interventions (Hutton, Wyss, & N'Diékhor, 2003). For a population such as FSWs who may be skeptical or untrusting of outsiders, peers may be perceived as a more credible and relatable source of information (Perry, 1989). Peer educators (PEs) can thus provide an otherwise difficult if not impossible to establish link between researchers and practitioners involved in health promotion and the FSW community (International Labour Organization, n.d.). The theoretical underpinnings of peer education stem from Rogers' (1983) diffusion of innovation theory, which

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asserts that all community populations have popular and well-liked "opinion leaders" who have the ability to create new peer norms by endorsing and modeling behavior standards that spread throughout the population (Ross & Williams, 2002, p. 59). Because of their potential to establish healthier and more positive peer norms, peer education programs may be better able to help individuals develop and sustain behavior change compared to programs targeting individual behavior change in isolation (Ross & Williams, 2002).

Peer education methods may be appropriately labeled as a "black box" because reports often fail to include detailed process information and instead focus only on program effectiveness (Backett-Milburn & Wilson, 2000). This has resulted in an overall lack of information regarding how to effectively design and implement peer education programs targeting FSWs. Medley et al. (2009) conducted a meta-analysis to assess the impact of peer education programs on HIV- and STI-related outcomes in low- and middle-income countries across a wide range of target populations, including youth, sex workers, transport workers, heterosexual adults, prisoners, and minors. Of the 30 studies reviewed, only 14 reported how PEs were recruited and selected, 20 reported information (although often limited) regarding how PEs were trained, 19 reported process information related to supervision of PEs, and eight and 10, respectively, discussed compensation and retention of PEs. Medley et al. (2009) also found a lack of rigorous program evaluation, with a majority of studies implementing cross-sectional or pre or post designs without a control group.

The deficiency of information regarding how to effectively design and implement peer education programs and lack of systematic outcome evaluations may increase the propensity for repetition among failed strategies. The goal of this paper is to outline the process of designing, implementing, and evaluating a pilot peer education intervention to promote psychosocial health

and empowerment among women working in the sex industry in Nepal, with a focus on the

specific steps involved in program design, implementation, and evaluation, and the challenges

faced and effective strategies implemented along the way.

About the Intervention

The commercial sex industry in Nepal is commonly referred to as the entertainment

sector (Frederick, Basynat, & Aguettant, 2010), and participants in the pilot study will from here

out be referred to as women in the entertainment sector (WES). WES work in various

establishments, such as massage parlors, dance bars, and cabin restaurants (i.e., establishments

serving food and drinks in which waitresses accompany customers in private plywood cabins;

Frederick et al., 2010; National Centre for AIDS and STD Control [NCASC], 2011). Although

not all WES actively engage in sex work and face the risk of contracting human

immunodeficiency virus (HIV) and other sexually transmitted infections, all WES are exposed to

poor working conditions, various forms of exploitation, harassment, and abuse, and stigma and

discrimination due to the nature of their work (Frederick et al., 2010). These myriad harms

jeopardize their mental, social, emotional, and spiritual health (i.e., psychosocial health;

(Donatelle, 2009) and agency to protect themselves from the various hazards they face as part of

their work (Chudakov, Ilan, Belmaker, & Cwikel, 2002; Ghimire, Smith, van Teijlingen, Dahal,

& Luitel, 2011).

In close collaboration with a local non-governmental organization (NGO), a brief peer

education intervention was designed, pilot tested, and evaluated for its effectiveness in

promoting the psychosocial health and empowerment of WES in Kathmandu, Nepal. Peer

education programs have proven to be effective in promoting safer sexual practices among FSWs

(Luchters et al., 2008; Medley et al., 2009); however, there have been no published studies to

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date directly aiming to use peer education methods to promote psychosocial health among FSWs in Nepal or elsewhere.

Participants were members of an existing community empowerment network established by the partner NGO in 2010 to promote solidarity and social support among WES in Kathmandu. The network consisted of 20 groups (formed based on geographic location and establishment type) with approximately 16-28 WES in each group. Each group had a cooperative savings account and an elected leadership structure consisting of a Chairperson, Vice Chairperson, Secretary, and Treasurer and met bimonthly to discuss the issues faced by their respective members in meetings facilitated by two field staff from the partner NGO.

Ten women from 10 of the 20 groups were selected and trained as PEs through six, three-hour sessions conducted across seven and a half weeks at the headquarters of the partner NGO. The first three trainings (i.e., Phase 1) focused on basic peer education skills (e.g., communication and teaching strategies), and the second three trainings (i.e., Phase 2) focused on different topics related to psychosocial health (e.g., self-care, spiritual health). Each Phase 2 training consisted of two hours of new training content followed by a one-hour interactive debrief session. The PEs were asked to share the lessons learned after each Phase 2 training with their peers both formally during their biweekly network meetings and informally while at work. The evaluation consisted of two main components: 1) a quasi-experimental impact evaluation comprised of a baseline and post intervention survey to assess psychosocial health and empowerment outcomes among WES who were and were not exposed to the PEs ($N = 193$), and 2) a mixed-methods evaluation to assess the feasibility of the program and its impact on the 10 PEs. The challenges faced and strategies employed during program design, implementation, and evaluation will be outlined.

Challenges and Strategies

Program Design

The three primary challenges encountered at the program design stage were: 1) garnering the full commitment of the partner NGO; 2) designing the program to accommodate low levels of education and literacy; and 3) ensuring congruence of training content with the unique psychosocial health conceptualizations of WES in Kathmandu.

Garner NGO commitment and ownership. In order to ensure their full commitment and buy-in, the approach (i.e., peer education), aims of the program (i.e., to promote psychosocial health and empowerment), and all training and evaluation content and logistics were determined through a highly collaborative process with the partner NGO and members from the target population. The collaborative process was guided by a community-based participatory research (CBPR) approach (Israel, Eng, Schulz, & Parker, 2013). CBPR methods aim to bring together researchers and community members in order to address community-identified needs and build capacity through establishing trust, fostering co-learning, sharing power, and enhancing strengths (Israel et al., 2013). The partner NGO and members of the target population were actively engaged throughout all stages of the intervention process. Two field staff (who are here out referred to as "the two key field staff"), whose primary job was to visit entertainment sector establishments and educate WES about the NGO's programs and services, were the most heavily involved in the project.

Although leadership from the partner NGO expressed immediate interest in developing a peer education program to promote the health, safety, and well-being of WES, they were not clear on which occupational hazards to address through the program. When adopting a CBPR approach, and there is uncertainty or flexibility in the research plan, it is important to first

develop and prioritize research questions based on community needs, concerns, resources, and strengths (Israel et al., 2013). A multi-step process was conducted to determine the focus of the program. First an initial list of the occupational hazards faced by WES in Kathmandu was created through a literature review. Interviews were then conducted with representatives from six other NGOs and two international NGOs (INGOs) targeting WES in Kathmandu to better understand the programs and services provided, challenges faced and effective strategies utilized during program implementation, and perceived gaps in programs and services. Based on this reconnaissance work, eight possible program topics were identified as follows: sexual health; reproductive health; violence and exploitation; trafficking and safe migration; labor relations; laws and rights; psychosocial health; and substance use/abuse. A meeting was convened in which the two key field staff selected five topics they perceived as the most beneficial for WES. The 20 network group Chairpersons were then invited to a meeting (15 of 20 Chairpersons attended) at the partner NGO headquarters in which the two key field staff briefly described the overall goal of the project, reviewed the five possible training topics, and asked the Chairpersons to vote on the topics they would be most interested in learning about. To accommodate low levels of education and literacy, each topic was assigned a color, and the Chairpersons were asked to indicate their top three choices using color-coded stickers using a simple voting form. Next, a meeting was convened with the project advisory board (which included leadership and staff from and other existing external advisors to the partner NGO) to review the training topics and the voting outcomes from the Chairperson meeting. The President of the partner NGO was asked to make the final decision regarding which topic(s) to cover in order to instill her sense of ownership and control over the direction of the project. She made the final decision to focus the entire training on psychosocial health.

The two key field staff were asked to select a name for the program to further build their sense of ownership. They chose *Haamro Raksha,* which translates to "our protection." Throughout the entire design stage, the author continuously emphasized to the staff and leadership from the partner NGO that their extensive knowledge of and expertise working with the target population was invaluable to the success of the project. Probing questions were often used to solicit their input (e.g., *Are you sure that is the best way to do this? Is there a downside to doing things this way versus that way?)* and encourage them to have an influential role over the direction and details of the program.

Design for low education and literacy. A number of steps were taken to ensure the program was designed to accommodate low levels of education and literacy. The training was designed to be highly interactive (e.g., including a lot of discussions, pictures, role-playing activities, games). A majority of the Phase 1 training content and activities were designed based on training manuals from previous peer education programs, primarily those targeting HIV prevention among FSWs (e.g., (Corridors of Hope, 2005; Family Health International, 2006). All training materials were reviewed with NGO staff, a female Nepali research assistant, a psychologist who provided pro-bono trauma counseling for WES through the partner NGO, and two Nepali women with experience developing train-the-trainer programs related to preventing sex trafficking in Nepal to ensure the materials covered all important content and were at the appropriate level.

Ensure cultural congruence with conceptualization of psychosocial health. Considerable effort was also invested into ensuring congruence of the program with the unique psychosocial health conceptualizations of WES in Nepal. A focus group was conducted with five WES recruited by the President of the partner NGO, during which they were asked to: define

what psychosocial health means to them and why they perceive it as important; describe some of

the common factors that influence the psychosocial health of WES in Kathmandu; brainstorm

strategies they have found helpful in dealing with psychosocial health problems; and suggest

psychosocial health topics about which they would be interested in receiving training.

Additionally, three native Nepalis with expertise in psychosocial health—the previously

mentioned psychologist who provided pro-bono counseling for WES via the partner NGO, a life

skills trainer[11] from another Kathmandu-based NGO working with WES, and a meditation

guru—were recruited to help deliver the Phase 2 trainings. The former two trainers had previous

experience training WES in Nepal, and a pilot training was conducted with the third trainer with

staff from the partner NGO to ensure appropriateness of training content and methods. Finally,

given the focus group participants' prioritization of their children as well as the meta-analysis

findings of Karr, Pascual, and Chickering (1999) that women in empowerment programs are

often motivated by a "deep commitment to protect and promote the wellbeing of their children

and families" (p. 1452), the potential of the training to help them excel in their role as mothers

was continuously emphasized.

Two female artists were recruited from an online Kathmandu expatriate community

listserv to attend the hour-long Phase 2 debrief sessions and create customized visual teaching

aids to assist the PEs in their practice teaching. As the trainees discussed lessons learned during

each debrief session, one of the artists sketched visual representations on a piece of chart paper

posted on the wall, allowing the trainees to view, react to, and interpret the drawings in an

interactive fashion. The other artist simultaneously copied the final drawings on an electronic

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[11] This trainer typically provides a 36-hour training that her NGO refers to as a "life skills" training. This training covers a variety of topics to help WES foster the personal and relational knowledge and skills to be happy and successful in life, such as communication skills, positive thinking, and self-awareness.

drawing tablet. A copy of the drawing was then printed and distributed to each PE (see Figure 5.1 for an example). The process of creating the aids during the debrief sessions served as a powerful way to review and solidify the lessons learned during the training, and the aids themselves helped the PEs to remember training content and garner the interest and attention of their peers. This novel process was pilot tested in advance of the training with the two artists and a number of staff members from the partner NGO to elucidate the best way to plan the logistics of these interactive debrief sessions.

Implementation

Challenges faced at the implementation stage of the project included: promoting research competence and engagement among the staff from the partner NGO; educating the staff from the partner NGO about psychosocial health; eliciting the interest of WES in the program; recruiting committed WES to be trained as PEs; overcoming translation and cultural issues during Phase 1 of the training; and promoting teaching efficacy among the PEs. Effective strategies employed to overcome these challenges are reviewed below.

Promote research competence and engagement and among NGO staff. The staff from the partner NGO had minimal previous research experience (i.e., prior to this project they had only administered basic surveys) and therefore had little understanding of how (and why it was necessary) to conduct a methodologically rigorous study. In order to overcome this challenge, a half-day orientation meeting was held with all staff and leadership prior to the start of the program to ensure a common understanding of the aims and steps of the program and their respective roles throughout the implementation process. The meeting was conducted in Nepali, co-facilitated by the author and previously mentioned psychologist, and took place off-site at the Nepal Fulbright program offices to avoid the distractions of the day-to-day demands at the NGO

headquarters. During this meeting, the author reviewed the program goals and steps in detail, and the NGO staff were encouraged to ask questions and offer suggestions for how to improve the implementation plan. The NGO staff provided a number of useful insights, including valuable information regarding the scheduling of program activities in order to maximize trainee participation. This orientation meeting not only ensured that all NGO staff understood the project and what their roles would be in it, but it also served to make them feel as though they were valued and influential members of the team, thus increasing their ownership of and commitment to the project.

The evaluation of the program, namely the administration of surveys to nearly 200 WES before and after the intervention, was the most time demanding aspect of the project for the two key field staff. In order their to gain their buy-in, the evaluation was framed in terms of how it would be beneficial for the NGO (i.e., it could help them to better understand the women from their target group, apply for more funding, and identify ways to enhance the program in the future). Additionally, a number of steps were taken to train the field staff in survey administration. A protocol was created in Nepali detailing the steps involved in and materials needed for survey administration (e.g., consent forms, surveys, writing instruments, compensation). After reviewing and discussing the survey administration protocol, the field staff were asked to practice giving the survey to one another to confirm understanding and ensure proper implementation. They were each given a laminated copy of the protocol to serve as a reference, as well as a clipboard to provide a convenient writing surface during administration.

Foster psychosocial health understanding among NGO staff. In the initial program planning meetings, it became clear that the staff and leadership from the partner NGO had limited understanding of what psychosocial health is and how it influences WES. Without

comprehension of the underlying importance of the program, it is likely the staff would not be very invested in the implementation process. Therefore, the psychologist who co-facilitated the orientation meeting provided an interactive training on psychosocial health, covering what it is, why it is important, and how it affects WES. In this way, the staff orientation meeting also served as a way to help NGO staff understand the rationale for program.

Elicit interest in the program. WES in Kathmandu face frequent requests to participate in an array of other programs offered by the partner NGO and other NGOs targeting WES in Kathmandu, so eliciting interest in the program was another challenge. Numerous strategies were implemented to elicit interest in the program. The two key field staff put considerable effort into announcing the training opportunity to women from all 20 network groups during the biweekly network group meetings and their regular establishment visits. The program was also advertised by the author on a local radio program targeting WES in Nepal, and a logo of the program (that complemented the partner NGO's logo) was designed[12] and used on all recruitment materials to give the program a professional and official appearance. Although the limited spaces (i.e., only 10 women would be selected to be trained as PEs) and competitive application process were instrumental in eliciting interest in the program, the incentives offered to trainees, including transportation money, lunch after each training, and completion certificates, were likely the most influential strategy to elicit interest in the program.

Recruit committed WES to be trained as PEs. Past peer education interventions with FSWs have reported PE drop out rates as high as 50% within the first four months (Walden, Mwangulube, & Makhumula-Nkhoma, 1999), so recruiting PEs who would be committed to carrying out all components of the program (e.g., attend trainings, conduct practice teaching,

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[12] A graphic designer generously offered to design the logo pro-bono.

complete evaluation activities) was another difficulty. WES were encouraged to attend an information session at the office of the partner NGO if they were interested in learning more about the program. During the information session, program expectations, eligibility requirements (i.e., network member, 18 years or older), and incentives were clearly outlined. Attendance at this session served as a way to eliminate potential candidates who may have expressed an interest in the training but, in reality, were not able to take the time to attend a meeting to get more information. Women who were confident they could accomplish all program activities were encouraged to complete an application (administered verbally in Nepali by NGO staff), which was designed to assess motivations, background experiences, and other characteristics (e.g., conscientiousness, extraversion, communication efficacy) that would influence their ability to excel as a PE (Barrick & Mount, 2005; Vuylsteke & Jana, 2001). Two different groups of 10 recruits from 10 of the 20 network groups were selected to be final candidates. One group was selected by the two key field staff based on who they felt would be most successful in the role of PE, and the author selected the other group based on application scores. The author and field staff then met to compare lists and select candidates. When discrepancies arose, the field staff were allowed to make the final selection decisions in order to leverage their intimate knowledge of the candidates. When asked to explain their rationale for why lower scoring candidates should be selected over higher scoring candidates, the most common response was that the WES who scored higher on the screening survey had busy schedules, family obligations, or other issues that would prevent them from being able to fully commit to the program.

Overcome translation and cultural issues during training. Because educational norms in Nepal (as well as many other Asian countries) often deem students as passive recipients of

knowledge (Richmond, 2007), extra efforts were required to encourage active participation. One strategy used to facilitate equal participation was to design activities and discussions in a way that required a contribution from every participant. For example, for one of the icebreaker activities, each participant was asked to select a picture of an animal they felt embodied some of their unique characteristics and then describe the rationale for their selection (i.e., the shared qualities they perceived between themselves and the animal). This not only ensured that all participants had a chance to speak, but also served as a way to combat overly vociferous participants who would have otherwise dominated the conversation. Additionally, given their familiarity with and ability to frame concepts in a way that can be understood by the target population, the two key field staff were asked to attend all training sessions and help lead and facilitate discussion for some of the activities. Giving the staff a key role in the implementation of the training made them feel as though they were valued members of the team and was also beneficial in terms of building internal capacity. A Nepali research assistant/translator was also asked to write notes in Nepali for many of the activities on a chart paper posted on the wall as a way to reinforce key points and make the trainees feel as though their contributions were valued and important.

Promote PE teaching efficacy. In an effort to help the PEs develop teaching efficacy, the training was designed to promote training transfer (i.e., the extent to which the knowledge and skills learned in training get transferred to life outside of training; Grossman & Salas, 2011). To this aim, the training included positive and negative examples of trained skills through behavioral modeling, error management activities, opportunities to practice the lessons learned, and performance feedback (Grossman & Salas, 2011). For instance, Phase 1 included role-playing activities to practice the teaching and communication skills learned. This practice also

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helped to ensure that the two key field staff, who would be observing and rating the PEs during their practice teaching sessions, understood what was expected. The final Phase 1 training session also included a discussion in which the PEs anticipated the challenges they may face during their practice teaching and brainstormed possible strategies to overcome them. Additionally, the two key field staff were encouraged to provide support and coaching to the PEs during their practicing teaching.

Evaluation

Evaluation challenges were primarily related to developing and administering the surveys and ensuring accuracy of the data collected. Challenges faced during survey development included the lack of previously validated scales in Nepal for the constructs of interest; the content and length restrictions placed on the survey by the partner NGO; and the difficulty in ensuring accurate translation from English to Nepali. Challenges related to survey administration included the low levels of education and literacy and high mobility of WES as well as the distracting nature of their workplaces (in which a majority of the surveys were administered). The accuracy of the data collected was also compromised due to the busy schedules and self-preservation biases of the WES and the limited previous research experience of the NGO staff. A number of strategies were implemented in order to develop, translate, and administer the surveys and to ensure collection of accurate data.

Develop and translate surveys. Because there were no scales for the constructs of interest that had been previously validated with WES in Nepal, scales that had been validated with similar populations (e.g., an empowerment scale validated with FSWs in India, Blanchard et al., 2013) and scales that had been validated with diverse, cross-cultural samples (e.g., a single-item measure to assess overall health, DeSalvo et al., 2006) were utilized to the extent possible.

Given that only 69% of the participants were literate and just 5% had completed education beyond the 10th grade (Chapter 3), it was necessary to use modified versions of these preexisting scales in order to maintain an appropriate reading level. A medical anthropologist with extensive experience conducting research on mental health in Nepal was consulted, and revisions to the survey were made based on his advice (e.g., an item he had written specific to Nepali conceptualizations of psychosocial health was added to the survey; B. Kohrt, personal communication, December 9, 2013).

In an effort to overcome the survey content restrictions imposed by the partner NGO, the staff were allowed to re-word questions in a way they were comfortable with as long as conceptual equivalence was maintained. For instance, they did not want to refer to the women as sex workers or even as WES, as they did not want to make participants feel uncomfortable or stigmatized. A number of questions were also eliminated based on NGO staff suggestions (e.g., they voiced a preference to not ask questions about sex work activity or HIV status again out of fear that such questions would make participants feel uncomfortable). Through adoption of a door-in-the-face technique (Cialdini et al., 1975), the version of the survey that was used for the pilot test was intentionally lengthy (~100 questions), so the NGO staff would perceive a medium length survey (~60 questions) as reasonable in comparison (i.e., if a 60-item survey had been pilot tested, the staff may have advocated for a 40-item survey instead). The survey was shortened and edited based on the pilot test feedback. For instance, the two key field staff and many of the pilot test participants perceived some of the survey items as redundant. In trying to reduce redundancy and shorten the length of the survey, items with simple language were given preference while attempting to maintain enough items to capture the breadth of each construct.

To ensure accurate translation from English to Nepali, the survey was translated and back translated numerous times. Throughout the translation process, a decentering approach was adopted in which both the English and Nepali versions of the survey remained subject to revisions until appropriate grammatical structures and conceptual clarity were achieved (Brunette, 2004). Decentering has been suggested as a superior approach to simple back-translation when conceptual equivalence is the primary goal (Behling & Law, 2000; Werner & Campbell, 1970) as decentering deems both languages as equally important, whereas back translation places more importance on the original language as the standard for comparison (Moure-Eraso & Friedman-Jimenez, 2005). Additionally, multiple informants with diverse backgrounds (e.g., NGO staff, a female Nepali research assistant, a Nepali language instructor) were asked to review the survey and provide feedback. Finally, cognitive interviewing was conducted with a bilingual staff member from the partner NGO to ensure the survey items were being interpreted in Nepali in the intended way. Cognitive interviewing is a technique commonly used to identify potential sources of response error by asking the respondent to provide a detailed description of their thought processes when considering how to respond to survey questions (Fujishiro et al., 2010). Translation issues were also identified through the pilot.

Administer surveys. There were also many challenges related to survey administration. During the pilot test of the survey with 12 WES, the field staff attempted to administer the surveys in a group format (i.e., in which one of the field staff read the survey items and response options and the participants selected their own responses). However, it was clear that some of the participants were copying responses from other participants (perhaps those with lower literacy were copying from those with higher literacy). In order to prevent this, all surveys were administered one-on-one in Nepali and filled out by one of the field staff. The field staff reported

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challenges in delivering the surveys due to the distracting nature of the workplace environments. For example, there were often other people (e.g., clients, establishment owners, coworkers) in the room as well as instances when participants were required to go into another room with a client mid-survey (upon which the survey administrator waited, and the participant finished completing the survey after concluding her interaction with the client). The field staff also reported experiencing a great deal of hardship while attempting to track down the participants post intervention due to the high levels of mobility among WES. Dropout rates at follow-up as high as 70% have been reported in previous peer education studies with FSWs (e.g., Sarafian, 2012). With regards to the distracting nature of the entertainment sector establishments and the high mobility of the participants, there was little that could be done. The uncharacteristically high response rate achieved at post intervention (97.9%) was solely the result of the undying commitment and extraordinary efforts of the two key field staff.

