RHRC CONSORTIUM

HIV/AIDS Prevention and Control

A short course for humanitarian workers

Facilitator's Manual

Developed by the Women's Commission for Refugee Women and Children on behalf of the Reproductive Health Response in Conflict Consortium


Behavior Change Communication
Development Interventions
Health Services Interventions
Lack of Awareness
Lack of Power
Lack of Services


THE IMMUNE SYSTEM AFFECT
meningitis
skin infections
HIV
HIV
TB
pneumonia
antibody
antibody
STIs
cancer
candida
diarrhea


message
feedback
message

Contents

Acknowledgements

The *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers* was principally developed by Wendy Venter, an independent consultant to the Women's Commission for Refugee Women and Children. Sandra Krause, Julia Matthews, Diana Quick and Sarah Chynoweth of the Women's Commission for Refugee Women and Children provided project direction, support and editorial oversight.

We would like to acknowledge Wendy Holmes and the International Rescue Committee for the development of the manual, *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations*, which is used as a main resource in this course.

We would like to thank the following people for reviewing the curriculum and providing important recommendations:

- Doris Bartel, *CARE International*
- Meriwether Beatty, *JSI Research and Training Institute*
- Rick Brennan, *International Rescue Committee (IRC)*
- Samantha Guy, *Marie Stopes International*
- Mary Otieno, *International Medical Corps (formerly of IRC)*
- Susan Purdin, *IRC* (*formerly of Columbia University)*
- Paul Spiegel, *United Nations High Commissioner for Refugees*

We would also like to express our appreciation to the participants of the pilot testing and trainings in Sierra Leone, Kenya, Thailand and Pakistan who enriched the curriculum with their knowledge and experience from their conflict-affected settings.

Thanks to the agencies who hosted the pilot testings and trainings (MSI Sierra Leone, IRC Kenya, ARC Thailand and ARC Pakistan) and Wendy Venter's co-facilitators, Susan Purdin, Julia Matthews and Sandra Krause.

Appreciation goes to Lucy Alexander and Tania Vergnani for their expertise in curriculum development, Hennie Venter for his help in illustrating PowerPoint presentations and Border Technicon FM Campus Radio, South Africa, for its assistance in editing audio interviews.

In addition, we'd like to recognize Sandra Green and her team at Green Communication for their outstanding design and production assistance, and Alain Coté and his team at Expression Multimédia for their production assistance of the CD ROMS.

Finally, the University of the Western Cape HIV/AIDS student support group made the HIV/AIDS issue real and personal for everyone involved in the project and we are grateful for their willingness to share their experiences, including Mfundo Alfred Damoyi, Busisiwe Maqungo and Bonile Peter.

The *HIV/AIDS Prevention and Control: A Short Course for Humanitarian Workers* was made possible by the generous support of the Andrew W. Mellon Foundation.

> *...I always felt there is no hope for those infected but the training changed this in me. I will be able to help those infected and affected in living positively – a chance they may not have had...*
>
> (Kenya)

> *...provided an excellent foundation to build on...*
>
> (Thailand)

> *...Actually beyond my expectations in all respects...*
>
> (Pakistan)

Introduction

Course overview

Conflict-affected settings are associated with conditions in which HIV/AIDS and other sexually transmitted infections (STIs) may thrive. These settings often coincide with limited access to means of prevention, treatment and care. STIs, including HIV, if not addressed, may spread rapidly among conflict-affected populations for many reasons. The disturbance of community and family life among displaced populations may disrupt social norms governing sexual behavior. In the absence of traditional socio-cultural constraints, adolescents may begin sexual relations at an earlier age, take sexual risks and face exploitation. Women and children may be coerced into having sex to obtain their survival needs. During civil strife and flight, displaced persons, especially women and girls, are at increased risk of sexual violence, including rape. Proximity to armed forces, a population that has been associated with high rates of HIV, facilitates the spread of HIV in conflict situations. Finally, in displaced settings, populations from low HIV prevalence areas may mix with populations from high prevalence areas, increasing the overall HIV rate in the region.

Given the clear need to address HIV/AIDS in conflict settings and the opportunities which humanitarian interventions may bring, the Women's Commission for Refugee Women and Children (Women's Commission) has developed a course on HIV/AIDS prevention and control aimed at humanitarian workers. The course was developed on behalf of the Reproductive Health Response in Conflict (RHRC) Consortium with funding from the Andrew W. Mellon Foundation.

The course primarily targets health program management staff and clinical staff. Technical aspects of HIV/AIDS programs are presented, but there is a strong emphasis on broader programmatic issues and staff members from non-medical backgrounds will also find the course beneficial.

The course aims to deepen individual understanding of the complexities of HIV/AIDS and to equip participants with knowledge and skills to improve HIV/AIDS program design and implementation. A further important aim is the encouragement of positive attitudes toward people living with HIV/AIDS.

The teaching style is participatory, with short presentations alternating with group activities. The issues covered in the course are applicable to a variety of settings and activities encourage participants to apply information to their own contexts and share examples and experience from their own settings. Based on the topics covered each day, participants are encouraged to develop a daily objective and activities applicable to their program and to review these with facilitators. Follow-up on the activities of course participants as a result of the course is encouraged to monitor and evaluate course outcomes.

A limitation of the course is the breadth of the subject matter to be covered in five days. Therefore, the course does not attempt to provide in-depth knowledge on any of the issues covered, but rather to offer an overview of a comprehensive approach to HIV/AIDS. Clinical aspects of HIV/AIDS management are not covered in detail. However, additional resource materials are suggested to supplement course content and may be used to extend the course for those who have more time to delve deeper into the range of issues presented. Due to the intense nature of the course, it is recommended that at least two facilitators conduct the course, and a maximum of 25 participants attend.

Course outline:

Day 1: Basic facts: transmission routes; vulnerability; clinical manifestations

Day 2: Addressing HIV/AIDS; behavior change communication (BCC)

Day 3: Sexually transmitted infections; voluntary counseling and testing; condoms

Day 4: Universal precautions; mother-to-child transmission; stigma

Day 5: Care of people living with HIV/AIDS: a holistic approach

The course is structured as a cohesive whole, with sessions and days shaped to follow each other. However, it is possible to use individual days or sessions as stand-alone training courses, with adaptation according to audience needs.

For example, Day 1 could be a one-day course for basic awareness-raising among all staff. Day 1, the stigma session in Day 4 and the non-clinical sessions in Day 5 could be combined as a two-day course aimed at raising awareness and addressing attitudes towards people living with HIV/AIDS. The BCC component of Day 2 could be expanded into a two- to three-day BCC course. The Day 3 session on STIs, the Day 4 session on universal precautions and the Day 5 sessions on medical care could each be expanded into a course for clinical staff.

How to use the manual

The manual provides detailed step-by-step direction through each day of the course. Daily session plans provide an outline of presentations and activities, with accompanying timing guides and teaching materials.

Detailed presentation content is provided to aid the facilitator. Presentations aim to be interactive and make use of PowerPoint, posters and flip charts to reinforce teaching. If PowerPoint is not available, an overhead projector can be used equally effectively.

Activities include group work, individual work, role-play, videos and CDs. The manual offers an introduction to each activity and provides notes to supplement plenary discussion.

It is suggested to determine the type of training experience, if any, participants have had prior to the course. This could help to tailor the training to the individuals in attendance and might also offer an opportunity to call upon some of the more experienced and knowledgeable participants to assist in some of the training exercises.

Visual aids are an important component of the course. Posters are used in conjunction with PowerPoint presentations. Facilitators are encouraged to obtain local posters and also to create simple visual aids using the examples provided. A wall display is created each day, building upon the previous day's learning, and remains in place for the duration of the course. The wall display serves as a reminder of subject material covered and also assists participants in reviewing concepts and forming a picture of the course as a whole.

Video and audio materials are also important teaching aids and facilitators should attempt to obtain the resources recommended. Facilitators are also encouraged to identify or create other audio or visual materials that highlight the local context.

Building positive attitudes toward people living with HIV/AIDS (PLWA) is a vital aim of the course and is achieved by drawing attention to the human element of the epidemic. Case studies are taken from the publication "A Broken Landscape" which, through words and photos, provides sensitive and informative insights into the lives of people living with HIV/AIDS in Africa. A theme of the course is the participation of a group of HIV-positive university students from Cape Town, South Africa. They tell their stories through interviews and photographs. Participants are drawn along emotionally by this group and their counselors, who highlight many of the issues faced by PLWA. At the conclusion of the course, participants are given an opportunity to write messages to the group. The course facilitator may email these to them. The involvement with this group of "real people" has played a significant role in bringing about attitude change among course participants during pilot courses. Course facilitators are encouraged to engage with local or regional groups of PLWA to explore possibilities for creating similar context-specific teaching aids that are relevant and meaningful to the context in which the course is conducted. If possible, PLWA should also be involved in presenting the course.

Facilitators are encouraged to contact local government officials, such as representatives from the ministry of health, to invite them to participate in the course or to inform them of the training activities taking place in their region. In addition, facilitators are urged to contact UNAIDS (e.g., resident coordinator, country program advisor, country coordinating mechanism) in an effort to support the sustainability of HIV/AIDS prevention and control efforts in their area. Contact information for UNAIDS is available at www.unaids.org.

Participants should be aware that the course is intensive, covering many subjects in a short period of time. Therefore, careful time keeping is important in order to cover all of the subject matter in the allotted time period. It is helpful to start each day with an overview noting the heavier and lighter sessions so that participants are clear about expectations. This is also a good time to briefly review any remaining questions from the previous day, conduct pre-tests and respond to any logistical concerns of workshop participants.

Frequent energizers help keep everyone focused and the discussions lively. A resource containing a selection of energizers is provided. Participants can be requested to assist in maintaining the time schedule, conducting energizers and reviewing concepts for their colleagues. A daily "host team" can be recruited, consisting of two participants who volunteer to assist facilitators with the day's activities.

Resource materials

The International Rescue Committee's manual, *Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations*, is the main training resource for participants. Sections of the manual are suggested as preparatory reading for each day of the course.

A number of additional materials are suggested for each day. As the course cannot cover subjects in adequate detail, facilitators may wish to provide additional information through handouts or on CD, according to the needs of the audience. Some of the suggested resources may also be helpful to facilitators in preparing for the course.

HIV/AIDS policies and practices are constantly improving and the list of published materials on HIV/AIDS is vast. The lists in this manual therefore serve as a guideline only. In preparing to deliver course content, facilitators should review global resources and national and agency guidelines to update the statistics and practice recommendations that are included in this course. Providing information relevant to the local context where the course is hosted will serve to engage participants.

- Protecting the Future: International Rescue Committee (2003) Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations.
  The manual may be ordered from www.kpbooks.com/details.asp?title=Protecting+the+Future ($30 USD)
- Case studies from "A Broken Landscape":
  Gideon Mendel (2001) "A Broken Landscape: HIV and AIDS in Africa. "Africa." M&G Books, Auckland Park, South Africa.
  Amazon books - www.amazon.com ($21 USD)
- Handouts: Provided on CD.
- Additional resources: Provided on CD and website addresses provided.
- Visual aids: Provided on CD: may be used in PowerPoint or as examples for making posters.
- Videos: Pandemic: Facing AIDS: www.amazon.com
  Guilty, The Moment, Mother to Child,
  A Fighting Spirit and A Red Ribbon around my House:
  Day Zero Film & Video
  P.O. Box 21545, Kloof Street, Cape Town, 8008,
  South Africa, steps@dayzero.co.za
- Audio materials: Provided on CD.
- Energizers: International HIV/AIDS Alliance. 100 ways to energize groups: games to use in workshops, meetings and the community. www.aidsalliance.org
  Provided on CD.
- Contact for UWC student group: Bonile Peter.
  Email: 2350497@uwc.ac.za

Course preparations

Course facilitators should allow sufficient time for:

- Arranging an appropriate venue which has sufficient wall space for displaying visual aids
- Ordering or downloading "Protecting the Future"
- Ordering "A Broken Landscape"
- Downloading additional resources
- Photocopying handouts
- Photocopying evaluation tools
- Obtaining local posters, videos and other media examples, e.g., newspaper articles
- Making visuals aids
- Obtaining activity supplies (e.g., HIV test kit, vinegar, gloves, etc.)
- Ordering recommended videos and CDs
- Obtaining equipment and other supplies such as name tags, folders, colored paper, etc.
- Engaging local PLWA groups to participate in the course or in making audio-visual materials
- Preparing transparencies if not using LCD projector
- Preparing certificates of course completion for participants

Summary of learning objectives

By the end of the course participants will be able to:

DAY 1

- Critically consider their attitudes toward people with HIV/AIDS
- Have an awareness of the extent of the epidemic
- Understand how HIV affects the immune system and the body
- Explain the stages of the disease and the difference between HIV and AIDS
- Describe the transmission routes
- Describe biological factors which increase risk
- Analyze the socio-economic factors which increase vulnerability to HIV infection
- Understand the role of individual, community and societal influences on vulnerability

DAY 2

- Understand the need for a multidimensional approach to HIV/AIDS
- Relate risk and vulnerability factors to interventions
- Have an awareness of the processes underlying behavior change
- Understand principles of communication
- Assess the role of specific types of communication in behavior change communication strategies
- Design and evaluate a poster
- Develop participatory activities
- Have an awareness of strengths and challenges of peer education

DAY 3

- Describe common symptoms and signs of STIs
- Understand the consequences of STIs
- Explain the concept of a syndromic approach to STI management
- Design a community-based approach to STIs
- Discuss the advantages and disadvantages of HIV testing
- Understand the counseling and testing process
- Have an awareness of issues impacting confidentiality
- Understand issues impacting condom use
- Conduct condom demonstrations

DAY 4

- Understand the risks of HIV transmission in health care settings and through traditional practices
- Describe universal precautions
- Have an awareness of the management of occupational and rape-related exposure, including post-exposure prophylaxis
- Describe mother-to-child transmission
- Analyze options for preventing mother-to-child transmission
- Explain the meanings of stigma, prejudice and discrimination
- Analyze causes of stigma
- Propose approaches for reducing stigma

DAY 5

- Explain the term "PLWA"
- Analyze the impacts of HIV/AIDS
- Describe the components of comprehensive care
- Understand issues impacting treatment options
- Appreciate the value of support groups for PLWA
- Acknowledge the role of PLWA in addressing HIV/AIDS

Summary of teaching aids

PowerPoint

General

HIV/AIDS tree

DAY 1

1.3a Definitions & immune system
1.4a(i) Measuring the epidemic
1.4a(ii) UNAIDS epidemic update 2003
1.4a(iii) Regional prevalence 1986-2001
1.5b(i) Timeline of HIV/AIDS
(ii) Symptoms & signs, diagnosis, opportunistic infections
1.6a Transmission routes
1.7a Biological risk factors.ppt
1.7b Poster: Everyone he is sleeping with
1.7d Disasters maps
Teaching aids Day 1

DAY 2

2.3a Behavior change
2.4a BCC
2.5a Posters for analysis
2.5b Introduction to communication
2.6a Participatory approaches
2.8a BCC in conflict setting
Teaching aids Day 2

DAY 3

3.2a Why worry about STIs?
3.2c Diagnosis and management of STIs
3.2e Important STI service issues
3.2g STIs in conflict settings
3.3b HIV testing
3.3c VCT service delivery
3.3h VCT in conflict settings
3.4b Condoms (optional)
Teaching aids Day 3

DAY 4

4.2b Blood route facts
4.2c Implementing universal precautions
4.2d Accidental exposure
4.2f Managing accidental exposure
4.3a MTCT
4.4b Illustrating stigma
4.4e Fighting stigma
Teaching aids Day 4

DAY 5

5.4a Medical care of PLWA
5.4c Antiretroviral therapy
5.4d(i) Introduction to debate
5.4d(ii) ARVs in resource-poor settings
Teaching aids Day 5

Posters

DAY 1

Examples in teaching aids Day 1 and HIV tree:

- Immune system army (Show with 1.3a)
- Timeline of HIV/AIDS (Show with 1.5b(i))
- Transmission routes (Show with 1.6a)
- Vulnerability areas (Show with 1.7e)
- HIV/AIDS tree: lower branches, roots, fertilizers, soil

DAY 2

- Intervention areas (In PowerPoint: Teaching aids for Day 2)
- ABCD (Make from text: 2.3a)
- Stages of change model (In PowerPoint 2.3 & 2.4)
- Diffusion of ideas model (In PowerPoint 2.3 & 2.4)
- Target group assessment (Make from text in 2.4a)
- Posters for analysis (In PowerPoint: Posters for analysis)
- Communicator and receiver: two way (In PowerPoint: Teaching aids Day 2; show with 2.5b)
- Communicator and receivers: one way (In PowerPoint: Teaching aids Day 2; show with 2.5b)
- Building blocks of communication (Make from text: diagram in 2.5b)

DAY 3

- List of STI symptoms and signs (Make from text: 3.2b)
- STI syndrome table (Make from text: 3.2c)
- What people need to know about STIs (Make from text: 3.2e)
- HIV testing flowchart (Make from text: 3.3b and PowerPoint 3.3b & 3.3c)

DAY 4

- Blood route (Show with PowerPoint 4.2b)
- Universal precautions: make poster of 7 points (Show with PowerPoint 4.2b)
- Managing occupational exposure (Make from text 4.2f)
- MTCT/PMTCT (Make from text: 4.3a & b)
- PMTCT poster by Kenya participants (Show as introduction to debate 4.3e)
- "What is stigma?" (Show with 4.4a)
- Stigma quotations (Make from text: 4.4d)

DAY 5

- Infected and affected (In PowerPoint: Teaching aids Day 5)
- Holistic approach (Make from diagram in text: 5.4a)
- AIDS is not a death sentence (In PowerPoint: Teaching aids Day 5)
- Mandela's speech (In PowerPoint: Teaching aids Day 5)

Audio-visual

DAY 1

- Video: Pandemic: Facing AIDS
- Video: Guilty

DAY 3

- Audio CD Tracks 01 to 06
- Video: The Moment

DAY 4

- Audio CD Tracks 07 and 08
- Video: Mother-to-child transmission
- Video: A fighting spirit

DAY 5

- Audio CD Tracks 09 to 16
- Video: A red ribbon around my house

Miscellaneous

DAY 1

- A4 sheets of colored paper
- One set of case studies per table of 5 or 6 participants from Gideon Mendel: "A Broken Landscape: HIV and AIDS in Africa". 2001. M&G Books, Auckland Park, South Africa. Case studies from: pp. 14-19; 22-23; 54-55; 69-70; 80-81; 130-131; 132-133
- Cards for transmission picture card game
- HIV epidemic game: clear glasses or plastic cups, white vinegar, water, phenol red, instruction cards

DAY 3

- HIV rapid test kits
- Condoms: male, female, novelty
- Penis model (a cucumber works well and adds humor)
- Female anatomical diagram
- Oranges/mangoes for condom game

DAY 4

- PEP kit

DAY 5

- Case studies from "A Broken Landscape"
- Research on drug availability

Summary of resource materials

DAY 1

Handouts:

- Adapted from: UNAIDS. (2002) Report on the Global HIV/AIDS Epidemic. Table of country-specific HIV/AIDS estimates and data, end-2001. http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_32_en.htm
- From: WHO. (2004) Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach: WHO staging systems for HIV infection and disease in adults, adolescents and children. http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf

Additional resources:

- Reproductive Health Response in Conflict Consortium. (2003) Monitoring and Evaluation Toolkit. Draft for field testing. The Causal Pathway Framework. www.rhrc.org
- UNAIDS (1998). HIV-related opportunistic diseases. http://data.unaids.org/Publications/IRC-pub05/opportu_en.pdf
- ICASO. (2003) The Science of HIV/AIDS Vaccines. http://www.popline.org/docs/281973
- WHO. (Revised March 2004) Fact sheet no. 104. Tuberculosis. http://www.who.int/mediacentre/factsheets/fs104/en/
- UNAIDS. (2003) Questions and answers. http://www.unaids.org/epi/2005/doc/docs/en/QA_PartI_en_Nov05.pdf
- EngenderHealth. (2001) HIV and AIDS online minicourse. http://www.engenderhealth.org/pubs/courses/about-hiv-aids-minicourse.php

DAY 2:

Handouts:

- World Bank. (2001) HIV/AIDS at a glance. www.worldbank.org
- Matrix from: Inter-Agency Standing Committee. (2004) Guidelines for HIV/AIDS Interventions in Emergency Settings. http://hivaidsclearinghouse.unesco.org/ev.php?ID=4503_201&ID2=DO_TOPIC
- Course notes: Introduction to behavior change communication.
- Course notes: Introduction to communication.
- Course notes: Poster design form.
- Extract from: Family Health International. (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/lowliteracyquide.htm
- Course notes: Using codes.
- Example for analysis: Commercial sex worker peer educators. From: Singhal A & Rogers EM. (2003) Combating AIDS.
- Example for analysis: Adolescent peer educators. Adapted from: Campbell, C. & McPhail, C. (2002) Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. Social Science and Medicine. 55. pp331-345.

Additional resources:

- Inter-Agency Standing Committee. (2004) Guidelines for HIV/AIDS Interventions in Emergency Settings. https://www.unfpa.org/publications/detail.cfm?ID=165&filterListType=
- Family Health International. (2003) Control of Sexually Transmitted Diseases: A handbook for the design and management of programs. Chapter 4: An approach to effective communication. http://www.fhi.org/en/HIVAIDS/pub/guide/stdhandbook/index.htm
- FHI/AIDSCAP. (2003) How to create an effective communication project. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/effectivecommunication.htm
- FHI/AIDSCAP. (2003) How to create an effective peer education project. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/peereducation.htm
- The International HIV/AIDS Alliance. (2003) Working with men, responding to AIDS: Gender, sexuality, and HIV - A case study collection. http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=82&language=en
- Family Health International. (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/lowliteracyquide.htm

DAY 3:

Handouts:

- Course notes: Comprehensive care for sexually transmitted infections. From: Reproductive Health Response in Conflict Consortium. (2004) Guidelines for the Care of Sexually Transmitted Infections in Conflict-affected settings: Checklist for comprehensive STI care.
- From: EngenderHealth. (2001) HIV and AIDS web course: Female Condom Instructions. www.engenderhealth.org/res/onc/hiv/hiv.pdf
- How to talk about condoms with your partner. Adapted from: Grieco, A. (1987) Cutting the risks for STDs. Medical Aspects of Human Sexuality. March issue.

Additional resources:

- EngenderHealth. (2003) Sexually transmitted infections web course. www.engenderhealth.org/res/onc/sti/sti.pdf
- UNAIDS. (2000) Voluntary counseling and testing. Technical update. http://www.popline.org/docs/169778
- Family Health International. (2003) Models of VCT Service Delivery. www.fhi.org > HIV/AIDS > Fact Sheets > Models of VCT Service Delivery
- UNAIDS. (2002) HIV voluntary counseling and testing: a gateway to prevention and care – five case studies. http://data.unaids.org/Publications/IRC-pub02/JC729-VCT-Gateway-CS_en.pdf

DAY 4:

Handouts:

- Course notes: Universal precautions.
- Course notes: Management of occupational exposure.

Additional resources:

- EngenderHealth. (2001) Infection Prevention Online Course. www.engenderhealth.org/ip/about/ip.pdf
- Centers for Disease Control and Prevention. (2001) Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis. MMWR 2001; 50 (No. RR-11). www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
- UNAIDS. (2001) Counseling and voluntary testing for pregnant women in high HIV prevalence countries. http://data.unaids.org/Publications/IRC-pub01/JC245-Couns_Test_en.pdf
- WHO/UNICEF/UNAIDS. (1998) HIV and infant feeding: a guide for health care managers and supervisors. http://www.who.int/nutrition/publications/HIV_IF_guide_for_healthcare.pdf
- Understanding and challenging HIV stigma – a toolkit for action. (2003) Facilitator's guide. The CHANGE project. www.changeproject.org/technical/hivaids/stigma.html
- WHO/UNHCR. (2002) Clinical Management of Survivors of Rape - A guide to the development of protocols for use in refugee and internally displaced person situations. http://whqlibdoc.who.int/publications/2004/924159263X.pdf
- Asia Pacific Network of People Living with HIV/AIDS. (2004) AIDS-related Discrimination in Asia. http://www.synergyaids.com/documents/Asia_AIDSDiscrimination.pdf
- Engender Health. (2004) Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers, Trainer's Manual and Participant's Handbook. http://www.popline.org/docs/273667

DAY 5:

Handouts:

- Course notes: Experiences of managing a support group.
- From: EngenderHealth. (2001) HIV and AIDS online minicourse. Common side effects of antiretroviral drugs. http://www.engenderhealth.org/pubs/courses/about-hiv-aids-minicourse.php

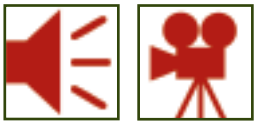
Additional resources:

- Food and Agriculture Organization. (2002) Living well with HIV/AIDS. http://www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM
- WHO. (undated) Caregiver booklet: A guide for patients, family members and community caregivers. www.who.int/entity/3by5/publications/documents/en/IMAI_Caregiver.pdf
- WHO. (2002) Community home-based care in resource-limited settings. A framework for action. http://www.who.int/hiv/pub/prev_care/isbn9241562137.pdf
- UNAIDS. (2001) Best practice collection. Reaching out, scaling up: Eight case studies of home and community care for and by people with HIV/AIDS. http://data.unaids.org/publications/irc-pub02/jc915-reachout_en.pdf
- AIDSCAP. (2003) HIV/AIDS care and support projects: Using behavior change communication techniques to design and implement care and support projects. http://pdf.usaid.gov/pdf_docs/PNADH527.pdf
- WHO. (2004) Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach. www.who.int/entity/3by5/publications/documents/arv_guidelines/en

- UNAIDS. (2000) AIDS: palliative care. Technical update. http://data.unaids.org/publications/IRC-pub05/jc453-pallicare-tu_en.pdf
- International HIV/AIDS Alliance. (2000) Care, Involvement and Action: Mobilising and supporting community responses to HIV/AIDS care and support in developing countries. www.aidsalliance.org or http://www.popline.org/docs/171373
- Family Health International. (2003) HIV/AIDS Care and Treatment: A Clinical Course for People Caring for Persons Living with HIV/AIDS. http://www.fhi.org/en/HIVAIDS/pub/guide/careandtreatmentclinicalcourse.htm
- WHO. (2003) Saving Mothers, Saving Families: the MTCT- Plus Initiative. http://www.who.int/hiv/pub/prev_care/en/Saving_Mothers_E.pdf
- WHO. (2003) Antiretroviral Therapy in Primary Health Care: Experience of the Khayelitsha Programme in South Africa. www.who.int/hiv/pub/prev_care/en/South_Africa_E.pdf
- International HIV/AIDS Alliance. (2003) Building Blocks: Africa-wide briefing notes, a series of booklets on psychological support, health and nutrition, economic strengthening, education and social inclusion, for communities working with orphans. http://hivaidsclearinghouse.unesco.org/file_download.php/Education.pdf?URL_ID=2459&filename=10579185481Education.pdf&filetype=application%2Fpdf&filesize=335071&name=Education.pdf&location=user-S/.
- www.fhi.org > HIV/AIDS > Fact Sheets > Models of VCT Service Delivery

Legend


PowerPoint


Audio-visual


Poster


Paper (handout)


Flipchart

HIV/AIDS tree

Manual Protecting the Future

Acronyms

3TC	Lamivudine
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral medicines
AZT	Zidovudine
BCC	Behavior change communication
CDC	Centers for Disease Control and Prevention
CSW	Commercial sex worker
EFV	Efavirenz
ELISA	Enzyme-linked immunosorbent assay
HAART	Highly active anti-retroviral therapy
HIV	Human immunodeficiency virus
IEC	Information, education and communication
MTCT	Mother-to-child transmission
NRTI	Nucleotide reverse transcriptase inhibitor
NNRTI	Non-nucleotide reverse transcriptase inhibitor
NVP	Nevirapine
PEP	Post-exposure prophylaxis
PCP	Pneumocystis carinii pneumonia
PI	Protease inhibitor
PLWA	Person/people living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
SARS	Severe acute respiratory syndrome
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary counseling and testing
WHO	World Health Organization

"This training has changed my way of thinking on HIV/AIDS. The testimonies and videos were a challenge to my life and career."

(Kenya)

DAY 1

◎ HIV/AIDS - Basic facts

Day 1 presents an overview of the scope of the HIV/AIDS epidemic, the disease and its manifestations, and the multitude of factors underlying the epidemic. Participants are encouraged to consider their own attitudes towards HIV/AIDS and people living with HIV/AIDS and also their feelings on discussing sex candidly.

Learning objectives

By the end of Day 1, participants will be able to:

- Critically consider their attitudes to HIV/AIDS
- Have an awareness of the extent of the epidemic
- Understand how HIV affects the immune system and the body
- Explain the phases of the disease and the difference between HIV and AIDS
- Describe the transmission routes
- Describe biological factors that increase risk to HIV infection
- Analyze socio-economic factors that increase vulnerability to HIV infection
- Understand the role of individual, community and societal influences on vulnerability

Resource materials

Manual:

- International Rescue Committee. (2003) Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations. Chapters 1, 2 & 3.

Handouts:

- Adapted from: UNAIDS. (2002) Report on the Global HIV/AIDS Epidemic. Table of country-specific HIV/AIDS estimates and data, end-2001. http://www.unaids.org/bangkok2004/GAR2004_html/GAR2004_00_en.htm
- From: WHO. (2004) Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach: WHO staging systems for HIV infection and disease in adults, adolescents and children. http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf

Additional resources:

- Reproductive Health Response in Conflict Consortium. (2003) Monitoring and Evaluation Toolkit. Draft for field testing. The Causal Pathway Framework. www.rhrc.org
- UNAIDS. (1998) HIV-related opportunistic diseases. http://data.unaids.org/Publications/IRC-pub05/opportu_en.pdf
- ICASO. (2003) The Science of HIV/AIDS Vaccines. http://www.popline.org/docs/281973
- WHO. (Revised March 2004) Fact sheet no. 104. Tuberculosis. www.who.int/mediacentre/factsheets/fs104/en/print.html
- UNAIDS. (2003) Questions and answers. http://www.unaids.org/epi/2005/doc/docs/en/QA_PartI_en_Nov05.pdf
- EngenderHealth. (2001) HIV and AIDS online minicourse. www.EngenderHealth.org

Teaching materials

PowerPoint:

1.3a Definitions, immune system, history
1.4a(i) Measuring the epidemic
1.4a(ii) UNAIDS epidemic update 2003
1.4a(iii) Regional prevalence 1986-2001
1.5b(i) Timeline of HIV/AIDS
1.5b(ii) Symptoms and signs, diagnosis, opportunistic infections
1.6a Transmission routes
1.7a Biological risk factors
1.7d Disasters maps
Teaching aids Day 1

Posters:

Examples in teaching aids Day 1 and HIV tree:

- Immune system army (Show with 1.3a)
- Timeline of HIV/AIDS (Show with 1.5b(i))
- Transmission routes (Show with 1.6a)
- Vulnerability areas (Show with 1.7e)
- HIV/AIDS tree: lower branches, roots, fertilizers, soil

Audio-visual:

- Video: Pandemic: Facing AIDS
- Video: Guilty

Other:

- A4 sheets of colored paper
- Gideon Mendel: "A Broken Landscape: HIV and AIDS in Africa". (2001) M&G Books, Auckland Park, South Africa. Case studies from: pp. 14-19; 22-23; 54-54; 69-69; 80-81; 130-131; 132-133; one set per table of 5 or 6 participants.
- Cards for transmission picture card game
- HIV epidemic game: glasses or clear plastic cups, white vinegar, water, phenol red, instruction cards

DAY 1 – Session plan

Time	Topic		Materials
	1.1 Introduction		
60 min	1.1a	Course introduction	Flipchart; map
15 min	1.1b	Activity: **Why don't people talk about sex?**	
	1.2 Exploring attitudes		
25 min	1.2a	Activity: **Exploring our own attitudes**	A4 colored sheets; flipchart
30 min	1.2b	Activity: **Challenging our attitudes**	Video: Pandemic: Facing AIDS
30 min	Break		
	1.3 HIV/AIDS – Basic facts		
25 min	1.3a	Presentation: **Definitions & immune system**	Immune system army poster; PowerPoint
	1.4 What is the extent of the HIV/AIDS problem?		
30 min	1.4a	Presentation: **Measuring the epidemic**	PowerPoint; flipchart
	1.5 How does HIV/AIDS affect the body?		
30 min	1.5a	Activity: **Identifying physical manifestations of HIV/AIDS**	Case study handouts from "A Broken Landscape"; flipchart
40 min	1.5b	Presentation (i): **Timeline of HIV/AIDS**	PowerPoint; Timeline of HIV/AIDS poster; HIV/AIDS tree: lower branches
		Presentation (ii): **Symptoms & signs, diagnosis, opportunistic infections**	PowerPoint
60 min	Lunch		
	1.6 How do people get HIV?		
10 min	1.6a	Presentation: **Transmission routes**	PowerPoint; Transmission routes poster HIV/AIDS tree: roots
25 min	1.6b	Activity: **Transmission picture card game**	Flipchart sheets; picture cards
	1.7 Why do people get HIV?		
10 min	1.7a	Presentation: **Biological risk factors**	PowerPoint - HIV/AIDS tree: fertilizers
25 min	1.7b	Activity: **The concept of spread of disease: epidemic exercise**	PowerPoint; instruction cards, water, white vinegar, phenol red, glasses
15 min	1.7c	Activity: **Illustrating spread of disease**	Video: Guilty
15 min	Break		
50 min	1.7d	Activity: **"But why?" exercise**	Casestudies; Flipcharts; PowerPoint HIV/AIDS tree: soil
10 min	1.7e	Presentation: **Organizing the vulnerability factors**	Vulnerability areas poster
30 min	**1.8 Conclusion**		Post-tests

1.1 Introduction

1.1a Getting started

- Welcome
- Logistics
- Participant and facilitator introductions. If possible, create a map so people can show where they work and offer a 2-minute description of the work they do.
- Course overview
- Introduce idea of individual objectives: participants are encouraged to formulate a daily objective and activities, relevant to their work settings, based on topics covered during the day. (Refer to handout: *The Causal Pathway Framework.*)
- Code of conduct
- Select host team for the day
- Pre-test
- Brief overview of the day. (*Daily course objectives are written on a flipchart sheet and become part of the wall display for the day.*)

Activity

1.1b *Why don't people talk about sex?*

Discuss in small groups.
Discussion – 5 minutes. Feedback in plenary – 10 minutes.

Facilitator...

...introduces:

In this course we will frequently be discussing the subject of sex. People are often uncomfortable talking about sex. Why don't people like to talk about sex?

...notes:

Examples:

- Discussing sex is taboo in many cultures.
- Intimate subject: embarrassment because we have been trained not to talk about it in public.
- Fear of seeming ignorant.
- Fear of seeming immoral, etc.

...concludes:

In many cultures and for a variety of reasons, people are afraid or embarrassed to talk about sex. Yet sex is a very basic part of our existence. Sex is also a core issue in addressing HIV/AIDS. Unless people are prepared to talk openly about sex, it will be difficult to learn about HIV and to take action against HIV. If we are going to fight the enemy, we must acknowledge and understand the enemy.

We need to agree that, in this course, it is acceptable and necessary to talk about sex, because fighting the HIV/AIDS epidemic is important to all of us as responsible adults, professionals, partners, parents and community members. We also hope that after this course, participants will share with others the things they have learned and encourage others to break the silence. (Add "speak openly about sex" to code of conduct.)

1.2 Exploring attitudes

Activity

1.2a *Exploring our own attitudes*

Work in small groups.
Discussion – 10 minutes. Feedback in plenary: part 1: 10 minutes, part 2: 5 minutes.
Materials: Sheets of colored A4 paper; Flipchart
(Example in PowerPoint: Teaching aids Day 1)

Facilitator...

Part 1:

...introduces:

Many things are said about HIV and AIDS and about people who are living with HIV/AIDS (PLWA). For example, sometimes it is said "people who get HIV are immoral" or "if you are infected with HIV, you will die very soon" or "HIV is spread by the polio vaccine."

What are some of the things you have heard other people say about HIV/AIDS?

Participants write each point on a different piece of paper; use thick markers and half A4 sheets; these sheets are handed to the facilitator who reads them out and sticks them up on a large sheet of paper.

...concludes:

(Note: Are there common themes among responses to highlight?)

There are many misconceptions and negative attitudes about HIV/AIDS and about people living with HIV/AIDS. Think about whether you yourself hold or have in the past held any of these beliefs and attitudes (even just a little – be honest with yourself!). In this course we aim to increase your knowledge and, if necessary, change your ideas and attitudes. We will leave this poster of ideas and attitudes up for the duration of the course to serve as a reminder of some of the issues we need to deal with, in ourselves and in others. At the end of the course you will have a chance to consider if anything has changed about the way you feel about HIV/AIDS and PLWA.

Part 2:

Facilitator takes feedback in plenary and writes responses on a flipchart sheet which is placed next to the part 1 answers.

Sometimes people have particular views about refugees. What are some of these views?

...notes:

Examples: Refugees spread HIV into host communities; refugees are responsible for theft and banditry; refugees are an economic burden to the host country; refugees are a security risk; refugees cause increased workloads for staff in national facilities; refugees get more assistance than host communities; refugees are responsible for witchcraft; refugees should go home.

...concludes:

Refugees can be the subject of resentment, fear and unfair blame. Refugees with HIV/AIDS may thus suffer a double burden of stigma and discrimination, as a result of both their refugee status and their HIV status.

Activity

1.2b *Challenging our attitudes*

Video – 20 minutes. (Select excerpts totaling 20 minutes) Discussion in plenary – 10 minutes.
Materials: Video: Pandemic: Facing AIDS (order of countries profiled: Uganda, Russia, Brazil, Thailand, India)

Facilitator...

...introduces:

Think about how the people in this video challenge some of the things people say about HIV/AIDS and PLWA.

After the video, facilitator asks for comments on the video.

...concludes:

This video shows some of the challenges faced by PLWA. It also demonstrates that PLWA can live productive lives and make valuable contributions to society. It shows that they come from all segments of society and that PLWA are people just like you and me.

In the context of your work in the field of HIV, you will have to deal with your own attitudes as well as the attitudes of colleagues and clients. We are all human and we need to recognize that we all hold certain beliefs. You need to be aware of your own perceptions as well as the views held by those around you and to develop strategies for confronting them. Wrong information and negative attitudes increase the potential for the epidemic to spread and increase the suffering of people living with HIV/AIDS. In this course we are going to examine why this is so and give you some tools to help you deal with lack of information, incorrect information and negative attitudes.

1.3 HIV/AIDS – Basic facts

1.3a PRESENTATION: *Definitions & immune system*


Presentation – 25 minutes.
Materials: PowerPoint: 1.3a Definitions & immune system
Poster: Immune system army (Example in PowerPoint: Teaching aids Day 1)

HIV stands for Human Immunodeficiency Virus.
AIDS stands for Acquired Immune Deficiency Syndrome.

AIDS is caused by the HIV virus. A virus is a very small organism, called a micro-organism or sometimes a "germ." It can only be seen using a very specialized microscope called an electron microscope. Sixteen thousand HIV viruses can fit on the head of a pin. Viruses can get inside the human body, where they multiply to reach very high numbers and make the person sick. Viruses multiply by getting inside the cells of the body and use these cells as a "factory" in which to reproduce themselves. Examples of viruses that make people sick (Ask participants): the common cold virus, the polio virus, the measles virus, the hepatitis virus and more recently, the Severe Acute Respiratory Syndrome (SARS) virus.

(Explain first using immune system army poster, then repeat with PowerPoint.)
To protect itself against attacks by viruses and other micro-organisms, the body has its own defense system, called the immune system. The immune system consists of a number of different types of white blood cells and special blood proteins. We can think of the immune system as an army of cells trained to fight off any foreign organism that invades the body. A very important component of the immune system is a group of cells called CD4 cells, sometimes also called the T helper cells. These are specialized white blood cells, controlling the functioning of the immune system. We can think of these CD4 cells as immune system "army commanders." When a foreign organism enters the body, the CD4 cells give the command for the immune system to attack the invader. It may take some time (a few days or several weeks) for the immune system to build up an effective response to the invading organism, so initially the person may have some symptoms and signs of illness. But, after a while, the immune system is usually able to overcome the invader and the person recovers from the illness.

The immune system uses various methods to fight infections. Sometimes white blood cells directly attack the foreign organism. Another method involves the production of antibodies. Antibodies are proteins produced by certain white blood cells against specific organisms. These antibodies are used as "weapons" against invading micro-organisms in the blood.

For some viruses, like polio, measles and hepatitis, vaccines have been developed which prepare the immune system so that it can inactivate the virus quickly after it enters the body. This stops the virus from multiplying inside the body and therefore prevents the person from developing the illness. For other viruses, like the common cold and HIV, scientists have not been able to develop a vaccine yet.

When the HIV virus gets into the human body, it attacks the immune system. Although there are many different viruses that can cause illnesses in humans, HIV differs from these in that it is the only virus we know of that specifically attacks the CD4 cells. The HIV virus gets inside the CD4 cells and multiplies there. Up to 10 million viruses are produced daily. HIV gradually disables or destroys more and more of the CD4 cells. Without the commanders, the defense force is not able to defend its territory properly. The immune system also produces antibodies ("weapons") to combat the HIV virus, but they are not able to overcome the virus. These antibodies are usually what we measure when we do HIV tests.

Over time, the immune system gradually becomes increasingly weakened as a result of the HIV virus. We say the immune system becomes deficient or compromised, or the person is immunodeficient. This is the reason for the terms "human IMMUNODEFICIENCY virus" and "acquired IMMUNE DEFICIENCY syndrome." The word "ACQUIRED" is used because the immune deficiency is the result of something that "comes from outside into the body." (There are other causes of immune deficiency: In very rare cases, people are born with immune deficiencies, and certain kinds of cancer treatments also weaken the immune system; but HIV is by far the most common cause of immune deficiency in the world today.)

(Ask participants: What do you think happens to a person when their immune system is weakened?)
When the immune system is weakened, the body gradually loses its ability to fight off diseases caused by other micro-organisms, and so the person becomes vulnerable to many infections. People with HIV can contract the same infections as other people, for example, pneumonia or diarrhea or STIs, but they get these common infections more often and more severely.

As a result of the weak immune system, people with HIV are also vulnerable to certain infections that do not usually cause illness in people without HIV. Although these infections can get into the body of a healthy person, a healthy immune system destroys the infection easily and the person does not become sick. In a person whose immune system is weak, the infections have an opportunity to multiply inside the person and make them sick. These infections are called opportunistic infections, because they make use of the opportunity provided by a weak immune system. Examples of opportunistic infections include candida (infection of the mouth and throat), pneumocystis carinii pneumonia and cryptococcal meningitis. The weakened immune system also makes the body vulnerable to certain kinds of cancers, e.g., Kaposi's sarcoma, cancer of the cervix.

Because of the variety of infections and cancers that can affect a person with HIV, they can show a variety of different symptoms and signs. The word "SYNDROME" refers to a group of symptoms and signs that can all be part of the same underlying medical condition, in this case HIV/AIDS. We will explain this again when we look at how HIV/AIDS affects the body.

The difference between HIV and AIDS:
When the HIV virus enters the body, we say the person is infected with HIV or "has got HIV." When people with HIV show signs of illness, these are mostly caused by infections or cancers, and not by the HIV virus itself. When the person's immune system has been weakened to the point at which s/he is suffering severe opportunistic infections, we say s/he has AIDS. We will discuss this again later.