Collect accurate data. To encourage WES to participate in the evaluation, they were compensated with 100 Nepali rupees (approximately $1 US) for each survey completed. The two key field staff advised that, due to their busy schedules and other priorities, WES may be inclined to rush through responding to survey items without fully contemplating their feelings and experiences. They may also be motivated to be dishonest out of concerns regarding privacy and confidentiality given the stigmatized nature of their work (Shaver, 2005). To overcome these tendencies that would compromise the accuracy of the data collected, the importance of providing honest answers was emphasized to participants in the survey instructions and repeatedly stressed to the field staff who were administering the surveys. Confidentiality was guaranteed by assigning each participant an ID number that was recorded on their survey instead of their name. Participants were assured that the list of names connected with ID numbers would

be securely stored separately from the surveys in order to instill a sense of security in providing honest answers. Due to the high mobility of WES (i.e., they often go to different workplaces based on where they can best earn money, M. Thapa, personal communication, October 1, 2013), there was concern of cross-contamination between experimental and control participants (e.g., a control participant being exposed to a PE). In order to control for this possibility, the post intervention survey assessed for exposure to the PEs. Based on this data, 26 cases (i.e., four experimental participants who reported no exposure to the PEs and 22 control participants who reported exposure to the PEs) were dropped.

Data accuracy was also compromised by the minimal previous research experience of the NGO staff. For instance, some responses, especially at baseline, were not properly recorded. One strategy that helped to circumvent this problem was to collect multiple data sources (surveys, exit interviews, observational rating forms, post training reactions) to allow for triangulation. Unfortunately, the missing data and incorrect responses collected at baseline were not identified until after the baseline surveys had been administered. These issues were remedied for the post intervention survey by clarifying the administration protocol with the field staff. In retrospect, the initial baseline surveys (e.g., the first 10 or 20) should have been reviewed to ensure proper completion and avoid recording mistakes across the remainder of the baseline surveys.

Discussion and Overall Recommendations

Despite the aforementioned challenges, as well as the myriad other challenges inherent in conducting applied research in Nepal (e.g., rolling blackouts, unreliable transportation infrastructure, limited resources), the program was found to have a positive impact on numerous aspects of psychosocial health and empowerment among the WES who were exposed to the PEs (Chapter 3) as well as the 10 WES who were trained as PEs (Chapter 4).

The process outlined has numerous implications for future peer education programs, including those working with FSWs and other vulnerable and hard-to-reach populations in Nepal and other low-income countries. Although the optimal methods are likely to vary considerably depending on the context and intended outcomes of the program (Turner & Shepherd, 1999), many of the lessons learned in the present study can be translated to other circumstances. In addition to the effective strategies outlined during program design, implementation, and evaluation, overall recommendations include:

- **Building trust and rapport.** The importance of building trust and rapport with the partner organization and target population cannot be understated. The author demonstrated commitment to the partner NGO by attending other formal and informal events outside of the scope of the project and by assisting with other projects and day-to-day activities. The author also put substantial effort into engaging in communication with the partner NGO and study participants in the local language (with a great deal of help from a Nepali language instructor and other Nepali colleagues and friends). For instance, at the beginning of the information session, first training session, and closing ceremony, the author drafted and read out loud a brief introduction in Nepali.

- **Relinquish control.** Allowing the partner organization to influence the direction and execution of the project is important for a variety of reasons: their commitment is necessary for successful execution of the project; they know the target group better than anyone else and understand what strategies will and will not work; and the resulting project will be more aligned with their needs and vision.

- **Tailor to the target population.** Considerable efforts were made to tailor the program to meet the specific needs of WES in Nepal. The focus of the program was selected based

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on community-voiced needs. The content and logistics of the program were customized based on background research about WES, the focus group related to psychosocial health, and a diverse group of key informants with varied expertise regarding WES, psychosocial health, and effective training and research strategies in Nepal.

- **Be resourceful.** Another key strategy lies in being resourceful. The success of the program would not have been possible without garnering the support of the key informants, local trainers, artists, Nepali research assistants, and other advisors.

- **Pilot test as much as possible.** The value of pilot testing the program plan and evaluation materials is also critical. Numerous lessons were learned through the pilot test of the survey as well as other aspects of the project (e.g., the trainer who did not have experience working with WES, the debrief session with the artists).

- **Limit demands and maximize fun.** A somewhat unexpected lesson learned was related to the importance of limiting demands and maximizing fun while working with both the partner NGO and the program participants. The psychologist who served as a key informant to the project helped to design and facilitate enjoyable teambuilding activities that were incorporated into the information session, staff orientation meeting, and training. As time passed, it became clear that the more fun we had together, the more both parties wanted to continue and expand their involvement in the program. In a similar vein, it was also important to focus on the positive and avoid the negative throughout the duration of the program (e.g., by designing the training to be fun, minimizing negative questions in the surveys, giving lots of positive feedback to the PEs and NGO staff). FSWs in Nepal and the organizations that serve them have difficult lives and rarely get

opportunities to consider their strengths, be in supportive contexts, and get positive

feedback.

Conclusion

Peer education methods have gained recognition as an increasingly popular way to

promote the health of sex workers and other vulnerable and hard-to-reach populations (Turner &

Shepherd, 1999). Overall, this study reinforces the value of using community-based participatory

research and mixed-methods when piloting new peer education programs. As future programs

are developed, researchers are encouraged to detail and share their methodologies, as well as the

challenges faced and effective strategies implemented in an effort to further uncover the black

box of peer education.

CHAPTER 6: DISCUSSION

This pilot study marks the first attempt to use the methods of peer education to promote the psychosocial health and empowerment of WES in Nepal. In collaboration with a Kathmandu-based NGO, 10 WES from an existing community empowerment network were trained as PEs and asked to teach their peers about different topics related to psychosocial health. By teaching their peers both formally during their biweekly network group meetings and informally while at work, it is estimated that the PEs reached well over 140 WES with psychosocial health promotion messages. The impact of the program on psychosocial and occupational health and empowerment was assessed through a quasi-experimental pre and post intervention evaluation with 193 WES, including women who were and were not exposed to the PEs. The impact of the program on the PEs was assessed through a mixed-methods evaluation. The PEs completed the same survey that was administered to the impact evaluation participants (with the addition of peer education efficacy questions) at four time points (baseline, post intervention, two-months post intervention, and 10-months post intervention), and participated in one-on-one exit interviews conducted post intervention. Exit interviews were also conducted with the two key field staff from the partner NGO. Reactions to the six training sessions and the performance of the PEs during their formal practice teaching sessions were also assessed.

Overall, this pilot program revealed that peer education is a feasible and promising approach to improving psychosocial and occupational health and empowerment outcomes among WES in Nepal. With regards to the impact of the program, WES who were exposed to the psychosocial health promotion messages of the PEs reported significantly higher scores on the efficacy component of power *within*, power *over resources*, psychosocial health knowledge,

happiness, and job control post intervention compared to participants who were not exposed to the PEs. Exposure to the PEs did not have a significant effect on the confidence component of power *within*, power *with*, health, shame, stress, burnout, or the physical dimension of workplace bullying. These findings are partially incongruent with the finding that participation in the community empowerment program evaluated by Blanchard et al. (2013) was associated with significant increases in power *within* and power *with others*, but not power *over resources*. This is likely due, in part, to the discrepancies in the measures used to assess these two constructs across the two studies as well as the substantial differences in the nature of the two programs (e.g., duration, context, program type).

Contrary to the hypothesis, WES who were exposed to the PEs reported significantly higher scores on the personal dimension of workplace bullying post intervention compared to control participants. This finding may be due in part to increased awareness of the bullying they experienced resulting from a general heightened awareness of their psychosocial health status as opposed to an actual increase in experienced bullying. It is also possible that increased self-efficacy and perceptions of control led to an increase in confrontational behaviors that could result in more perceived bullying.

In terms of the impact of the program on the 10 WES trained as PEs, the PEs reported a significant increase in the confidence component of power *within* at the two-month follow-up compared to baseline, and this effect remained significant at the 10-month follow-up. These findings are aligned with previous studies demonstrating that involvement in peer education programs can have beneficial effects on the PEs (Jackson et al., 2001; Phelps et al., 1994). The PEs also reported a significant increase in happiness and overall health at the two-month follow-up compared to baseline, and the effect on happiness remained significant at the 10-month

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follow-up. The intervention did not have a significant effect on the PEs' scores on power *with others*, power *over resources*, psychosocial health knowledge, burnout, stress, shame, job control, workplace bullying, or peer education efficacy. However, many of these variables showed positive trends with small to medium effect sizes. The finding that many of the improvements in outcomes had diminished by the 10-month follow-up survey suggests that it may be valuable to provide refresher training to PEs sometime between two and 10 months after the initial training. Although resources did not allow for evaluation, I was able to arrange for follow-up training for the 10 PEs as well as PE training for 10 WES from the control groups in February-April of 2015 through a colleague who was living in Nepal.

During the exit interviews, the PEs expressed positive reactions to the training and pointed to role-playing exercises and incentives as particularly effective strategies to promote learning and motivation respectively. These comments were echoed on the post training reaction surveys. The PEs also reported positive feelings about their practice teaching experiences; they felt confident and well prepared as a result of the training and highlighted the customized teaching aids and coaching provided by the NGO field staff as particularly helpful. In line with the survey findings, nearly all of the PEs reported an enhanced sense of confidence, efficacy, psychosocial health knowledge, and happiness as beneficial impacts of participating in the program during the exit interviews. Many also reported positive social impacts, including improved communication skills and positive influences on their relationships with others, as well as having a generally more positive outlook on life. A number of PEs had noticed some of these positive changes in their peers as well, namely improved communication and relational skills and increased self-care attitudes and behaviors. These comments were corroborated during the exit interviews with the two key field staff from the partner NGO.

Despite the lack of significant survey findings related to peer education efficacy, the two key field staff reported increased teaching efficacy and ability in the observational rating forms as well as during the exit interviews. The field staff perceived the PEs as generally better at facilitating discussion and asking and answering questions related to training content, but reported they struggled a bit more when trying to keep the discussion on topic. Future programs should incorporate opportunities for PEs to practice keeping the discussion on topic. For instance, future programs could include a role-play exercise in which one trainee acts as a PE trying to teach, and the others act as peers and purposefully try to derail the conversation.

Given that no published studies worldwide have attempted to improve the psychosocial health of FSWs through peer education methods, we were unsure if WES would completely reject or generally show a lack of interest in the program. To the contrary, the program had low rates of attrition compared to other programs targeting FSWs (Medley et al., 2009), and the PEs reported that their peers were generally interested in and engaged with the training content during their practice teaching sessions.

Strengths

The success of this program can be attributed to a number of factors, especially the strong participatory role assumed by the partner NGO and WES. As previously mentioned, active engagement with FSWs and the organizations working with them at all stages of the intervention process is a crucial strategy to adopt when designing interventions for FSWs (Rekart, 2005; Ross et al., 2012). The leadership and staff of the partner NGO were granted a great deal of decision making power with regards to all aspects of the program, from selecting psychosocial health as the focus of the program and the WES to be trained as PEs, to coordinating the logistics of the program, determining the content of the surveys, and assuming a lead role in program

implementation. The incredible efforts of the two key field staff to ensure that all PEs attended the training sessions and conducted their practice teaching during the network group meetings, as well as their commitment to ensure that all participants who took the survey at baseline also took the survey post intervention, contributed significantly to the low attrition. Members of the target population were also engaged throughout the process through the voting session, focus group, pilot of the survey, and their role as PEs. This high level of participation made the staff of the partner NGO and members of the target group feel as though their needs and desires were being taken into account and was essential in garnering their interest in and commitment to the program. The important role of trust and relationship building—in terms of trust between the partner NGO and the WES as well as between myself and the partner NGO/WES—in facilitating this high level of participation cannot be understated. The necessity of developing trust and building strong relationships has also been mentioned as a key factor that contributed to the success of the Sonagachi Project in India (Newman, 2003).

There are also a number of design factors that likely contributed to the success of the program, including the use of Nepali experts to deliver culturally congruent training related to psychosocial health, the built in opportunities for practice teaching, and the coaching and support for the PEs provided by the two key field staff. The customized visual teaching aids also contributed to the success of the program. The process of creating the aids during the debrief sessions served as a powerful way to review and solidify the lessons learned during the training, and the aids themselves helped the PEs remember the training content and garner the interest and attention of their peers. Finally, the provision of incentives, especially the program completion certifications, was another factor that facilitated success. The previously mentioned review of PE programs across various populations, including sex workers, conducted by Medley et al. (2009)

found programs that provided even small incentives showed positive effects on condom use. The closing ceremony, in which completion of the program was formally recognized and celebrated, likely helped the PEs feel valued and proud of their accomplishment. Newman (2003) emphasized celebration as an important, yet often overlooked, tool to foster positive reinforcement in the context of empowerment programs for FSWs.

Limitations

Despite the aforementioned strengths, there are a number of limitations that should be considered when interpreting the findings of this pilot study. Of course, the ability to detect an effect was limited by the small sample size after deleting over 30 participants, resulting in a final sample with an unequal number of participants in the experimental and control groups. It is possible that additional significant effects would have been observed if an adequate sample size in both treatment groups had been maintained. The generalizability of the findings is restricted given that the participants were part of an existing community empowerment network. It is possible that program acceptance and attrition rates would look different if conducted with WES who were not already so heavily engaged in such a network. Furthermore, as previously mentioned the women selected to be trained as PEs (which dictated which groups were in the experimental condition) were all from network groups that were clustered inside of Kathmandu proper in close proximity to Thamel and the headquarters of the partner NGO. The groups located outside of Kathmandu proper and further away from the headquarters of the partner NGO did not have PEs and were therefore designated as control groups. This may have influenced the findings as perhaps members of groups located closer in proximity to the NGO headquarters have more interaction with and involvement in the programs of the partner NGO (and other Kathmandu-based NGOs with programs targeting WES) compared to members of groups that

are located outside of Kathmandu proper. There were also differences in the workplace types between the treatment groups, with greater representation of massage parlor groups in the experimental condition and greater representation of cabin restaurant groups in the control condition.

A limitation of the customized teaching aids is that they were created by non-Nepali (i.e., Canadian and Israeli) artists. Given the variation in how pictorial images are interpreted by people of different cultures (Deregowski, 1972), it is likely that Nepali artists would have been more capable of creating culturally congruent drawings to represent the key lessons from the trainings. To ensure the cultural relevance of customized teaching aids, future programs should aim to recruit native artists.

There are also limitations related to program evaluation. Due to restrictions enforced by the partner NGO, the survey was brief and did not measure sex work activity. As a result, many constructs were assessed with just a few items or, in some cases, just a single-item, and the extent to which participants engaged in sex work is unknown . Although engagement in sex work is not directly related to the outcomes in this pilot study, our lack of information regarding sex work activity limits our ability to generalize the methods and findings to other sex worker populations. Furthermore, given the scant psychological research conducted in Nepal, particularly with WES, there were no measures that had been previously validated with the target population related to the constructs of interest. Future research is needed to validate measures to assess psychosocial and occupational health and empowerment among FSWs in Nepal and elsewhere.

Additionally, the fact that data were only collected at baseline and post intervention renders the longer-term effects of the program unknown. However, many interventions targeting

FSWs only survey at one time point, do not include a control group, and/or have high attrition rates (Shahmanesh, Patel, Mabey, & Cowan, 2008), so this study is certainly a step in the right direction in terms of methodological rigor and retention. Finally, the fact that the process data (i.e., the post training reaction surveys, observational rating forms, and exit interviews) were only collected from those directly involved and invested in the program likely impacted the results. If more objective raters (e.g., peers who were taught by the PEs, other external observers) had been involved in the process evaluation, additional insights may have surfaced. Objective observers could help to assess the fidelity of the messages delivered by the peer educators.

It is also possible that participants reported better psychosocial and occupational health and empowerment due to self-preservation bias and the stigma surrounding poor mental health. The underreporting of depression due to denial or stigma has been well documented (e.g., Kessler, 2005). Also, because the surveys were administered one-on-one, verbally by the NGO field staff, the participants may have even more likely to respond in a socially desirable way (Hochstim, 1967) and to agree or acquiesce when responding to questions on the survey than disagree (Javeline, 1999). Others have suggested that in many cultures, it may be perceived as easier to agree than to disagree, especially when interacting with another individual (Javeline, 1999).

Future Research

There are a number of important directions for future research. First and foremost, these results provide support for conducting a larger scale trial of the program. Luchters et al. (2008) stressed the importance of achieving high coverage with peer education programs in order to reduce overall risk and vulnerability. Although a randomized controlled trial (RCT) is likely not feasible or ethical (i.e., considering this pilot demonstrated primarily positive intervention

effects), a wait-list control or stepped-wedge design (Brown & Lilford, 2006) may be suitable alternatives. A factorial design in which different aspects of the program are examined individually as well as in combination may help to identity the most active or influential components of the intervention. Time and resource limitations only allowed for baseline and post intervention outcome assessment in the present study; however, future programs should assess change at multiple occasions post intervention. It is also likely that greater effects would be observed with an intervention that is longer in duration. Forsman, Nordmyr, and Wahlbeck (2011) reviewed the effectiveness of psychosocial health interventions targeting older adults and found more positive effects associated with interventions lasting for three or more months compared to shorter interventions.

It is also important to examine the potential of pairing a psychosocial health promotion intervention with other types of health promotion interventions targeting FSWs, such as HIV and violence prevention programs, to enhance the effectiveness of such programs. Given the growing global investment in new HIV prevention initiatives targeting FSWs (UNAIDS, 2015), there may be a window of opportunity to integrate psychosocial health approaches into new programming (Cournos et al., 2005). There is a particular need to further explore the relationship between psychosocial health and experiences of violence among FSWs. Bagley and Young (1987) compared former Canadian FSWs who had experienced sexual abuse in childhood with women from the general population who had also experienced sexual abuse in childhood. They found severity of sexual abuse before the age of 16 to be a stronger predictor of poor mental health than being involved in sex work. Similarly, Farley (2003) noted the significant role of lifetime physical and sexual violence in predicting the severity of PTSD symptoms, and Rössler et al. (2010) found one-year prevalence rates of mental disorders to be associated with experiences of

violence and rape. Violence clearly plays a large role in influencing the psychosocial health of sex workers, suggesting the importance of pilot testing combined psychosocial health promotion and violence prevention programs.

The feasibility and impact of peer education to promote psychosocial health and empowerment of FSWs should also be examined in other contexts (e.g., rural areas of Nepal, in other countries) and with other sex worker populations (e.g., street-based FSWs, male and transgender sex workers). Given that street-based or other public place-based sex work is the most widespread type of sex work globally, programs are especially needed to target this group (Harcourt & Donovan, 2005). Future research should also focus on younger populations of WES in Nepal; it is estimated that between 16-33% of females in the industry are under the age of 18 (National Human Rights Commission, 2004; Shakti Samuha, 2008). Given the disparate needs that different communities of sex workers in different, and even in the same, countries may have, it is likely that a psychosocial health promotion peer education program would have to look quite different in order to be effective for a different population of sex workers (Newman, 2003). However, many of the methodological features of this pilot study, namely the high level of participation of the partner NGO and target population and the use of native trainers, apply across contexts. The creation of the customized visual teaching aids through interactive debrief sessions seems to be a particularly beneficial element that should be adopted by future programs, especially when the target population is characterized by low levels of education and literacy.

In addition to extending the length of the program, there are a number of additional ways in which future programs could enhance the PE training program and practice teaching experiences. For instance, there are other topics related to psychosocial health and empowerment that may be beneficial to cover, such as healthy relationships, stress management, mindfulness,

positive thinking, substance use/abuse, and mental health first aid. The effectiveness of PEs may also be enhanced by including training related to development of "critical consciousness" (Campbell & MacPhail, 2002, p. 331). The famed Brazilian educator and theorist, Paulo Freire (1970, 1973), asserted that empowerment related to positive health behavior change requires the development of a critical consciousness. Critical consciousness consists of two key components. The first is the intellectual understanding of how one's social conditions have contributed to situations of disadvantage (Campbell & MacPhail, 2002). The second is the development confidence and agency to safeguard one's health through actively challenging or resisting the adverse social forces at play (Campbell & MacPhail, 2002). If trained in the elements of critical consciousness, PEs may be able to help their peers foster identities that are less damaging to their health, thus empowering them to engage in more health enhancing behaviors (Campbell & MacPhail, 2002).

In addition to helping PEs develop a critical consciousness, future research should place more emphasis on training PEs in the provision of social support. Sarafian (2012) evaluated the presence of and outcomes related to different types of social support in a peer education program targeting hotel-based sex workers in Dhaka, Bangladesh. Exposure to PEs high in informational support (i.e., the provision of information and advice to help solve problems) was associated with higher self-efficacy and more self-reported condom use at follow-up, and exposure to PEs high in emotional support (i.e., the provision of caring and empathic support) was associated with greater STI treatment seeking at follow-up. These findings suggest that informational and emotional support may make differential contributions to behavioral health outcomes and thus should both be emphasized in PE training.

As suggested by UNAIDS (2003), program impact could also be enhanced by including goal-setting elements for PEs (e.g., related to the number of peers to teach each day). It may also be beneficial to include goal-setting elements for those receiving the lessons from the PEs (i.e., the peers). For example, when teaching about self-care, PEs could encourage their peers to set a goal for engaging in one self-care activity in the following week. In line with best practices, goals should be aligned with the SMART acronym: Specific, Measurable, Attainable, Realistic, and Time-bound (Williams, 2012). Furthermore, feedback on goals should be provided, given the importance of performance feedback in fostering motivation (Locke, 1968). One of the PEs made the recommendation during her exit interview to include structured exercises or homework assignments for PEs to assign to their peers during their practice teaching as a way to foster more discussion and social support. This type of activity may lead to an increase in power *with others* as well as other outcomes.

There are also other methods that could be utilized within the context of using peer education to promote the psychosocial health and empowerment of FSWs. For example, Rickard and Growney (2001) piloted a novel peer education approach with 15 FSWs in London, in which they created a short (28 minute) audio cassette tape including stories based on an oral history project with other FSWs to stimulate knowledge, awareness, self-esteem, and life skills related to health and safety issues. A process evaluation revealed that the cassettes stimulated discussion of health and safety issues among FSWs, and 12 of the 15 FSWs who listened to the cassette reported that the tape had increased their awareness of the health and safety aspects of their work. Sanders (2004) suggested the potential of using humor as a way to promote psychosocial health among sex workers.

In addition to programs aiming to enhance the psychosocial and occupational health and empowerment of FSWs, it is also important to develop programs to promote psychosocial health knowledge and supportive behaviors of gatekeepers (e.g., owners, managers, and staff of sex work establishments; Ross et al., 2012). Yang et al. (2005) found perceived gatekeeper support to be associated with an increase in a number of outcomes related to sexual health among sex workers, including increased condom use communication with sexual partners, condom use frequency and intention to use condoms, and self-efficacy to use condoms (Ross et al., 2012). Health professionals and others who provide services to FSWs (e.g., NGO staff) are another important gatekeeper population (Wong et al., 2006).

There are also many important directions for future research with regards to program evaluation. For instance, additional psychosocial outcomes (e.g., quality of life, depression, anxiety) and additional occupational outcomes (e.g., job satisfaction, work stress) that may also be affected by such programs should be assessed. It is also important to track the impact of the program on behavioral outcomes (e.g., self-care behaviors) and longer-term impacts, such as whether participants stay in or leave the sex industry. Future studies should specifically focus on the depersonalization component of burnout (i.e., negative, detached and cynical feelings towards other people) since it was found to be significantly higher in FSWs compared to a comparison group of female health care workers (Vanwesenbeeck, 2005). Future research should also explore the possibility that the effect of interventions on improved psychosocial and occupational health outcomes may be mediated by increased empowerment, and particularly power *with others*. Parker et al. (2001) found sense of community to be a significant predictor of fewer depressive symptoms and better reported health.

There are also important directions for future research in terms of process evaluation. As previously suggested, objective observers should be enlisted to provide process feedback. Future research should also include the peers who are receiving the teaching in process evaluation efforts in order to gain additional insights regarding effective PE teaching strategies and challenges faced so training programs can be tailored accordingly. Finally, it would also be beneficial, although likely challenging, to collect data on how many times the PEs taught informally and for how long, as the frequency and duration of teaching may moderate the impact of the intervention on psychosocial and occupational health and empowerment outcomes. The WHO (2009) advocated for PEs to play an active role in monitoring and recording their own outreach activities with written activity logs or with easy-to-use pictorial activity registers. Other non-written recording strategies have also been suggested for use with illiterate populations, such as color coded-necklaces with different colored beads to represent different activities (Butcher, Beral, Bista, & Adhikary, 1998)

Future research should also focus on how to promote program sustainability. With limited resources and other priorities, the partner NGO was not able to continue the program. If they had access to funding mechanisms that would allow them to hire someone (perhaps even a graduate of the training) to run the program, sustainability may have been more feasible. A series of reports was prepared for the partner NGO (see Appendix O) with hopes they can use the findings from this pilot study to apply for funding to continue the program by training more WES as PEs and/or providing refresher training for the 10 WES trained through this pilot program as well as the 10 WES from the control groups who were also trained (a third and final report based on the quantitative findings will be prepared for the partner NGO after successful

defense of this dissertation). Future research should examine additional ways to streamline the program and reduce the burden on NGO staff in order to promote sustainability.

Finally, and perhaps most importantly, in order to fully promote psychosocial and occupational health and empowerment among WES in Nepal, more efforts are needed to help them gain access to education, vocational skills, and job opportunities. Micro-credit enterprises have been hypothesized as a particularly effective way to improve health outcomes based on the hypothesis that women will spend their increased earnings on children's and families health (ILO, n.d.). Although it is not possible to help all FSWs exit the sex industry, this is a primary goal of many NGOs in Nepal (including the partner NGO) and elsewhere. In one of the additional questions included in the post intervention surveys at the request of the President of the partner NGO, almost half (46.1%) of those surveyed indicated that they would like to leave the entertainment sector. The primary reasons for staying in their current jobs included financial strain, difficulty finding a job, and lack of education/qualifications.

Conclusion

Overall, the findings from this pilot study indicate the methods of peer education methods as a feasible and promising means of enhancing the psychosocial and occupational health and empowerment of WES in an existing community empowerment network in Kathmandu, Nepal. This study reinforces the value of using community-based participatory research and mixed-methods when piloting new programs with FSWs. This pilot study can inform future programs aiming to promote the psychosocial and occupational well-being and empowerment of FSWs as well as other vulnerable and hard-to-reach working populations.

(Candid) Lessons Learned

The lessons I learned through this experience are many. First and foremost, I would like to thank my dissertation committee for encouraging me to be flexible and open during my initial program planning meetings with Raksha (my partner NGO). I largely attribute the success of this program to the fact that I allowed them to play a lead role in determining the direction and logistics of the program. If I had demanded my own agenda, I am certain program acceptance and effectiveness would have been severely diminished. I continuously expressed my gratitude to the leadership and staff of Raksha for their incredibly valuable knowledge, insights, and efforts that made the program possible. Throughout the planning and implementation of the program, I also learned the value of being resourceful. For instance, relying on my key informant/supporter (i.e., the psychosocial counselor who had been doing pro-bono trauma counseling for women through Raksha), who believed in my program and had a strong relationship with the President of Raksha, was indispensible. She not only supported the project by helping to design the training, facilitate the staff orientation session, and conduct one of the phase two trainings on psychosocial health, but I was also able to solicit her help numerous times throughout the project in navigating various challenges. I also relied on a number of additional mentors (e.g., researchers from other countries with relevant expertise, colleagues in Nepal) and local resources (e.g., Nepali trainers, my Nepali language instructor, the ktmktm Google group to find the artists) to aid with the design and implementation of the project.

A somewhat unexpected lesson learned was related to the importance of limiting demands and maximizing fun while working with both Raksha and the WES. As time passed, I noticed that the more fun we had together, the more both parties wanted to continue and expand their involvement in the program. In a similar vein, I also learned how important it was to focus

on the positive and avoid the negative throughout the duration of the program (e.g., designed the training to be fun, minimized negative questions in the surveys, gave lots of positive feedback to the PEs and the staff at Raksha). WES in Nepal and the organizations that serve them have difficult lives and rarely get opportunities to consider their strengths, be in supportive contexts, and get positive feedback.

If I had the opportunity to do it again, there are a number of things I would do differently at the design, implementation, and evaluation phases of the project. At the initial design phase, I would have made more effort to start planning with Raksha from the US prior to my departure. This would have saved me from writing an entire proposal, which was largely overthrown shortly after my arrival. Although I had tried to email some initial planning documents to the President of Raksha to get her input in advance, I learned shortly after arriving that email is not an immediate form of communication in Nepal in the same way it is in the US. In retrospect, I think I would have been more successful in connecting with her in advance by phone or Skype. If I could go back, I would also apply for additional grant funding (i.e., other than the Fulbright fellowship) in advance to obtain more resources in order to extend the length of the program and/or train additional WES as PEs. I would also plan to spend some initial time at Raksha to learn about their day-to-day work and priorities and to develop trust and rapport with the leadership and staff. I came in with zeal to get started (motivated by pressures of finishing the project before my return to the US), and realized later on they were not as fully onboard as I had hoped. Trying to earn their trust while moving full steam ahead with the project proved to be very challenging. It also would have been beneficial to visit more entertainment sector establishments during the initial design and planning phase. Although I was able to visit a couple of dance bars and *dohoris* and had visited a few massage parlors during my initial trip to

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Kathmandu in 2012, I feel it would have been beneficial to do more establishment visits, especially to the types of establishments I had not previously been to (e.g., cabin restaurant, *bhatti pasal*). In retrospect, I also would have conducted more focus groups (and possibly some in-depth individual interviews) with WES to better understand their psychosocial health perceptions and needs. This would have helped me in my efforts to relate to them and design the program in way that was more customized to their unique needs.

In terms of implementation, I would have placed greater pressure on Raksha's field staff to let me attend a network group meeting and/or observe the PEs teaching in one of their biweekly meetings. I would also schedule meetings with the two key field staff for immediately after the PEs had practiced teaching so I could collect more proximate insights into their teaching strategies and challenges. This would have allowed me to give more specific feedback and suggestions to the PEs during the following training sessions.

I have also reflected on "what ifs" in terms of measurement. I realized after the fact that I tried to measure too many constructs with too few items and, as a result, cannot feel very confident in the validity and reliability of my findings. If timing had allowed, I would have ideally started by validating existing (and preferably cross-culturally validated) scales for the constructs of interest with Nepali WES. However, even without scales that have been validated in Nepal, I think I would have been better off if I had attempted to evaluate fewer outcomes so I could have used a greater number of items for each. I also realized after the fact that the question used to assess job control was double-barreled. In future studies, I will solicit advice from colleagues with expertise in measurement to prevent such oversights. In order to prevent the issue I encountered with the baseline surveys not being filled out properly, I would also more

closely monitor the data collection (e.g., check first surveys to ensure they were being completed correctly).

      All in all, this was an incredible learning and developmental experience for me, both personally and professionally. I very much aspire to conduct similar research in the future, and I am optimistic of my ability to overcome many of the aforementioned shortcomings and challenges in order to optimize the rigor and impact of future programs. To everyone who contributed to this project in one way or another: I can't thank you enough. *Dherai dhanyabhad* (thank you very much in Nepali)!

Table 2.1

Measurement Information for All Outcome Variables

	Construct	N	# of Items (r/α)	Sample Item	Scale
Empowerment	*Within-Confidence*	149	2 (.44)	"I feel confident giving advice to my coworkers, neighbors and friends."	4-pt scale from 'Disagree a lot' to 'Agree a lot'
	Within-Self-efficacy	144	4 (.67)	"It is easy for me to accomplish my goals."	4-pt scale from 'Disagree a lot' to 'Agree a lot'
	With others	156	4 (.67)	"I can trust my coworkers."	4-pt scale from 'Disagree a lot' to 'Agree a lot'
	Over resources	155	5 (.84)	"I can access sexual health services, including HIV/STI testing and treatment?"	4-pt scale from 'Disagree a lot' to 'Agree a lot'
Psychosocial Health	*Knowledge*	149	2 (.61)	"I understand what psychosocial health is and why it's important."	4-pt scale from 'Disagree a lot' to 'Agree a lot'
	Stress	153	2 (.53)	"How often did you feel that difficulties were piling up so high in your life that you could not overcome them?"	4-pt scale from 'Disagree a lot' to 'Agree a lot'
	Overall health	155	1 (N/A)	"How is your current health?"	4-pt scale from "Poor" to "Excellent"
	Happiness	148	1 (N/A)	"Mark a check on the line to show how happy you have been in your life in the last month."	Line from "Extremely unhappy" (sad face) to "Extremely happy" (happy face)
Occupational Health	*Job control*	156	1 (N/A)	"How often did you feel you could decide what you do at work and how you do your work?"	4-pt scale from "Never" to "Always"
	Burnout	150	4 (.86)	"Regarding your work, how often do you feel tired?"	4-pt scale from "Never" to "Always"
	Bullying-Personal	155	2 (.46)	"How often have your coworkers been rude or disrespectful to you?"	4-pt scale from "Never" to "Always"
	Bullying-Physical	157	1 (N/A)	"How often have your coworkers threatened or abused you?"	4-pt scale from "Never" to "Always"

Note. The number of participants (*N*) varies by construct because of missing data.

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Table 2.2

Demographic Characteristics Across All Participants (N = 160)

	N	Min	Max	M	SD
Age	158	19	45	25.75	4.73
Education (years completed)	160	0	10	2.76	3.25
Children	112	1	4	1.73	.74
Time in Kathmandu	160	1	19	8.89	2.99
Time in entertainment sector	144	1	16	6.65	2.79
Time in network	155	.08	3	1.50	.61
Number of workplaces	157	1	5	1.45	.83
Number of social entitlements	160	0	4	1.64	.99
Social desirability	159	0	4	2.38	.94

Construct (Number of responses)	N	%
Home Region (159)		
Far West	2	1.3%
Midwest	6	3.8%
Western	15	9.4%
Central	116	73%
Eastern	20	12.6%
Caste (151)		
Brahmin	15	10%
Chhetri	33	22%
Janajati	90	60%
Dalit	12	8%
Marital Status (160)		
Married	133	83.1%
Husband support (129)	13	10.1%
Religion (158)		
Hindu	110	69.6%
Buddhist	21	13.3%
Hindu & Buddhist	24	15.2%
Other	3	1.9%
Workplace type/s (158)		
Massage	91	57.6%
Cabin	42	26.6%
Dance	20	12.7%
Guest House	36	22.8%
Bhatti Pasal	28	17.7%
Other	11	7%
Previous PH training (156)	16	10.3%
Drug use at work in last month (159)	19	11.9%
Alcohol use at work in last month (159)	122	76.7%

Note. Percentages calculated based on number of responses for each construct. PH =

psychosocial health.

Table 2.3

Descriptive Statistics for All Outcome Variables at Baseline and Post intervention for Experimental and Control Participants

Outcome (# of items)	Experimental (*n* = 90-96)				Control (*n* = 60-64)			
	Baseline		Post		Baseline		Post	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Empowerment								
Within—Confidence (2)	3.08	.59	3.29	.59	2.86	.53	3.30	.58
Within—Efficacy (4)	2.52	.65	3.53	.53	2.55	.50	3.04	.56
With (4)	3.04	.59	3.40	.37	3.00	.51	3.30	.49
Over (5)	3.31	.68	3.51	.46	3.24	.58	3.14	.50
Psychosocial Health								
Knowledge (2)	2.76	1.02	3.46	.78	2.85	.81	3.00	.79
Stress (2)	3.45	.53	3.03	.44	3.20	.68	2.96	.58
Shame (2)	2.95	.88	2.85	.64	3.16	.66	2.66	.75
Happiness (1)	4.68	4.65	4.26	2.84	5.16	5.06	2.93	2.14
Overall Health (1)	2.23	.77	2.19	.84	2.28	.80	2.17	1.01
Occupational Health								
Job Control (1)	3.13	.72	3.51	.62	2.97	.58	2.91	.64
Burnout (4)	3.59	.57	3.33	.61	3.34	.63	2.91	.60
Bullying—Personal (2)	2.88	.69	3.41	.67	2.73	.59	2.93	.63
Bullying—Physical (1)	3.06	.95	3.02	.43	3.03	.71	2.97	.59

Note. Sample sizes ranged from 90-96 for experimental participants and 60-64 for control participants due to missing data. All constructs were assessed on a 4-pt Likert scale with the exception of happiness, which was assessed on a sliding scale from 1-13 (1 = extremely unhappy and 13 = extremely happy).

Table 2.4

Correlations for All Predictor and Outcome Variables

		01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
Predictors	01 TX	-----															
	02 Time in NET	.04	-----														
	03 Time in ES	.10	.15	-----													
Empowerment	04 Within—Conf	-.01	.03	.08	-----												
	05 Within—Eff	.40***	-.02	-.04	.18*	-----											
	06 With	.11	.03	.11	.42***	.24**	-----										
	07 Over	.35***	.05	-.11	.27**	.72***	.30***	-----									
Psychosocial Health	08 Knowledge	.28***	-.02	-.01	.16*	.82***	.24**	.67***	-----								
	09 Stress	.06	-.02	-.07	.15*	.30***	.17*	.28***	.20*	-----							
	10 Shame	.14	.10	.16	.17*	.44***	.48***	.49***	.44***	.06	-----						
	11 Happiness	.25**	-.06	-.04	.05	.28**	.10	.21**	.24**	.10	.09	-----					
	12 Health	.01	.00	-.04	.15	.12	.19*	.09	.19*	.31***	-.03	.01	-----				
Occ Health	13 Job Control	.43***	-.06	-.05	.16*	.66***	.11	.63***	.55***	.19*	.26**	.21*	.13	-----			
	14 Burnout	.32***	-.02	-.02	.25**	.70***	.33***	.73***	.65***	.43***	.41***	.16*	.22**	.77***	-----		
	15 Bullying-Per	.34***	-.08	-.05	.08	.65***	.20*	.64***	.55***	.40***	.30***	.27**	.21**	.57***	.72***	-----	
	16 Bullying-Phy	.05	-.08	-.06	.20*	.33***	.12	.33***	.31***	.61***	.05	.12	.27**	.29***	.39***	.56***	-----

Note. The number of participants ranges from 149-160 due to varying amounts of missing data across variables. TX = treatment. NET = network. ES = entertainment sector. Conf = confidence. Eff = efficacy. Per = personal. Phy = physical. Occ = occupational.
*$p \le .05$. **$p < .01$. ***$p < .001$.

Table 2.5

Hierarchical Linear Multiple Regression Models for All Outcome Variables

Outcome (R^2, p)	Intercept (SE)	b (SE)	p	95% CI
EMPOWERMENT				
Within-Confidence (.00, .934)	3.28 (.10)		.000	3.11, 3.45
TX		.02 (.14)	.872	-.21, .25
Baseline Within-Confidence		-.01 (.10)	.917	-.17, .15
Within-Efficacy (.17, .008)	3.04 (.09)		.000	2.89, 3.20
TX		**.48 (.10)**	**.000**	**.32, .66**
Baseline Within-Efficacy		.04 (.07)	.518	-.07, .15
With (.01, .609)	3.30 (.08)		.000	3.17, 3.43
TX		.10 (.09)	.290	-.05, .24
Baseline With		-.02 (.08)	.825	-.14, .11
Over (.16, .049)	3.13 (.09)		.000	2.97, 3.28
TX		**.40 (.11)**	**.000**	**.22, .58**
Baseline Over		-.05 (.05)	.317	-.12, .03
PSYCHOSOCIAL HEALTH				
Knowledge (.08, .133)	3.00 (.13)		.000	2.79, 3.20
TX		**.46 (.15)**	**.003**	**.21, .71**
Baseline Knowledge		.04 (.05)	.423	-.05, .13
Health (.01, .527)	2.18 (.12)		.000	1.98, 2.37
TX		.02 (.13)	.904	-.19, .22
Baseline Health		.10 (.09)	.237	-.04, .24
Happiness (.08, .076)	2.93 (.29)		.000	2.45, 3.41
TX		**1.36 (.39)**	**.000**	**.73, 2.00**
Baseline Happiness		.07 (.05)	.168	-.01, .15
Time in ES		-.06 (.10)	.544	-.22, .10
Shame (.04, .192)	2.67 (.09)		.000	2.53, 2.82
TX		.18 (.11)	.115	-.01, .36
Baseline Shame		.02 (.06)	.699	-.08, .13
Time in ES		.04 (.02)	.124	.00, .07
Stress (.01, .739)	2.96 (.11)		.000	2.78, 3.14
TX		.07 (.11)	.538	-.12, .26
Baseline Stress		-.01 (.06)	.825	-.11, .08
OCCUPATIONAL HEALTH				
Job Control (.19, .004)	2.91 (.09)		.000	2.76, 3.07
TX		**.60 (.11)**	**.000**	**.41, .79**
Baseline Job Control		.04 (.08)	.647	-.09, .16
Burnout (.13, .011)	2.95 (.11)		.000	2.77, 3.13
TX		.36 (.13)	.007	.14, .58
Baseline Burnout		.21 (.09)	.023	.06, .36
Bullying-Personal (.14, .002)	2.94 (.09)		.000	2.79, 3.10
TX		**.46 (.11)**	**.000**	**.27, .64**
Baseline Bullying-Personal		.19 (.09)	.034	.04, .34
Bullying-Physical (.00, .798)	2.96 (.11)		.000	2.79, 3.14
TX		.06 (.12)	.634	-.14, .25
Baseline Bullying-Physical		-.01 (.07)	.930	-.12, .11

Note. Unstandardized coefficients are reported because treatment condition is a dichotomous variable. A Bonferroni correction was applied to account for multiple comparisons ($p = .05/13 = .004$). Significant results are in bold. TX = treatment. ES = entertainment sector.

Table 2.6

Hierarchical Linear Multilevel Regression Models with Time in Network Group as a Moderator for All Outcome Variables

Outcome (R^2, p)	Intercept (SE)	β (se)	p	95% CI
EMPOWERMENT				
Within-Confidence (.00, 909)	3.28 (.10)		.000	3.11, 3.45
TX		.03 (.25)	.921	-.39, .43
Baseline Within-Confidence		-.02 (.10)	.864	-.18, .14
Time in Network		.03 (.09)	.737	-.12, .18
TXxTime in Network		.00 (.14)	.989	-.23, .22
Within-Efficacy (.17, .009)	3.48 (.09)		.000	2.89, 3.20
TX		.49 (.11)	.000	.31, .66
Baseline Within-Efficacy		.05 (.07)	.478	-.06, .15
Time in Network		.00 (.09)	.994	-.14, .14
TXxTime in Network		-.06 (.14)	.669	-.30, .18
With (.01, .641)	3.30 (.08)		.000	3.17, 3.43
TX		.06 (.13)	664	-.16, .28
Baseline With		-.02 (.08)	.839	-.14, .11
Time in Network		.01 (.07)	.902	-.11, .13
TXxTime in Network		.03 (.07)	.732	-.09, .14
Over (.12, .192)	3.13 (.10)		.000	2.97, 3.28
TX		.30 (.20)	.121	-.02, .62
Baseline Over		-.05 (.05)	.303	-.13, .03
Time in NET		.01 (.08)	.890	-.11, .13
TXxTime in NET		.07 (.11)	.546	-.11, .24
PSYCHOSOCIAL HEALTH				
Knowledge (.15, .307)	3.00 (.13)		.000	2.79, 3.21
TX		.61 (.28)	.027	.16, 1.06
Baseline Knowledge		.04 (.06)	.470	-.05, .13
Time in Network		.02 (.15)	.878	-.22, .27
TXxTime in Network		-.10 (.19)	.591	-.42, .21
Health (.09, .709)	2.17 (.24)		.000	1.78, 2.57
TX		-.32 (.58)	.578	-1.28, .63
Baseline Health		.09 (.25)	.695	-.31, .51
Time in Network		-.15 (.27)	.585	-.59, .30
TXxTime in Network		.23 (.36)	.528	-.37, .82
Happiness (.21, .142)	2.93 (.30)		.000	2.44, 3.41
TX		2.25 (.84)	.007	.87, 3.63

Baseline Happiness		.07 (.05)	.169	.01, .16
Time in ES		-.05 (.10)	.615	-.20, .11
Time in Network		.06 (.34)	.850	-.49, .61
TXxTime in Network		-.60 (.47)	.202	-1.38, .17
Shame (.04, .515)	2.68 (.09)		.000	2.37, 3.06
TX		.16 (.33)	.630	-.43, .66
Baseline Shame		.03 (.06)	.621	-.07, .21
Time in ES		.03 (.03)	.181	-.16, .32
Time in Network		.09 (.15)	.564	-.16, .04
TXxTime in Network		.01 (.18)	.942	-.25, .36
Stress (.29, .041)	2.95 (.10)	--	.000	2.79, 3.11
TX		-.32 (.18)	.072	-.60, -.03
Baseline Stress		-.03 (.05)	.583	-.11, .06
Time in Network		-.17 (.07)	.021	-.29, -.05
TXxTime in Network		.27 (.10)	.011	.09, .44
OCCUPATIONAL HEALTH				
Job Control (.15, .004)	2.91 (.09)		.000	2.77, 3.05
TX		.36 (.17)	.031	.09, .63
Baseline Job Control		.04 (.08)	.578	-.09, .17
Time in Network		-.18 (.10)	.062	-.34, -.02
TXxTime in Network		.17 (.13)	.189	-.04, .37
Burnout (.11, .012)	2.94 (.10)		.000	2.77, 3.12
TX		.19 (.20)	.339	-.14, .51
Baseline Burnout		.20 (.10)	.035	.04, .36
Time in Network		-.10 (.06)	.119	-.21, .01
TXxTime in Network		.12 (.13)	.345	-.09, .33
Bullying-Personal (.12, .002)	2.94 (.08)		.000	2.80, 3.08
TX		.31 (.26)	.230	-.11, .73
Baseline Bullying-Personal		.18 (.09)	.049	.03, .33
Time in Network		-.15 (.12)	.232	-.34, .05
TXxTime in Network		.10 (.17)	.538	-.17, .38
Bullying-Physical (.31, .023)	2.95 (.10)		.000	2.80, 3.11
TX		-.33 (.17)	.057	-.61, -.04
Baseline Bullying-Physical		-.02 (.07)	.790	-.12, .09
Time in Network		-.22 (.07)	.001	-.33, -.11
TXxTime in Network		.27 (.10)	.010	.10, .44

Note. Unstandardized coefficients are reported because treatment condition is a dichotomous variable. Significant results are in bold. A Bonferroni correction was applied to account for multiple comparisons ($p = .05/13 = .004$). TX = treatment. ES = entertainment sector.