The difference between HIV1 and HIV2:
HIV1 and HIV2 are different types of the HIV virus. HIV1 is the most common type worldwide. Both are transmitted in the same way, but HIV2 is less infectious and HIV2-infected people stay well for a longer time after infection. HIV2 was first identified in West Africa, where it is common, but it has also been identified in other parts of the world.

The history of HIV/AIDS:
HIV has been around for many years. (*Ask participants if they know for how long.*) We do not know exactly how long the HIV virus has caused illness in humans, but scientists estimate the time at about 50 years. The first known case of HIV occurred in 1959 in a man living in the Democratic Republic of Congo. The virus was identified in a blood sample that had been stored by scientists for many years for other purposes.

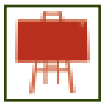
Where did HIV come from?
(*Ask participants what they have heard.*) We are still not absolutely sure about the origin of HIV, but today scientists have a good idea. It sometimes happens in nature that viruses can transfer from animals to humans. For example, mad cow disease comes from cattle and SARS comes from civet cats. Scientists think that it is likely that HIV evolved from viruses found in monkeys. It is possible that one of these viruses transferred to humans from chimpanzees in Central Africa (HIV1) and from the Macaque or Sooty Mangabey monkey in West Africa (HIV2). This does not mean that scientists assume that people had sex with monkeys and chimpanzees; it is more likely that people first got infected through cuts on their hands when they were handling the meat of these animals (which they killed for food).

The AIDS syndrome was first recognized as a new disease in 1981 in the USA. In 1983, the HIV1 virus was identified by scientists in the United States. The HIV2 virus was identified in France the same year.

Over the years there have been many myths around HIV/AIDS. (*Ask participants for examples.*) For example, people have claimed that HIV does not exist, that it's a conspiracy to discriminate against Africans, that HIV does not cause AIDS, or that AIDS is caused by poverty, not by the HIV virus. However, there is by now overwhelming scientific evidence, from many studies in different places by different researchers, that HIV exists and that it causes AIDS. (For further details refer to additional resources: UNAIDS. *(2003) Questions and answers*)

1.4 What is the extent of the HIV/AIDS problem?

1.4a PRESENTATION: *Measuring the epidemic*

Presentation – 30 minutes total: 1.4a (i), (ii) and (iii).
Materials: PowerPoint: 1.4a (i) Measuring the epidemic
Flipchart

When talking about the severity of an epidemic, the words "prevalence" and "incidence" are often used.

What is prevalence?
The prevalence of a disease is the proportion or percentage of individuals in a defined population that has the disease at a specific point in time. Prevalence gives us a "snapshot" of the situation and is most often used to measure chronic diseases. For HIV, prevalence figures usually represent the sexually active population (aged 15 to 59 years).

$$\text{Prevalence} = \frac{\text{Number of people infected with HIV}}{\text{Population}}$$

What is incidence?
The incidence of a disease is the number of new cases occurring in a defined population during a defined time interval. It tells us how quickly the epidemic is spreading. Incidence is usually used to measure acute diseases.

$$\text{Incidence} = \frac{\text{Number of people newly infected with HIV over the course of one year}}{\text{Population}}$$

Draw on flipchart:

Incidence
Prevalence
Population

Which of these terms is more commonly used when talking about HIV/AIDS?
Prevalence includes both old and new infections. As it does not distinguish between people who were infected recently and those who were infected several years ago, it does not show recent trends in the epidemic. Because incidence measures new infections, it is useful in telling us about how quickly people are becoming infected currently. It is much more difficult to measure incidence (ask participants why), so most of the time we use prevalence. HIV prevalence in young people is sometimes used as a proxy measure for HIV incidence because young people have usually become sexually active relatively recently and so would have been infected recently. Changes in HIV prevalence among the age groups 15 to 19 years and 15 to 24 years can therefore be important in revealing new trends in the epidemic. For example, Uganda has seen decreasing HIV prevalence among young people in recent years, reflecting an overall slowing of the epidemic in the country.

How do we measure HIV prevalence?
Prevalence can be measured in different ways. These include: population-based surveys, sentinel site surveillance, e.g., antenatal clinic data, or data from blood donors or STI clinic clients. Population-based surveys provide the most accurate measurement of prevalence, but are complex and costly to carry out. Antenatal clinic data are considered to provide a reasonably accurate reflection of HIV prevalence in the sexually active population and are thus used as a proxy measure. Data from blood donors and STI clinic clients do not accurately reflect HIV prevalence in the general population. (Ask participants why this is so.) Blood donors and STI clients represent only a small fraction of the general population and may have specific characteristics which make them different from the population as a whole, e.g., injecting drug users may

donate blood for money to support their drug habit; people with STIs may engage in unprotected sex with high risk groups. HIV prevalence in these groups may therefore not be a good reflection of HIV prevalence in the general population. However, blood donor and STI client data can provide an indication of prevalence trends over time, especially where no other data are available.

Prevalence is usually measured through anonymous unlinked testing, which means that blood samples are stripped of all identifying markers before being tested and thus cannot be traced back to the individual. As the test is anonymous, consent is not required and people do not receive their results. For example, blood taken routinely in antenatal clinics for syphilis or Rhesus screening may be used.

Why is it important to know the prevalence of HIV in a population?
Prevalence gives an indication of the overall scale of the problem. This helps with planning of services, resource allocation, advocacy and raising public awareness. Over an extended period of time, changes in incidence and prevalence can illustrate whether or not prevention interventions were successful.

Classification of HIV epidemics
Low-level epidemic:
HIV prevalence is less than or equal to 5% in any defined sub-population (e.g., a core group)

Concentrated epidemic:
HIV prevalence is consistently over 5% in at least one defined sub-population (e.g., the military)
HIV prevalence is below 1% in pregnant women in urban areas

Generalized epidemic:
HIV prevalence is consistently over 1% in pregnant women


Materials: PowerPoint: 1.4a (ii) UNAIDS epidemic update 2003 (This information is updated on an annual basis and can be accessed on the UNAIDS website. Data from the local context may also be used.)
Flipchart

According to the 2003 World Health Report, HIV/AIDS is now the leading cause of death worldwide among adults aged 15-59 years. Since the beginning of the epidemic, it is estimated that 21 million people have died of AIDS. In 2003 alone, 3 million people died and 2.3 million of these deaths occurred in sub-Saharan Africa. Every day, 5,000 men and women and 1,000 children die of AIDS in sub-Saharan Africa. In some parts of Africa, current adult mortality rates are higher than they were three decades ago. In Botswana, Lesotho, Swaziland and Zimbabwe, HIV/AIDS has reduced life expectancy by more than 20 years. In South Africa, life expectancy is predicted to fall to 40 years in 2008. This is down from a pre-epidemic high of 65 years.

At the end of 2003, an estimated 40 million people were living with HIV worldwide. At present, 95 percent of people living with the virus are in the developing world and 26.6 million (two thirds of the total) are living in sub-Saharan Africa.

There were 5 million new infections worldwide during 2003: this is equivalent to 14,000 new infections every day. This means that 10 people are getting infected every minute. The new infections included an estimated 700, 000 children under 15 years - over 90% of them infected through mother-to-child transmission. 3.2 million of the new infections were in sub-Saharan Africa.

More than 50% of new infections are occurring in young people under the age of 25 years. According to UNAIDS, at the end of 2002 in sub-Saharan Africa, about twice as many young women as men were infected.

There are a number of reasons why women, and young women in particular, are more vulnerable to HIV infection than men. (*Ask participants to suggest reasons – use flipchart.*)

Reasons include:

Biological:

- The vagina is a receptive organ and thus holds infected fluids.
- The vagina has a larger exposed surface area than the penis.
- The mucous membrane of the vagina is more easily damaged than the skin of the penis.
- Women are exposed to a greater amount of infected fluids (semen) than men.
- In young women, the cells of the cervix are particularly vulnerable to infection.
- Scarring as a result of female genital cutting may increase the risk of injury during sex.

Socio-economic:

- Women are often economically dependent on men and thus not in a position to negotiate safer sex.
- Sex may be an economic survival mechanism.
- For cultural and social reasons women may fear rejection if negotiating safer sex or refusing sex.
- Refusal of sex may lead to violence against women.
- Sexual violence against women is common.
- Young women often have relationships with older men. Gender issues and the large differences in ages may create a power imbalance.

PowerPoint: 1.4a (iii) Regional prevalence 1986-2001 (This information should be updated according to the most recent data available.)

Ask participants to refer to the handout: "Table of country-specific HIV/AIDS estimates and data, end-2001." Ask different groups to find prevalences in a number of countries, including where they are working. If possible have a large world map and use pins and flags to show country prevalences. Then continue with PowerPoint presentation 1.4a (iii).

UNAIDS and WHO produce new country estimates of HIV prevalence every two years. The most recent estimates of the status of the epidemic in specific countries published by UNAIDS are as of end-2001 (and are detailed in the "Table of country-specific HIV/AIDS estimates and data, end-2001" in the Report on the Global HIV/AIDS Epidemic, 2002). The next set of country estimates will be published in the UNAIDS Report on the Global HIV/AIDS Epidemic, 2004, in July 2004.

HIV/AIDS has spread rapidly, particularly in southern Africa. At the end of 2001 there were seven countries in which adult HIV prevalence was higher than 20%, all in southern Africa: Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, Zimbabwe.

While the highest HIV prevalences are in Africa, the fastest growing epidemic is in the European region, in particular in the countries of the former Soviet Union. This epidemic is fueled mainly by injecting drug use.

In Asia, prevalences are not high yet (mostly under 1 percent), but because of the high populations of countries like India and China, absolute numbers of people with HIV are high, e.g., India is home to around 4 million PLWA. Furthermore, the large populations may obscure serious sub-epidemics occurring in certain areas or among core groups, such as injecting drug users and commercial sex workers.

There are various reasons for the different prevalences in different countries. (Ask participants to suggest reasons.) For example, different standards of health care, cultural practices, poverty, conflict, political commitment, and probably other reasons which we do not yet understand. One important reason for the differences is that countries are at different stages of the epidemic. In the early stages, the epidemic is usually concentrated in certain groups of the population called core groups, which engage in a high level of risky sexual behavior, e.g., commercial sex workers and their clients; men who have sex with men; migrant workers, truck drivers, the military and sometimes adolescents. The epidemic later spreads from the core groups into the general population, e.g., from the clients of sex workers to their wives.

While it is important not to attach negative "labels" to high-risk groups, it is also important to recognize the role of core groups in the epidemic, and to aim specific interventions at these groups.

In countries where a low percentage of the population is at present HIV-positive, a few years could see a dramatic increase, if urgent action is not taken. For example, in Swaziland, HIV prevalence was 4% in 1992 and 33% in 2001.

1.5 How does HIV/AIDS affect the body?

Activity

1.5a *Identifying physical manifestations of HIV/AIDS*


Work in small groups.
Discussion - 15 minutes. Feedback in plenary - 15 minutes.
Materials: Case study handouts.
Flipchart

Facilitator...

...introduces:

In this activity we look at what HIV/AIDS does to the body. Read the case studies and study the photos. Identify symptoms and signs of illness associated with HIV/AIDS. Also write down any other symptoms and signs associated with HIV/AIDS that you know about.

...takes feedback:

Writes down symptoms and signs on flipchart using diagram of a person.
From text and photos: weight loss, weakness, diarrhea, ulcer, TB, vomiting, blindness, confusion, sores, fungal skin infections.

...concludes:

HIV/AIDS results in a variety of symptoms and signs. We will go into more detail on the clinical manifestations in the next presentation.

Start HIV/AIDS tree: symptoms and signs = lower branches.

1.5b PRESENTATION: *Timeline of HIV/AIDS*

Presentation – 40 minutes total: 1.5b (i) and (ii).
Materials: PowerPoint: 1.5b (i) Timeline of HIV/AIDS
Poster: Timeline of HIV/AIDS (Example in PowerPoint: Teaching aids Day I)
HIV/AIDS tree: lower branches

From the time of infection with HIV, a person goes through a number of phases until s/he reaches the final phase called AIDS.

CD4 count:
It is possible to measure the degree of damage to the immune system by measuring the number of CD4 cells in a person's blood. Recall CD4 cells are the body's immune system's "army commanders." The CD4 count will reflect the phase of the disease.
Normal CD4 count: 500-1200 cells/ml
Beginning of HIV-related illness: 200-500 cells/ml
AIDS: under 200 cells/ml

The risk of death increases significantly when the CD4 count drops to below 50. In most developing countries, CD4 counts are not readily available. Where CD4 counts can be done, they are used to make decisions on the type of treatment the person should be getting and when they should start taking antiretrovirals (ARVs), if these are available. It also seems to be helpful to people with HIV to know their CD4 count as it gives them a sense of where they stand with regard to their HIV/AIDS situation.

Phases of HIV/AIDS:

1. Infection with HIV
This is the moment the virus gets into the body - sometimes called "inoculation."

2. Window period
Time frame: up to 3 months after infection.
No symptoms or signs.
The virus is multiplying rapidly. There are very high levels of virus in the blood and other body fluids at this time (i.e., the viral load is high), so the person is very infectious. But the HIV test is negative because the person has not yet started to make the antibodies that the test measures.

3. Seroconversion
Time frame: marks the end of the window period; lasts a week or two.
At this point, the body starts to make antibodies against the HIV virus. Antibodies are proteins that are made by the immune system to use as weapons to fight the virus. It is these antibodies that are measured in most HIV tests. From the time of seroconversion onwards, the person will have a positive HIV test. At this time, the person may have a flu-like illness with fever, headache, sore throat, tiredness, swollen glands, joint pains and a rash. This brief period of illness often passes unnoticed. After recovery, the person is completely well again. 25% of people do not experience illness at seroconversion.

4. Asymptomatic period, i.e., period of no symptoms (latent period)
Time frame: variable; less than one year to 15 years or more.
Most people remain healthy for about 3 years, but the actual number of years will vary from person to person. About 5 to 10% of people start to experience health problems after 1 to 2 years. Another 5-10% have no symptoms for up to 15 years. This timeframe depends a lot on the socio-economic circumstances of the person. If they have enough money to buy good food, live in healthy conditions and have access to drugs, they can live longer. (In babies and young children who have HIV, illness will often happen much earlier because they have an immature immune system.) During the asymptomatic period, the person feels and looks healthy. However, even though there are no outward signs of illness, the virus continues to actively multiply and gradually weakens the immune system. During the asymptomatic period, the person is also able to transmit the virus to others.

5. HIV/AIDS-related illness

Time frame: months to years; 4 or 5 years on average.

Signs and symptoms of illness start to appear, mild at first, but gradually becoming more frequent, more severe and longer-lasting.

6. AIDS

Time frame: Usually less than two years, unless treatment is available. In developing countries, most people die within one year of reaching this phase. In places where ARVs are used, the person can live for many years.

This is the final phase of HIV infection. At this point the immune system has become very weak and the person is very vulnerable to infections and cancers. During this phase the virus levels in the blood are very high again and the person is very infectious to others. The HIV test may however be negative, as the immune system may be so weak that it is unable even to produce antibodies. The patient dies when an untreatable infection or cancer develops.

Summary:

Without treatment, people usually progress to AIDS about 7-8 years after being infected with HIV. (This is the case in most developing countries.) It is not possible to accurately predict the course of the illness in any one person. The duration of the different stages will vary from person to person. Some people progressively deteriorate, while others have periods of illness alternating with periods of good health. The factors that determine the course of the disease in different people are not yet fully understood, but nutrition, emotional stress and access to health care can all play an important role.

A person living with HIV can transmit the virus to others during all the stages. Most people living with the virus are not aware that they are infected and so can transmit the virus to other people without realizing it. It is important to realize that it is not possible to tell whether or not a person is infected with HIV just by looking at him/her. Someone who has HIV can appear completely healthy for many years. On the other hand, a person who loses a lot of weight and is coughing could have TB and not have HIV. HIV is like termites infesting a house. The house looks good on the outside, but the termites are eating away the inside of the wood where they can't be seen. In the end, the house starts to collapse.

NB: It is also important to know that even if a person has HIV, s/he can be re-infected with different strains of the HIV virus. If this happens, s/he goes through the process of having a very high viral load for the second time. This is an additional attack on the immune system, which weakens it further, so the person will probably progress to AIDS more quickly. People with HIV therefore need to protect themselves against re-infection by abstaining or using condoms.

Materials: PowerPoint 1.5b (ii) Symptoms and signs, diagnosis, opportunistic infections

Symptoms and signs of HIV/AIDS

We saw from the case studies that a wide range of symptoms and signs are associated with HIV infection. HIV mainly affects the respiratory system, the gastro-intestinal system, the skin and the central nervous system. Usually there is a combination of symptoms and signs that vary from person to person, and according to the stage of the disease. Some are due to a direct effect of the virus on certain body cells, such as those of the gastro-intestinal system and the brain. However, most clinical manifestations are caused by other infections and cancers that occur as a result of a weakened immune system.

WHO has developed a staging system that classifies HIV/AIDS disease into four stages, based on clinical signs and/or laboratory criteria. This staging system is used when making decisions about treatment options for PLWA. *(Ask participants to refer to handout: "WHO staging system." Illustrate with PowerPoint visuals. Compare WHO stages with Timeline of HIV/AIDS poster.)*

In developing countries, the main causes of death in people with HIV/AIDS are TB, chronic diarrhea, chest infections, cryptococcal meningitis and disseminated (widespread) Kaposi's sarcoma.

The diagnosis of AIDS

Diagnosing whether a person is infected with HIV is not difficult – it is quickly done using an HIV test. However, making the diagnosis of AIDS (i.e., WHO stage 4 of HIV infection) is more complex. A diagnosis of AIDS requires a positive HIV test, a CD count of below 200 and the presence of at least one of the stage 4 clinical criteria.

However, in many places there are no facilities to measure CD4 counts and many of the opportunistic infections require specialized laboratory tests for diagnosis. For places where laboratory tests are not available, WHO has established clinical guidelines for the diagnosis of AIDS.

WHO guidelines for the clinical diagnosis of AIDS in an adult:

To make the diagnosis of AIDS, at least two major and one minor sign should be present, in the absence of any other clear explanation for the signs:

Major signs:

- Weight loss of more than 10% body weight
- Diarrhea for more than 1 month
- Fever for more than 1 month

Minor signs:

- Persistent cough for more than one month
- Generalized itching skin rash
- Recurring shingles (herpes zoster)
- Thrush of mouth and throat
- Chronic severe and spreading cold sores (herpes simplex)
- Generalized enlarged lymph nodes.
- Loss of memory
- Loss of intellectual capacity
- Peripheral nerve damage

Why do people with HIV lose weight? *(Ask participants)*

There are a number of reasons for the severe weight loss associated with HIV infection:

- Loss of appetite, nausea and digestive problems, which prevent people from eating and absorbing what they need from their food.
- Diarrhea which causes dehydration and poor absorption of food.
- High metabolic rate due to infection with HIV.
- Increased energy requirements due to fever from illnesses such as malaria or TB.
- Anemia due to inadequate iron intake or diseases such as malaria or hookworm, causing lack of energy, reducing appetite and ability to cook, work, buy food, etc.
- Infections in the mouth or throat, making it difficult to chew and swallow food.
- Socio-economic reasons: no money for food, too weak to work or prepare food, etc.

Opportunistic infections

Many of the clinical manifestations of HIV/AIDS are the result of opportunistic infections. We do not have time to discuss opportunistic infections in detail and the handout "HIV-related opportunistic diseases" gives a good overview. Opportunistic infections will be discussed further on Day 5. However, two types of opportunistic infections deserve special mention:

Sexually transmitted infections

STIs are a significant public health problem. The STI and HIV epidemics reinforce each other, i.e., STIs help HIV to spread and HIV helps STIs to spread. The spread of STIs is a threat to both HIV-positive and HIV-negative people. We will discuss STIs in depth on Day 3 of this course.

Tuberculosis

TB is also a serious public health problem. Nearly 2 million people die from TB every year. 95% of cases occur in developing countries.

About one-third of PLWA also become ill with TB. Most of these people are living in developing countries. In some countries in sub-Saharan Africa, up to 70% of patients with pulmonary tuberculosis are HIV-positive. TB accounts for up to a third of AIDS deaths worldwide and 40% in Africa.

TB and HIV also reinforce each other: A person with HIV is 10 times more likely to develop TB than a person who does not have HIV. The presence of TB may allow HIV to multiply more rapidly. TB and HIV are referred to as the "dual epidemic."

Most people who are infected with TB are not sick and are not infectious to others. The TB infection is kept under control by the immune system and is latent, or inactive, and may remain so for life. In people with HIV however, the immune system is weakened and unable to control the TB infection, so the person develops active TB and becomes ill.

Only people with active lung TB are infectious to others. When they cough, sneeze, spit or even talk, they spread TB germs into the air, which can infect other people. Untreated, a person with active lung TB will infect an average of 10-15 people per year. However, after two weeks of appropriate treatment, people with TB are generally no longer infectious. People with TB of other parts of the body (e.g., TB meningitis) cannot infect others.

TB is a serious public health threat to people with and without HIV. WHO has developed a treatment strategy for TB called Directly Observed Therapy Short course (DOTS). Treatment of TB through DOTS is ranked by the World Bank as one of the top ten most cost-effective public health interventions. People with HIV can also take a relatively inexpensive anti-TB drug, INH (isoniazide) to protect them against developing TB.

Services for HIV and TB should be linked. All HIV programs should include a component that addresses TB.

1.6 How do people get HIV?

1.6a PRESENTATION: *Transmission routes*

Presentation – 10 minutes.

Materials: PowerPoint:1.6a Transmission routes
Transmission routes poster (Example in PowerPoint: Teaching aids Day 1)
HIV/AIDS tree: roots

How HIV is transmitted

HIV is found in all body fluids of infected people. *(Ask participants to name some body fluids.)*
However, it is only when HIV is present in high enough concentrations in a body fluid that it can be transmitted to other people. Blood, semen, vaginal secretions and breast milk are the only body fluids through which HIV transmission has been documented. These are the only body fluids in which the concentrations of HIV are high enough to infect others.

HIV is not transmitted through tears, sweat, saliva, vomit, feces or urine. Although these substances can contain HIV, they do not contain the virus in amounts high enough to cause infection. To date, there is no documentation of HIV transmission through these substances.

HIV can only be passed on to another person if the fluids get into that person's body. The virus needs a specific entry route. This may be through damage to the skin, mucous membrane or placenta, in the form of cuts, sores or infection. HIV is a weak virus and this also affects transmission: HIV can only survive outside the body for a very short time and must be able to enter a new host immediately. For example, HIV cannot survive on toilet seats or in dried blood.

HIV can get inside a person's body through three channels only: *(poster)*

Sex:	70%
Blood:	20% (Blood transfusions/needles: 5-10%; Injecting drug users: 10%)
MTCT:	10%

1. Sexual route

a) Unprotected sexual intercourse: vaginal, anal or oral.
Tiny tears in the skin or the mucous membranes of the genitals, or the mouth or anus, which may occur during sex, allow the virus to enter. If there is an open sore in any of these areas, it is even easier for the virus to enter.
The receptive partner is at greater risk in vaginal, anal and oral sex. With penile-vaginal sex, the female partner is at greater risk because of the greater exposed surface area in the female genital tract than in the male genital tract, the higher concentrations of HIV in seminal fluids than in vaginal fluids, and the larger amount of semen than vaginal fluid exchanged during intercourse. With anal sex, the receptive partner is particularly at risk because of the fragile mucous membrane of the rectum.

b) Close sexual contact even without penetration carries a risk of infection if there is exposure to blood, open sores, semen or vaginal fluids, e.g., a woman has a sore on her external genitals: some semen gets onto this sore.

2. Blood route

a) Transfusions (receiving infected blood or blood products) or transplant of an infected organ
b) Injections (contaminated needles: health care setting or injecting drug users)
c) Cutting instruments (contaminated cutting or skin-piercing instruments, such as scalpels, needles, tattoo needles, circumcision instruments). (Ask participants for examples of instruments used in cultural practices)
d) Contact with broken skin (exposure to blood through cuts or sores, e.g., traditional birth attendant with sore on hand, not wearing gloves)
e) Needle stick injury
f) Mucous membrane splash
g) Sharing utensils such as razor blades and toothbrushes

3. Mother-to-child route

During pregnancy, delivery or breastfeeding. About one in every three babies born to HIV-positive mothers will also become infected with HIV.

We will discuss the blood route and mother-to-child route in further detail on Day 4.

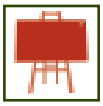
HIV/AIDS tree: transmission routes = roots

How HIV is NOT transmitted

Many myths exist about how HIV is transmitted. (*Ask participants for examples.*) HIV is NOT transmitted through: coughing, sneezing, donating blood, shared clothing, touching, shared food or dishes, water, kissing, shaking hands, toilet seats, insect bites, telephones, living or working with a person with HIV.

(Refer to p.26 of "Protecting the Future" for an explanation of why mosquitoes cannot transmit HIV.)

1.6b ACTIVITY: *The concept of levels of risk*



Work in groups.
Discussion – 15 minutes. Feedback in plenary –10 minutes.
Materials: Picture cards
Flipchart sheets

Transmission picture card game. Protecting the Future: page 10.

1.7 Why do people get HIV?

1.7a PRESENTATION: *Biological risk factors*


Presentation – 10 minutes.
Materials: PowerPoint 1.7a Biological risk factors
HIV/AIDS tree: fertilizers

It should by now be easy to answer the following questions:

What causes AIDS?
The HIV virus.

How does the HIV virus get into a person's body?
Three routes:

- sex
- blood
- mother-to-child transmission (MTCT)

In the risk factor game, we saw that some situations carry a higher risk for transmitting HIV than others. We know that unprotected sex with an HIV-infected person carries a significant risk of getting HIV. But although this is already a high risk situation, there are some factors that make the risk even higher: we can call these biological risk factors. For the moment, we will focus on biological risk factors for the sex route. (The biological risk factors for the other two routes will be covered later on in the course.)

1. Viral load
Viral load refers to the amount of HIV virus in the blood. The higher the amount of viruses in the infected person's blood, the greater the chance that s/he will transmit the infection. This happens soon after infection during the window period, and again at the stage of AIDS. It also happens when there is reinfection. High viral loads increase the risk of transmission for all routes.

The following are biological risk factors associated with the sexual transmission route:

2. Receptive partner
In penile–vaginal sex, women are more susceptible to getting HIV than men because of the structure of the female genital tract: greater exposed area, more mucous membrane, vagina is a receptive organ. In penile-anal sex, the receptive partner is more susceptible because of the fragile nature of the rectal mucosa.

3. Age
Young women (adolescents) are particularly susceptible because the genital tract is immature and the skin is delicate. Men are also at increased risk for acquiring the infection from an infected young girl because of the risk of bleeding from tears in vaginal mucosa or skin.

4. Sex during menstruation
The woman is more vulnerable as a result of the change in the uterus lining, and the man is also more vulnerable because of the exposure to blood.

5. Uncircumcised male
Uncircumcised men are more easily infected. Research has shown biological explanations for a link between HIV infection and lack of circumcision. The inside of the foreskin can absorb HIV very efficiently, mainly because it contains HIV "target cells" in much greater quantities than other genital tissue. Also, the internal foreskin has a mucous membrane surface, which is particularly vulnerable to tears and abrasions, and, consequently, infection with STIs and HIV. (It is important to remember though that some circumcision practices may in fact result in HIV infection, e.g., using unclean instruments.)

6. Damage to the skin or mucous membranes

The risk of both giving and getting HIV increases when there is damage to the skin or mucous membrane of the genital area, such as abrasions or tears, as may occur during violent sex or with practices such as dry sex. Female genital cutting poses a particular risk for HIV transmission. Scar tissue formed after cutting may be easily damaged during sex, resulting in a wound that facilitates HIV infection and transmission.

7. STIs

Having an STI significantly increases the risk of both giving and getting HIV. (Discussed in detail on Day 3.)

HIV/AIDS tree: biological risk factors = fertilizers

Activity

1.7b *The concept of spread of the disease*

Plenary – 25 minutes.

Materials: Vinegar, water, phenol red, glasses or clear plastic cups, instruction cards
PowerPoint poster: in Teaching aids Day I:
"Everyone he's slept with is sleeping with you"

1. Facilitator shows PowerPoint poster: "Everyone he is sleeping with is sleeping with you." What is the message here? Facilitator concludes: When you have sex with someone, there is a chance that you will acquire an infection that any of his/her previous partners may have had and passed on to him/her.
2. HIV epidemic exercise. Protecting the future: p13. (Use 6 or 8 participants to carry out the exercise in front of the class.)

Note: The exercise in "Protecting the Future" uses laundry starch and 10% iodine solution as reagents. A more dramatic effect can however be achieved by using white vinegar instead of starch solution and phenol red instead of iodine. (Phenol red is used for testing pH – it can be obtained in kits used to test the pH of swimming pools or may be available in some pharmacies.) Any weak colorless acid can also be used instead of vinegar.

Activity

1.7c *Video: the concept of spread of the disease*

Video show – 15 minutes; discussion in plenary – 5 minutes.

Materials: video: Guilty (Note: This video may not be appropriate or relevant to all contexts. The facilitator should assess the suitability before showing the video.)

Facilitator...

...introduces video:

This video tries to trace the source of an HIV infection. The story unfolds in a township in Cape Town, South Africa. Think about what message the video is trying to convey. Explain to the participants that such an attempt at "contact tracing" is not acceptable. However, the video is attempting to highlight some realities about the way the epidemic can spread and how people may blame each other.

After the video, the facilitator asks about what the message was, and for any other impressions.

...concludes:

The video is shocking in that it is violent and uses explicit and sometimes coarse language. This, however, reflects the context of the story: a poverty-stricken township with many social problems. Transmission of the virus through shared needles as well as sex is shown. The video illustrates vividly how HIV can spread through a number of different segments of a society and that it is impossible to ascribe "guilt" for where it began. The video also looks at a number of social issues underlying the HIV epidemic.

Activity

1.7d *Demonstrating the multiple factors underlying the HIV/AIDS epidemic*



Work in three groups.
Preparation – 25 minutes. Feedback in plenary – 25 minutes.
Materials: Case studies written on flipchart sheets; flipcharts
Example in PowerPoint: Teaching aids Day I: "But why?" flowchart
PowerPoint 1.7d Disasters maps
HIV/AIDS tree: soil

Facilitator...

...introduces:

So far we have looked at symptoms and signs (branches of the AIDS tree), transmission routes (roots) and biological risk factors (fertilizers). Now we are going to look at the soil in which the tree grows: the underlying reasons why people get HIV/AIDS. We can call these the socio-economic **"vulnerability factors."**

"But why?" exercise.
Facilitator demonstrates the idea of a "But why?" flowchart. (Refer to example in PowerPoint: Teaching aids Day 1.) Each group then reads and responds to one of the following case studies. Participants draw a "But why?" flow chart on a flipchart sheet and prepare to present it in the plenary session. (Note: Facilitators should adapt case studies or create their own case studies to reflect the local context. For instance, facilitators could modify or add examples specific to a refugee or internally displaced setting. Also note, there are no "right" or "wrong" answers. The "But why?" exercise is used to draw out factors relevant to the context in which participants are living or working.)

Case study A
As a child, Marie was subjected to genital cutting in a traditional ceremony. When she was 15 years old, Marie and her three younger siblings were forced to flee to a neighboring country when fighting broke out near their village. Their father was killed and they became separated from their mother while they were fleeing. Marie and her siblings now live in a refugee camp. Marie had never had any sexual partners before coming to live in the camp. Within a few months she is infected with HIV. Why did Marie get HIV?

Case study B
Michael is 17 years old. He has had several girlfriends. He and his friends like to visit bars and often sit and talk about their sexual experiences. None of them uses condoms. One day Michael develops a small sore on his penis. He continues to have sex with the girlfriend of the moment. A week later Michael is infected with HIV. Why did Michael get HIV?

Case study C
Fatima lives in a rural area. She has no education. She married her husband Abdul when she was 16. She has had no other sexual partners. They have one child. Fatima would like another child but has been unable to become pregnant again. Abdul works as a truck driver for an NGO and is away from home a lot. Fatima knows he sleeps with other women. At age 25, Fatima starts to get frequent chest infections and loses weight. She is HIV positive. Why did Fatima get HIV?

...takes feedback:

Each group presents their flow chart. Other groups comment.

Activity 1.7d cont'd

On the flow charts, some reasons or "vulnerability factors" come up repeatedly. Ask participants to identify a few of the factors that were repeatedly involved. Then ask them to spend 5 minutes identifying the main vulnerability factors in the contexts where they are working. Ask them to specifically think about the role of conflict and displacement in increasing vulnerability. Then take feedback in plenary.

...notes:

Vulnerability factors which may come up repeatedly: youth, gender issues, cultural taboos on discussing sex, cultural pressures on men and women, resources, education, availability of services/commodities, knowledge, beliefs (and other factors that participants may identify).

Factors specifically relating to conflict may include:

- Social disruption may result in breakdown of traditional norms and loss of protective networks around women and young people.
- Conflict is often associated with population movements, resulting in mixing of populations with different HIV prevalences.
- There may be high levels of sexual violence and exploitation, (e.g., by community members, military or even NGO workers).
- Women may be forced to resort to sex for survival.
- The presence of military, both enemy and friendly, poses a risk, both through sexual violence, social interactions with the population and commercial sex work. Military have been shown to have HIV prevalences significantly higher than their civilian counterparts.
- Commercial sex work often flourishes in conflict-affected populations, where men may be separated from families, and some groups such as peace keeping forces and relief workers have a high income relative to the population.
- There may be a breakdown of health services, with limited supplies and unsafe practices such as unscreened blood transfusions.
- Humanitarian workers may also be vulnerable, due to stress, isolation, high levels of alcohol use and little support or opportunities for recreation.

Show PowerPoint maps: ask participants for their impressions.

...concludes:

The reason we did the "But why?" exercise is to show the complexity of the factors that can influence the spread of HIV, and to identify factors that seem to be playing an important role in fueling the epidemic.

A number of factors were identified that increase vulnerability to HIV. The conditions surrounding conflict and displacement may exacerbate existing vulnerabilities and/or increase vulnerability in their own right.

The factors that influence the spread of HIV in conflict-affected situations are complex and not yet fully understood. In some countries, e.g., Bosnia and Sierra Leone, HIV prevalence remained low despite long-standing conflict. It may be that factors such as closure of transportation routes, which limit access to conflict-affected areas, may slow the progression of the disease. However, it may also be that conflict has a delaying effect and that there may be rapid growth of the epidemic in the post-conflict phase, for example, when transport routes reopen, military return home, and when there is a lack of awareness among the population about HIV risk.

Although all these factors are not yet well understood, the potential vulnerability factors associated with conflict cannot be denied and all conflict-affected populations should be considered vulnerable. Sometimes HIV may not seem a priority issue in emergencies, compared with health problems that are obvious and immediately life threatening, e.g., cholera or measles outbreaks. However, the consequences of failing to address HIV are likely to result in significant human suffering in the future.

AIDS tree: vulnerability factors = soil

1.7e PRESENTATION: *Organizing the vulnerability factors*

Presentation – 10 minutes.
Materials: Vulnerability areas posters (Example in PowerPoint: Teaching aids Day I)

Because there are many factors influencing the spread of the HIV/AIDS epidemic, it can sometimes seem as if these are circumstances beyond our control. This can make us feel helpless and hopeless. It can also be easy to throw the responsibility for addressing the problem onto other people or the government. But we should never forget the issue of personal responsibility. Even though circumstances may seem overwhelming, each person needs to say "What can I do?" This could be in our personal lives, or in our work, or in our social interactions. We may not be able to solve every problem immediately, but we have to start somewhere and we need to start by looking at what can realistically be done within our own contexts.

If we want to address a problem, we need to understand where it is coming from. This is the reason we did the "But why?" exercise. We saw that there are many vulnerability factors contributing to the problem of HIV. Trying to find a way to address all these individual factors would be complicated. To make it easier to think about all of the factors, it is helpful to categorize them. There could be many different ways of categorizing the vulnerability factors. In this course, we are going to use the following method which groups vulnerability factors into three "socio-economic vulnerability areas":

Socio-economic vulnerability areas:

1. Unsafe behavior

   Unsafe behavior is influenced by a range of factors including knowledge, attitudes and beliefs, as well as personal circumstances and environment.

2. Power issues

   We can think of power here in terms of the ability to take control of your situation. It involves two issues: power imbalances within relationships, and lack of power to do something about your circumstances because of lack of resources. Power is influenced by culture, gender, poverty, education, government, etc.

3. Health services issues

   This includes clinical services, counseling services, laboratory services, condoms, drugs, etc.
   Availability of services is influenced by the economic and political situation, infrastructure, rural versus urban areas, etc.

One way of approaching the HIV/AIDS problem would be to see what could be done in each of these vulnerability areas. It is also important to realize that addressing only one vulnerability area will not solve the problem: the three areas influence each other and therefore all three must be addressed. (*Ask participants for examples of how the areas influence each other. For example, condoms may be available, but people may lack awareness of the need to use them, or may not be able to afford them, or women may lack the power to negotiate condom use with their partners.*)

The "But why?" exercise also highlights the fact that an individual does not exist in isolation. The way in which an individual lives is influenced by personal factors, by the community in which they live and by the broader society in which the community exists. We can therefore say that a person is subject to three different **levels of influence:**

Levels of influence:

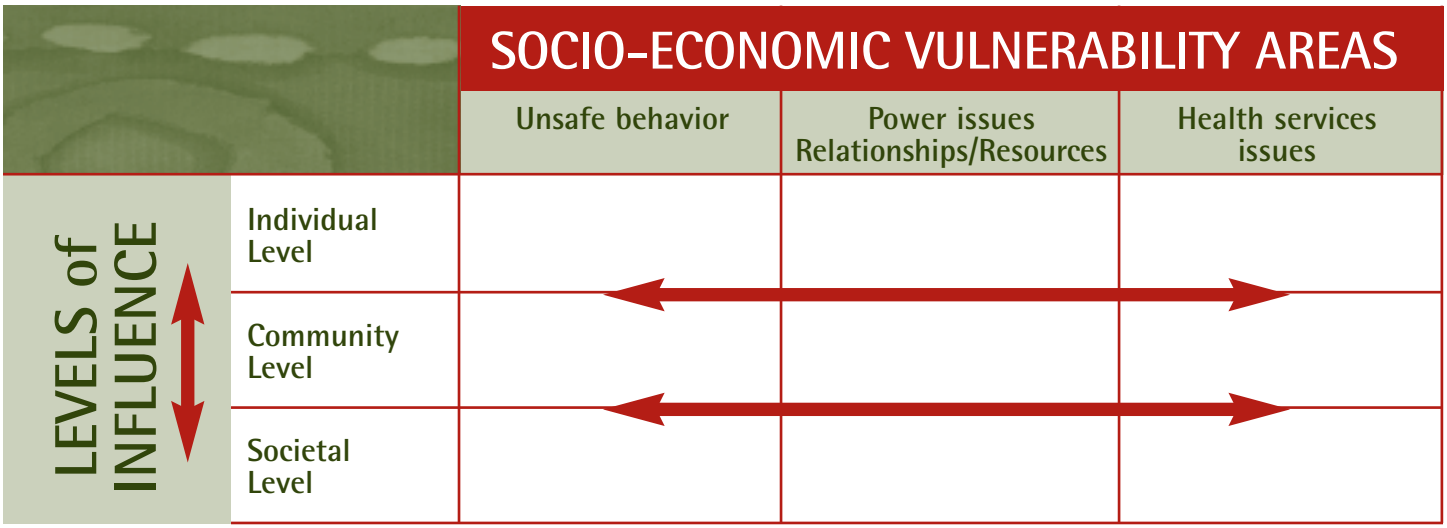
1. Individual (personal) level:
   Includes:
   Knowledge, attitude, beliefs, age, gender, health status, education level, economic status.

2. Community ("near") level:
   Includes:
   Social influences of family, friends, peers; social norms ("how things should be done"); cultural/religious beliefs, traditions, taboos; "fashion."
   Living and working conditions: physical environment, availability of services, access to education, access to information.

3. Societal ("overarching") level:
   Includes:
   Culture, religion, social action, economy, infrastructure, government policy, political stability, dependence on foreign aid.

All three levels also affect each other. Therefore, if we are going to address HIV, we must consider all three levels. The socio-economic vulnerability factors we identified are present in all three levels. (Ask participants for examples of how the different levels of influence affect each other. For example, a young man may want to use condoms, but may be influenced by his peers to have unprotected sex, or the religion to which he belongs may disapprove of condom use.)

In summary, therefore, we need to look at three vulnerability areas and three influence levels. In other words, we need a **multidimensional approach**.



We will apply these concepts on Day 2 when we start looking at HIV programs.

1.8 Conclusion

- Overview of the day, with link to Day 2 ("Where have we come from and where are we going?")
- Suggested reading
- Post-test
- Daily evaluation

DAY 2

◎ A framework for HIV/AIDS interventions

◎ Behavior Change Communication

Day 2 begins by presenting a framework for interventions, based on the vulnerability areas identified on Day 1. Participants use the framework to identify interventions and gaps in their own work contexts. This course addresses two key intervention areas: behavior change communication and health services provision. Day 2 focuses on behavior change communication. We begin by examining the background to the behavior change process and proceed to the communication process and its various components. Behavior change and communication concepts are applied using a variety of communication channels.

Learning objectives

By the end of Day 2, participants will be able to:

- ◎ Understand the need for a multidimensional approach to HIV/AIDS
- ◎ Relate risk and vulnerability factors to interventions
- ◎ Have an awareness of the processes underlying behavior change
- ◎ Understand principles of communication
- ◎ Assess the role of specific types of communication in behavior change communication strategies
- ◎ Design and evaluate a poster
- ◎ Develop participatory activities
- ◎ Have an awareness of strengths and challenges of peer education

Resource materials

Manual:

- International Rescue Committee. (2003) Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations. Chapters 5, 6 and 8.

Handouts:

- World Bank. (2001) HIV/AIDS at a glance. www.worldbank.org
- Matrix from: Inter-Agency Standing Committee. (2004). Guidelines for HIV/AIDS Interventions in Emergency Settings. https://www.unfpa.org/publications/detail.cfm?ID=165&filterListType=
- Course notes: Introduction to behavior change communication.
- Course notes: Introduction to communication.
- Course notes: Poster design form.
- Extract from: Family Health International. (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/lowliteracyguide.htm
- Course notes: Using codes.
- Example for analysis: Commercial sex worker peer educators. From: Singhal, A & Rogers EM. (2003) Combating AIDS .
- Example for analysis: Adolescent peer educators. Adapted from: Campbell, C. & McPhail, C. (2002). Peer education, gender and the development of critical consciousness: participatory HIV prevention by South African youth. Social Science and Medicine. 55. pp331-345.