Table 2.7

Peer Educator Demographic Characteristics (N = 10)

	N	Min	Max	Mean	SD
Age	10	24	48	34	7.07
Education (years completed)	10	0	8	2.15	2.93
Children	10	1	5	2.8	1.23
Time in Kathmandu	10	8	25	12.70	4.88
Time in entertainment industry	10	4	20	9.05	4.40
Time in network group	10	1	3	2.23	.70
Number of workplaces	10	1	2	1.30	.48
Number of social entitlements	10	2	4	3.10	.57
Social desirability	10	2	4	2.60	.70
Construct (Number of responses)	**N**	**%**			
Home Region (10)					
Far West	0	0%			
Midwest	0	0%			
Western	2	20%			
Central	6	60%			
Eastern	2	20%			
Caste (9)					
Brahmin	2	22.2%			
Chhetri	2	22.2%			
Janajati	4	44.4%			
Dalit	1	11.1%			
Marital Status (10)					
Married	9	90%			
Husband support (9)	1	11.1%			
Religion (10)					
Hindu	6	60%			
Buddhist	2	20%			
Hindu & Buddhist	1	10%			
Other	1	10%			
Workplace type (10)					
Massage	6	60%			
Cabin	2	20%			
Dance	0	0%			
Guest House	0	0%			
Bhatti Pasal	3	30%			
Other	2	20%			
Previous PH training (9)	1	11.1%			
Drug use at work in last month (10)	1	10%			
Alcohol use at work in last month (10)	4	40%			

Note. Percentages were calculated based on number of responses for each construct. PH =

psychosocial health.

Table 2.8

Repeated Measures ANOVA Results Across all Four Survey Time Points with Post Hoc Tests for all Outcome Variables. (N = 10)

	T1 M(SD)	T2 M(SD)	T3 M (SD)	T4 M (SD)	F(3, 27)	p	η^2	Tukey's HSD
Empowerment								
Within—Confidence	3.20 (.59)	3.58 (.50)	4.00 (.00)	4.00 (.00)	9.51	.000	.51	1<3*, 1<4*
Within—Self-efficacy	2.88 (.59)	3.08 (.26)	3.58 (.39)	3.20 (.42)	4.63	.032	.34	--
With	2.91 (.69)	3.57 (.38)	3.51 (.49)	3.38 (.63)	3.10	.043	.26	--
Over	3.12 (.69)	3.69 (.26)	3.82 (.18)	3.44 (.32)	4.89	.039	.35	--
Psychosocial Health								
Knowledge	3.21 (.42)	3.20 (.26)	3.65 (.41)	3.10 (.21)	7.40	.001	.45	2<3*, 3>4**
Overall health	2.30 (.67)	2.10 (.32)	3.44 (.68)	2.80 (.92)	10.74	.000	.54	1<3**, 2<3**
Happiness	5.35 (3.77)	6.70 (2.84)	10.39 (2.62)	9.10 (3.21)	7.24	.001	.45	1<3*, 1<4*
Stress	2.95 (.76)	3.20 (.35)	2.55 (.76)	3.05 (.44)	1.94	.147	.18	--
Shame	1.75 (.72)	3.00 (.85)	2.55 (1.17)	2.85 (1.25)	4.12	.016	.31	--
Occupational Health								
Job control	3.50 (.53)	3.70 (.48)	3.80 (.42)	3.00 (.00)	8.14	.001	.48	2>4**, 3>4**
Burnout	3.33 (.49)	3.26 (.47)	3.00 (.17)	3.05 (.11)	4.11	.016	.31	--
Bullying—Personal	2.75 (.98)	3.31 (.40)	2.69 (.53)	2.95 (.37)	2.10	.124	.19	--
Bullying--Physical	3.00 (.82)	3.30 (.48)	2.50 (.85)	2.80 (.63)	2.10	.124	.19	--
PE Efficacy								
Communication	3.57 (.52)	3.80 (.18)	3.93 (.14)	3.85 (.23)	3.01	.100	.25	--
Teaching	3.59 (.46)	3.78 (.35)	3.97 (.11)	3.92 (.21)	2.42	.088	.21	--
Leadership	3.27 (.81)	3.68 (.28)	3.87 (.32)	3.82 (.32)	2.74	.107	.23	--
Helping others	3.30 (.66)	3.76 (.36)	3.70 (.51)	3.80 (.28)	2.20	.111	.20	--

Note. A Bonferroni correction was applied to account for multiple comparisons (*p* = .05/17 = .003).
*p ≤ .05. **p < .01. ***p < .001.

Table 3.1

Demographic Characteristics Across All Participants (N = 160)

	N	Min	Max	M	SD
Age	158	19	45	25.75	4.73
Education (years completed)	160	0	10	2.76	3.25
Children	112	1	4	1.73	.74
Time in Kathmandu	160	1	19	8.89	2.99
Time in entertainment sector	144	1	16	6.65	2.79
Time in network	155	.08	3	1.50	.61
Number of workplaces	157	1	5	1.45	.83
Number of social entitlements	160	0	4	1.64	.99
Social desirability	159	0	4	2.38	.94
Construct (Number of responses)	**N**	**%**			
Home Region (159)					
Far West	2	1.3%			
Midwest	6	3.8%			
Western	15	9.4%			
Central	116	73%			
Eastern	20	12.6%			
Caste (151)					
Brahmin	15	10%			
Chhetri	33	22%			
Janajati	90	60%			
Dalit	12	8%			
Marital Status (160)					
Married	133	83.1%			
Husband support (129)	13	10.1%			
Religion (158)					
Hindu	110	69.6%			
Buddhist	21	13.3%			
Hindu & Buddhist	24	15.2%			
Other	3	1.9%			
Workplace type/s (158)					
Massage	91	57.6%			
Cabin	42	26.6%			
Dance	20	12.7%			
Guest House	36	22.8%			
Bhatti Pasal	28	17.7%			
Other	11	7%			
Previous PH training (156)	16	10.3%			
Drug use at work in last month (159)	19	11.9%			
Alcohol use at work in last month (159)	122	76.7%			

Note. Percentages were calculated based on number of responses for each construct. PH =

psychosocial health.

Table 3.2

Descriptive Statistics for All Outcome Variables at Baseline and Post intervention for Experimental and Control Participants

Outcome (# of items)	Experimental (*n* = 90-96)				Control (*n* = 60-64)			
	Baseline		Post		Baseline		Post	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Empowerment								
Within—Confidence (2)	3.08	.59	3.29	.59	2.86	.53	3.30	.58
Within—Efficacy (4)	2.52	.65	3.53	.53	2.55	.50	3.04	.56
With (4)	3.04	.59	3.40	.37	3.00	.51	3.30	.49
Over (5)	3.31	.68	3.51	.46	3.24	.58	3.14	.50
Psychosocial Health								
Knowledge (2)	2.76	1.02	3.46	.78	2.85	.81	3.00	.79
Stress (2)	3.45	.53	3.03	.44	3.20	.68	2.96	.58
Happiness (1)	4.68	4.65	4.26	2.84	5.16	5.06	2.93	2.14
Overall Health (1)	2.23	.77	2.19	.84	2.28	.80	2.17	1.01
Occupational Health								
Job Control (1)	3.13	.72	3.51	.62	2.97	.58	2.91	.64
Burnout (4)	3.59	.57	3.33	.61	3.34	.63	2.91	.60
Bullying—Personal (2)	2.88	.69	3.41	.67	2.73	.59	2.93	.63
Bullying—Physical (1)	3.06	.95	3.02	.43	3.03	.71	2.97	.59

Note. Sample sizes ranged from 90-96 for experimental participants and 60-64 for control participants due to missing data. All constructs were assessed on a 4-pt Likert scale with the exception of happiness, which was assessed on a sliding scale from 1-13 (1 = extremely unhappy and 13 = extremely happy).

Table 3.3

Hierarchical Linear Multiple Regression Models for All Outcome Variables

Outcome (R^2, p)	Intercept	b (SE)	p	95% CI
EMPOWERMENT				
Within-Confidence (.00, .934)	3.28 (.10)		.000	3.11, 3.45
TX		.02 (.14)	.872	-.21, .25
Baseline Within-Confidence		-.01 (.10)	.917	-.17, .15
Within-Efficacy (.17, .008)	3.04 (.09)		.000	2.89, 3.20
TX		**.48 (.10)**	**.000**	**.32, .66**
Baseline Within-Efficacy		.04 (.07)	.518	-.07, .15
With (.01, .609)	3.30 (.08)		.000	3.17, 3.43
TX		.10 (.09)	.290	-.05, .24
Baseline With		-.02 (.08)	.825	-.14, .11
Over (.16, .049)	3.13 (.09)		.000	2.97, 3.28
TX		**.40 (.11)**	**.000**	**.22, .58**
Baseline Over		-.05 (.05)	.317	-.12, .03
PSYCHOSOCIAL HEALTH				
Knowledge (.08, .133)	3.00 (.13)		.000	2.79, 3.20
TX		**.46 (.15)**	**.003**	**.21, .71**
Baseline Knowledge		.04 (.05)	.423	-.05, .13
Health (.01, .527)	2.18 (.12)		.000	1.98, 2.37
TX		.02 (.13)	.904	-.19, .22
Baseline Health		.10 (.09)	.237	-.04, .24
Happiness (.08, .076)	2.93 (.29)		.000	2.45, 3.41
TX		**1.36 (.39)**	**.000**	**.73, 2.00**
Baseline Happiness		.07 (.05)	.168	-.01, .15
Time in ES		-.06 (.10)	.544	-.22, .10
Stress (.01, .739)	2.96 (.11)		.000	2.78, 3.14
TX		.07 (.11)	.538	-.12, .26
Baseline Stress		-.01 (.06)	.825	-.11, .08
OCCUPATIONAL HEALTH				
Job Control (.19, .004)	2.91 (.09)		.000	2.76, 3.07
TX		**.60 (.11)**	**.000**	**.41, .79**
Baseline Job Control		.04 (.08)	.647	-.09, .16
Burnout (.13, .011)	2.95 (.11)		.000	2.77, 3.13
TX		.36 (.13)	.007	.14, .58
Baseline Burnout		.21 (.09)	.023	.06, .36
Bullying-Personal (.14, .002)	2.94 (.09)		.000	2.79, 3.10
TX		**.46 (.11)**	**.000**	**.27, .64**
Baseline Bullying-Personal		.19 (.09)	.034	.04, .34
Bullying-Physical (.00, .798)	2.96 (.11)		.000	2.79, 3.14
TX		.06 (.12)	.634	-.14, .25
Baseline Bullying-Physical		-.01 (.07)	.930	-.12, .11

Note. Unstandardized coefficients are reported because treatment condition is a dichotomous variable. A Bonferroni correction was applied to account for multiple comparisons (p = .05/12 = .004). Significant results are in bold. TX = treatment. ES = entertainment sector.

Table 4.1

Repeated Measures ANOVA Results Across all Four Survey Time Points with Post Hoc Tests for all Outcome Variables. (N = 10)

	T1 M(SD)	T2 M(SD)	T3 M (SD)	T4 M (SD)	F(3, 27)	p	η^2	Tukey's HSD
Empowerment								
Within—Confidence	3.20 (.59)	3.58 (.50)	4.00 (.00)	4.00 (.00)	9.51	.000	.51	1<3*, 1<4*
Within—Self-efficacy	2.88 (.59)	3.08 (.26)	3.58 (.39)	3.20 (.42)	4.63	.032	.34	--
With	2.91 (.69)	3.57 (.38)	3.51 (.49)	3.38 (.63)	3.10	.043	.26	--
Over	3.12 (.69)	3.69 (.26)	3.82 (.18)	3.44 (.32)	4.89	.039	.35	--
Psychosocial Health								
Knowledge	3.21 (.42)	3.20 (.26)	3.65 (.41)	3.10 (.21)	7.40	.001	.45	2<3*, 3>4**
Overall health	2.30 (.67)	2.10 (.32)	3.44 (.68)	2.80 (.92)	10.74	.000	.54	1<3**, 2<3**
Happiness	5.35 (3.77)	6.70 (2.84)	10.39 (2.62)	9.10 (3.21)	7.24	.001	.45	1<3*, 1<4*
Stress	2.95 (.76)	3.20 (.35)	2.55 (.76)	3.05 (.44)	1.94	.147	.18	--
Occupational Health								
Job control	3.50 (.53)	3.70 (.48)	3.80 (.42)	3.00 (.00)	8.14	.001	.48	2>4**, 3>4**
Burnout	3.33 (.49)	3.26 (.47)	3.00 (.17)	3.05 (.11)	4.11	.016	.31	--
Bullying—Personal	2.75 (.98)	3.31 (.40)	2.69 (.53)	2.95 (.37)	2.10	.124	.19	--
Bullying--Physical	3.00 (.82)	3.30 (.48)	2.50 (.85)	2.80 (.63)	2.10	.124	.19	--
PE Efficacy								
Communication	3.57 (.52)	3.80 (.18)	3.93 (.14)	3.85 (.23)	3.01	.100	.25	--
Teaching	3.59 (.46)	3.78 (.35)	3.97 (.11)	3.92 (.21)	2.42	.088	.21	--
Leadership	3.27 (.81)	3.68 (.28)	3.87 (.32)	3.82 (.32)	2.74	.107	.23	--
Helping others	3.30 (.66)	3.76 (.36)	3.70 (.51)	3.80 (.28)	2.20	.111	.20	--

Note. A Bonferroni correction was applied to account for multiple comparisons (*p* = .05/16 = .003).
*p ≤ .05. **p < .01. ***p < .001.
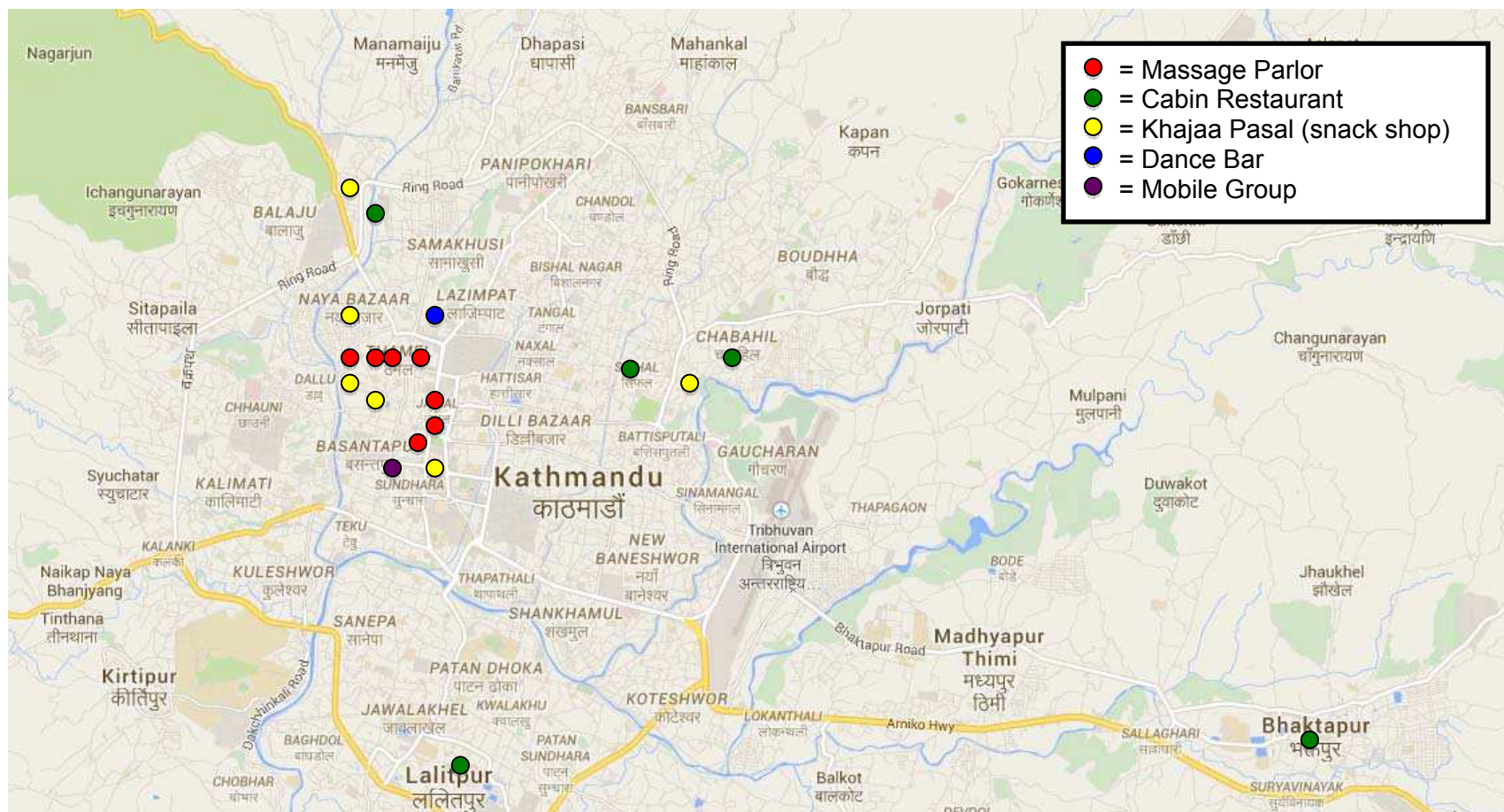
Figure 2.1. Map of network groups by group type.
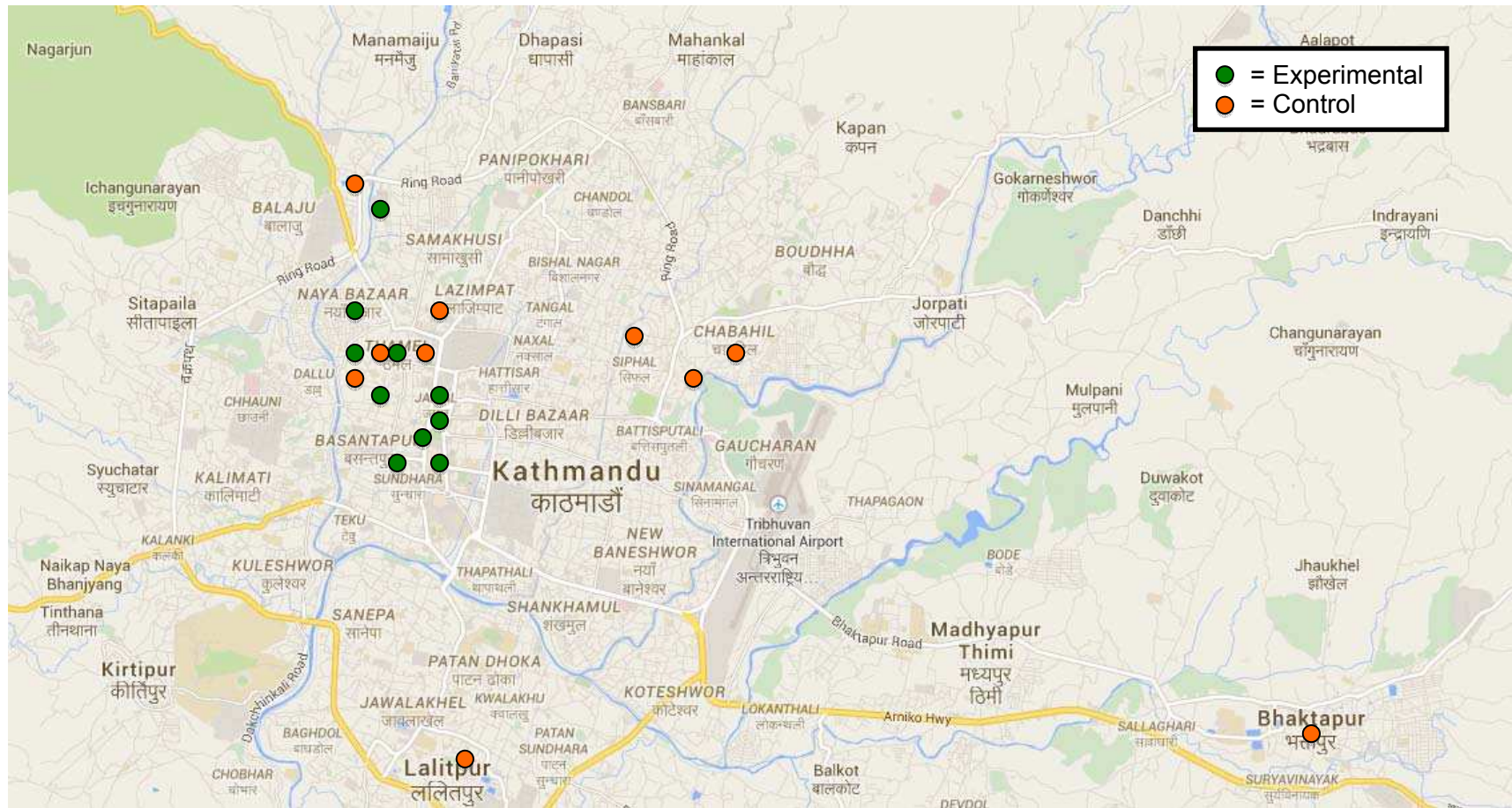
Figure 2.2. Map of network groups by experimental condition.
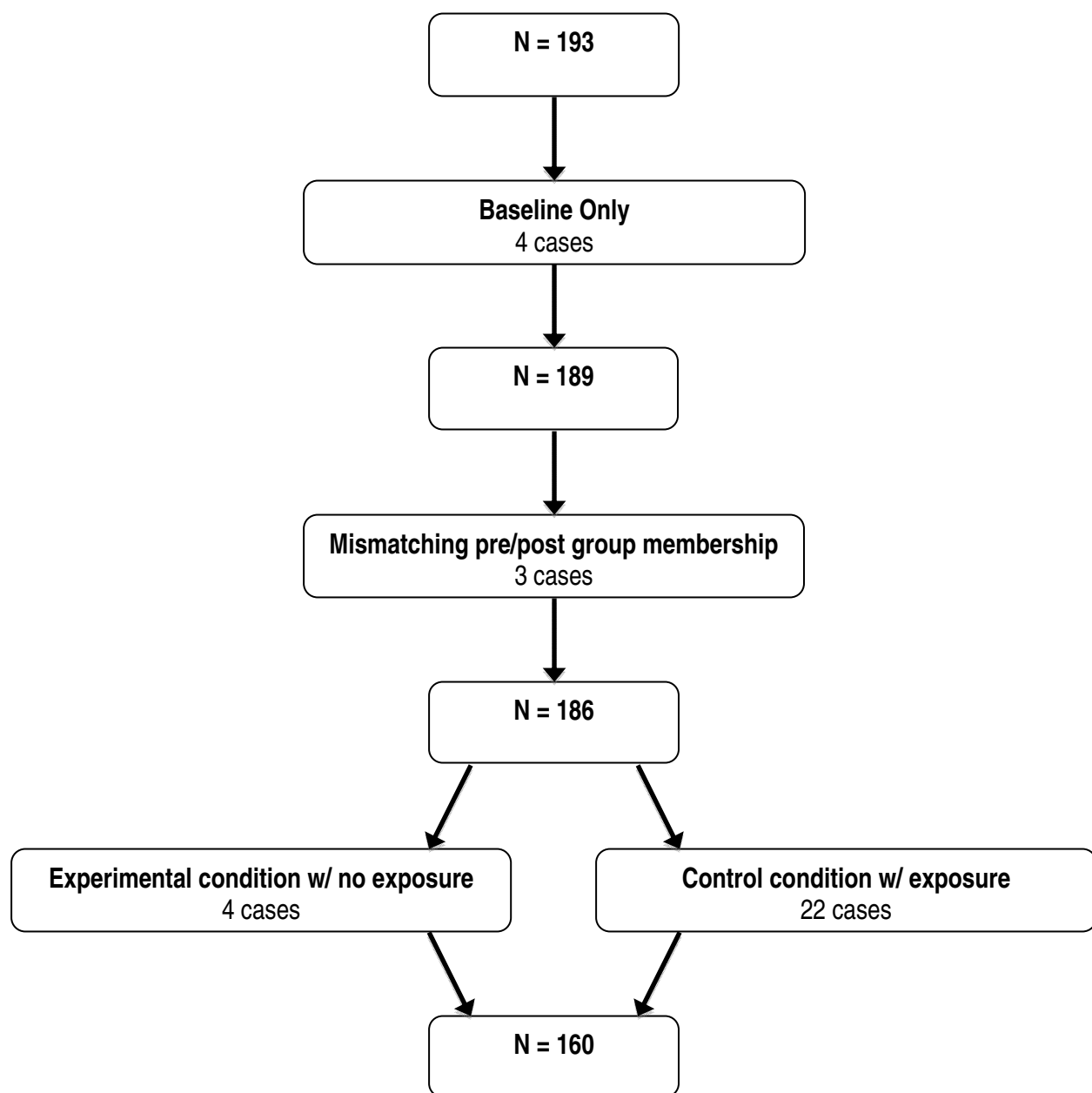
Figure 2.3. Flowchart of deleted cases.