Additional resources:

- Inter-Agency Standing Committee. (2004) Guidelines for HIV/AIDS Interventions in Emergency Settings. https://www.unfpa.org/publications/detail.cfm?ID=165&filterListType=
- Family Health International. (2003) Control of Sexually Transmitted Diseases: A handbook for the design and management of programs. Chapter 4: An approach to effective communication. http://www.fhi.org/en/HIVAIDS/pub/guide/stdhandbook/index.htm
- FHI/AIDSCAP. (2003) How to create an effective communication project. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/effectivecommunication.htm
- FHI/AIDSCAP. (2003) How to create an effective peer education project. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/BCC+Handbooks/peereducation.htm
- The International HIV/AIDS Alliance. (2003) Working with men, responding to AIDS: Gender, sexuality, and HIV - A case study collection. http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=82&language=en
- Family Health International. (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences. www.fhi.org/en/HIVAIDS/Publications/manualsguidebooks/lowliteracyguide.htm

Teaching materials

PowerPoint:

2.3a Behavior change
2.4a BCC
2.5a Posters for analysis
2.5b Introduction to communication
2.6a Participatory approaches
2.8a BCC in conflict setting
Teaching aids Day 2

Posters:

- Intervention areas (In PowerPoint: Teaching aids for Day 2)
- ABCD (Make from text: 2.3a)
- Stages of change model (In PowerPoint 2.3 & 2.4)
- Diffusion of ideas model (In PowerPoint 2.3 & 2.4)
- Target group assessment (Make from text in 2.4a)
- Posters for analysis (In PowerPoint: Posters for analysis)
- Communicator and receiver: two way (In PowerPoint: Teaching aids Day 2; show with 2.5b)
- Communicator and receivers: one way (In PowerPoint: Teaching aids Day 2; show with 2.5b)
- Building blocks of communication (Make from text: diagram in 2.5b)

DAY 2 - Session plan

Time	Topic		Materials
30 min	**2.1 Introduction**		
	2.2 A framework for HIV/AIDS interventions		
10 min	2.2a	Presentation: **Relating vulnerability areas to interventions**	Poster: Intervention areas
50 min	2.2b	Activity: **Agency interventions**	Flipcharts
	2.3 Understanding behavior		
10 min	2.3a	Presentation: **Introduction to behavior change**	PowerPoint; Posters: ABCD, Stages of Change
10 min	2.3b	Activity: **Applying the Stages of Change model**	
10 min	2.3c	Activity: **Applying the Diffusion of Ideas model**	PowerPoint (cont'd from 2.3a) Poster: Diffusion of ideas
30 min	Break		
	2.4 Understanding Behavior Change Communication		
15 min	2.4a	Presentation: **What is BCC?**	PowerPoint; Poster: Target group assessment
	2.5 Understanding communication		
35 min	2.5a	Activity: **Analyzing posters**	Posters and/or PowerPoint
40 min	2.5b	Presentation: **Introduction to communication**	PowerPoint; Posters: one-way and two-way communication; building blocks of communication process
30 min	2.5c	Activity: **Designing a poster**	Flipcharts, colored markers, crayons
60 min	Lunch		
20 min	Designing a poster – feedback		
	2.6 Using participatory approaches		
15 min	2.6a	Presentation: **Introduction to participatory approaches**	PowerPoint
45 min	2.6b	Activity: **Using "sculptures"**	
	2.7 Peer education		
10 min	2.7a	Presentation: **Peer education**	Flipchart
30 min	Break		
50 min	2.7b	Activity: **Strengths & challenges of peer education**	Flipchart
	2.8 Field example		
10 min	2.8a	Presentation: **BCC project in conflict-affected setting**	PowerPoint
30 min	**2.9 Conclusion**		

2.1 Introduction

- Brief overview of previous day with review of wall displays. Feedback on pre- and post-tests and evaluations
- Select host team for the day
- Pre-test
- Overview of the day

2.2 A framework for HIV/AIDS interventions

2.2a PRESENTATION: *Relating vulnerability areas to interventions*

Presentation – 10 minutes.
Materials: Vulnerability and intervention areas poster (Example in PowerPoint: Teaching aids Day 2)

Day 1 looked at how and why people get HIV. Today looks at what can be done about it. We said that if we want to address a problem, we need to understand where it is coming from.

Ask participants. Refer to AIDS tree:

A. What are the routes through which HIV gets into the body?

- sex
- blood
- MTCT

B. What are the biological risk factors that make it easier for HIV to get into the body through the sexual route?

- viral load
- being the receptive partner
- being a young female
- being an uncircumcised male
- damage to the genital skin/mucous membranes (e.g., female genital cutting)
- having an STI
- having sex during menstruation

C. What are the three socio-economic vulnerability areas that make people more vulnerable to getting into situations where transmission could take place?

- unsafe behavior
- power issues
- health service issues

D. What are the three levels of influence that can affect a person's vulnerability to getting HIV?

- individual level
- community level
- societal level

We can group the transmission routes, the biological risk factors, the socio-economic vulnerability factors and the levels of influence all together and call them the "**determinants**" of the epidemic.

If we are going to do something about HIV/AIDS, we need to look at all of these determinants and also at the ways in which they interact with each other. We need a multidimensional approach to a multidimensional problem. Addressing HIV/AIDS is complex. To help us get started, we can think about interventions according to the three vulnerability areas. We need to:

1. Change behavior
We need to help people to get to **know** about HIV, to **recognize** the fact that it could affect them personally, to **want** to do something about it, to have the **skills** to do it and then actually **do it.** A different way of saying this is that we want to bring about behavior change.

2. Address power issues
We need to address the problem of lack of resources through improving the general socio-economic environment. This requires long-term, multi-sectoral involvement.

We need to address issues of power in relationships. This is not easy and will take time. Power issues are often deeply entrenched in cultures, in gender relations and in people's view of themselves. Feelings of disempowerment can be the result of a lifetime of being made to feel powerless and therefore passive. Challenging those who have power will probably meet with resistance. We need to find ways of approaching these issues effectively.

3. Address health services issues
This includes clinical services, counseling services, provision of condoms, etc.

If we relate the needs in the HIV/AIDS vulnerability areas to interventions, we can group them into **three main intervention areas**:

1. Behavior change communication interventions
   e.g., mass media, counseling, peer education.

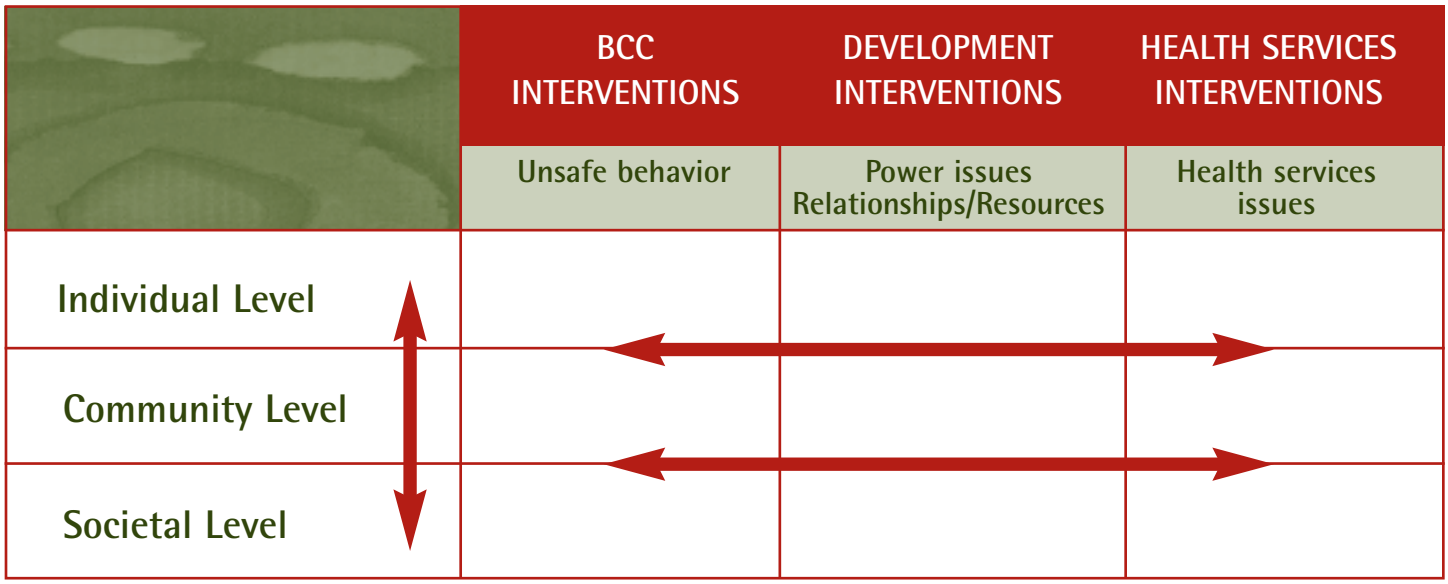
2. Development (empowerment) interventions which improve general living conditions.
   e.g., infrastructure, income generation, education, programs to address gender issues.

3. Health services interventions.
   e.g., condom distribution, management of STIs, provision of VCT services, care of PLWA, etc.

These three intervention areas all affect each other - they are interdependent.

Because vulnerability is further affected by three levels of influence, we must ensure that interventions address the three different levels appropriately.

HIV/AIDS interventions framework

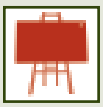


We have seen that the determinants of HIV/AIDS are complex. Therefore, it is necessary to approach the problem from different angles and on multiple levels. Such a multidimensional approach is reflected in multi-sectoral interventions addressing HIV/AIDS.

On Day 1, we identified some vulnerability factors associated with conflict and displacement. Addressing HIV in conflict-affected settings also requires a multi-sectoral approach, with recognition of the specific vulnerabilities related to conflict. Such an approach is presented in the IASC "Guidelines on HIV interventions in emergency settings." (Show copy and refer to handout and additional resources.) Despite the vulnerabilities associated with conflict and the challenges of working in conflict-affected settings, humanitarian interventions can bring new opportunities for addressing HIV that the affected populations may not otherwise have had, e.g., access to information and health services. For example, UNHCR found that returning Angolan refugees had more knowledge about HIV than non-displaced Angolans. It is essential for humanitarian workers to recognize the vulnerabilities of conflict-affected populations and to capitalize on opportunities to address HIV/AIDS.

Activity

2.2b *Agency interventions*



Work in small groups (by organization)
Discussion - 20 minutes. Feedback in plenary – 30 minutes.
Materials: Example of HIV/AIDS interventions framework on flipchart

Facilitator...

...introduces:

A multidimensional approach is essential to effectively address HIV. A supportive environment is required to assist individuals in making positive behavior changes and sustaining them. Therefore, it is necessary to address all three vulnerability areas, cutting through all three levels of influence. Different interventions at different levels support and strengthen each other. Although your organization may not be in a position to intervene in all areas and at all levels, the organization should coordinate with other organizations and together build a comprehensive, multidimensional approach to HIV/AIDS.

Examples of how various interventions on different levels strengthen each other: (Use examples to illustrate how different levels and interventions fit into the HIV/AIDS interventions framework.)

1. Teaching adolescent girls about the need to use condoms (safe behavior) is of limited value if they are unable to negotiate use of condoms (power issues) with their partners and/or they do not have access to condoms (health services issues). Creating awareness of the need to use condoms for protection should be done on a national scale (societal level); acceptability of condom use should be endorsed by peers (community level); individuals need to know how to use condoms and where to get them (individual level). Condoms must be readily available and affordable.

2. Voluntary counseling and testing (VCT) services. There must be general awareness and acceptance in the community about the idea of testing so services will be used; VCT services must be accessible to individuals; support services must be in place to help individuals cope with results; national guidelines and standards must be created to ensure quality of services.

Apply the HIV/AIDS interventions framework to your work context, identifying activities in different intervention areas (BCC, development, health services) and at different levels (society, community, individual):

a) Summarize interventions through which your organization is already making a contribution to address HIV/AIDS

b) Identify any gaps. (Refer to IASC matrix and World Bank table for examples of interventions.)

Each organization presents its framework. (5 minutes each)

Activity 2.2b cont'd

...concludes:

There is a wide range of potential interventions to address HIV/AIDS. Over the next few days, we will focus on selected interventions within the BCC and health services intervention areas. Development interventions will not be covered in this course, but it is important to be aware of the need for development interventions as a vital component in fighting HIV/AIDS.

When considering interventions to address HIV/AIDS comprehensively, there are two aims:

1. Prevention: preventing new infections of HIV.

2. Care: helping people who are infected and/or affected by HIV/AIDS.

While prevention and care are closely linked, we begin this course with a focus on prevention and follow with aspects of care.

We are now going to look at the first intervention area: behavior change communication. BCC is a wide subject and we cannot adequately cover it in this course. However, we are going to provide an overview of some important issues which you may be able to apply in your program and even in conversations with colleagues, friends and family.

2.3 Understanding behavior

2.3a PRESENTATION: *Introduction to behavior change*


Presentation – 30 minutes total.
Materials: PowerPoint 2.3a Behavior change
Posters: ABCD; Stages of change (Example in PowerPoint 2.3a)

How can people avoid getting HIV through sex? (Ask participants – Flipchart)

A: Abstain
or
B: Be faithful to one uninfected partner
or
C: Use Condoms
and
D: Damage and Disease control:
- Diagnosis and Drugs for STIs
- Don't have sex while you have a STI (alternately, use a condom)
- Avoid damage to genital skin/mucous membranes: address behaviors that can cause damage (*ask participants what these could be: e.g., practices such as dry sex; female genital cutting; sexual violence; sex with very young girls*)
- Don't have sex while there is damage to genital skin/mucous membranes

These four factors (A,B,C and D) represent safer sexual behavior and if people followed these recommendations, the problem of transmitting HIV through sex would be significantly reduced. However, people are not behaving in these ways. Therefore, if the battle against HIV/AIDS is to be won, people must adjust their behaviors. In fact, the single most effective way of stopping the spread of HIV is for people to change their sexual behavior. Thus, we need to look at ways of helping individuals, communities and societies to start adopting safer sexual behaviors.

However, behavior change is a very complex process: People tend to be generally resistant to changing their behavior, even when given the right information. For example, people are warned about the negative effects of alcohol, drugs, smoking, eating unhealthy foods, etc, but they continue to smoke, drink, eat, etc. This is sometimes called the "knowledge-behavior gap." Why does this gap exist?

There could be several reasons:
(Ask participants)
Examples:

1. People may not understand the message.
2. People may not see themselves as vulnerable (particularly young people – "it won't happen to me").
3. People are prepared to take the risk now and to deal with the consequences later.
4. Life is so hard anyway that one more risk does not make much difference (e.g., soldiers).
5. Behavior is not necessarily based on rational thought. Humans are human. People sometimes prioritize according to their immediate desires rather than in terms of what would objectively be best for them. And often they don't even think about prioritizing – they simply don't think.

So what does make people change their behavior?
Because behavior change is a complex process, researchers have developed theories (also called models) to help us understand behavior change. These models cannot explain every aspect of behavior change in every situation but they do provide a framework to help us think about the factors involved. We are going to look briefly at two such models:

1. The Stages of Change Model

2. The Diffusion of Ideas Model

Researchers suggest that behavior change is not a one-time event, but rather a process consisting of different stages through which a person moves. (Poster: stages of change)

Think about your own awareness of HIV/AIDS. Did you go through these stages?

Stages of change:

- Pre-contemplation: Individual is unaware of the problem
- Contemplation: Becomes aware of the problem
  Becomes concerned that his/her behavior places him/her at risk
- Preparation: Acquires knowledge about the problem and what can be done about it
  Considers costs and benefits of current behavior versus costs and benefits of alternate behaviors
  Prepares for action through acquiring skills and resources necessary for change
- Action: Tries out the new behavior
  Assesses how well the new behavior works, and if successful,
- Maintenance: Maintains the behavior change.

Behavior change may take a long time. Different people go through these stages at different speeds; they may become "stuck" at any stage. Although a person may intend to maintain a new behavior, s/he might find it difficult. For a range of reasons, people might move back to the earlier stages, e.g., a person may stop using condoms because a new partner won't accept them or because a supportive counselor moves away or because their sense of vulnerability decreases over time. Just because someone reverts to an earlier pattern of behavior, this does not mean that s/he has "failed to change." Many people who eventually adopt a new habit make several attempts before the behavior is maintained in the long term.

Activity

2.3b *Applying the Stages of Change model*

Work in pairs.

Discussion – 5 minutes. Feedback – 5 minutes.

Facilitator...

...introduces:

Imagine that you are working with a youth group. Your aim is to increase safer sex among the members of this group. How could the stages of change model help you to design and implement your program? Think in terms of interventions relevant to the different stages.

...notes:

Ways to help the youth move through the stages could include:

Pre-contemplation stage:

- Posters and leaflets designed by and for youth promoting safer sex and suggesting the various options
- Information on where to access STI care, family planning services and condoms

Contemplation stage:

- Dramas showing adolescents in high-risk situations
- Peer education
- Role models addressing youth group
- PLWA addressing the group

Preparation stage:

- Pamphlets/books with detailed information on HIV/AIDS and other STIs
- Workshop on basic facts about HIV/AIDS
- Condom demonstrations and games
- Role plays on condom negotiation
- Provision of condoms
- Confidential assistance/support in accessing STI care and family planning services
- Confidential advice/counseling

Action and maintenance stages:

- All of the above
- Counseling services available for ongoing support
- Ongoing support of peer educators
- Education, skills training and income generation opportunities

Facilitator concludes: This model helps us to understand the need for different types of support to people at different stages of the behavior change process. It also illustrates that providing information alone is not enough to bring about behavior change.

Activity

2.3c *Applying the Diffusion of Ideas model*


Work in pairs.
Discussion – 5 minutes. Feedback 5 minutes.
Materials: PowerPoint 2.3a Behavior change (cont.)
Poster: Diffusion of ideas (example in PowerPoint 2.3a)

Facilitator...

...introduces: (with PowerPoint and poster)

The Stages of Change model addresses the behavior change process at the level of the individual. Behavior change can also be addressed at community level.

Researchers suggest that people are most likely to adopt a new behavior if people whom they respect or admire endorse the behavior, e.g., a movie star, a sports star, a politician, a community leader, a religious leader. These people are opinion leaders. Opinion leaders can influence an initial group of followers who adopt the behavior and thus establish a new social norm. The rest of the community is subsequently influenced by what they perceive to be the norm, and begin to adopt the new behavior. (Ask group if they can think of examples. e.g., fashionable clothing styles, brand names, music, places of entertainment.)

How could you use this theory to increase condom use among the youth in your community?

...notes:

For example:

- Invite people respected by the youth to address schools/youth groups.
- Involve local youth leaders in communication campaigns.
- Expose youth to media, e.g., videos or music, where role models endorse condom use.

...concludes:

There is no "magic formula" for getting people to change their behavior and behavioral theories cannot explain the process of behavior change completely. However, they do highlight important issues to consider when designing behavior change communication projects and they also provide a framework to help shape interventions.

2.4 Behavior Change Communication (BCC)

2.4a PRESENTATION: *What is BCC?*


Presentation: 15 minutes.
Materials: PowerPoint 2.4a: BCC
Poster: Target group assessment

The terms BCC and IEC are commonly used. What exactly do they mean and what is the difference between BCC and IEC? (*Ask participants?*)

Information, Education and Communication:
IEC is a process of working with individuals, communities and societies to:
- develop communication strategies to promote positive behaviors that are appropriate to their settings.

Behavior Change Communication:
BCC is a process of working with individuals, communities and societies to:
- develop communication strategies to promote positive behaviors that are appropriate to their settings; AND
- provide a supportive environment that will enable people to initiate and sustain positive behaviors.

What is the difference between BCC and IEC?
Show cartoon: "Teaching Spot to whistle."
Experience has shown that providing people with information and telling them how they should behave ("teaching" them) is not enough to bring about behavior change. While providing information to help people to make a personal decision is a necessary part of behavior change, BCC recognizes that behavior is not only a matter of having information and making a personal choice. Behavior change also requires a supportive environment. Recalling the interventions model, we learned that "behavior change communication" is influenced by "development" and " health services provision" and that the individual is influenced by community and society. Community and society provide the supportive environment necessary for behavior change. IEC is thus part of BCC while BCC builds on IEC.

An introduction to BCC programs
Before designing a BCC intervention, it is important to be clear about exactly whose behavior is to be influenced and which aspect of their behavior should be the focus for change. Communities are made up of different groups with different risk and vulnerability factors. Even within the same broad group, there may be subgroups with distinct characteristics. Different target groups will require different approaches. Therefore, when making decisions about which target groups and which factors to address, it is necessary to consider: (*Make poster of following list*)

- which target groups are most vulnerable;
- which risk/vulnerability factors are most important;
- which factors may be related to the impact of conflict and displacement;
- which target groups and risk/vulnerability factors the community wants to address;
- which services/resources are accessible to the target group;
- which target groups and risk/vulnerability factors are feasible in terms of expertise, resources and time.

A successful BCC program requires careful research and thorough pre-testing of communication materials. It is important not to underestimate the effort that is needed to carry out good quality behavioral research that yields findings that are accurate and useful. A recent analysis by UNHCR of behavioral studies in a number of refugee camps found that the methodology often needed improvement.

"...Research and proper planning form the foundation of an effective communication campaign. Knowing the needs of the population and the best means of reaching that audience are crucial in achieving the goal of raising awareness and, ultimately, changing attitudes and behaviors. The key is to determine the needs and desires of the audience, then deliver messages and products that offer real benefits. Many social change campaigns fail because the message is not meaningful or relevant and consequently not motivating to members of the target audience..." (AIDSCAP/FHI. Control of Sexually Transmitted Diseases. Chapter 4: An approach to effective communication. Undated: AIDSCAP Electronic library.)

Family Health International (through the AIDSCAP project) has made available a series of helpful booklets on BCC projects. (Refer to additional resources: "How to create an effective communication project")

In the next section we are going to examine the communication process.

2.5 Understanding communication

Activity

2.5a *Analyzing posters*


Individual. Analysis – 15 minutes. Feedback – 20 minutes.
Materials: Posters for analysis obtained locally and/or PowerPoint examples.

A selection of posters may be arranged around the room and participants are given an opportunity to study them. Try to obtain a variety of local HIV/AIDS/STI posters. Alternately, use the PowerPoint sequence of poster examples.

Facilitator...