Figure 4.1. Example of a customized visual teaching aid created in the post training debrief sessions during phase two of the PE training program. This example was based on the training session facilitated by the psychologist. The primary themes represented in these drawings include the connection between mental and physical health and the importance of self-care.

Figure 5.1. Example teaching aid created during the post training debrief after the session facilitated by the psychologist (i.e., the first Phase two training session). Dominant themes from this training include the importance of self-care and the connection between physical and mental health.

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APPENDICES

THE ENTERTAINMENT SECTOR IN KATHMANDU
A SNAPSHOT OF NGO /INGO PROGRAMS, CHALLENGES, GAPS & STRATEGIES

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September 2014

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OVERVIEW

In order to better understand the programs and services currently being offered for women in the entertainment sector in Kathmandu, representatives from six non-governmental organizations (NGOs) and two international NGOs (INGOs) were interviewed between September and December 2013.

Interviews were conducted with one or more staff members from each of the eight organizations. Different staff members from two of the organizations were interviewed at several time points. All interviews were conducted at offices in Kathmandu. Additionally, two psychosocial counselors (affiliated with two of the local NGOs) were interviewed.

Participants were asked to describe their target service populations, programs and services provided, and to comment on the challenges they face and effective strategies they implement (particularly with regard to the use of peer educators) in addition to perceived gaps in programs and services.

Understanding the experiences and perceptions of the organizations working with women in the entertainment sector is key to developing more effective programs and services.

*Note: The organizations interviewed did not include all NGOs and INGOs that work with women in the entertainment sector in Kathmandu.

TARGET GROUPS

Main target group
The main target group of the NGOs consists of women who work in the commercial entertainment sector (sex industry) in Kathmandu. The establishments in this sector include dance bars, cabin restaurants, massage parlors, guest houses, *dohoris*, and *bhattipasals*.
- The target group was described as marginalized, poor, largely illiterate, uneducated and unskilled
- A majority are married (60-70%) and about half have children
- Most of the women came to Kathmandu from rural villages in search of a better life (job opportunities, education for their children); many also came to escape conflict or domestic violence
- Due to a lack of alternatives, these women end up working in the entertainment sector and, oftentimes, they are unaware that their job tasks will include sexual services until some time after starting the job

Other target groups

- Street- and home-based sex workers
- Clients of sex workers (especially high-risk clients, such as migrants, men working in transportation)
- Police
- Trafficking survivors
- GBV/domestic violence survivors
- Brick and carpet factory workers
- Establishment owners
- Other target locations include Bhaktapur, Lalitpur, and Pokhara.

Risks facing the main target group

Women in the entertainment sector are exposed to many risks as part of their occupation, including:

- Physical health issues
  - Sexual health (e.g., STI/HIV infection, lack of power to negotiate safe sex/condom use)
  - Reproductive health (unwanted pregnancy, unsafe abortion, uterine prolapse)
  - Other physical health problems (headaches, eye and ear problems, ulcers, kidney failure, lack of sleep)
  - Gender based-violence and sexual abuse by clients and establishment owners
  - Unsafe work environment (poor lighting, dirty, narrow hallways, no water)
- Psychosocial health issues
  - Generally poor psychosocial health: low self-esteem/self-efficacy; lack of motivation; pessimistic outlook; sense of hopelessness; isolation
  - Susceptibility to mental illness, including depression, anxiety, suicidal thoughts and behaviors, post-traumatic stress disorder
  - Lack of security/stability: don't feel like human beings, always searching for security (love, protection, affection), emotional manipulation by customers (customers use them and then treat them like untouchables)
  - Lack of social support: disconnected from family and friends back home
  - Fear of being "found out" and rejected by family
  - Workplace bullying (being treated poorly/harassed by coworkers)
- Financial issues
  - Not getting paid on time, as much as promised or at all
  - Clients stealing money & other valuables
  - Debt owed to establishment owners
- Other issues
  - Police harassment (mostly massage parlors)

- o Risk of trafficking
- Some noted specific issues faced in different work environments. For instance:
  - o Dance bar workers have more problems associated with working at night; they can also earn more than others, which puts them at greater risk of theft
  - o Establishment-based sex workers have more regular clients than street-based sex workers, leaving them susceptible to more emotional manipulation/abuse by owners and clients
  - o Massage parlor workers face more police harassment/raids than workers in other establishments

CURRENT PROGRAMS & SERVICES

The NGOs interviewed offer a broad array of programs and services to help educate, empower, and protect women in the entertainment sector. Some of these programs and services are conducted in house, while others are based on referrals. Also, some programs are delivered in a formal setting and some are given informally through outreach staff and peer educators.

Educational programs & trainings
- The most common topics mentioned were:
  - o HIV/STI education (transmission, detection, treatment, prevention)
  - o Family planning (counseling, birth control)
- Other topics mentioned:
  - o Stigma and discrimination (what it is, what are its effects, stigma management strategies)
  - o Life skills (decision making, financial management)
  - o Gender-based violence /domestic violence (awareness, prevention)
  - o "Leadership" skills (how to bargain/negotiate with clients/police, condom negotiation)
  - o Entrepreneurial skills
  - o Relational problems (divorce, separation, remarriage)
  - o Self defense (to build confidence & strength)
  - o Laws & rights (regarding work, but also divorce, property)
  - o Paralegal training/certification
  - o Safe migration, trafficking prevention & foreign employment (assistance with legal provisions, documentation & process; information on how to stay safe and on resources in Nepal and abroad)

Health services
- Condom distribution
- HIV counseling and testing

- Mobile clinics
- Medical check-ups & services
- Psychosocial healing (individual & group counseling, cognitive-based therapy (CBT), art/dance therapy, trauma healing)

Women's empowerment programs
- Cooperative savings programs
- Skill-based trainings (tailoring, computer skills, beauty parlor, paralegal, driving, candle making, henna, spa therapist, security guard, cooking, handicraft making)
- Women's schools (non-formal education, literacy, SLC prep)
- Social mobilization (programs to strengthen social support and solidarity)

Other programs & services
- Drop in centers (distribution of educational materials, games)
- Childcare (day care, transit homes)
- Awareness raising and advocacy through print and radio media
- Legal aid/support
- Shelter homes
- Occupational health & safety promotion programs
- Reporting systems for trafficking victims
- Reintegration and support for women who have left or want to leave the entertainment sector (support groups, future planning, how they can help other women)

CHALLENGES

Outreach challenges
- The women are highly mobile, so it's difficult to follow-up with them regularly to build rapport and trust and influence attitudes/behavior
- Some women don't want to leave the sector, even if they have opportunities for free housing and other services
- Minors are more difficult to reach—some of the girls are very young and beautiful and enjoy making money, so it's hard to get them to listen
- Owner-resistance—entertainment sector owners either don't let NGOs in or they tell the women either not to listen or to pretend to listen, and/or threaten to fire women for listening to or visiting NGOs; owners sometimes accuse NGOs of just taking money from donors & detracting from the women's ability to work

Advocacy challenges
- The Nepal government doesn't take these issues very seriously; there are regulations but they aren't enforced

- o Note: Efforts are being made to bring all NGOs together to pressure the government to implement the existing directive to control sexual harassment and unsafe conditions of women working in the entertainment sector
- Weak/corrupt law enforcement & legal institutions; lack understanding of human/women's rights and how to treat women

Program implementation challenges
- Trainings are very expensive and funding is limited
- The women are always busy and have limited time
- The women are spoiled by donors & many expect to get money every time they go to a NGO
  - o There is a need to remind the women that NGOs are providing good education/services for free and invite them to leave if they only want money
- The women want immediate gratification—if they don't see immediate results/positive benefits of programs, they don't want to attend

STRATEGIES

Outreach strategies
- Build trust and rapport with the women through regular/frequent workplace visits
- Treat the women with respect—they will only start to respect themselves if they are treated with respect by others
- Use personal stories and peer models the women can relate to (e.g., get an HIV-infected woman from the entertainment sector to talk during an HIV awareness program to share her story)
- Help the women realize like they don't need to be stuck in this job forever, but they need to be prepared to leave and committed to developing new skills
- Build rapport with owners/managers & help them understand the business case for protecting and promoting the health and well-being of their employees
  - o Help owners understand if the women are happy and healthy they can work better, and the business will be more successful
  - o Help them understand that there are easy, low cost things that can be done to make meaningful improvements

Program strategies
- Understand target group(s) and be flexible to their needs, expectations, and ambitions—don't just cater to the donors, but develop programs based on

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what challenges the women are facing, their future plans, what kinds of training they've already received, what skills they already have, etc.

- Foster the development of modern and marketable skills that will help the women gain income and respect within society
    - Some suggestions include paralegal counselor, tourist guide, health educator, housemaid/cook
- Target programs toward all relevant stakeholders, not just the women (owners, clients, police)
- Link the women to each other and help them find social support and solidarity as a group

Other strategies
- Interorganizational collaborations—conduct interorganizational meetings to determine how to divide responsibilities for different programs and services across NGOs to maximize efficiency (in other words, reduce redundancy of efforts); take turns hosting meetings
- Invest in branding—if women see your logo, you want them to associate it with trusted, confidential, dependable services

PEER EDUCATORS

There was a general consensus that peer educators (current or former women from the target group) are a key population that can help to educate and empower women in the entertainment sector because they know how to access the women and relate to them in a meaningful way.

What characteristics make them effective?
- Activists by heart, ready to confront challenges, committed, goal-oriented
- Strong communication skills

Challenges
- High turnover because women are volunteers and very mobile
- Hard to get women to commit to attending training
- Women have a low attention span—can't cover a lot of training material at once

Strategies
- Provide incentives and prizes (for example, offer training certificates, hold a peer educator of the year competition)
- Recognize their needs (for example, be flexible to their schedules) and make them feel like "this organization is mine"
- Hold quarterly check-in/support meetings to promote accountability and let them share their experiences

- o Structure meetings around their needs and interests
- o Provide lunch & transportation
- o Offer additional trainings and materials when possible
- Provide recognition—emphasize the important difference they are making & how their efforts are contributing to women's health and well-being at the district and national levels
- Offer periodic refresher trainings to support ongoing learning
- Supply them with materials and tools that are easy to use and remember—generally games and flip charts are much better than brochures; be mindful of literacy levels
  - o Teach them *how* to use materials and tools in a way that will be relevant for their peers (just giving them training materials is not enough!)
- Encourage them to ask their peers questions, rather that just giving them the answers—learning and behavior change is more likely to happen when the people recognize their own problems and come up with their own solutions
- Give peer educators information about various services available in the community (especially free ones!) and train them on how to make a referral
- Celebrate and have fun together!

GAPS IN CURRENT PROGRAMS/SERVICES

Program evaluation
- Impact evaluation for many NGO programs are insufficient or non-existent
- Mostly limited to counts of how many new women were contacted or brought to service centers, post-program reaction surveys, and observations made by NGO staff
- Need more objective measures and measurement of change over time

Suggested program topics requiring more attention
- Gender equality & how to raise voices against discrimination
- Entrepreneurial training
- Laws, rights, regulations and how to effectively deal with the police
- Life skills (self confidence, self awareness/understanding, how to make decisions & solve problems, how to use strengths)
- Self defense
- Awareness about programs and services available in the community
- Disease prevention and treatment, especially causes of disease, importance of accessing timely care, where to access care
- Risks of trusting 'regular' clients (reminding them it's important to use a condom with *all* clients!) and how to avoid emotionally abusive relationships
- Drug and alcohol abuse/addiction

Other gaps

- Focus on primary prevention—many programs provide assistance for women after they have been victims of trafficking, violence, and exploitation, but there should be more programs to help women before getting to those stages
- Staff training—oftentimes NGO staff are in a reactionary mode and consumed with 'putting out fires,' but it's important to provide staff with adequate training to ensure they understand the target population and how to effectively implement programs and services
  - Need to assess strengths/weaknesses in staff knowledge and skills and provide trainings to fill in the gaps
- Programs that help the women translate skills trainings into income generation activities—importance of helping with job placement & providing seed money; can't just give training and then send them off
- Target internal trafficking—most NGOs focus on external, not internal trafficking

RECOMMENDATIONS

Based on the lessons learned across all interviews, below are some recommended strategies for moving forward:

- Continue to **encourage the government** to recognize the sexual harassment and unsafe conditions faced by women in the entertainment sector and to increase _implementation_ of existing policies and regulations
- **Develop rapport** with the women by recognizing them as real people with real lives (not just as a problem to be fixed)
- **Identify the tangible benefits of program participation** and clearly communicate them to the women
- **Build trusting relationships with establishment owners** – this can help to develop organizational support for your programs
- **Be flexible** to the women's needs, expectations, and ambitions—don't just offer programs based on what donors want
- Help the women **develop marketable skills** that will empower them both financially and socially outside of the entertainment sector—help them realize that they have options!
- Expand programs to **target all groups** that impact the health and well-being of entertainment sector workers (owners, clients, police, family members)
- Implement innovative strategies to **foster more social support** among the women—help them understand that together they will have a more powerful voice

- **Collaborate with other NGOs** to capitalize on one another's knowledge, experiences, and strengths, build capacity, and to reduce redundancies in programs and services
- **Train peer educators** who can access and relate to the women on a personal level and increase the diffusion of NGO programs
  - Provide peer educators with ongoing learning, refresher programs and support systems
- Increase efforts to **evaluate program effectiveness**—data proving positive program impact (as opposed to just number of participants) is powerful information that can be used to get more funding
- **Focus on topics that are not receiving adequate attention** (see "suggested program topics" on p. 9)
- **Place more emphasis on identified gaps**—primary prevention, staff training, skills translation & internal trafficking

If you have any questions or comments about the contents of this report, please feel free to contact Lauren Menger at lauren.menger@colostate.edu.

Appendix B: Focus Group Guide

Introduction
- I am a volunteer from the U.S. and I am helping Raksha Nepal develop a program to promote women's psychosocial health
- I want to ask you some questions today to learn more about the psychosocial health of women in Nepal so we can create the best program possible for you
- You can contribute as mush or as little as you feel comfortable.
- There are no right or wrong answers, and all of your answers will be kept confidential.
- It will work best if only one person speaks at a time.
- Please respect that what is said in this group should remain private and confidential, and not discussed with others outside of this group.

Questions
- Can you describe the characteristics of a woman with good health? (If they only talk about physical health, ask if they think of psychosocial, mental, emotional or spiritual health as a part of good health as well).
- What does 'psychosocial health' mean to you? (Describe the difference between psychological or mental + social)
- What are some of the common psychological or mental problems of the women you work with?
- What are some of the common social problems of the women you work with?
- Can you describe the characteristics of a woman with good psychosocial health?
- What factors have a negative influence on a woman's psychosocial health?
- What factors have a positive influence on a woman's psychosocial health?
- Why do you think it's important to have good psychosocial health?
- There are abusers and protectors of women's psychosocial health. Who are the abusers and who are the protectors?
- What can the women you work with do to help improve one another's psychosocial health and reduce stress and tension at work?
- If you were going to go to a workshop on psychosocial health, what would you want to talk about?
- Is there anything else related to psychosocial health that you would like to talk about?

HAAMRO RAKSHA

Raksha Nepal Peer Education Program

<u>Goal:</u> Train 10 peer educators how to promote better psychosocial health and well-being among their peers by facilitating workshops during biweekly group meetings.

(ORANGE) = Time

{GREEN} = Type of activity

[PURPLE] = Notes for RA or artist

<BLUE> = Visuals/materials

<u>PHASE 1: BASIC PEER LEADERSHIP TRAINING</u>

DAY 1: Introductions, overview, ground rules, leadership & teamwork

Objectives: By the end of this training, participants should:

- Be more aware of their own and others' strengths
- Understand who peer educators are, why they are important, what they do, and what makes them effective
- Understand the goals of the program and what will be covered during the training
- Agree on ground rules
- Recognize the importance of maintaining trust and confidentiality
- Understand the importance of teamwork
- Be more aware of their own and others' ideas about leadership
- Be excited about the rest of the training!

Outline of Activities

1. **Distribute name tags and binders as women arrive**
2. **Opening statements (10 min) {LECTURE}**
   a. Thank you all for coming…we are exited to have you here!

b. Briefly introduce facilitators

c. The main purpose of this training is to promote psychosocial health—both for yourselves and the women in your groups

d. What is psychosocial health?

    i. Psycho: good health in our heart, mind and soul

    ii. Social: good relationships with our friends, family, coworkers, etc.

e. When people have good psychosocial health they:

    i. Are more peaceful, strong, positive and happy

    ii. Have less tension in their lives

    iii. Are better at solving their problems and achieving their goals, and

    iv. Enjoy good relationships with work colleagues, friends and family

f. Also, if we take good care of our own psychosocial health, we will be better able to take care of others, such as our children and other family members.

g. We do things to protect and promote our physical health, such as eating healthy, getting exercise, and getting enough sleep. In the same way, it's also important to do things to promote our psychosocial health.

h. Through this training program, we hope that you learn how you can better protect and promote your own psychosocial health. We also hope you will develop the knowledge and skills to teach other women how to protect and promote their psychosocial health.

3. **Overview of training program (5 min) {LECTURE} <Show visual outline of training overview>**

a. Brief review of training schedule and topics covered during each training

    i. Trainings 1-3

        1. Basic peer education skills: leadership, communication and facilitation strategies

    ii. Trainings 4-6

        1. Trainings on different topics related to psychosocial health and well-being

2. After each of these trainings, we will ask you to lead a short workshop on the topic in your next group meeting. We will help you plan these workshops.

b. We have designed the training to be fun and interactive. The more you share your ideas and experiences, the more you will benefit and learn from the training. We hope you will enjoy it!

c. But, first a few logistics…

   i. Start and end time

   ii. Toilet location

   iii. Rs 100 for travel

   iv. Daal bhat after

4. **Introductions / Daily ice breaker/energizer / Today's agenda (25 min) {PAIRED DISCUSSION & GROUP DISCUSSION}**

a. Get in pairs (preferably with someone you don't know), sit down and tell each other your names. Then take turns telling one another about two of your strengths or what other people like most about you.

   i. A couple of examples of strengths from the applications you filled out are: good at handling any situation and helping others.

   ii. Pay close attention to what your partner says because we are going to ask you to introduce her and tell us about her strengths.

b. Go around and have all participants introduce one another. **[Write all strengths on big paper]**

c. As we can see, you all already have many important strengths!

d. In this training program, we hope to learn more about your strengths.

e. Today's agenda

   i. Talk about peer educators: who they are and why they're important

   ii. Establish some ground rules

   iii. Do some fun activities

5. **Set ground rules (10 min) {GROUP DISCUSSION}**

a. I'd like to set up some ground rules that we will all follow as we go through our meetings.

b. What ground rules do you think we should have for the trainings? **[Write all ground rules on big paper]**

c. Fill in the blanks with…

    i. Come to all meetings

    ii. Turn off (or at least silence) mobile phones

    iii. Respect everyone's opinion even if different from our own

    iv. Give everyone a chance to talk

    v. Maintain confidentiality—keep the personal experiences shared here in this room

    vi. Be open to give and receive feedback and suggestions

d. We will hang the ground rules on the wall during all trainings to make sure everyone remembers them. We can always agree to add more ground rules later.

6. **Overview of peer education (5 min) {GROUP DISCUSSION & LECTURE}**

a. Does anyone have any ideas about who a peer educator is?

b. Fill in the blanks with…

    i. A peer educator is someone who is similar to other people in a group. For example, they could be similar in age, culture, background experiences, occupation, and so on.

    ii. Peer educators take special training so they can inspire and encourage others

    iii. Because you share experiences with other women you work with, you are better able to understand their emotions, problems and strengths. And, because you have this understanding, you are better able to inspire and encourage them.

7. **Qualities of a good peer educator (5 min) {GROUP DISCUSSION & LECTURE]**

a. What qualities does a peer educator need to have?

b. Fill in the blanks with…

    i. Learners – devoted to learning and self-improvement

    ii. Role models – what we do is more important than what we say

    iii. Leaders – inspire and motivate others

      iv. Coaches – help others set goals and plan for how to reach them

      v. Good communicators – able to listen and communicate effectively

      vi. Respectful, non-judgmental, open-minded and accepting

      vii. Caring, compassionate and sensitive to the problems and challenges of others

      viii. Energetic, lively

  c. Most importantly! Stay positive & having fun!

8. **Quick Break** **(5 min)**

9. **Establishing trust and confidentiality** **(15 min)** **{SELF-REFLECTION & GROUP DISCUSSION}**

  a. Close your eyes and think about a problem or worry that you feel deep in your stomach. This could be a current problem or a past problem.

  b. Imagine that you want to tell someone about this problem and ask for their advice.

  c. What qualities would you look for in the person? Have each woman say a quality they would look for. **[Write all responses on big paper]**

  d. Would anyone else like to add any additional qualities? **[Write additional responses on big paper]**

  e. Point out that we all have problems that we'd like to share with others and that most people look for the same qualities in people they feel comfortable confiding in.

  f. The greatest source of learning in the trainings will come from sharing our experiences, so it's important to be trusting and respectful and keep everything shared confidential so everyone feels comfortable.

10. **Teamwork activity** **(25 min)** **{TEAM ACTIVITY & OPEN DISCUSSION}** **<Pens, bangles & chocolates>**

  a. Split into 2 groups.

  b. Pass the bangle activity.

      i. Tell the women in each group to sit in a line.

      ii. Tell each group to pick a group leader.

      iii. Give each woman a pen and tell them to hold it with their teeth.

    iv. Put a bangle on the end of one woman's pen (at the end of the line).

    v. Ask the women to pass the pen to their neighbor without using their hands until they get from the first woman to the last woman. The last woman will run the bangle back to the first woman and they will pass it down the line again. The first group to complete 3 cycles and get the bangle back to the first person wins.

c. Discussion questions:

    i. Why did you pick your group leaders?

    ii. What comes to mind when you think of someone who is a good leader? **[Write leadership characteristics on big paper]**

        1. Fill in the blanks with: being honest & trustworthy, inspiring, innovative, perseverant, committed, courageous, respected, and a good communicator and listener **[Write leadership characteristics on big paper]**

    iii. All of you already have leadership characteristics and you will develop even more as the training goes on.

    iv. Other than leadership, what else do you think this exercise was about? (teamwork!)

    v. Why is teamwork important?

        1. We all have different strengths that can be helpful when solving different kinds of problems

        2. We can learn more from each other if we have good teamwork

    vi. How can we have good teamwork?

    vii. It's important to think of one another as your team members throughout this training. You are all here to learn together.

11. Wrap-Up (5 min)

a. What are the most important things you learned today?

b. Does anyone have any questions or comments on today's session?

c. Overview of next session

d. Reminder to turn in nametags

12. Brief reactions survey (10 min)

DAY 2: Communication & listening skills

Objectives: By the end of this training, participants should:

- Understand the importance of having good communication skills
- Understand the difference between verbal and non-verbal communication
- Feel more confident in their ability to ask questions, use tone of voice, use body language and facial expressions, and engage in active listening

Outline of Activities

1. **Daily ice breaker/energizer (10 min) {PAIRED DISCUSSION & GROUP DISCUSSION} <Pictures of animals>**
   a. Pair up with someone other than the person you paired up with at the beginning of the last training.
   b. Pick a picture of an animal that you relate to (either right now or in general).
   c. Take turns telling your partner why you chose your animals.
   d. Go around and each woman to introduce her partner's animal and why they chose it.

2. **Review last session & link to current training (10 min) {GROUP DISCUSSION & LECTURE}**
   a. What did we talk about yesterday? Fill in the blanks with:
      i. Peer educators: who they are and why they're important,
      ii. Ground rules
      iii. Importance of trust & confidentiality
      iv. Teamwork & leadership
   b. Does anyone have any questions from last session?
   c. Since one of the most important qualities of a good peer educator, leader and team member is to be a good communicator, we are going to spend a majority of today's training talking about communication skills

3. **Verbal vs. non-verbal communication (10 min) {ROLE PLAYS}**
   a. Ask a volunteer to tell everyone what time she woke up in the morning. Explain that this is verbal communication. It includes the use of words, questions and tone of voice.

b. Ask another volunteer to stand up and pretend like she is very happy with the group and giving them praise for a job well done, but she can't speak. This is non-verbal communication. It includes body language and facial expressions.

c. In order to be a good communicator, we need to have good verbal and non-verbal communication. It is also important to have good listening skills. Today, we will talk about and practice all of these forms of communication.

4. **Tone of voice exercise** (20 minutes) {PAIRED ACTIVITY & GROUP DISCUSSION}

a. Find a new partner that you have not been paired up with yet

b. Practice saying "My name is _____" in the tone of voice called out

   i. Friendly

   ii. Bored

   iii. Relaxed

   iv. Angry

   v. Excited

   vi. Sad

   vii. Impatient

c. Think about how you feel when you are the one talking and listening

d. Discussion questions:

   i. How did it make you feel when the other person spoke with a _____ tone of voice?

   ii. Repeat discussion question with a couple more examples

e. Key learning points: We need to pay close attention to our tone of voice. If we sound impatient, angry or bored, we can break the communication. Peer educators should always try to have a friendly and relaxed tone of voice to make others feel comfortable to share their ideas and experiences.

5. **Body language exercise** (15 minutes) {ROLE PLAY & GROUP DISCUSSION}

a. Ask for a volunteer to stand up and demonstrate an emotion without speaking. Whisper one of the following in her ear and tell everyone else to try to guess what her emotion is:

   i. Anger/frustration

    ii. Understanding/compassion

    iii. Boredom

    iv. Interest/curiosity

b. After someone correctly guesses the emotion, ask the group:

    i. How did you know she was feeling _____?

    ii. How do you feel when someone uses this type of facial expression or body language?

c. Repeat with other emotions if there's time.

d. Key learning points:

    i. Another influential part of communication is our body language and facial expressions.

    ii. We need to pay attention to all of the ways we communicate, including the tone of voice we use, our body language and our facial expressions.

6. Quick Break (5 min)

7. Asking good questions exercise (25 min) {GROUP DISCUSSION, ACTIVITY & LECTURE} <Ball or other object to throw back and forth>

a. Asking good questions is another part of effective communication.

b. Why do we ask questions? Fill in the blanks with…

    i. Because we are interested or want to show interest

    ii. Because we want to know more

    iii. Because we are curious

    iv. Because we want to understand someone better

c. Ask for a volunteer to talk about their favorite hero

    i. Tell participants that you are going to ask questions and that they should pay attention to 1) how easy and quickly the volunteer is able to respond, and 2) how interesting the conversation is, and 3) how much we are learning about the person.

        1. Facilitator asks a series of simple close-ended questions about the hero. After each question is asked, the facilitator throws the ball (or other object) to the volunteer to answer. After answering the volunteer throws the ball back to the facilitator.

       2. Is it a boy or a girl?

       3. What is the his/her name?

       4. What does the he/she look like?

       5. What does he/she do?

  ii. Ask the volunteer: How do these kinds of questions make you feel?

  iii. Ask the group: How much are we learning about the volunteer from asking these questions? (answer = not that much)

  iv. Then the facilitator asks an open-ended question

       1. Why do you like him/her?

       2. How does he/she inspire or motivate you?

  v. The volunteer should pause to think about her answer.

  vi. Ask the volunteer: How do these kinds of questions make you feel? Ask the group: Are we learning more about her after asking these questions? (answer = yes, we are learning more about who she is as a person!)

  vii. Point out the difference in her response, how the last question really made her think, and how we learned more about her when she answered the last question.

d. Open-ended vs. close-ended questions

  i. Close-ended questions require a specific short answer, usually "yes" or "no," and are good for collecting facts or details about a situation.

  ii. Open-ended questions have unlimited answers and ask someone to describe their opinions or feelings. We usually learn a lot more about someone by asking open-ended questions.

  iii. Sometimes we need close-ended questions to learn the specific details about a problem or situation, but if we really want to engage someone in a discussion, make them think and learn about them, open-ended questions are usually more beneficial.

e. Key learning points: Asking questions thoughtfully can make us better communicators. They can help us understand others and make others want to talk/share more with us.

8. **Active listening exercise** (40 min) {ROLE PLAY & GROUP DISCUSSION}

<Pictures of good and bad listening skills>

   a. What else is one of the most important communication skills? (If they don't say listening facilitator should point to her ear to prompt them)

   b. Active listening encourages others to talk more deeply, to feel we are really interested and that we understand what they are saying. If we understand what someone is saying, we are also able to respond in a more useful way.

   c. Show pictures illustrating good and bad listening skills and ask them to describe what they see in the pictures. Fill in the blanks with:

      i. Bad: facing away from the other person, looking bored/distracted/judgmental, talking on the phone while the other person is talking

      ii. Good: making eye contact, nodding head, looking interested, facing the person

   d. What are some of the things people do that make you feel they are really listening to you? Fill in the blanks with:

      i. Don't interrupt

      ii. Ask questions, give comments, or repeat what was said for clarification

      iii. Smile and nod when appropriate

      iv. Make eye contact

      v. Avoid distractions (phone, starting another conversation)

   e. In order to show someone we are actively listening to them, we need to focus on what they are saying and *use all of our communication skills together*.

      i. Asking questions, making comments, repeating or rephrasing what they said

      ii. Tone of voice (supportive, interested, relaxed)

      iii. Body language/facial expressions (nodding head, face her, lean forward, arms not crossed)

   f. Practice with feedback

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    i.   Ask for a volunteer to practice active listening. Ask for another volunteer to tell a short story or incident (this could be anything, e.g., something that happened over Dashain or Tihar or a childhood memory).

    ii.   Ask the volunteer to try to apply everything we just discussed related to active listening.

    iii.   Have the person analyze their listening skills. What did you do well? What could you have done better?

    iv.   Ask the person who told the story how they felt. What did your partner do to make you feel like she was listening to you?

    v.   With the person's permission, ask the group to give feedback. What else did she do well? What else could she have done to improve her active listening skills?

    vi.   Repeat in pairs if there's time.

g.   Key learning points:

    i.   Listening is one of the most important communication skills: we cannot be good communicators if we are not also good listeners.

    ii.   We need to use all of our communication skills to be good, active listeners.

9. **Repeat communication skills/lessons learned (5 min) {GROUP DISCUSSION & HOMEWORK ASSIGNMENT}**

  a. We discussed and practiced a lot of important skills today that can help you in your role as peer educators and can also help you to have better communication with your friends, family, coworkers and other people in your lives.

  b. Can you help me summarize the different communication skills we talked about today? Fill in the blanks with:

    i.   Tone of voice

    ii. Body language & facial expressions

    iii. Asking good questions

    iv. Active listening

    c. How can these communication skills help you in your day-to-day lives (e.g., at work, as a mom, in your friendships and relationships)?

    d. Ask for everyone to try to practice one of these skills between now and the next session. Tell them that they will be asked to share examples.

10. **Wrap-Up** (5 min)

    a. What are the most important things you learned today?

    b. Questions or comments on today's session?

    c. Overview of next session

    d. Reminder to turn in nametags

11. **Brief reactions survey** (10 min)

DAY 3: Facilitation strategies & practice

Objectives: By the end of this session the women should…

- Understand that people remember more and learn better through saying and doing and the related importance of practicing peer educator skills

- Understand the difference between a peer educator and a teacher

- Know the steps for facilitating a discussion or activity

- Develop efficacy to plan and facilitate discussions and activities

- Be able to critically examine the facilitation skills of themselves and others

- Understand some of the difficulties or challenges they might face while facilitating workshops and have ideas for how to address them

- Have increased awareness of community resources and how to make a referral

Outline of Activities

1. **Review last class** (10 min) {GROUP DISCUSSION}

    a. Last week we talked about:

        i. Verbal and non-verbal communication and why both are important

        ii. How to be more effective communicators through tone of voice, body language/facial expressions, asking good questions, and active listening

    b. Does anyone have any questions from last session?

    c. At the end of the last session, we asked you to practice these communication skills. Ask for a couple of volunteers to share examples of how they practiced:

      i. Tone of voice

      ii. Body language/facial expressions

      iii. Asking questions

      iv. Active listening

2. **Daily ice breaker/energizer / Today's agenda** **(20 min)** **{GROUP ACTIVITY & LECTURE}** **<Charts of how much we remember>**

   a. We are going to start off today by playing the telephone game

   b. Sit in a circle. We are going to whisper something in one person's ear. Then, that person will whisper what she said into the ear of the person sitting next to them, and so on until the last person hears the story.

   c. Ask everyone to say what they heard starting from the last person and going back to the first.

   d. There has been some research about how much we remember when we learn things in different ways. Review pie charts of how much we remember (start with hearing since it's most related to the telephone exercise).

   e. Because we remember much more when we *say* and *do* things compared to when we just hear things, we want to give you some opportunities today to practice your peer educator skills.

   f. But first, we want to make sure everyone is clear on the difference between teachers and peer educators.

3. **Teachers vs. peer educators** **(10 min)** **{LECUTURE & GROUP DISCUSSION}** **<Pictures of teachers vs. peer educators>**

   a. Show pictures of teachers vs. peer educators. What do you see in these pictures? How are they different from one another?

   b. A teacher…

      i. Tells the learners facts and spends a lot of time lecturing

      ii. Teaches students or pupils who usually are younger than her.

      iii. Does more talking than the learners who usually have less knowledge then her.

   c. A peer educator…

      i. Considers all equal and all wants everyone to learn from one another.

ii. Works with adult learners who have knowledge and life experiences that can greatly enrich the lesson.

iii. Most of the time, a peer educator spends *less* time talking than the participants.

iv. Encourages active participation in the learning process—provides opportunities for asking questions, sharing experiences, practicing skills, etc.

4. **Steps of facilitating workshops (10 min) {LECTURE} <Copies of steps as handouts>**

a. We put together the following steps and tips for how to facilitate workshops in your group meetings. These are just meant to be suggestions.

b. Thank everyone for coming

c. Make brief introductions (if necessary)

d. Tell everyone the topic and why it's important

e. Review the plan and objective for the workshop

f. Set some basic ground rules (e.g., be respectful, maintain confidentiality, let everyone have a chance to talk).

g. Begin workshop

    i. Review top 3 learning points

    ii. Facilitate discussion or activity

h. Tips for success

    i. Stay with the plan—restate the objective if things go off track

    ii. Encourage participation—if someone is talking too much, encourage them to listen and if someone isn't talking, encourage them to share their experiences and ideas (this is your main job!)

    iii. Try to make things fun! People learn best when they are having fun!!

i. Ask for everyone to help summarize key learning points at the end:

    i. What have you learned from this training?

    ii. How is this information important/relevant to your lives?

j. Thank everyone for coming

5. **Quick Break (5 min)**

6. **Practice facilitation** (60+ min) {TEAM ACTIVITY & GROUP DISCUSSION} <Candy prizes>

    a. Because you will be facilitating your first workshop after the next training session, we want to spend a large part of our training today giving you opportunities to practice

    b. Split into 2 groups

    c. Ask for one brave person from each group to volunteer to practice facilitating a short workshop.

    d. Have each volunteer pick a communication skill to practice teaching (tone of voice, body language/facial expressions, asking questions, active listening).

    e. As the facilitator, you will go through the steps we just covered for facilitating a workshop.

        i. You can either 1) lead a brief discussion or 2) facilitate an activity about the topic

    f. But first as a group you will come up with a plan for the workshop. We want this to be very simple and short, so don't make your plan too detailed or complicated. (10 min)

    g. We have a prize for whichever team does the best job!

    h. Conduct practice facilitation #1 (10 min)

    i. Ask facilitator to evaluate their own performance. What did you do well? What could you have done better?

    j. With permission, ask the facilitator's group members to give feedback. What did she do well? What could she have done better?

    k. Repeat process for practice facilitation #2 (10 min)

    l. Both teams did so well we can't pick a winner, so we will give all of you chocolates as a prize!!

    m. We will help you come up with plans for how to give workshops in your group meetings after the next three trainings. We will also have a couple of artists join us to help draw a visual representation of what topics you plan to cover with your group members.

7. Role play of one-on-one peer education

a. In addition to facilitating workshops during your group meetings, we hope that you will share your new knowledge and skills with other women you work with while you are at work.

b. Now, we'd like to do another practice round in which a new member from each team volunteers to role play a peer educator in an everyday, on-the-job situation.

c. Ask for one brave person from each group to volunteer to do a role play of their peer educator skills in a real life situation.

d. Again, as a group you will come up with a plan for the role play. We want this to be very simple and short, so don't make your plan too detailed or complicated. (10 min)

e. We have a prize for whichever team does the best job!

f. Conduct practice facilitation #1 (10 min)

g. Ask peer educator to evaluate their own performance. What did you do well? What could you have done better?

h. With permission, ask the peer educator's group members to give feedback. What did she do well? What could she have done better?

i. Repeat process for practice facilitation #2 (10 min)

j. Both teams did so well we can't pick a winner, so we will give all of you chocolates as a prize!!

8. **Anticipate challenges & brainstorm strategies to overcome them (15 min) {GROUP DISCUSSION}**

a. What do you think are some of the difficulties or challenges you may encounter while facilitating the workshops?

b. What do you think you could do to overcome these difficulties or challenges?

c. Emphasize the value of making mistakes & learning from them

9. **Community resources & how to make a referral (10 min) {LECTURE & GROUP DISCUSSION} <List of community resources>**

a. As peer educators, it's important for you to know about the different resources in the community that might be beneficial for your peers. We prepared a list of some resources with contact information.

b. Distribute and quickly review list of resources

c. If you have any questions about any of these resources or how to make a referral, just ask Som or Renu.

10. **Wrap-Up** (5 min)

a. What are the most important things you learned today?

b. Questions or comments on today's session?

c. Overview of next session

d. Reminder to turn in nametags

11. **Brief reactions survey** (10 min)

PHASE 2: PSYCHOSOCIAL WELL-BEING TRAINING & PRACTICE FACILITATION

Overview

1. Local expert provides 1.5 to 2-hour training in specific topic.

2. Immediately after, Lauren will lead a 1-hour debrief and planning session.

a. What are the most important things you learned today that you'd like to share with your group members? Ask each woman to say what she thought was most important. **[Write all lessons learned on big paper]** <Artist draws a visual representation of these things>

b. What kind of discussion or activity could you facilitate to in your next group meeting to help your peers understand the importance of these things? **[Write all ideas on big paper]** <Artist draws a visual representation of these things>

c. Ask for 1 or 2 volunteers to walk through drawings and explain what each image represents to them. Ask women for feedback on:

    i. Are there any images we could add to this?

    ii. Are there any Nepali words we could add that would help you remember what the different images represent?

3. Peer educators will then facilitate workshops during next group meeting.

4. Repeat steps 1-3 with experts #2 & #3,

**Note 1: First 15 minutes of experts 2 & 3 will be reflection on teaching experience

    a. How was your experience?

    b. What went well? What didn't go well?

    c. Do you have any ideas for what you can do next time?

**Note 2: Review of strengths at the end of Day 6,

    d. Bring out list of strengths from Day 1 and post on wall

    e. Review what they said their strengths were on the first day

    f. Now that you've spent more time together, what other strengths do you see in each other **[Add these strengths to list from Day 1]**

Trainers

1. Life Skills: Biswas Nepal
2. Psychosocial: Karuna
3. Spiritual: Brahma Kumaris

MATERIALS

- Large post-it notes
- Name tags
- Binders with sleeves for graphic workshop guides
- Pens
- Bangles
- Chocolates
- Copies of teaching aids
    - How people learn & what they remember (for Day 3 ice breaker)
    - Pictures of good/bad listening (for Day 2 active listening exercise)
    - Pictures of animals (for Day 2 ice breaker)
    - Visual outline of training program
- Handouts
    - Steps for facilitating workshops (Day 3)
    - List of community resources (Day 3)

- Reaction surveys for all days

Appendix D: Phase 2 Expert Trainer Outlines

Expert Trainer #1 Training Outline: Psychologist

Objectives
- Understand mental health—what it is, why it's important
- Promote stability and motivation
- Focus on changing their focus
- Provide easy-to-adopt self-care strategies

Outline
- Understand mental health and why it's important
  - Recognize that mental health is something friendly
  - How it affects our physical health and day-to-day lives
- Understand their own mental health—causes and consequences
  - How stress leads to unproductive decisions & problems
  - Tendency to rely on others too much and how to be more self-reliant
  - Boat exercise – thinking about problems as all of ours, not just his problems or her problems or their problems; we need to try to save everyone, not just ourselves
- Stability work/exercises
  - Unstable life conditions and importance of having stability
  - Left/right brain exercise
  - Mini group-counseling/therapeutic work
- Practical/easy self-care strategies
  - Taking water
  - Breathing exercises
  - Eating food on time
- Motivation
  - Make them feel like there is someone who thinks they are special; give them the title of special women because they are doing special work
  - Promoting productivity and self-reliance

Note:
- Karuna will offer to give pro-bono counseling to interested women

Expert #2 Training Outline (Meditation Guru)

Objectives
- Raise awareness about women and power in Nepal
- Provide brief overview of Brahma Kumaris (BK)
- Stress the role of moral strength in helping women gain more equality/power
- Explain why money is not the only thing that determines wealth
- Create a sense of optimism about empowering women in the entertainment sector
- Importance of having a positive attitude
- True introduction and powers of the soul
- Our role in creating and solving problems
- Importance of self awareness and having a clean mind
- Practice guided meditation

Key Learning Points
- Understand real identity and fundamental qualities of the soul
- Help them start to overthrow the mindset that they are 'weak' women
- Develop a strong and inspiring personality

Outline
- Women in Nepal
  - Raise awareness of male-domination in Nepali society and how it affects women (illiteracy, poverty, low self esteem)
  - Discuss how women are becoming more powerful and strong (more women in powerful positions, such as politicians, doctors, police)
  - But still, there is an imbalance between power of men and power of women and many women are still victims (e.g., domestic violence, cruel behavior)
  - Women should be respected and seen as powerful; paradox between worship of powerful goddesses and lack of power/respect given to women
- About Brahma Kumaris (BK)
  - BK as sisterly organization led by women
  - Teach about values, how to get rid of inferiority complex, and try to give knowledge and a new awareness
  - Example of how BK helped a group of very disadvantaged rural women find their internal power and moral strength
  - Importance of moral strength; women can move forward easily if they are morally strong
  - Example of a laborer who turned his life around after coming to BK
  - Empowering other women
    - If we are very determined and are a good facilitator with the women in the entertainment sector, we can help them change their lives
    - There are a lot of NGOs working for these women and at least they have come out of their thinking that they can't do anything and aren't educated, so they are becoming empowered
- Money is not the only thing that determines wealth

- o Wealth without work will never give you peace; without honesty or sincerity, money will not give you peace
- o Rich people are not always happy; they are sometimes poor spiritually so they can't sleep properly and are always worrying
- o Example of an Australian man who was born without legs and arms
- o Example of women in remote village who have no access to money or industry but were still able to start their own cooperative and sustain themselves through farming and saving a very small amount of money
- Importance of having a positive attitude
  - o If you have a negative attitude, you see everyone negative; if you have a positive attitude, you see everyone positive
  - o If you are happy with yourself and positive then you will be happy
  - o Example of a guy who was very frustrated with life and met a saint who sent him on a quest for cloth from someone good/happy
  - o Lesson: Everyone has different reasons for being unhappy
- True introduction and powers of the soul
  - o Understanding body vs. soul – true introduction
  - o 7 inherent powers of the soul (peace, love, prosperity, power, happiness, purity, knowledge) – our souls all come from a place full of these virtues, and we all have the inner power to reconnect with these inherent virtues
  - o Importance of self-awareness and reconnecting with these powers through meditation/introspection
  - o Reconnecting with these soul powers can help promote positive thoughts and behaviors and abolish negativity in our lives
- Our role in creating and solving problems
  - o We create our problems through bodily and material expectations, but we also have the inner power to solve these problems
  - o One of the goals of meditation is to accept our karmic account and move forward in a way that helps us build positive karma
  - o If we keep our mind clean, embody love and have a strong connection with our spirituality/soul consciousness, we will have no problems in our life
- Importance of cleaning the mind
  - o Importance of regularly checking in with yourself throughout the day
  - o We clean our bodies and clothes, and in the same way it is also important for us to clean our mind.
  - o With a clean mind, we are better able to control our mind and generate more positive/necessary thoughts and less negative/unnecessary thoughts
  - o Importance of aligning thoughts, words and actions
- Practice guided meditation

Expert Trainer #3 Training Outline (Life Skills Trainer)

Objectives
- Will be able to say: " Who am I? "
- Will be able to self realize
- Will be able to find a person's capacity and ability
- Self assess ones' ethics and beliefs
- How ones' ethics and beliefs effect on their behavior (discuss)

Techniques
- Self-thinking, paired discussion, group discussion, picture discussion, and games etc.

Materials
- One-one picture of a male and female, newsprint, chart paper

Process
- Explain training objectives
- Play a game re: "I like it, I don't like it"
- Display a man's and a woman's picture
- Distribute metacards to each and everyone and ask them to write the things they have as in like, physical, mental, social, and family things
- Ask them to paste them over a poster
- Discuss on each and every points
- Paste "Who am I" chart on the wall and do the discussion and make comparisons
- Make them realize that even just an individual/they have so many things with them
- Make a discussion on each participants' notebook contents
- Assign group work (discuss and write in newsprint)
- Distribute their written ethics and beliefs
- Make a discussion on their written ethics and beliefs
- Make a pair of two each and ask them to discuss on one ethic/belief each
- Ask them what changes can be brought in their behavior with their ethics and beliefs
- Then, ask them how can they amend or make changes to their difficult ethics and beliefs and discuss upon them

Discuss on some traditional sayings
- Will get good pay job and earn money even if we do not study
- Drinking alcohol will reduce sorrows and pain
- We need to tolerate everything our clients do to us else we will lose our job
- Female shouldn't do male's work
- We should also lie
- It's good to help others etc.

Two cyclic charts

    I, Me, Myself (points in the chart)

Pain, occupation, family, physical structure, ambitions, relatives, interests, skills, fear, imagination, education, body, excitement, voice, beauty, goals and thoughts.