...introduces:

As you study the posters, think about:
a) Which ones do you like or dislike and why? (Think about: colors, writing style and size, words, pictures, messages.)
b) Are there any that you don't understand?
c) How do you think these posters would be received by the communities in which you work?

...notes:

During the feedback session, participants are invited to comment. The facilitator should draw out details such as the use of images, color and font. (Refer to handout on poster design.)

Some possible reasons for a target group to reject a poster include: the poster does not fulfill message "criteria" (will cover in next session, but introduce the idea here); saturation with a message (after people have seen or heard a message too many times); changing norms, so the message may no longer be appropriate.

...concludes:

Different poster styles will appeal to different target groups and different individuals, but there are some features which generally make a poster eye-catching, appealing, easy to understand and useful in getting a message across.

2.5b PRESENTATION: *Introduction to communication*


Presentation – 40 minutes.
Materials: PowerPoint: 2.5b Introduction to communication
Posters: Communicator and receiver: two way;
Communicator and audience: one way; (Examples in PowerPoint: Teaching aids Day 2);
Building blocks of communication process

Developing effective communication programs has been described as both an art and a science.

What is communication? *(Ask participants for a definition.)*

Communication is part of our everyday lives. It is an exchange of information that can be about knowledge and beliefs, or about feelings and attitudes. Communication can be a one-way or two-way process. In two-way communication, the communicator intentionally sends a message to the receiver and the receiver responds with feedback. This is usually what happens in interpersonal communication. *(Poster)*

TWO-WAY COMMUNICATION:

However, a significant proportion of communication happens through one-way processes, such as television, radio, billboards and print media, where there is no immediate feedback. (Poster)

It is important to think about communication from the receiver's point of view. While the communicator creates the **message**, it is the receiver who creates the **meaning**.

ONE-WAY COMMUNICATION:

Messages may not be understood in exactly the way the communicator intended. If the message comes across in the wrong way, this can create misconceptions. Both the communicator and the receiver are subject to a variety of past and present experiences that influence each person's understanding of the world they live in. These experiences affect how each person will send out and receive information.

In two-way communication, it is possible to avoid misunderstandings because the receiver has the opportunity to ask for clarification and the communicator and receiver can together establish the meaning of the message through their interaction.

In the case of one-way communication (as in mass media), the messages are developed by teams of communicators working together, e.g., television commercials or advertisements in magazines. These communicators do not get immediate feedback from their receivers (audiences). Therefore they must find ways of developing an understanding of their mass audiences. This can be accomplished in a number of ways:

- thorough situation analysis of the target audience
- involving the target audience in developing the messages
- careful pre-testing of the messages
- ongoing research to find out how the messages are received

The following provides information on the communication process in more detail.

Building blocks of the communication process

The communication process contains four components or building blocks:

- the communicator
- the receiver (or audience)
- the channel (or medium)
- the message

It is important to examine the characteristics of each individual building block and to understand how the blocks fit together. Depending on the purpose of the communication, these building blocks can be used in different ways, but they must fit together in whatever setting they are used. Firstly, the message, the channel and the communicator must be appropriate to the audience. For example, in some cultural settings, it may be inappropriate to have posters displaying pictures of genitals, or of people having sex. Secondly, not all messages are appropriate to all channels, for example, it is difficult to convey the message of abstinence to an illiterate audience using posters. Radio programs or community theatre may be more appropriate channels in these circumstances.

1. The communicator:

The source of the message is very important. The communicator could be either the actual person conveying the message or the organization responsible for producing the message, or both.

Ask participants: What sort of characteristic should the communicator have? (What kind of person would gain your attention? – Think about commercial advertising.)

A communicator should have at least one of the following characteristics:

- Attractiveness: Men and women who are physically attractive or have appealing characteristics; "cute" children.
- Similarity to audience: (audience is able to identify with communicator), e.g., peer educators.
- Inspire emotional involvement: (engage the heart as well as the mind) e.g., children; pregnant women.
- Credibility: (expertise and trustworthiness) Individuals or institutions, e.g., elders of a community; the Centers for Disease Control (CDC); the Ministry of Health or a government official.
- Power: (perceived as successful) e.g., statesmen/women, athletes, musicians, businessmen/women. Both credibility and power inspire respect.

(Ask participants to give examples of communicators in their contexts.) Try to illustrate with locally obtained examples if possible. Ask participants to bring any examples of locally developed HIV/STI communication materials.

2. The receiver (audience):

It is important to understand the audience:

- Who are they?
- What are their circumstances?
- What kinds of issues impact on their behavior?
- What could be motivators for and barriers to behavior change?
- What kinds of media would reach them?
- What kinds of messages would be meaningful to them?

This involves a thorough situation analysis and ongoing research. Please refer to the handouts for comprehensive guidelines on a situation analysis.

3. The message:

Ask participants: What are the characteristics of an effective message? (Think back to the posters)

Must catch attention:

- Shock, humor, emotion, authority.
- Eye-catching colors and images.

(Be careful about using fear. Studies have shown that a message which is too frightening can create psychological barriers. People may laugh it off or deny the danger. Fear mixed with ignorance can also lead to misunderstandings and stigma.)

Must be appropriate to audience:

- Use local languages.
- Conform to cultural norms to ensure it is culturally appropriate/acceptable to audience.
- Make sure audience can relate to it.

Must be easy to understand:

- Simple, precise words
- Short sentences
- Unambiguous (no double meanings)

Must be informative and accurate:

- Should contain information that target groups require, but do not currently have
- Facts must be correct
- Should stimulate thought and the need for more information
- Should encourage actions that the target groups need to take (but are not yet taking)
- Should highlight the benefits of the actions
- Should include information on where to get detailed information and advice
- May include suggestions for overcoming potential obstacles

Must be appropriate to the channel:

- Posters and billboards usually work best to convey simple key messages – ideally a single concept supported by a strong visual image.
- Radio jingles can also be used to convey a simple key message and can be reinforced through repetition.
- Sometimes posters are also used to convey complex information, such as how to use a condom, or how HIV is spread, but this is in specific environments where people have time to read them, e.g., health facility, school, workplace.
- Stickers are small, so need to have a simple strong slogan and/or simple design.
- T shirts: simple strong message.
- Leaflets and booklets are usually aimed at people with a fairly high level of literacy, so can be more detailed, but should include diagrams to make the information user-friendly.
- Some messages work better in some media than in others, e.g., condom negotiation would be more easily communicated through radio or drama than through posters.

4. The channel (medium):

The channel is the way through which a message is sent out. It is also called the medium of communication. We can loosely group channels into four categories. (Poster)

- Mass media (one-way)
- Small media (one-way)
- Dialogue-oriented media (two-way)
- Participatory media (two-way)

Present as a table on a flipchart or overhead projector. Ask participants to give an example of each media type, how the various media are used, advantages and disadvantages.

	Mass media	Small media	Dialogue-oriented approaches	Participatory approaches
Examples:				
How the channel is used (purpose):				
Advantages:				
Disadvantages:				

Facilitator's notes:

	Mass media	Small media	Dialogue-oriented approaches	Participatory approaches
Examples:	Print: newspapers, magazines; Radio; Television; Theatre. Outdoor media: billboards, advertisements on vehicles	Can imitate mass media: billboards in a limited area Print media: posters, stickers, leaflets, brochures Audio media: tapes, CDs Visual media: slides, photographs Audiovisual: videos Utility items: key rings, pens, T-shirts, badges Internet	Counseling services, e.g., in health centers Telephone helplines Radio and television: call-in shows, write-in shows Workshops and events that include dialogue at community level	Peer counseling Role plays Marches, parades, events Community theatre Folk/traditional media: songs, poetry, dance Clubs, special interest groups
How the channel is used (Purpose):	To raise awareness or serve as reminders. Communicate basic info: Simple, short key messages. E.g., slogans, logos, jingles. Allow people to internalize messages over time through repetition. To provide more in-depth information or to evoke emotions which get people thinking. e.g., newspaper articles; television or radio documentaries or dramas. Play an important role in background communication. Help to reinforce one-to-one communication.	They are often used as a supplement to dialogue and participatory approaches. For example, brochures in a health facility; T-shirts given to students at a workshop; slides to aid health worker training.	Even if people have received basic information, they often have not absorbed or understood everything or may have questions relating to their personal situation. Dialogue-oriented approaches are used to address individual needs.	Representatives of target audiences are drawn into the message-development process.
Advantages:	Make use of an established distribution system; can reach a wide audience.	Can be tailored to suit the audience; Costs are relatively low.	Allow direct interaction between communicator and audience. Tailored to individual's needs. Telephone helplines and call-in shows have the advantage in that people can remain anonymous. Counseling services provide a safe environment in which people can ask questions.	Allow interaction between communicator and audience. Participatory approaches are very good for overcoming language and cultural barriers, because the people doing the communicating are part of the target audience. People drawn into these communication activities often make changes in their own behavior and serve as catalysts for change in their communities.
Disadvantages:	No interaction between the communicator and the receiver, therefore no feedback and no opportunity for establishing the meaning of the message together. A high degree of expertise is often required; Costs are often high.	No interaction between the communicator and the receiver. Need to set up a distribution system and ensure the materials are reaching the target population.	Labor-intensive; Requires staff with counseling expertise. May have a limited audience	Requires particular expertise: participatory methods plus technical knowledge plus in-depth understanding of context, e.g., cultural issues. Limited audience.

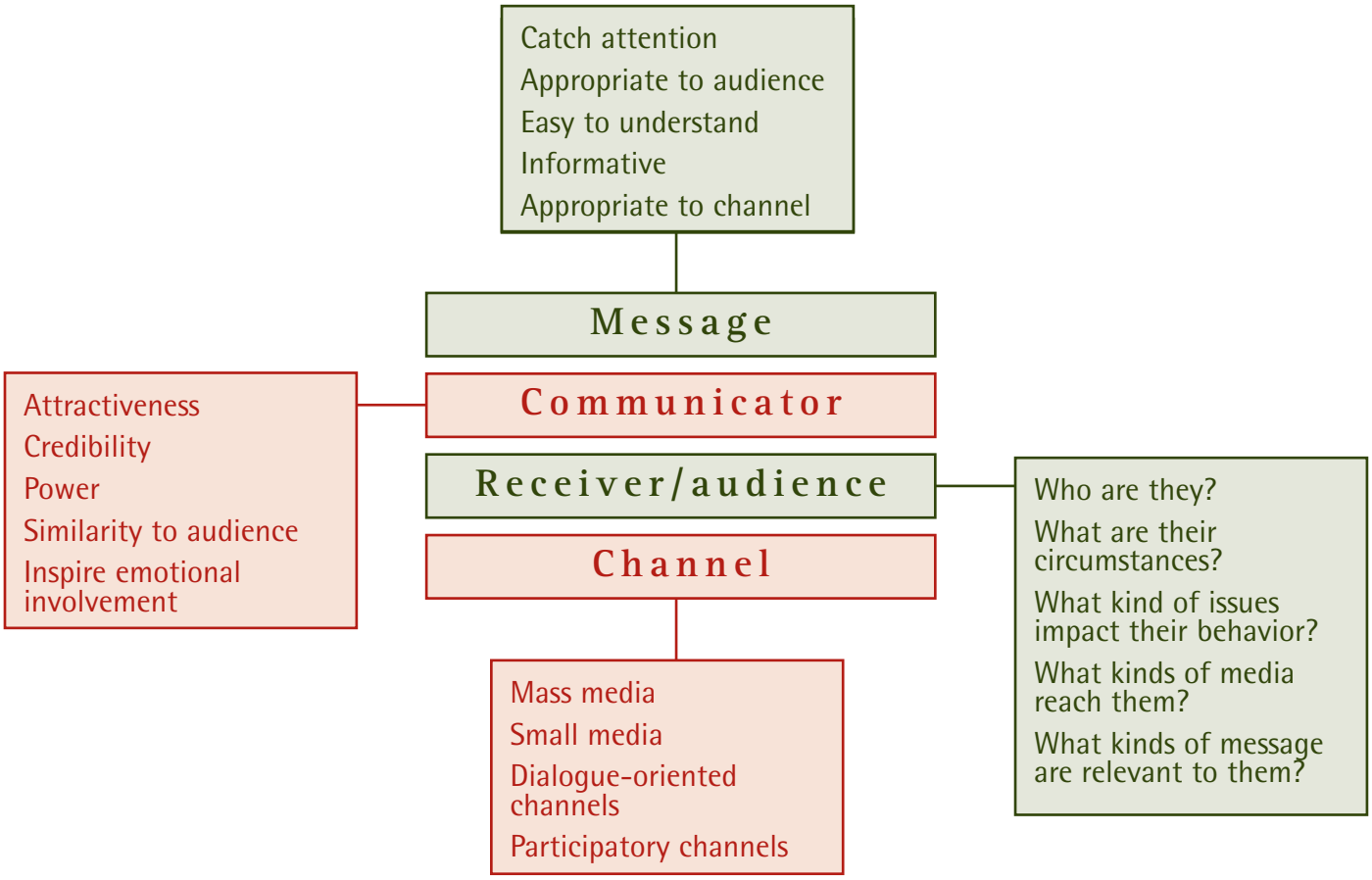
In summary:

Mass media are important in raising initial awareness and promoting a general understanding of an issue, e.g., at the pre-contemplation/contemplation stages in the "Stages of Change" model. Mass media often provide the background for other communication activities. The other three channels may be more important further along in the behavior change process, when people need more detailed or personalized information and support in implementing change. The choice of communication channels will depend on many factors, including the target audience's access to and preference for particular channels.

Different media types reinforce each other, so a communication program should try to use more than one channel. If the same message or complementary messages along the same theme are presented through a variety of channels, there is a greater chance that one of the messages may impact an individual.

Make wall display using different colored posters:

Building blocks of the communication process



The next activity involves the practice of designing posters, as an example of applying some of the principles relevant to small and mass media. We will follow this with two examples of participatory approaches. Dialogue-oriented approaches will be addressed tomorrow during the VCT session.

Activity

2.5c *Designing a poster*

Work in small groups.
Poster design - 30 minutes. Feedback in plenary – 30 minutes.
Materials: Flipchart sheets; colored markers; crayons.

Facilitator...

...introduces:

Refer to the following handouts:

- Introduction to communication;
- Poster design form;
- Extract from: Family Health International. (2002) Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences.

Decide on an HIV/AIDS-related message you want to convey using a poster. Design an outline of a poster and use the form in the handout to draw up an instruction sheet for an artist who will make the poster.

Half the class designs a poster for a literate audience, the other half for an illiterate or low-literacy audience.

Participants vote on the two best posters. Qualities of winning posters are then discussed in plenary.

2.6 Using participatory approaches

2.6a PRESENTATION: *Introduction to participatory approaches*

Presentation – 15 minutes.
Materials: PowerPoint 2.6a: Participatory approaches

We are now going to discuss some participatory communication methods that can be used in workshops or small group meetings, e.g., youth groups.

We have discussed methods of communication that can facilitate the process of behavior change. For behavior change to take place, people must **learn** a new behavior. The process of learning happens more easily when there is a form of interaction which involves the learners, rather than simply presenting them with information and expecting them to absorb it. For example:

A. People learn more easily when the new idea is linked with what they already know: their existing knowledge and experience. The new idea then has a "hook to hang on."

B. People learn more easily when they identify problems themselves and find solutions themselves.

C. People learn more easily when they go through a process of critical analysis and reflection: they examine the new idea carefully, consider its pros and cons, and then reflect on how it could apply to their situation.

When working with adults, it is also helpful to be aware of some of the principles of adult learning:

- Respect: Adults have experience and opinions that need to be respected.
- Safety: People should feel secure enough in the learning environment to experiment and ask questions without fear of ridicule.
- Immediate use: Adults learn more easily when they can see the immediate usefulness of what they are learning.
- Experience: Adults should be given the opportunity to put into practice what they have learned as soon as possible.

Codes:

As facilitators in workshops or meetings, we need to find ways of getting people to interact with information in order to help them learn. One way of doing this is through the use of "codes." A code is a starting point that provides a link to people's experience. A code could be a photograph, a drawing, a cartoon, a story, a poem, a role play, a video, etc. The choice of code is important as it is used to get people thinking and talking and to arouse emotions. Hopefully this process will then bring about debate and ultimately problem solving.

The spontaneous discussion generated by a code is in itself useful, but in order to get the most out of such a discussion, the facilitator can use a set of questions to prompt the analysis process. The following set of questions can guide participants to delve deeper into the meanings they identify from the code:

Show a photograph (e.g., refugee camp scene/gender violence) as an example and go through analysis process:

Analysis of a code:

Step 1: Describe what is happening here.
Step 2: How does it make you feel?
Step 3: Have you seen anything like this in your own community? (If not relevant, move on to next question.)
Step 4: Why is it happening? (Use the "But why?" process)
Step 5: What can we do to stop it from happening or to change the situation? (Participants work in groups to come up with ideas.)
Step 6: Who will do what? (If appropriate, plan actions to address the situation and set dates by when it should happen.)
Step 7: If relevant, participants commit to report back, reflect on and evaluate what has been achieved at a point in the future. More planning will be necessary to further develop the process.

While discussion of the problem can be interesting and beneficial, it is important to work through all of the steps to promote the idea that talking is followed by action.

A further example of a code is a "sculpture." A sculpture is a "frozen" role play. For example, at a women's group meeting, a few of the women are asked to make a sculpture representing a community problem which concerns them. They make a sculpture showing a man beating a woman and bystanders looking the other way. Now the facilitator has a starting point for discussion. The facilitator then takes the group through the step-by-step analysis process, ending up with a plan for developing strategies of what the women's group will do to begin addressing gender-based violence in their community. The women have thus identified a problem themselves, critically analysed and reflected upon the problem themselves, and come up with solutions themselves. (Refer to earlier three points which facilitate learning.) Members of the target audience were involved in creating the message, thus illustrating how a participatory channel/medium is used. (Refer to table of channels/media.)

Activity

2.6b *Using "sculptures"*

Work in small groups.
Preparation – 20 minutes. Feedback - 25 minutes.

Facilitator...

...introduces:

Imagine that you are members of a community group committed to fighting HIV. Make a sculpture illustrating an issue relevant to HIV and then go through the seven-step analysis process.

Scenarios:
Group 1: a married woman
Group 2: group of soldiers
Group 3: an adolescent girl
Group 4: group of adolescent boys
Group 5: a person living with HIV

(The facilitator may adapt scenarios to have relevance to settings in which participants work.)

...takes feedback:

Each group demonstrates their sculpture. One person presents a summary of the analysis process his/her group used on a flipchart sheet.

...concludes:

What did you learn from this activity?

Making sculptures is a quick, fun and perhaps less intimidating alternative to role play. However, it is important to focus not only on the fun of creating the sculpture, but also on the process of analysis and problem-solving.

We will now look at another participatory channel of communication:

2.7 Peer education

2.7a PRESENTATION: *What is peer education?*

Presentation – 10 minutes.
Materials: Flipchart

Ask participants for a definition of peer education.
Peer education involves non-professional teachers (peer educators) talking to, working with, motivating and supporting their peers. Trained people are used to assist others in their peer group to make decisions about STIs/HIV/AIDS through activities undertaken in one-to-one or small group settings.

Ask participants for examples/their experience of peer education programs.
Peer education has been used successfully in some settings. However, it is not necessarily an effective BCC strategy in all situations. There may be challenges for peer educators and program managers.

Activity

2.7b *Examining the strengths and challenges of peer counseling*

Work in small groups.
Discussion - 20 minutes. Feedback - 30 minutes.
Materials: Flipchart

Refer to peer education examples in handouts.

Group 1: List advantages of using peer education as a BCC technique. (Use the commercial sex worker example and draw on own experience.)
Group 2: List challenges to peer education programs. (Use adolescent example and draw on own experience.)
Group 3: List the qualities a peer educator should have.

Facilitator...

...notes:

Advantages include:

- Peer educators can present information in culturally appropriate ways.
- Peer education is community-based and can be linked to other community- based activities.
- Peer education can be more cost-effective than other methods of BCC.
- Peer educators may be more readily accepted by target audience than outsiders.
- Peer education can be empowering for the peer educators.
- Peer education makes use of an already established means of sharing information and advice.
- Peer educators can act as positive role models.
- Peer education has been shown to bring about behavior change among those involved in providing it.
- Peer education can be used to educate those who are hard to reach through conventional methods, e.g., out-of-school young people, CSWs.
- Peers can reinforce learning through ongoing contact.

Challenges include:

- Some people may be shy about talking about sex and HIV.
- Issues of age and gender may undermine the credibility of the peer educators.
- Peer educators may be ridiculed or intimidated by their peers.
- Confidentiality may be an issue.
- Peer educators may display behavior contrary to the messages they are attempting to send.
- Lack of time may be an issue in some groups.
- The question of incentives may be a problem.
- Intensive monitoring and supervision are needed to ensure that accurate information is conveyed and to determine program effectiveness.
- Peer educators may lose interest and drop out of the program.

Qualities of a peer educator working to promote HIV prevention: (From: Family Health international. *How to Create an Effective Peer Education Project*)

Peer educators should:

- have the ability to communicate clearly and persuasively with their peers;
- have good interpersonal skills, including listening skills;
- have a socio-cultural background similar to that of the target audience (this may include age, sex and social class);
- be accepted and respected by the target group (their peers);
- have a nonjudgmental attitude;
- be strongly motivated to work toward HIV risk reduction;

Activity 2.7b cont'd

- demonstrate care, compassion and respect for people affected by HIV/AIDS;
- be self-confident and show potential for leadership;
- be able to pass a practical, knowledge-based exam at the end of the training;
- have the time and energy to devote to this work;
- have the potential to be a "safer-sex" role model for their peers;
- be able to get to the location of the target audience;
- be able to work irregular hours.

...concludes:

Peer education programs can be effective but need careful planning and ongoing support. To meaningfully involve adolescents, young people must be involved as more than peer educators and should participate in the design, monitoring and evaluations of programs that affect them. It is essential that peer educators receive adequate training and supervision. Some programs have found that it is more cost effective to provide very thorough initial training, as fewer peer educators will then drop out and less supervision and retraining are needed. It is also helpful to provide peer educators with teaching aids such as posters and leaflets.

2.8 Field example

2.8a PRESENTATION: *Example of a BCC project in a conflict-affected setting*

Presentation – 10 minutes.
Materials: PowerPoint 2.8a: BCC in a conflict setting

In South Sudan the Reproductive Health Response in Conflict (RHRC) Consortium worked with community members, government representatives and other stakeholders to design and implement a BCC strategy as part of a project to reduce HIV/AIDS transmission and improve related RH practices.

The initial phase of the project included a rapid assessment, a behavioral and sero-prevalence survey conducted by the CDC and a BCC formative assessment using focus groups and key informant interviews. Target audiences were identified: in- and out-of-school youth, military and women. A number of behavior change objectives were identified, e.g., to promote safer sex practices, to promote improved STI care-seeking behavior, and to promote the use of voluntary counseling and testing (VCT) services. A BCC strategy development workshop was held, involving community leaders and members of the target audiences. At the workshop a theme, key messages and channels of communication were identified.

The theme chosen was "New weapons for a new enemy."
Communication channels included:

- peer education;
- community events, such as drama and music performances, quizzes and video shows;
- small media, such as posters, caps, T-shirts and brochures;
- community sensitization workshops for community leaders;
- HIV/AIDS/STI training for traditional healers, traditional birth attendants, drug vendors and maternal and child health care workers.

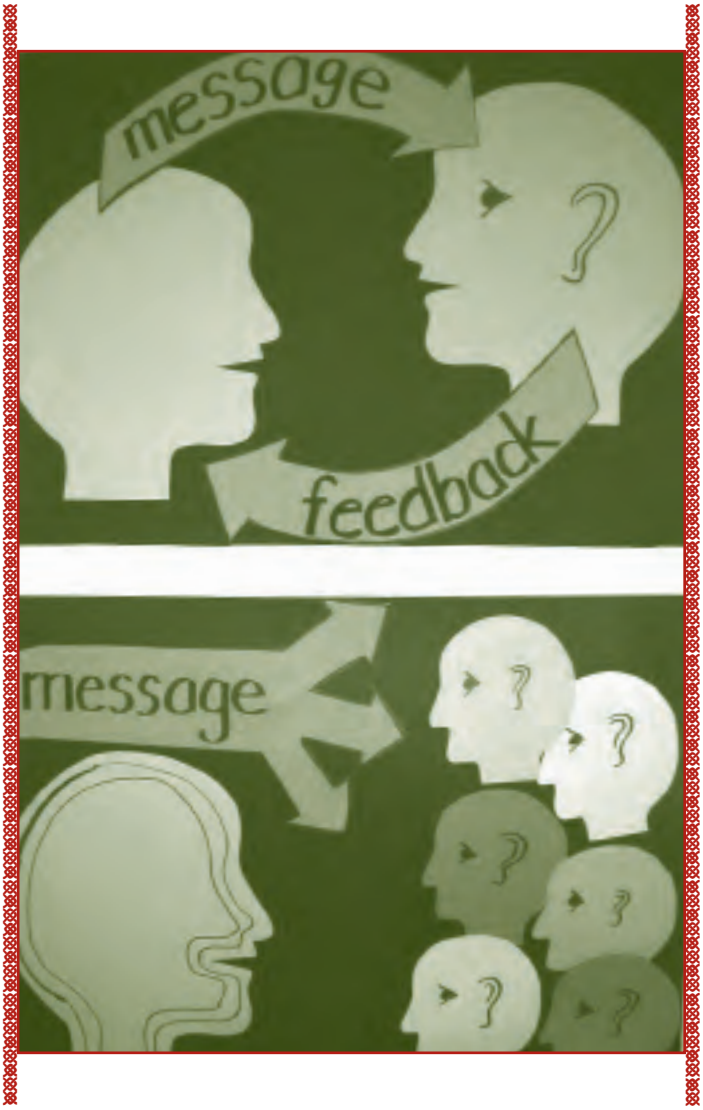
Pre-testing of various versions of materials was done with various members of the target audiences. Key stakeholders were also involved in pre-testing and message selection. (Examples in PowerPoint)

Lessons learned from this project include:

- Incentives are necessary to motivate peer educators.
- Adequate initial and refresher training is needed for peer educators.
- Materials should be developed in local languages.
- Ensure a supply of condoms before creating a demand.
- Collaboration and involvement of community leaders in monitoring of peer education activities should be strengthened for ownership, accountability and sustainability of activities.

2.9 Conclusion

- Overview of the day with link to Day 3
- Suggested reading
- Post-test
- Daily evaluation



DAY 3

- Sexually transmitted infections
- Voluntary counseling & testing
- Condoms

Day 3 considers sexually transmitted infections (STIs) in terms of clinical presentation, implications and syndromic management.
The session on voluntary counseling and testing (VCT) highlights important issues in program management and attempts to provide participants with insights into the complexities of HIV counseling and testing. The last part of the day provides a fun approach to condom demonstrations.

Learning objectives

By the end of Day 3, participants will be able to:

- Describe common symptoms and signs of STIs
- Understand the consequences of STIs
- Explain the concept of a syndromic approach to STI management
- Design a community-based approach to STIs
- Discuss the advantages and disadvantages of HIV testing
- Understand the counseling and testing process
- Have an awareness of issues impacting confidentiality
- Understand issues impacting condom use
- Conduct condom demonstrations

Resource materials

Manual:

- International Rescue Committee. (2003) Protecting the Future: HIV Prevention, Care and Support Among Displaced and War-Affected Populations. Chapters 7 & 8; Appendices B & D.

Handouts:

- Course notes: Comprehensive clinical care for sexually transmitted infections. From: Reproductive Health Response in Conflict Consortium. (2004) Guidelines for the Care of Sexually Transmitted Infections in Conflict-affected Settings: Checklist for comprehensive STI care.
- From: EngenderHealth. (2001) HIV and AIDS web course: Female Condom Instructions. www.engenderhealth.org/res/onc/hiv/hiv.pdf
- How to talk about condoms with your partner. Adapted from: Grieco, A. (1987) Cutting the risks for STDs. Medical Aspects of Human Sexuality. March issue.

Additional resources:

- EngenderHealth. (2003) Sexually transmitted infections web course. www.engenderhealth.org/res/onc/sti/sti.pdf
- UNAIDS. (2000) Voluntary counseling and testing. Technical update. http://www.popline.org/docs/169778
- Family Health International. (2005) Models of VCT Service Delivery. http://www.fhi.org/NR/rdonlyres/enjgjg3dojredmsbucesa6ey2i2wbz3ersczzmhjl6pz62ogzln4guycffb4kk2egibf6p5oafwg3k/ModelsofCT2pager122706.pdf
- UNAIDS. (2002) HIV voluntary counseling and testing: a gateway to prevention and care – five case studies. http://data.unaids.org/Publications/IRC-pub02/JC729-VCT-Gateway-CS_en.pdf

Teaching materials

PowerPoint:

3.2a Why worry about STIs?
3.2c Diagnosis and management of STIs
3.2e Important STI service issues
3.2g STIs in conflict settings
3.3b HIV testing
3.3c VCT service delivery
3.3h VCT in conflict settings
3.4b Condoms
Teaching aids Day 3

Posters:

Make the following to use with presentations and on wall display:

- List of STI symptoms and signs (Make from text: 3.2b)
- STI syndrome table (Make from text: 3.2c)
- What people need to know about STIs (Make from text: 3.2e)
- HIV testing flowchart (Make from text: 3.3b and PowerPoint 3.3b & 3.3c)

Audio-visual:

- Audio CD: Tracks 01 to 06
- Video: The Moment

Other:

- HIV rapid test kits
- Condoms: male, female, novelty
- Penis model (a cucumber works well and adds humor)
- Female anatomical diagram
- Oranges/mangoes for condom game

DAY 3 - Session plan

Time		Topic		Materials
30 min		**3.1**	**Introduction**	
10 min		3.1a	Introduction to the health services intervention area	Refer to wall displays
		3.2	**Sexually Transmitted Infections**	
15 min		3.2a	Presentation: **Why worry about STIs?**	PowerPoint
30 min		3.2b	Activity: **Relating STIs to local context**	Flipchart; Poster: STI symptoms & signs
40 min		3.2c	Presentation: **Diagnosis and management of STIs**	PowerPoint; Poster: STI syndrome table
30 min			Break	
50 min		3.2d	Activity: **Identifying challenges to STI management**	Flipchart
		3.2e	Activity: **Identifying ways to increase STI service utilization**	Flipchart; PowerPoint; Poster: What people need to know about STIs
		3.2f	Activity: **Addressing issues around partner notification**	Flipchart
5 min		3.2g	Presentation: **STI interventions in conflict settings**	PowerPoint
		3.3	**Voluntary counseling and testing**	
30 min		3.3a	Activity: **Issues around knowing your HIV status**	Audio CD
30 min		3.3b	Presentation: **HIV testing**	PowerPoint; Posters: Immune system army; Phases of HIV/AIDS; HIV testing flow chart; HIV rapid test kits
10 min		3.3c	Presentation: **Contexts for VCT**	PowerPoint
60 min			Lunch	
15 min		3.3d	Activity: **Identifying client concerns around VCT**	Flipchart
40 min		3.3e	Activity: **Gaining insights into the counseling process**	Audio CD
45 min		3.3f	Activity: **Planning VCT services**	Flipchart
		3.3g	Activity: **Understanding confidentiality**	Flipchart
60 min			Break	
5 min		3.3h	Presentation: **VCT in conflict settings**	PowerPoint
		3.4	**Condoms**	
25 min		3.4a	Activity: **Identifying complexities around condom use**	Video: The Moment
30 min		3.4b	Activity: **Teaching condom use**	Condoms, penis model, oranges/mangoes, female anatomical diagram, PowerPoint (optional)
30 min		**3.5**	**Conclusion**	

3.1 Introduction

- Brief overview of previous day with review of wall displays. Feedback on pre- and post-tests and evaluations
- Select host team for the day
- Pre-test
- Overview of the day

3.1a PRESENTATION: *Introduction to the health services intervention area*

Presentation – 5 minutes.
Materials: refer to wall displays

Socio-economic vulnerability factors underlying the HIV epidemic are categorized into three areas:

- Unsafe behavior
- Power issues
- Health services issues

Based on these factors, interventions are categorized into three areas:

- BCC programs to address unsafe sexual behavior
- Development programs to address power issues related to relationships and resources
- Health programs to provide services

There are two key aims involved in addressing HIV/AIDS:

- Prevention of new infections
- Care of PLWA

To address HIV prevention, we must consider the three transmission routes: sexual, blood and MTCT. Yesterday we discussed BCC in relation to sexual behavior. Today we focus again on the sexual route, looking at three interventions that fall into the health service delivery area and remembering that all three intervention areas are linked.

- Management of sexually transmitted infections (STIs)
- Voluntary counseling and testing (VCT)
- Condom provision and promotion

Care of PLWA is also an important factor in HIV prevention and will be addressed in detail later on in the course.

3.2 Sexually Transmitted Infections

STIs are infections for which the main route of transmission is through sexual contact. HIV is also an STI, but in this discussion we will consider HIV as a separate problem and focus on STIs other than HIV.

3.2a PRESENTATION: *Why worry about STIs?*

Presentation – 15 minutes.

Materials: PowerPoint 3.2a: Why worry about STIs?

There are a number of reasons to be concerned about STIs:

1. The presence of an STI significantly increases the risk of getting or giving HIV.
   Why is this? *(Ask participants).*

Research has shown that:

- When a genital ulcer is present, there is a break in the skin or mucous membrane which provides an easy entry or exit point for the virus. Thus, for ulcerative STIs, the risk of HIV transmission is particularly high.
- When an STI (ulcerative or non-ulcerative) is present in the partner who has HIV, the number of viruses in the genital secretions is greatly increased.
- When an STI is present in the partner who does not have HIV, the STI increases the number of target cells (including CD4 cells) for HIV in the genital tract, thus increasing susceptibility.
- In contexts where condom use is low, treatment of STIs can have a significant impact on HIV transmission.

2. STIs are a very common health problem.
In 1999, WHO estimated that 340 million people were newly infected with STIs. (These are the most recently available global estimates.) Eighty-five percent of new infections have been estimated to occur in developing countries. In developing countries, STIs and their complications are among the top five disease categories for which adults seek health care. Even without considering HIV, STIs cause the second highest burden of disease in women aged 15 to 44 years in developing countries, after maternal mortality and morbidity.

3. STIs can have serious medical consequences. (*Ask participants what these are.*)
STIs can lead to infertility in both men and women; serious illness, e.g., arthritis associated with gonorrhea, heart problems and neurological problems associated with syphilis; chronic lower abdominal pain in women; cancers of the genital tract and anus; abortion; ectopic pregnancy; stillbirth; illness and death of the newborn.

4. STIs can have serious social consequences. *(Ask participants what these could be.)*
Relationship problems, violence, rejection, stigma of infertility and STI.

5. Even though STIs are potentially serious illnesses, many STIs are completely and easily curable with appropriate treatment. Some STIs, like herpes, are caused by viruses for which there is no cure; but even in these cases there are measures that people can take to protect themselves and others.

6. All STIs are preventable.

Activity

3.2b *Relating STIs to the local context*


Work in small groups.
Discussion – 10 minutes. Feedback in plenary – 20 minutes.
Materials: Flipchart sheets; Poster: STI symptoms and signs

Facilitator...

...introduces:

(Each group discusses a different question)

a) List some local names for genital organs. (This exercise may not be culturally appropriate in some settings.)
b) List some local names for STIs.
c) What kind of symptoms and signs do people associate with STIs?
d) What do people do or where do they go for help when they think they have an STI?

Activity 3.2b cont'd

...concludes:

People are often embarrassed to talk about STIs and may find it difficult to describe their problems. As health workers we need to be familiar with local terms and beliefs and sensitive to people's embarrassment, so that we can help them to feel at ease when they talk to us. It is also essential that we are careful not to come across in any manner that the person may perceive as judgmental.

Symptoms and signs that could indicate an STI include:

- Genital discharge (pus or bad smelling fluid)
- Sores or blisters on the genitals
- Lower abdominal pain in women
- Swelling and pain of the testes
- Swelling of glands in the groin area
- Itching of the genitals
- Warts in the genital area
- Pain or burning with urination
- Pain during sex
- Abnormal vaginal bleeding in women

These symptoms and signs can also be the result of other problems not related to an STI, but it is very important to get them diagnosed and treated promptly, whatever the cause.

3.2c PRESENTATION: *Diagnosis and management of sexually transmitted infections*


Presentation – 40 minutes.

Materials: PowerPoint 3.2c: Diagnosis and management of STIs
Posters: STI syndrome table; Comprehensive care of STIs

How are STIs diagnosed and treated? (Ask participants how STIs are diagnosed in their settings.)

There are over 30 organisms that can cause STIs. Many have similar symptoms and signs and it is usually not possible to tell exactly which organism is responsible without using a laboratory test. Studies have shown that even experienced clinicians cannot make an accurate diagnosis on physical examination only. Different organisms causing STIs are sensitive to different drugs. The only way to ensure that we prescribe the right drug is to do a laboratory test to identify the organism (and its sensitivity).

However, in many developing countries, laboratory tests to diagnose STIs are often not available. To address this problem, WHO developed a method of managing STIs called "the syndromic approach" or "syndromic management," which does not rely on laboratory tests. This approach has been tested in many countries since the 1970s and has been reviewed, adapted and improved many times.

Although there are many different STIs, they can be grouped together according to their symptoms and signs into seven main groups or syndromes. Each of these syndromes can be easily recognized on history and examination, i.e., without using laboratory tests. (*Go through table, illustrating syndromes with slides. Have syndrome table alongside on overhead projector screen or poster. Ask participants to follow on table in poster.*)

STI syndrome table

Syndrome	Causative organisms
Urethral discharge in men (urethritis)	Neisseria gonorrhea Chlamydia trachomatis Non-specific urethritis pathogens
Vaginal discharge (vaginitis/cervicitis)	Bacterial vaginosis Trichomonas vaginalis Candida albicans Neisseria gonorrhea Chlamydia trachomatis
Genital ulcers	Treponema pallidum (syphilis) Haemophilus ducreyi (chancroid) Herpes simplex virus type 2 Calymatobacterium granulomatis (donovanosis/granuloma inguinale) Chlamydia trachomatis L1-L3 (lymphogranuloma venereum)
Lower abdominal pain in women (pelvic inflammatory disease)	Neisseria gonorrhea Chlamydia trachomatis Anaerobic pathogens
Testicular pain and swelling (epididymo-orchitis)	Neisseria gonorrhea Chlamydia trachomatis Non-specific urethritis pathogens
Inguinal swelling	Chlamydia trachomatis Haemophilus ducreyi (chancroid)
Neonatal conjunctivitis (ophthalmia neonatorum)	Neisseria gonorrhea Chlamydia trachomatis

By identifying the syndrome, the range of possible causative organisms is also identified, even though it is not possible through clinical examination alone to identify exactly which one is present in each case. (In fact, more than one may be present.) Treatment includes a combination of antibiotics that will cover the most common organisms causing the syndrome in that part of the world. For example, for genital ulcers in an area where syphilis and chancroid are the most common causes, the treatment could be penicillin (for syphilis) plus ciprofloxacin (for chancroid).

Advantages of the syndromic approach:

- No laboratory tests are required: costs are reduced and patients do not have to wait or return for results.
- Research in many different parts of the world has shown that the syndromic approach is effective, particularly for the management of urethral discharge in men and genital ulcers in both men and women.
- The syndromic approach is simple to use and can be implemented at all levels of the health system.
- The syndromic approach promotes standardization of patient management and facilitates training.

There are also some limitations associated with the approach. For example: (ask participants)

1. The syndromic approach relies on the health worker's abilities to recognize symptoms and signs of STIs. However, a high percentage of STIs are asymptomatic, especially in women. The only way to identify these infections is to conduct screening of women in the population using laboratory tests. In most developing countries this is not feasible at present, and many STIs in women remain undiagnosed and untreated. At present the only means to reach these women is through referral by their symptomatic partner. Men are more likely to have symptoms when they have an STI; therefore, it is especially important that men get treatment and that they refer their partners for treatment as well.

2. In a man, a genital discharge almost always signifies an STI. In a woman, however, the discharge could be the result of an STI or a physiological discharge (i.e., a normal discharge) or a problem not caused by an STI. For example, candidiasis and bacterial vaginosis can be transmitted sexually, but are most commonly the result of an overgrowth of normal vaginal organisms. In places where laboratory tests are not available, it can be very difficult for the health worker to know whether the discharge is caused by an STI or not. In such cases, the health worker often treats for STIs just to be safe and will advise the woman to bring her partner for treatment. It is important to explain to patients and partners the different causes of vaginal discharge, because sometimes one partner could unfairly accuse the other of being unfaithful if they think the discharge is caused by an STI.

3. A further important issue is associated with the diagnosis of vaginal discharge. There are a number of different STI organisms that can cause vaginal discharge. Candida, trichomonas and bacterial vaginosis cause vaginitis (inflammation of the vagina), which remains localized in the vagina. Gonorrhea and chlamydia cause cervicitis (inflammation of the cervix) and may spread through the uterus to the Fallopian tubes and ovaries and into the abdominal cavity. It is not possible to tell accurately which organisms are responsible for the discharge without a laboratory test. This presents a dilemma: We can treat for vaginitis only and thus potentially not treat a serious infection that may have serious consequences. Or we can treat for vaginitis plus cervicitis and potentially overtreat, which means higher costs and possible side effects from unnecessary antibiotics. There has been considerable debate around this problem and it is not resolved yet. Each country usually establishes its own protocol, which should then be followed by all clinicians.

4. Problems associated with using a combination of drugs:
   - Overuse of drugs resulting in higher costs, greater potential for side effects and development of resistance
   - Potential drug interactions

   However, these issues must be weighed against the potential consequences of not treating an infection.

5. There is also debate around the syndromic approach in general. Some clinicians are reluctant to use the syndromic approach because of its limitations or because they feel it is not "scientific" or because they were trained to manage STIs in a different way. Due to time constraints, we are unable to pursue a thorough discussion of all these issues, but the IRC manual and the additional resources provide further details.

It is important to remember that, despite its limitations, the syndromic approach does work well for urethral discharge and genital ulcers. At present the syndromic approach remains the only feasible option for managing STIs in resource-poor settings, including conflict-affected settings. Therefore, it is essential that the syndromic approach is implemented as effectively as possible. Hopefully, in the future, inexpensive, field-friendly and easy-to-use tests will be available to allow laboratory diagnosis of vaginal discharge even in resource-poor settings.

In conflict-affected settings, syndromic management of STIs represents part of a minimum response, in keeping with the Sphere[1] minimum standard for control of HIV/AIDS in disasters and the Minimum Initial Service Package (MISP).[2] The syndromic management of STIs has also been included as part of the emergency response phase of the Interagency Standing Committee Guidelines for HIV/AIDS Interventions in Emergency Settings. (*Refer to handout and additional resources from Day 2.*)

In summary, STIs are a common problem with serious consequences and management challenges. However, individuals as well as health services can help to reduce the spread of STIs.