Self Realized Person (points in the chart)
Relation, contents, work, talk about positive behavior, weaknesses, strengths, clear, feel, with logical points, able to distinguish between right and wrong, friendly, ethics, thoughts and goals.

Appendix E: Phase 2 Customized Teaching Aids

Drawing for Expert Trainer #1: Psychologist

Appendix F: Peer Educator Screening Survey

RAKSHA NEPAL PEER EDUCATOR PRE-SCREENING SURVEY	

Name: _____ **Phone Number:** _____

Group name: _____

INSTRUCTIONS
- **It is very important for you to be entirely honest while answering these questions.**
- **This survey will be stored in a safe place. Only project staff will have access to it.**
- **There are no right or wrong answers!**

1. How old are you?	
2. What is your ethic group?	
3. What is your religion?	a. Hindu b. Buddhist c. Other _____
4. Are you married?	❑ Married ❑ Not married
5. How many children do you have?	
6. What is the highest level of school you've completed?	Level _____ ❑ I have never attended school
7. How long have you been a member of your Raksha group?	Years _____ Months _____
8. Have you taken any trainings provided by other NGOs?	❑ Yes ❑ No (skip next question)
9. Please list all trainings you've taken by other NGOs in the last year here: (When, topic of training, name of NGO, length of training in hours) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	
10. In the last year, have you been exposed to peer educators from other NGOs?	❑ Yes (From where:_____) ❑ No (skip next question)

11. What did they talk to you about?	
12. How long have you worked in the entertainment sector?	
13. Where do you currently work? (check '☐' all that apply)	☐ Massage parlor ☐ Cabin restaurant ☐ Dance bar ☐ Bhatti ☐ Guest house ☐ Other _____
14. In the past, where else have you worked?	☐ Massage parlor ☐ Cabin restaurant ☐ Dance bar ☐ Bhatti ☐ Guest house ☐ Nowhere else ☐ Other _____
15. How comfortable do you feel talking with the other women you work with?	☐ Very comfortable ☐ Somewhat comfortable ☐ Not very comfortable
16. How comfortable do you feel speaking your opinion in a large group of people?	☐ Very comfortable ☐ Somewhat comfortable ☐ Not very comfortable
17. In a group discussion, what role do you usually take?	☐ I do a majority of the talking ☐ I talk a lot but also make sure others can share their opinions/concerns ☐ I mostly let others talk, unless I have something important to say ☐ I rarely say anything
18. How often do your coworkers go to you when they need advice or help?	☐ Very frequently ☐ Somewhat Frequently ☐ Not frequently
19. How confident do you feel giving advice to your coworkers?	☐ Very confident ☐ Somewhat confident ☐ Not very confident

How strongly do you agree or disagree with the following?

20. I see myself as dependable and self-disciplined.	☐ Agree a lot ☐ Agree a little	☐ Disagree a lot ☐ Disagree a little
21. I see myself as disorganized and careless.	☐ Agree a lot ☐ Agree a little	☐ Disagree a lot ☐ Disagree a little

22. I see myself as anxious and easily upset.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
23. I see myself as calm and emotionally stable.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
24. I see myself as shy, soft-spoken.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
25. I see myself as extraverted, enthusiastic.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little

26. What are your personal strengths? What do people like most about you?

27. What do you think are your personal weaknesses?

28. Do you consider yourself a leader? Why or why not?

29. Why do you want to be a peer educator?

Availability: Please tell us days/times when you are available to participate in training:

Sunday: _____

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____

Saturday: _____

Appendix G: Post Training Reaction Survey

<table>
<tr><td colspan="3">

Haamro Raksha Peer Educator Training
Training Reaction Survey

</td></tr>
<tr><td colspan="3">

Date: _____ ID Number:
_____

</td></tr>
<tr>
<td>1. How would you rate today's training overall?</td>
<td colspan="2">❑ Excellent
❑ Good
❑ Average
❑ Poor
❑ Very poor</td>
</tr>
<tr>
<td>2. The length of today's training was…</td>
<td colspan="2">❑ Too long
❑ Too short
❑ Just right</td>
</tr>
<tr>
<td>3. I will be able to apply the lessons learned in this training to my daily life.</td>
<td>❑ Agree a lot
❑ Agree a little</td>
<td>❑ Disagree a lot
❑ Disagree a little</td>
</tr>
</table>

Please check '❑' the box to rate your level of satisfaction with the following.

The trainer:

	Excellent	Good	Average	Poor	Very Poor
4. Clearly stated the objectives/goals					
5. Presented the materials at an appropriate level and pace					
6. Was responsive to questions					

<table>
<tr><td>7. What did you like most about today's training?</td></tr>
<tr><td>8. What was the most important thing you learned in today's training?</td></tr>
<tr><td>9. Do you have any suggestions for how today's training could have been better?</td></tr>
</table>

Raksha Nepal Women's Network Group Pilot-Survey
Date: _____ID Number: _____
Group name: _____Group type: _____

INSTRUCTIONS
- **It is very important for you to be entirely honest while answering these questions.**
- **All of your responses will be kept 100% confidential.**
- **Your name will not be linked to your responses. No one will ever be able to find out your answers to these questions.**
- **There are no right or wrong answers.**

1. How old are you?	
2. What district are you from?	
3. What is your ethnic group?	
4. How long have you lived in Kathmandu?	Years _____ Months _____
5. What is your current marital status?	❑ Married ❑ Single ❑ In a relationship with one man (living together) ❑ In a relationship with one man (not living together) ❑ Separated/deserted ❑ Divorced ❑ Widowed ❑ Other _____
6. How many children do you have?	

7. What is your religion?	❑ Hindu ❑ Buddhist ❑ Christian ❑ Muslim ❑ None ❑ Other _____
8. What is the highest level of school you've completed?	Level _____ ❑ I have never attended school
9. How is your current health?	❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor
10. How long have you been a member of your Raksha network group?	Years _____ Months _____
11. How long have you worked in the entertainment sector?	
12. Where do you currently work? (check '❑' all that apply)	❑ Massage parlor ❑ Cabin restaurant ❑ Dance bar ❑ Bhatti ❑ Other
13. What is your current position/job title?	❑ _____ ❑ None
14. For what reason(s) did you start working in this sector? (check '❑' all that apply) ***When giving the survey, just read the question and circle all of their responses. Do not prompt them with these response options just circle what they say on their own.**	❑ To pay for living expenses (rent, food, bills) ❑ To pay for my education ❑ To pay for my children's education ❑ Someone forced me to do this job ❑ Had no other way to earn income ❑ A friend or relative was doing it ❑ Became a widow ❑ Was deserted by husband ❑ Other reasons: _____
15. At what other types of places have you worked in the past? (check '❑' all that apply)	❑ None ❑ Massage parlor ❑ Cabin restaurant ❑ Dance bar ❑ Bhatti ❑ Other
16. Do you ever drink alcohol at work?	❑ Yes ❑ No (skip next question)
17. How often?	❑ A lot ❑ Sometimes ❑ Only a little

18. Do you ever do drugs at work?	❑ Yes ❑ No (skip next question)
19. How often?	❑ A lot ❑ Sometimes ❑ Only a little
20. Do you have a **citizenship certificate** and if so, for how long have you had it?	❑ Yes (Since when:_____) ❑ No
21. Do you have saving in Rakshashree? If yes, since when?	❑ Yes (Since when: _____) ❑ No
22. Are you saving anywhere else besides Rakshashree? If yes, since when?	❑ Yes (Since when: _____) ❑ No
23. Do you have a **voter ID** and if so, for how long have you had it?	❑ Yes (Since when: _____) ❑ No
For questions 24 through 41, follow these instructions: • **Listen to each statement** • **Check '❑' the box that represents how strongly you agree or disagree.**	
24. I feel ashamed to tell others where I work.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
25. I feel ashamed to go to Raksha Nepal and other NGOs	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
26. I feel confident giving advice to my coworkers, neighbors, and friends.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
27. I feel confident speaking my opinion in front of others.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
I am confident that women in the entertainment sector can work together to…	
28. Keep each other safe from harm	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

29. Speak up for our rights.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
30. Improve our lives.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
Questions 31 through 41 are about your coworkers. Your coworkers are the other women you work with (not your boss/management or clients).	
31. I can count on my coworkers if I need to borrow money.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
32. I can count on my coworkers to take me to the hospital.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
33. I can count on my coworkers if I need to talk about my problems.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
34. I can count on my coworkers if I need advice.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
35. I can count on my coworkers if I need somewhere to stay.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
36. I can count on my coworkers to help with a violent or difficult client.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
37. The group of women I work with is a united group.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree
38. I can trust the majority of my coworkers.	❏ Strongly agree ❏ Agree ❏ Disagree ❏ Strongly disagree

In general, my colleagues…	
39. Get along well.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
40. Only worry about themselves.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree
41. Are always arguing with each other.	❑ Strongly agree ❑ Agree ❑ Disagree ❑ Strongly disagree

For questions 42 through 59, follow these instructions:
- **Listen to each statement**
- **Check '' the picture that represents how strongly you agree or disagree.**

If I'm in need, I can reach or access services related to…

42. Counseling/mental health

Strongly Disagree   Disagree   Agree   Strongly Agree

43. Sexual health, including HIV/STI testing treatment

Strongly Disagree   Disagree   Agree   Strongly Agree

44. Reproductive health and family planning

Strongly Disagree   Disagree   Agree   Strongly Agree

45. Medical healthcare, such as doctor visits and medications

Strongly Disagree   Disagree   Agree   Strongly Agree

46. Support for any forms of violence, whether at work or at home

Strongly Disagree   Disagree   Agree   Strongly Agree

47. Drug and alcohol addiction

Strongly Disagree   Disagree   Agree   Strongly Agree

48. Legal advice and services

Strongly Disagree   Disagree   Agree   Strongly Agree

How much do you agree with the following:

49. I take a lot of time to solve difficult problems in my life.

Strongly Disagree   Disagree   Agree   Strongly Agree

50. I can easily solve problems in my life.

Strongly Disagree   Disagree   Agree   Strongly Agree

51. I can solve difficult problems if I try hard enough.

Strongly Disagree   Disagree   Agree   Strongly Agree

52. I can always figure out how to get what I want.

Strongly Disagree   Disagree   Agree   Strongly Agree

53. It is easy for me to accomplish my goals.

Strongly Disagree   Disagree   Agree   Strongly Agree

54. I am confident I could deal efficiently with unexpected events.

Strongly Disagree   Disagree   Agree   Strongly Agree

55. I can solve most problems if I make the necessary effort.

Strongly Disagree   Disagree   Agree   Strongly Agree

56. I can remain calm when facing difficulties because I can rely on my coping abilities.

Strongly Disagree   Disagree   Agree   Strongly Agree

57. When I have a problem, I can usually find several solutions.

Strongly Disagree	Disagree	Agree	Strongly Agree

58. If I am in trouble, I can usually think of a solution.

Strongly Disagree	Disagree	Agree	Strongly Agree

59. I can usually handle whatever happens to me.

Strongly Disagree	Disagree	Agree	Strongly Agree

For questions 60 through 75, follow these instructions:
- **Listen to each statement**
- **Check '☐' the picture that represents how often you have felt that way.**

In the last month, how often have you felt…

60. Unable to control the important things in your life?

Never	Sometimes	Often	Always

61. Confident about your ability to handle your personal problems?

Never	Sometimes	Often	Always

62. That things were going your way?

Never	Sometimes	Often	Always

63. Difficulties were piling up so high that you could not overcome them.

Never	Sometimes	Often	Always

When you think about your work over the last month, how often did you feel the following…

64. You have a choice to decide WHAT you do at your work?

Never	Sometimes	Often	Always

65. You have a right to decide HOW you do your work?

Never	Sometimes	Often	Always

66. Tired

Never	Sometimes	Often	Always

67. Disappointed with people

Never   Sometimes   Often   Always

68. Hopeless/depressed

Never   Sometimes   Often   Always

69. Trapped

Never   Sometimes   Often   Always

70. Helpless

Never   Sometimes   Often   Always

71. Physically weak/Sickly

Never   Sometimes   Often   Always

72. Worthless

Never   Sometimes   Often   Always

73. Like a failure Never Sometimes Often Always	

73. Like a failure

Never   Sometimes   Often   Always

---

74. Difficulties sleeping

Never   Sometimes   Often   Always

---

75. "I've had it"

Never   Sometimes   Often   Always

For questions 76 through 81, follow these instructions:
- **Listen to each statement**
- **Check '☐' the box that represents how often you have felt that way.**

In the last month, how often have your coworkers…

76. Been disrespectful or rude to you?	☐ Always ☐ Often ☐ Sometimes ☐ Never
77. Shouted at you?	☐ Always ☐ Often ☐ Sometimes ☐ Never
78. Humiliated or ridiculed you?	☐ Always ☐ Often ☐ Sometimes ☐ Never
79. Ignored or excluded you?	☐ Always ☐ Often ☐ Sometimes ☐ Never

80. Abused you physically?	❏ Always ❏ Often ❏ Sometimes ❏ Never
81. Threatened you with violence?	❏ Always ❏ Often ❏ Sometimes ❏ Never

For questions 82 through 89 check '❏' true or false.

82. No matter who I'm talking to, I'm always a good listener.	❏True ❏ False
83. There have been occasions when I took advantage of someone.	❏True ❏ False
84. I'm always willing to admit when I make a mistake.	❏True ❏ False
85. I am always courteous, even to people who are disagreeable.	❏True ❏ False
86. I have never been annoyed when people expressed ideas different from my own.	❏True ❏ False
87. There have been times when I was quite jealous of the good fortune of others.	❏True ❏ False
88. I am sometimes irritated by people who ask favors of me.	❏True ❏ False
89. I have never deliberately said something that hurt someone's feelings.	❏True ❏ False
90. In general, how happy are you with your life? Mark a check '❏' on the line. :)- :(	

Appendix I: Baseline Survey

<table>
<tr><td colspan="2" align="center">Raksha Nepal Women's Group
Pre-Survey</td></tr>
<tr><td colspan="2">
Date: _____

ID Number: _____

Group name: _____
</td></tr>
<tr><td colspan="2">
<div align="center">INSTRUCTIONS</div>

- **All of your responses will be kept 100% confidential.**
- **Your name will not be linked to your responses. No one will ever be able to find out your answers to these questions.**
- **There are no right or wrong answers.**
- **It is very important for you to be entirely honest while answering these questions.**
</td></tr>
<tr><td>1. How old are you?</td><td></td></tr>
<tr><td>2. What district are you from?</td><td></td></tr>
<tr><td>3. What is your ethnic group?</td><td></td></tr>
<tr><td>4. How long have you lived in Kathmandu?</td><td>Years _____
Months _____</td></tr>
<tr><td>5. Why did you leave your village?</td><td></td></tr>
<tr><td>6a. Are you married?</td><td>❑ Yes
❑ No (skip next question)</td></tr>
<tr><td>6b. Does your husband help support you and your family financially?</td><td>❑ Yes
❑ No</td></tr>
<tr><td>7. How many children do you have?</td><td></td></tr>
<tr><td>8. What is your religion? (check '❑' all that apply)</td><td>❑ Hindu
❑ Buddhist
❑ Other

_____</td></tr>
<tr><td>9. What is the highest level of school you've completed?</td><td>Level _____
❑ I have never attended school</td></tr>
</table>

10. How is your current health?	❑ Excellent ❑ Good ❑ Fair ❑ Poor
11. How long have you been a member of your Raksha group?	Years _____ Months _____
12. In the last year, have you gone to any trainings or workshops related to psychosocial well-being or life skills?	❑ Yes ❑ No
13. How long have you worked in the entertainment sector?	
14. Where do you currently work? (check '❑' all that apply)	❑ Massage parlor ❑ Cabin restaurant ❑ Dance bar ❑ Guest house ❑ Bhatti ❑ Other: _____
15. For what reason(s) did you start working in this sector? (check '❑' all that apply) **When giving the survey, do not say these response options, just check what they say on their own.**	❑ To pay for living expenses (rent, food, bills) ❑ To pay for my education ❑ To pay for my children's education ❑ Someone forced me to do this job ❑ Had no other way to earn income ❑ A friend or relative was doing it ❑ Became a widow ❑ Was deserted by husband ❑ Other reasons: _____
16. Have you consumed alcohol during your work in the last month?	❑ Yes ❑ No
17. Have you consumed drugs during your work in the last month?	❑ Yes ❑ No
18. Do you have a **citizenship certificate**?	❑ Yes ❑ No
19. Do you have **saving in Rakshashree**?	❑ Yes ❑ No
20. Do you have **savings anywhere else besides Rakshashree**?	❑ Yes ❑ No
21. Do you have a **voter ID**?	❑ Yes ❑ No

How strongly do you agree or disagree with the following:

22. It is difficult for me to tell others where I work.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
23. I feel ashamed to go to Raksha Nepal	❑ Agree a lot	❑ Disagree a little

and other NGOs.	❑ Agree a little	❑ Disagree a lot
24. I feel confident giving advice to my coworkers, neighbors, and friends.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
25. I feel confident speaking my opinion in front of others.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
26. I am confident that women in my sector can work together to speak up for our rights.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot

Questions 27 through 31 are about your coworkers. Your coworkers are the other women you work with (not your boss/management or clients).

How strongly do you agree or disagree with the following:

27. I can count on my coworkers if I need advice.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
28. I can count on my coworkers to help with a violent or difficult client.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
29. I can trust my coworkers.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
30. In general, my coworkers get along well.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
31. In general, my coworkers only worry about themselves.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot

In need of help, how much do you agree or disagree that you can access…

32. Counseling/mental health services	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
33. Sexual health services, including HIV/STI testing treatment	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
34. Reproductive health and family planning services	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
35. Medical healthcare, such as doctor visits and medications	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
36. Help from anyone and from anywhere if you experience violence, whether at work or at home	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
37. Legal advice and services	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot

How strongly do you agree or disagree with the following?

38. It is easy for me to accomplish my goals.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
39. I can solve most problems if I make the	❑ Agree a lot	❑ Disagree a little

necessary effort.	❑ Agree a little	❑ Disagree a lot
40. If I am in trouble, I can usually think of a solution.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
41. I am aware of my strengths and weaknesses and understand how they influence my life.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
42. I have the power inside me to be happy and strong despite my problems.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
43. I understand what psychosocial health is and why it's important.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot

Questions 44-53 ask about how often (always, often, a little or never) you have felt a certain way in the last month. Only think about how you have felt over the last month.

44. How often did you feel you could decide what you do at work and how you do your work?	❑ Always ❑Often/Sometimes	❑ A little ❑ Never
45. Regarding your work, how often did you feel tired?	❑ Always ❑ Often	❑ A little ❑ Never
46. Regarding your work, how often did you feel depressed?	❑ Always ❑ Often	❑ A little ❑ Never
47. Regarding your work, how often did you feel helpless?	❑ Always ❑ Often	❑ A little ❑ Never
48. Regarding your work, how often did you feel "I've had it"?	❑ Always ❑ Often	❑ A little ❑ Never
49. How often have your coworkers been disrespectful or rude to you?	❑ Always ❑ Often	❑ A little ❑ Never
50. How often have your coworkers ignored or excluded you?	❑ Always ❑ Often	❑ A little ❑ Never
51. How often have your coworkers abused or threatened you?	❑ Always ❑ Often	❑ A little ❑ Never
52. How much have you had worries, sadness, or thoughts playing in your heart mind?	❑ Always ❑ Often	❑ A little ❑ Never
53. How often did you feel that difficulties were piling up so high in your life that you could not overcome them?	❑ Always ❑ Often	❑ A little ❑ Never

For questions 54 through 57 check '❑' true or false.

54. There have been occasions when I took advantage of someone.	❑ True ❑ False
55. I'm always willing to admit when I make a mistake.	❑ True ❑ False

56. I have never been annoyed when people expressed ideas different from my own.	❑ True ❑ False
57. I am sometimes irritated by people who ask favors of me.	❑ True ❑ False
58. Mark a check ' ❑' on the line to show how happy you have been in your life in the last month. Mark a check '❑' on the line. :)---------------------------------:(**Extremely happy** **Extremely unhappy**	

Raksha Nepal Women's Group **Post-Survey**	

Date: _____

ID Number: _____

Group name: _____

Have you changed groups within the last 3 months? _____

If yes, what was the name of your old group? _____

INSTRUCTIONS
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- **There are no right or wrong answers.**
- **It is very important for you to be entirely honest while answering these questions.**

10. How is your current health?	❑ Excellent ❑ Good ❑ Fair ❑ Poor	

How strongly do you agree or disagree with the following:

22. It is difficult for me to tell others where I work.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
23. I feel ashamed to go to Raksha Nepal and other NGOs.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
24. I feel confident giving advice to my coworkers, neighbors, and friends.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
25. I feel confident speaking my opinion in front of others.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
26. I am confident that women in my sector	❑ Agree a lot	❑ Disagree a

can work together to speak up for our rights.	☐ Agree a little	little ☐ Disagree a lot

Questions 27 through 31 are about your coworkers. Your coworkers are the other women you work with (not your boss/management or clients).

How strongly do you agree or disagree with the following:

27. I can count on my coworkers if I need advice.	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
28. I can count on my coworkers to help with a violent or difficult client.	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
29. I can trust my coworkers.	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
30. In general, my coworkers get along well.	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
31. In general, my coworkers only worry about themselves.	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot

In need of help, how much do you agree or disagree that you can access…

32. Counseling/mental health services	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
33. Sexual health services, including HIV/STI testing treatment	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
34. Reproductive health and family planning services	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
35. Medical healthcare, such as doctor visits and medications	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
36. Help from anyone and from anywhere if you experience violence, whether at work or at home	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot
37. Legal advice and services	☐ Agree a lot ☐ Agree a little	☐ Disagree a little ☐ Disagree a lot

How strongly do you agree or disagree with the following?

38. It is easy for me to accomplish my goals.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
39. I can solve most problems if I make the necessary effort.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
40. If I am in trouble, I can usually think of a solution.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
41. I am aware of my strengths and weaknesses and understand how they influence my life.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
42. I have the power inside me to be happy and strong despite my problems.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot
43. I understand what psychosocial health is and why it's important.	❑ Agree a lot ❑ Agree a little	❑ Disagree a little ❑ Disagree a lot

Questions 44-53 ask about how often (always, often, a little or never) you have felt a certain way in the last month. Only think about how you have felt over the last month.

44. How often did you feel you could decide what you do at work and how you do your work?	❑ Always ❑ Often/Sometimes	❑ A little ❑ Never
45. Regarding your work, how often did you feel tired?	❑ Always ❑ Often	❑ A little ❑ Never
46. Regarding your work, how often did you feel depressed?	❑ Always ❑ Often	❑ A little ❑ Never
47. Regarding your work, how often did you feel helpless?	❑ Always ❑ Often	❑ A little ❑ Never
48. Regarding your work, how often did you feel "I've had it"?	❑ Always ❑ Often	❑ A little ❑ Never
49. How often have your coworkers been disrespectful or rude to you?	❑ Always ❑ Often	❑ A little ❑ Never
50. How often have your coworkers ignored or excluded you?	❑ Always ❑ Often	❑ A little ❑ Never
51. How often have your coworkers abused or threatened you?	❑ Always ❑ Often	❑ A little ❑ Never
52. How much have you had worries, sadness, or thoughts playing in your heart mind?	❑ Always ❑ Often	❑ A little ❑ Never
53. How often did you feel that difficulties	❑ Always	❑ A little

were piling up so high in your life that you could not overcome them?	❑ Often	❑ Never

For questions 54 through 57 check '❑' true or false.

54. There have been occasions when I took advantage of someone.	❑ True ❑ False
55. I'm always willing to admit when I make a mistake.	❑ True ❑ False
56. I have never been annoyed when people expressed ideas different from my own.	❑ True ❑ False
57. I am sometimes irritated by people who ask favors of me.	❑ True ❑ False

58. Mark a check ' ❑' on the line to show how happy you have been in your life in the last month.

:)------------------------------------:(

**Extremely
happy**

**Extremely
unhappy**

59. Have you heard of the Haamro Raksha program?	❑ Yes ❑ No
60a. Does your group have a peer educator from the Haamro Raksha program?	❑ Yes ❑ No (skip to 61a)
60b. If yes, how many times did she share her training knowledge with you during your group meetings?	❑ 0 (skip to 61a) ❑ 1 ❑ 2 ❑ 3
60c. Which topics were covered? • What else do you wish she would've talked to you about related to psychosocial health?	
60d. What was your favorite topic?	
60e. What other topics related to psychosocial health would you be interested in learning about?	
61a. Do you want to stay at your current job?	❑ Yes ❑ No

61b. If yes, why? If no, what other kind of job would you rather have?
62. When thinking about the harassment you experience at work, what suggestions do you have and for whom?

Appendix K: Peer Education Efficacy Questions

Date: _____	ID Number: _____	
How much you agree or disagree with the following statements:		
1. I am able to share my thoughts and ideas with others easily.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
2. I am interested to hear others' thoughts and ideas.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
3. I am a good listener.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
4. I can facilitate group discussions.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
5. I am confident that I can teach others.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
6. I can explain difficult things to others.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
7. I have leadership skills. *Leader	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
8. I feel comfortable as a group leader.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
9. My colleagues see me as a leader.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
10. If someone comes to me with a problem, I am confident that I can help them.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
11. I can talk to others about problems in their heart-mind.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
12. I feel confident giving advice to others.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little
13. I can talk to others about my thoughts and feelings.	❑ Agree a lot ❑ Agree a little	❑ Disagree a lot ❑ Disagree a little

Appendix L: Survey Administration Protocol

SURVEY ADMINISTRATION & TRAINING ANNOUCEMENT

Goal: To give 200 surveys to network group members

What to Bring:
- This document
- Clipboards with ID number sheets
- Copies of survey
- Copies of consent forms
- Rs 100 bills
- Information session announcements

Survey Steps:
1. Confirm age 18 or older
2. Assign ID number by writing woman's **first** and **last** name next to a number on your clipboard sheet
3. Write this ID number on her survey
4. Read the consent form and ask her to sign if she agrees to participate
5. Keep the signed consent form and give her a blank copy
6. Read all bold instructions while giving survey
7. After the survey, give Rs. 100 and ask her to sign your clipboard sheet
8. Announce the peer educator training opportunity
9. Thank her for her time

Haamro Raksha Peer Educator Training:
- Raksha Nepal, in collaboration with a volunteer from the U.S., has developed a very unique and exciting training program to become a peer educator.
- The name of the program is "Haamro Raksha," and the goal is to help reduce stress and tension and enhance psychosocial health and well-being.
- There will be a total of six trainings that will take place over 4-6 weeks.
- Trainings will take place in the morning with daal bhat served after.
- All trainings will take place at Raksha Nepal.
- If selected for the training, you will receive Rs. 100 for transportation after each training.
- If you complete the training, you will also receive a certificate of completion.
- Spaces are limited, and we can only train 10 women.
- If you would like to learn more about the training and apply, we invite you to attend the informational session at Raksha. **Hand out information session announcements**
- Please only apply if you feel confident that you can commit to attending all trainings and program activities. If you miss a training session, you will not be allowed to attend any of the future trainings.

Appendix M: Sample Observational Rating Form

*Used to rate performance of practice teaching for content from Expert Trainer #1 (Psychologist)

Date: _____ Peer Educator Name: _____

Group Name: _____

PEER EDUCATOR PERFORMANCE CHECKLIST: Rate the skills of the peer educator on a scale of 1-5

1 Low; needs a lot of additional training and practice
2 Basic
3 Adequate
4 Good
5 Excellent; an outstanding role model for her peers

SKILL	RATING	SUGGESTIONS / COMMENTS
1. CLARITY OF CONTENT Spoke clearly, was easy to understand, didn't go into too much depth and explain more than needed		
2. OPENNESS TO QUESTIONS Answered questions and encouraged participants to ask questions		
3. MODEL & LEADER Encouraged others to speak and participate actively; helped participants to come to conclusions		
4. CHECK FOR UNDERSTANDING Asked questions to make sure participants understand		
5. EXPERIENTIAL PRACTICE Asked the participants how to apply the lessons learned in their daily life		
6. SELF CONFIDENCE Demonstrated confidence in teaching participants about the knowledge gained		
7. STAY FOCUSED Effectively managed participants who went off topic		

Check which topics were covered/not covered by the peer educator

Topic (TBD based on content of training)	Covered	Not Covered
9. Health is not just physical, also mental, emotional & social		
10. Physical health problems are a result of mental/emotional/social problems		
11. We always thinking about and taking care of others, important to think about and allocate time for ourselves too		
12. In order to help and empower others we must empower ourselves first		

Comments/Suggestions:

Appendix N: Exit Interview Guides

Peer Educator Exit Interview Questions

Training Experience

1. What skills did you gain from the training?
2. What did you like most about it? Why?
3. What didn't you like about it? Why?
4. What could have made the training better?
5. Are there certain topics you wanted to cover in more detail?
6. Are there topics not covered that you wish were included?
7. Do you have any specific comments about any of the trainers (positive or negative)?
8. Who was your favorite trainer and why?

Teaching Experience

In group meetings:

9. What are your general reactions to teaching in your group meeting?
10. What was easy for you?
11. What was difficult for you?
12. Looking back, is there anything you could have done differently to be more effective?
13. Were the artist drawings useful to you? If yes, how so? If no, why not?
14. Are there any other tools or resources that would have been helpful to you as you were teaching?
15. How did the women in your group react to your teaching?
    a. What did they like most?
    b. What did they like least?
    c. Do you think they benefited from your teaching? If so, how? If not, why not?
    d. What could have made the teaching more beneficial for them?
    e. Did they have any suggestions for you? If so, what were they?

At work:

16. Have you done any peer education at work with your coworkers? If no, why? If yes,
    a. How did you go about it? What was your approach?
    b. What are your general reactions to teaching at work with your coworkers?
    c. What challenges did you face?
    d. What strategies did you use to overcome these challenges?
    e. What would help you be more effective teaching your peers at work?

Overall

17. Have you benefited from participating in this program? If so, how? If not, why not?
18. Have you gained any skills from this experience? If so, what did you gain?
    a. Will those skills help you in your everyday life? How?
19. Has participation in this program influenced… (If so, how?)
    a. The way you feel about yourself
    b. Your work life

       c. Your relationships with friends and family

       d. Your thoughts about the future

20. Have you changed significantly in any way because of your participation in this training program? How? What did you do? Describe your change in detail.

21. What additional topics would you like to receive training on in the future?

22. Is there anything else you think I should know about this training program or your experiences in teaching?

Field Staff Exit Interview Questions

Training Experience
1.   Overall, how would you describe the training?
23. Thinking about the first 3 days of the training:
      a.   What did you like most? Why?
      b.   What did you like least? Why?
24. Thinking about the 3 expert trainers:
      a.   Which one did you like most? Why?
      b.   Which one did you like least? Why?
      c.   Do you have any comments about any of the other trainers (positive or negative)?
25. Thinking about the debrief sessions with the artists:
      a.   What did you like about them? Why?
      b.   What could have made these sessions more effective?
      c.   What could made the drawings better?
26. Are there certain topics you think should've been covered in more detail?
27. Are there topics not covered that you wish were included?
28. If you were going to give the training again in the future, what would you change to make it better?

Teaching Experience

In group meetings:
29. Please describe the women's teaching experiences in their group meetings.
      a.   What teaching strategies did they use?
      b.   What challenges did they face & what strategies did they use to overcome these challenges?
      c.   Did some peer educators have a more difficult teaching experience than others? Why?
30. How did you help them with their planning/teaching?
31. How could they have been more effective as teachers?
32. Were the artist drawings useful? If yes, how so? If no, why not?
33. Can you think of any other tools or resources that would have been helpful to them?
34. How did the group members react to the teaching?
      a.   What did they seem to like most?
      b.   What did they seem to like least?
      c.   Do you think they benefited from the teaching? If so, how? If not, why not?
      d.   What could have made the teaching more beneficial for them?

At work:
35. Did you observe the peer educators doing any informal peer education at work with their coworkers? If yes:
      a.   How did they go about it? What was their approach?
      b.   How did their coworkers react to the teaching?
      c.   What challenges did they face?
      d.   What strategies did they use to overcome these challenges?

e. How could they be more effective teaching their peers at work?

Overall
36. How do you think the peer educators benefited from participating in this program?
    a. Do you think the women have changed significantly in any way because of their participation in this program?
    b. What skills did they gain from this experience?
    c. Do you think those skills will help them in their everyday lives? How?
37. How do you think their participation in this program has influenced…
    a. The way they feel about themselves
    b. Their work lives
    c. Their relationships with friends and family
    d. Their thoughts about the future
38. Is there anything else you think I should know about this training program or the women's teaching experiences?

Future
39. What do you think about the future of these 10 peer educators?
    a. What should their role be?
    b. How could Raksha continue to train and support them?
    c. Do you have any ideas for other 'expert trainers' that could be recruited to give trainings?
40. What do you think about the future of the Haamro Raksha program?
41. Do you think it is important to continue this program? If no, why? If yes:
    a. Why is it important?
    b. How can this be done?
    c. What role would you like to play?

About the Peer Educators
42. For each of the 10 women, please describe their:
    a. Work history
    b. Current workplace
    c. Title/position
    d. Education/background training
    e. Personal life (e.g., relationship status, children)
    f. Why you chose her as a peer educator?
    g. Was there anything going on in her life that affected her ability to be a peer educator?

Haamro Raksha

Preliminary Report of Findings

Results! on a pilot peer education program to promote psychosocial health among women in the entertainment sector

OVERVIEW

Women in the entertainment sector (ES) in Kathmandu face many dangers as part of their work, including violence, exploitation, harassment, stigma, exposure to STIs/HIV, and forced alcohol and drug use. All of these dangers have a negative impact on their psychosocial health --decreasing their emotional health, social well-being, and sense of empowerment--which in turn affects their ability to protect themselves from future harms.

Raksha Nepal, in collaboration with a Fulbright student researcher from the United States, developed and pilot tested the Haamro Raksha ("our protection") peer education program in order to promote the psychosocial health and empowerment of women working in the ES in Kathmandu, Nepal. Through a 6-week program, 10 women were trained as peer educators and tasked with teaching their peers about different topics related to psychosocial health. (See table to the right for information about the peer educators)

This preliminary report provides an overview of the program and its impact as reported in exit interviews with the peer educators and Raksha field staff.

About Peer Educators N = 10	
Age	24#18%%%Average%%34
Home'District	• Eastern:%2 • Western:%2 • Central:%6
Reason'for' Leaving' Village*	• Conflict:%5 • Domes@c%problem/violence:%5 • Poverty/looking%for%a%job:%3
Time'in'KTM	8#25%rs%%%Median%%8.75%rs
Caste**	• Brahmin:%2 • Chhetri:%2 • Janaja@%4 • Dalit:%1 • Unknown:%1
Religion*	• Hindu:%6 • Buddhist:%2 • Both:%1 • Chris@an:%1
Educa>on	0#8%rs%%%Average%%2.15%rs
Marital'Status	• Married:%9 • Unmarried:%1 • Support%from%usband*:%1
Children	1#5%%%Average%%2.8
Type'of' Workplace*	• Massage:%6 • Cabin%Restaurant:%2 • BhaZ%:%3 • Other:%2
Time'Working' in'ES	4#20%rs%%%Average%%9.05%rs
Reasons'for' Working'in' ES*+	• Pay%for%iving%expenses:%10 • Pay%for%children's%educa@on:%10 • Husband%died/deserted:%6
Time'in' Raksha'Group	1#3%rs%%%Average%%2.23%rs
Social' En>tlements	• Ci@zenship%ard:%10 • Savings%in%akshashree:%10 • Other%avings:%9
Substance'use in'last'month	• Alcohol:%4 • Drugs:%1

* Allowed to select more than one response
**One response missing
+ Top 3 reasons

TRAINING OVERVIEW

- The Haamro Raksha peer education program included 6 training sessions across 6 weeks. Sessions 1-3 were on peer educator skills (communication, teaching, leadership). Sessions 4-6 were on different topics related to psychosocial health:

  - Mental health & importance of self-care (CMC-Nepal)

  - Spiritual health & well-being (Brahma Kumaris)

  - Life skills & understanding strengths, roles & values (Biswas Nepal)

- Two artists helped debrief after sessions 4-6 and created drawings of key psychosocial health lessons learned.

- The peer educators were asked to teach their peers lessons learned using the customized teaching aids.

Mental health & Self Care "My Life"

Spiritual Health & Well-Being "My World"

Life Skills & Understanding Self "Who Am I"

PEER EDUCATOR EXIT INTERVIEWS

9/10 peer educators were interviewed after the program to gather more in-depth feedback about the training and their teaching experiences. They mentioned numerous positive impacts of the program, including:

Expanded knowledge & skills

"Before coming here, we didn't know about these things. Now we know about so many things. We even taught our friends from outside the things that we learned here." (Kali, 40)

Increased confidence

"Before taking the class even while doing 'Namaste' I got nervous. But

now I have confidence in me...From where I was and where I am now, I can see the changes in me." (Ashika, 30)

Heightened self-awareness

"I never took time to understand myself. Now I have understood myself, which has helped to make others understand as well." (Sushila, 48)

Realization of the importance of self-care

"So many things I learned. Yes, also taking care of myself. I should also be strong and then only I can make others strong. Basically I should love myself more." (Sita, 30)

Improved speaking skills

"Earlier I could not talk in front of people. I used to get very nervous...Now it is all different. I feel very satisfied that I can speak without any hesitation." (Sushan, 37)

A more positive outlook

"I feel very happy. I nowadays feel I can do something for myself in life. Earlier even small things used to bother me. I felt helpless and used to cry. But now I look at problems from a different perspective." (Ashika, 30)

All nine peer educators expressed a desire to receive more training in the future.

*Pseudonyms used in place of peer educator names

FIELD STAFF EXIT INTERVIEWS

Two Raksha field staff were also interviewed after the program. Overall, they felt the program was well-designed and should be given to more women if possible. The field staff referred to the customized teaching aids, built in opportunities to practice teaching, and completion certificates as particularly effective aspects of the program.

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Raksha Nepal Research Report

Women in the Entertainment Sector in Kathmandu: Report of Experiences

OVERVIEW

It is estimated that 11,000-13,000 women currently working in the entertainment sector in Kathmandu, Nepal (Frederick, 2010). Women in the entertainment sector (WES) face many dangers as part of their work, including violence, exploitation, harassment, stigma, exposure to STIs/HIV, and forced alcohol and drug use.

In order to develop programming to best meet the needs of WES, it is important to understand their personal aspirations and suggestions for how the harms they face in their work can be reduced and for how they can be better supported.

Raksha Nepal, in collaboration with a Fulbright student researcher from the United States, surveyed 204 women from the entertainment sector and asked them to comment on: 1) their desire to leave or stay in their current jobs and 2) their suggestions related to reducing the harms they face as WES. This brief report provides an overview of the findings.

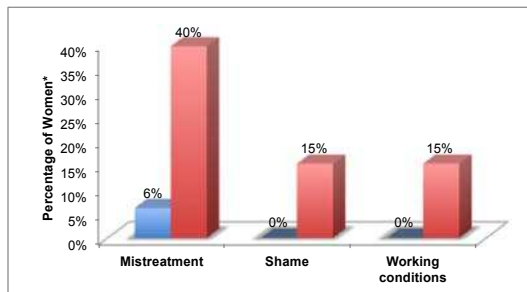| About the Women N = 204	
Age	18-50 years | Average = 26 years
Home District	• Far Western: 1% • Midwestern: 3% • Western: 9.8% • Central: 72.9% • Eastern: 13.3%
Time in KTM	1-25 years | Average = 9.16 years
Caste/Ethnic Group	• Brahmin: 11.3% • Chhetri: 20.1% • Janajati: 52.9% • Dalit: 10.8% • Unknown: 4.9%
Education	• 0-10 years | Average = 3.53 years • No Education: 45.3%
Marital Status	• Married: 78.9% • Unmarried: 21.1% • Support from husband: 8.7%*
Children	• Yes: 69.6% (Number = 1-5) • No: 19.6% • No response: 10.8%
Type of Workplace**	• Massage: 55.2% • Cabin Restaurant: 29.4% • Dance Bar: 13.4% • Guest House: 23.9% • Bhatti: 17/9% • Other: 7.4%
Time in ES	1-20 years | Average = 6.82 years
Reasons for Working in ES**	• No other way to earn income: 75.3% • Pay for children's education: 69.7% • Pay for living expenses: 68.6% • Was deserted by husband: 57.1% • A friend or relative was doing it: 24.2% • Someone forced me: 23.2% • Became a widow: 8.1% • Pay for my education: 7.1%
Social Entitlements	• Citizenship card: 32.8% • Savings in Rakshashree: 82.4% • Other savings: 47.1%

* Of those who are married
**Some indicated more than one

DO YOU WANT TO STAY IN YOUR CURRENT JOB? IF YES, WHY? IF NO, WHAT OTHER KIND OF JOB WOULD YOU RATHER HAVE?

91 women said that wanted to leave their current job and 113 said they wanted to stay in their current job. While responding to this question, some of the women discussed 1) dislikes about current job, 2) reasons for staying in job, and 3) future aspirations.

KEY
- ■ = Stay in job
- ■ = Leave job

Dislikes'about'Current'Job

Bar chart – Percentage of Women* vs. category:
- Mistreatment: 6% (blue), 40% (red)
- Shame: 0% (blue), 15% (red)
- Working conditions: 0% (blue), 15% (red)

Reasons'for'Staying'in'Job

Bar chart – Percentage of Women* vs. category:
- Financial Strain: 54% (blue), 3% (red)
- Difficulty Finding Job: 35% (blue), 3% (red)
- No Education / Qualifications: 25% (blue), 9% (red)

Future'Aspira<ons

Bar chart – Percentage of Women* vs. category:
- Other Work: 2% (blue), 20% (red)
- Own Business: 7% (blue), 9% (red)
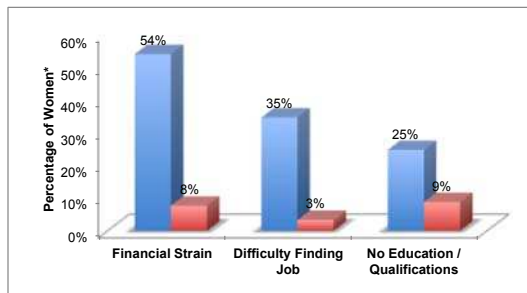- Training: 11% (blue), 27% (red)

Sample'Quotes**

Mistreatment by Society/Police: "I have the skill to massage plus the pay is also okay, but the police and the society has a negative view towards it."

Shame: "Have to live in fear, fear of relatives finding out about this."

Working Conditions: "No time for children. Have to drink forcefully. It is not healthy."

Financial Strain: "I want to remain here because I am financially weak and it is difficult to find a job nowadays."

Difficulty Finding Job: "Want to work in places like a school or a hospital but I have no education. Reference is needed to get a job here in Nepal, I don't know anyone here."

No Education/Qualifications: "I do not have any qualification. Nowadays one needs to have plus two degree to get a job, and I wont get any. So it is not that I want to be, it is okay because I don't have an option."
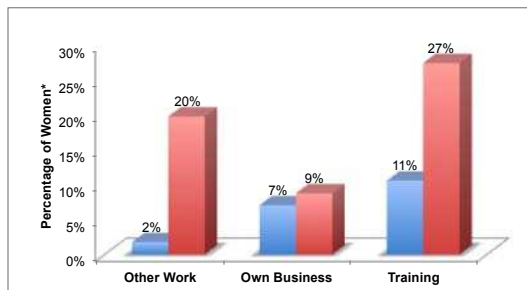
Other work: "I want to work in organizations or in schools, but what to do I have no education, I wont get a job."

Own Business: "I don't have money even to open a small shop."

Training: "I want to come out from this place and take parlor training"

Percentages for blue bars based on number of women who said they wanted to stay in their current job (N = 113) and percentages for red bars based on number of women who said they wanted to leave their current job (N = 91). **Blue text represents quotes from women who said they wanted to stay in their current job and red text represents quotes from women who said they wanted to leave their current job.

WHEN THINKING ABOUT THE HARASSMENT YOU EXPERIENCE AT WORK, WHAT SUGGESTIONS DO YOU HAVE AND FOR WHOM?

The women surveyed directed their suggestions to five targets: 1) government, 2) police, 3) organizations, including Raksha Nepal, 4) WES as a group, and 5) unspecified others (e.g., someone, anybody, people). Many women also made other comments, most often expressing hopelessness and/or praise for Raksha Nepal. The following represents the major themes identified and a sample of the comments made:

Target (%)	Sample Comments
Government of Nepal (3.9%)	**Work with police and other organizations to protect WES:** *"In times of crisis, government who know the policemen well should discuss and the government should not let the policemen take away our people who are innocent."* **Provide support, particularly related to jobs & education:** *"The government should make equal rules and regulations when it comes to education so that people like us could get some education. If I had some education, I would not have to work here."*
Police (2.5%)	**Work with government and other organizations to protect WES:** *"I feel that government and police should coordinate and support us when we have problems."* **Provide justice:** *"I wish the police to take people in custody those who try to abuse, but what to do there are no rules in Nepal."* **Stop unwarranted harassment and arrest of WES:** *"Police, without any reason arrests innocent people, charges case and don't let us clarify ourselves."*
Organizations, including Raksha Nepal (28.9%)	**Work with police, government and other organizations to protect WES:** *"It would be great if the government and women right organization helped the uneducated women to get a good reputed job."* **Unite to advance and provide a voice for WES:** *"Whenever policemen blame the girls and arrests them, I feel that all the women organizations should come together and protest against it. People from this organization aren't united in this issue. That is why people are in pain."* **Provide support, particularly related to jobs, training, education, housing & reestablishment:** *"When I am abused by people at my workplace, I feel organization like Raksha Nepal should provide me with trainings and reestablish me."* **Protect WES from police:** *"I expect Raksha Nepal and other organization should help free our people who get arrested for no valid reasons."* **Provide trainings targeting men:** *"There should also be male organizations so that they learn to respect women, they learn about giving a favorable environment for women to live."* **Understand problems of WES:** *"I wish the concerned organization to understand the problems of people who work in massage parlor/dance bar and do something to change other people's perception."*
WES (1%)	**Unite to advocate for their collective rights:** *"All the women working in this sector should unite with one organization to keep forward the problems of women."*
Unspecified Others (36.3%)	**Provide support, particularly related to education, training & reestablishment:** *"When I find that I am abused, I just wish if anybody could just get me out of this place, give me training and reestablish me."* **Give WES a voice:** *"Concerned people should make sure that we get a chance to defend ourselves."*
Other Comments (31.4%)	**Hopelessness:** *"Nothing is going to happen, nobody is going to do anything. My problems are with me only. I have filled such form many times. Nothing has happened."* **Praising Raksha:** *"I remember Raksha Nepal whenever people abuse me. This organization has always supported me."*