1 The Sphere project presents a set of universal minimum standards in core areas of humanitarian assistance, developed by a wide representation of individuals and agencies. (Sphere Project, Sphere Humanitarian Charter and Minimum Standards in Disaster Response, Chapter 5: Minimum Standards in Health Services, Revised Handbook 2004. www.sphereproject.org)

2 The Minimum Initial Service Package (MISP) is a series of actions which, together with kits of equipment and supplies, are needed to respond to the reproductive health needs of populations in the early phase of an emergency. The objectives of the MISP are to: identify an organization(s) or individual(s) to facilitate its coordination and implementation; prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess neonatal and maternal mortality and morbidity; and plan for the provision of comprehensive RH services. (Sphere Project, Sphere Humanitarian Charter and Minimum Standards in Disaster Response, Chapter 5: Minimum Standards in Health Services, Revised Handbook 2004. www.sphereproject.org)

What can individuals do to prevent the spread of STIs? (*ask participants*)

1. Protect themselves from getting an STI using ABCD approach:
   Abstain, Be faithful to one uninfected partner, use Condoms, Damage and Disease control;
2. Prevent transmission of an STI to their partners:
   a. Get STIs treated as soon as possible;
   b. Use a condom until the STI has healed, or abstain;
   c. If there is an ulcer in a place that is not protected by a condom, abstain until the ulcer has healed;
   d. Urge partners to go for treatment.

What can health services do to reduce the spread of STIs?

Ask participants to spend a few minutes reading through the handout "Comprehensive STI Care." Then ask to what extent comprehensive STI care is provided in their work settings.

Activities 3.2d, e and f are run concurrently in different groups. Feedback is in plenary.

Small groups. Discussion – 20 minutes. Feedback – 3 x 10 minutes.

Activity

3.2d *Identifying challenges to control of STIs*

Facilitator...

...introduces:

Identify issues within the health system and society that pose challenges to curbing the spread of STIs. (We already identified some of the reasons in the "But why?" exercise on Day 1.)

...notes:

Health system:

- Lack of drugs.
- Ineffective drugs.
- Poorly trained providers.
- Poor quality service due to lack of supervision.
- Attitudes of providers.

Society:

- Ignorance about STIs.
- Some STIs do not cause any symptoms so people do not know they are infected.
- People do not realize that the symptoms they have are caused by an STI: they may think the symptoms are normal or caused by, e.g., witchcraft, working too hard, riding a bicycle or other myths. (Ask about local myths.)
- People are embarrassed to go for treatment.
- People are afraid to go for treatment because health workers may be judgmental or not maintain confidentiality.
- People do not take drugs in the right quantities or for long enough.
- People do not refer their partners for treatment. (Discuss reasons.)
- People may prefer to visit informal providers or self medicate, and may thus not receive adequate treatment.

...concludes:

If we are going to succeed in curbing the spread of STIs, we must consider both health system and societal issues. It is essential for health workers and the public to understand that effective treatment of STIs is a very important means of fighting the spread of HIV. We have discussed what constitutes comprehensive STI care, but the important issue remains how to get people to access appropriate STI care.

Activity

3.2e *Identifying ways to increase utilization of effective STI treatment services*


Materials: Poster: What people need to know about STIs
PowerPoint 3.2e: Important STI service issues

Facilitator...

...introduces:

It is necessary to increase awareness about STIs among the general public. Begin by deciding what people in the community need to know about STIs and how best to convey this information to them. Make a list of the most important points and decide on the communication channels to use.

...notes: (Poster and PowerPoint)

People need to know the following:

- That STIs are very common.
- What the symptoms and signs are.
- How STIs are transmitted and not transmitted.
- Where they can get appropriate treatment.
- The consequences of not getting appropriate treatment, especially HIV and infertility in both men and women.
- The importance of the right treatment for the right amount of time.
- The importance of partner treatment.
- The importance of using a condom.

Further important issues for consideration:

- In addition to improving service provision and utilization in the general population, STI prevention and care efforts also need to address specific target groups of core transmitters. These are groups of individuals who have higher rates of partner exchange than the general population, e.g., CSWs, military, truck drivers. Effectively treating an STI in one of these individuals can prevent the spread of the infection to a number of other individuals.
- Men are an important target group because they show symptoms and signs more often, may have the means to access treatment more often and they frequently make the couple's decisions about sexual behavior. Due to power relations, it is often easier for a man to inform his partner that she should be treated than vice versa.
- A large number of STI patients may seek care in the private or informal sectors, e.g., traditional healers, market drug vendors. Any program that is going to comprehensively address STIs should consider what can be done to involve these sectors. However, this may not be easy. Financial and professional power issues need to be handled sensitively. How can this be done? (*Ask participants*)

Activity

3.2f *Addressing issues around partner notification*

Materials: Flipchart

Facilitator...

...introduces:

Partner notification is a very sensitive issue. What are some of the problems related to partner notification in your setting? How can health services ensure that they are addressed? (NB. This activity focuses only on partner notification for STIs, not HIV – the implications are different as HIV is an incurable, fatal disease.)

Activity 3.2f cont'd

Facilitator...

...notes:

Potential problems:

- Embarrassment
- Fear of rejection
- Violence
- Relationship problems

The health worker must discuss options for partner notification with the patient. The patient should never be coerced into notifying the partner.

Options include:

- The patient informs the partner of the STI.
- A letter is sent from the health facility to the partner advising him/her to seek care.
- A health worker visits the partner.
- The patient is given additional medication to take home to the partner.

General increased awareness among the public may make partner notification easier.

3.2g PRESENTATION: *Examples from conflict-affected settings*

Presentation - 5 minutes.
Materials: PowerPoint 3.2g: STI interventions in conflict settings

The first large scale HIV/AIDS/STI intervention program to be implemented in a refugee crisis took place in Rwandan refugee camps in Tanzania during 1994-1996. The project included a strong focus on community awareness and improvement of STI case management. Over the course of the project, the number of reported syndromes at clinics increased from 20 per week to 250 per week. Increased attendance could be the result of increased awareness, increased confidence in the services and improved diagnosis.

The RHRC Consortium, through the American Refugee Committee, implemented a project to strengthen AIDS prevention in Port Loko, Sierra Leone during 2001-2003. Activities consisted of BCC campaigns, condom distribution and STI treatment targeting youth, commercial sex workers and the military. A post-intervention survey showed improvements in all target groups on knowledge of STI signs, sources of STI care and the need to seek medical care quickly. (RHR Consortium Monitoring and Evaluation Program. ARC International – Sierra Leone. Strengthening AIDS Prevention in Port Loko: Post Intervention Survey Report. August 2003)

Conclusion of STI session:
STIs are a significant public health problem in their own right and an important factor in the spread of HIV. The management of STIs is challenging from both health services and societal perspectives. Conflict-affected settings may add further complexity. As health workers and staff working with conflict-affected populations, we must be aware of these challenges and advocate for the allocation of adequate resources.

3.3 Voluntary counseling and testing

Some people have argued that because HIV/AIDS cannot be cured and most people do not have access to antiretroviral treatment, there is little point in their finding out their HIV status. Some say that this knowledge may even be to their disadvantage. We are now going to look at advantages and disadvantages of knowing your HIV status.

Activity

3.3a *Issues around knowing your HIV status*

Individual work - 5 minutes. Audio - 15 minutes. Feedback – 10 minutes.
Materials: Audio CD UWC interviews: Tracks T01 to T05

Facilitator...

...introduces:

Ask yourself and write down your thoughts:

- If I had HIV, would I want to know? Why would I want to know?
- If I am negative, how would this knowledge help me?
- If I am positive, how would this knowledge help me?
- What could be some potential disadvantages of knowing that I am HIV positive?
- Who would I tell?
- How would they react?

On the CD, some HIV-positive university students from South Africa relate their experiences in relation to knowing their status. As you listen, write down the advantages and disadvantages they mention.

...notes:

Advantages:

Overall:

- Taking responsibility for themselves.

If negative:

- Peace of mind.
- Possible increased awareness of own vulnerability.
- Possible motivation to avoid risky behavior.
- Possibly more sympathetic toward people with HIV.

If positive:

- Can get appropriate health care to prolong and improve quality of life.
- Can take steps to live positively with the virus, e.g., nutrition, stress management.
- Can access support services (support groups, financial assistance).
- Can avoid the expense of unnecessary tests and ineffective treatments for unexplained illness.
- Can take measures to protect partner(s) and unborn children.
- Can make informed decisions about pregnancy and infant feeding.
- Can maintain a sense of control and dignity.
- Can make plans for the future.
- If large numbers of people come for testing, awareness in the community can increase and the idea of testing can become "normalized," thus helping to reduce stigma.

Activity 3.3a cont'd

Disadvantages:

If positive:

- Inability to cope psychologically: depression, anger, emotional breakdown, suicide

If status becomes known, may result in:

- Stigma: humiliation, rejection
- Distress for family
- Rejection by family community (especially important for women who risk blame and abandonment)
- Discrimination: job or study opportunities/financial assistance/insurance/immigration

...concludes

When raising awareness about VCT in the community, it is important to help people understand that while they should be prepared for some negative consequences, knowledge of their status does have important benefits.

"...The more you know about your situation, the more you can do about it..." Major Ruranga, PLWA activist, Ugandan Armed Forces.

3.3b PRESENTATION: *HIV testing*

Presentation – 30 minutes.

Materials: PowerPoint 3.3b: HIV testing
Posters: Immune system army; Phases of HIV/AIDS; HIV testing flowchart (Example in PowerPoint: Teaching aids Day 3)
HIV rapid tests kits

An HIV test is the only way a person can find out if s/he has HIV. It is impossible to tell if a person is HIV positive just by looking at him/her. While certain symptoms and signs may be suggestive of AIDS, these manifestations can also be the result of other illnesses.

How do HIV tests work?

The most common way to test for HIV is through a blood test. Tests can also be done on urine and saliva, but these are not widely available in developing countries. There are different kinds of blood tests. Some can detect the virus itself, but these are expensive and again not widely available in developing countries.

Usually HIV infection is detected by testing for the presence of HIV antibodies in the blood. There are two groups of tests that are commonly used to detect HIV antibodies: ELISA tests, and simple or rapid tests. ELISA tests require sophisticated equipment and are done in batches so people do not get the result immediately. Rapid tests do not require any special equipment, can be done individually and results can be available in less than 30 minutes.

Antibodies are specific protein molecules that the immune system makes as part of its defense against infection. (Refer to poster: Immune system army) HIV antibodies do not develop immediately after infection. (Refer to poster: Phases of HIV/AIDS) Most people with HIV will produce antibodies by about six weeks to three months after infection. In a small proportion it may take up to six months. The time between acquiring the HIV infection and the production of antibodies is called the "window period." If a person is tested during the window period, the HIV test will be negative. This is why people are advised to repeat the HIV test after three months if they test negative. Of course, they should not engage in any behavior that would put themselves or their partners at risk during the three months between the tests. (If a person is infected with HIV, the test may also be negative during the final stages of AIDS, when the immune system is so severely damaged that it cannot make antibodies anymore.)

(*Ask participants for names of tests used locally.*) Sometimes people are concerned that HIV tests are not accurate. The HIV tests that are currently available are very sensitive. This means that if there are antibodies in the blood, it is extremely unlikely that the test will fail to identify them. In other words, it is very unlikely that the test will give a false negative result (i.e., the person is infected with HIV but the test is negative). However, because the test is so sensitive, it may detect molecules in the blood that are similar to the HIV antibodies and thus give a false positive result (i.e. the person is not infected with HIV but the test is positive.) However, this will only happen in about 2 percent of cases but is the reason why a confirmatory test must be done if the first test is positive.

Show kit and demonstrate how test is done.

The meaning of test results

Use the HIV testing flowchart poster to explain the following:

- If the first test is negative:
    1. the person is not infected with HIV, or
    2. the person is infected, but is in the window period, or
    3. the person has reached the final stages of AIDS, is severely ill and no longer makes antibodies.

- Next step: Repeat the HIV test after 3 months.

- If the first test is positive:
    1. the person is infected with HIV, or
    2. the person is not infected, i.e., the test was "false positive".

- Next step: Do a confirmatory test: repeat the HIV test on the same blood specimen, but using a different type of test. (*Illustrate with names of different tests.*) The client is given the result only after the confirmatory tests is done.

- If the second test is positive, the person has HIV.

- If the second test is negative, both tests are repeated on a new blood sample and a third type of test is added. If all three tests are positive this time, the person has HIV. If there are still differences among the test results, the process gets repeated after 2 weeks, using a strategy recommended by WHO. (*See "Protecting the Future": appendix B.*)

The testing process

HIV testing should always be done in the context of a voluntary counseling and testing service. When a person goes for HIV testing, s/he should see a counselor for pre-test counseling before getting the blood test. This is to ensure that the person understands what HIV/AIDS is and what the consequences of a positive test could be. The counselor also provides him/her the opportunity to decide whether s/he really wants to take the test. In other words, the counselor helps the person make an informed decision.

3.3c PRESENTATION: *Context for VCT service delivery*

Presentation – 10 minutes.
Materials: PowerPoint 3.3c: VCT service delivery

VCT can be provided through a number of services. Options or models for VCT service delivery include:

- Stand-alone or free-standing models
- Integrated models
- Mobile or outreach models
- NGO models
- Private sector models
- Public sector/NGO partnership models

(Ask participants which models are found in their communities.)

Each model has advantages and disadvantages. (These are described in the document: "Models of VCT service delivery." Refer to additional resources.)

The community needs to be made aware of the different options for accessing VCT services. It is also important that if a health service does not provide VCT, it must be linked with services that do provide VCT.

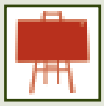
VCT services cannot exist in isolation. They must be integrated with other aspects of HIV prevention and care, and with other health services. VCT is not an isolated event, but part of a process consisting of:

- General HIV awareness and communication in the community
- Pre-test counseling
- HIV testing
- Post-test counseling
- Follow-up counseling and psychological support
- Referral to other appropriate services (medical care, support groups, etc.)

Now that we have placed VCT services within a context, we are going to look at the counseling process in more detail:

Activity

3.3d *Identifying client concerns around VCT*



Work in pairs.
Discussion – 5 minutes. Feedback – 10 minutes.
Materials: Flipchart

Facilitator...

...introduces:

If you decided to go for VCT, what would you like the place to be like and how would you like the staff to behave towards you?

...notes:

Physical environment: comfortable, peaceful, private, confidential. Consider the target group when selecting the site: what would be accessible and would minimize the risk of stigma? Discuss the challenges of participants' settings (e.g., lack of privacy in refugee camp, access to services in urban refugee settings, etc.

Staff attitudes and behaviors:

- Provide welcoming reception and introduction.
- Attempt to set client at ease, using discretion and sensitivity towards nervous or embarrassed clients.
- Reassure clients about confidentiality.
- Show sensitivity to language difficulties.
- Have a non-judgmental attitude, showing respect, interest and empathy.
- Conduct active listening (verbal and non-verbal), providing emotional warmth and support.
- Talk about sensitive issues in a straightforward manner appropriate to the culture, educational level and beliefs (spiritual and traditional) of the client.

...concludes:

Going for VCT can be a very stressful experience. As service providers, we need to do everything possible to be sensitive to the clients' feelings and needs, and to support people as much as possible.

Activity

3.3e *Gaining insights into the counseling process*


Work in groups of three.
Role play – 20 minutes. Feedback – 15 minutes. Audio CD – 5 minutes.
Materials: CD UWC interviews: Track 06

Facilitator...

...introduces:

UNAIDS defines counseling as "a confidential dialogue between a client and a counselor aimed at enabling the client to cope with stress and make personal decisions related to HIV/AIDS." Counseling is different from advising. When you advise someone, you tell him or her what you think they should do. When you counsel, you do not impose your own ideas and values, but guide the person to find solutions himself/herself.

Role play: One person is the counselor, another is the client. The third person observes and gives feedback, based on the checklists in "Protecting the Future": pp79-81.

- Conduct pre-test counseling, then post-test counseling for a positive result.
- The counselor should think about what information to give and how to provide support.
- The client should think about what s/he would need from the counselor.
- The observer should think about whether the checklist is appropriate.

Scenarios (optional):
Adolescent boy, high school; adolescent boy, illiterate; adolescent girl from prominent family; unmarried refugee man age 25, seeking resettlement; unmarried woman age 20, student; married village woman age 35, 3 children; married man age 40, community leader in displaced community; married refugee woman age 22, no children.

...gets feedback: facilitator asks:

How did you feel as the counselor?
How did you feel as the client?
As the observer, what did you learn?

...concludes:

It is not possible to teach people to become counselors in a few hours, so in this session we only highlight some of the important aspects of VCT programs. Health care workers do not automatically have the skills to be effective HIV counselors. Appropriate training is therefore essential. It is important to realize that you need to involve a skilled and experienced counselor if you want to train people in counseling skills. It is worth investing in good quality training: these skills can be used in helping all patients, not only in the context of VCT. Managers and funders may sometimes need to be convinced about the importance of investing in counseling training (and support). In addition to having the necessary skills, staff also need willingness and appropriate attitudes to engage in this work. For example, empathy and good listening skills are very important. Candidates selected for training as counselors must be carefully assessed, as not every personality will be suited to the task. It is also important to realize that counseling is a difficult and stressful job – counselors will need support: management and support of counselors should be a part of any counseling program.

Audio CD: Qualities of counselors – University of the Western Cape experience (5 minutes).

Activities 3.3f and 3.3g can be run concurrently in different groups.
Small group discussions – 15 minutes. Feedback in plenary – 30 minutes.

Activity

3.3f *Planning VCT services*

Materials: Flipchart

Facilitator...

...introduces:

Setting up a VCT service is not simple. Careful planning is needed. If you are going to establish a new VCT service in your community, what are some of the practical issues you would need to consider and plan for in order to ensure appropriate quality VCT services? Describe some of your organization's experiences, if relevant.

...notes:

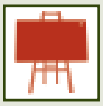
- Buy-in from stakeholders (community leaders, religious leaders, health staff, refugee committee, women's groups, adolescents).
- Education of community.
- Acceptance by community.
- Appropriate venue.
- Appropriate management systems.
- Assured confidentiality.
- Appropriate protocols.
- Reliable supply of tests.
- Staff capacity to do tests.
- Staff capacity to counsel.
- Means of monitoring quality of service (testing and counseling).
- Appropriate links with other services for care.
- Resources to sustain the services.
- Support for counselors.

...concludes:

Poor quality services may do more harm than good. If the community members do not have confidence in the services, they will not use them and may even become resistant to the idea of VCT. On the other hand, we also need to be careful about creating demand if we do not have the capacity to meet that demand. If you are unsure about being able to consistently provide all the components of VCT and the appropriate links to support services, it may be better to delay initiation of the service. Instead, concentrate on other aspects of HIV programs and continue preparations to begin a comprehensive and sustainable VCT program.

Activity

3.3g *Understanding confidentiality*



Materials: Flipchart

Facilitator...

...introduces:

Clients are usually very concerned about confidentiality.

- What is the meaning of confidentiality?
- What are possible consequences when confidentiality is broken?
- In the settings in which you work, what are the possible risks for breach of confidentiality?
- What measures could be taken to ensure confidentiality?

...concludes:

Clients have a right to confidentiality and have the right to take legal action if confidentiality is breached. Breach of confidentiality by a health worker is highly unethical.

Breach of confidentiality can have serious consequences for clients, for example, stigma and discrimination toward individual and family, ostracism, trauma to family, breakdown of relationships, gender-based violence, abandonment, loss of job, etc.

The assurance of confidentiality is one of the most important aspects of VCT services. If clients do not have confidence in this aspect, they are unlikely to use the service. Encouraging VCT is one of the most important strategies for HIV prevention and care. Lack of trust in the VCT service can do significant harm to efforts to control the epidemic.

Various methods can be used to help ensure confidentiality, such as using codes instead of names on blood specimens and results, and controlled access to medical records. However, confidentiality depends to a large extent on ethical behavior by health program staff. There should be clear policies on confidentiality and these should be explained to all staff. As concepts of confidentiality may vary among different cultures, it may be necessary to include such issues in health worker training and supervision. Confidentiality in refugee settings may be difficult to maintain with people living in close proximity, thus making it imperative to take every possible measure to strive for adherence to confidentiality policies.

Sometimes confidentiality may be a controversial issue, for example, when a health worker is aware that someone continues to have unprotected sex when s/he knows that person is HIV positive. There are no clear answers in such situations.

3.3h PRESENTATION: *VCT services in conflict-affected settings*

Presentation – 5 minutes.

Materials: PowerPoint 3.3h - VCT in conflict settings

In Kakuma refugee camp in Kenya, the International Rescue Committee, in collaboration with the CDC, has established a VCT service now regarded as a model for similar refugee settings. Over 2,000 people received VCT services during the first 18 months of the project. Post-test clubs have proved to be popular, with nearly two-thirds of people tested joining the clubs. The quality of counseling is periodically assessed using a VCT quality control tool. The camp has two free-standing VCT centers, which are also used as community meeting places. Confidentiality is ensured using a coding system. Only the counselor has access to clients' cards. VCT data are entered into a database using codes and data entry is at a site away from the refugee camp.

3.4 Condoms

In the "But why?" exercise, we identified a number of problems around condom use. Now we are going to focus on two very practical issues: condom negotiation and how to use a condom.

Activity

3.4a *Identifying complexities around condom use*


Video – 15 minutes. Feedback – 10 minutes.
Materials: Video: The Moment

Facilitator...

...introduces:

As you watch the video, think about the following:

- What are the messages in this video?
- What factors are seen here that could influence condom use?
- In your community, what factors influence condom use?
- At what point in a relationship should a couple start talking about using a condom?

...notes:

Negotiating condom use can be particularly difficult for a number of reasons, for example:

- Awkwardness in talking about sex.
- It means you have to admit that you are planning to have sex. (moral/religious/relationship issues).
- Assumptions associated with condom use: trust ("I love you so I trust you so I don't have to use a condom"); promiscuity ("only loose women use condoms"); perceptions of manhood ("real men don't wear condoms").
- Pressure to have children.
- Need to have a condom available.
- In many cultures, it is men who make the decisions about when and how to have sex.
- Cultural expectations for the woman to be submissive.
- Very difficult to address when issues of economic and social dependence are involved for women.

Sometimes it is helpful for people to practice ahead of time what they are going to say in the situation. The handout "*How to talk about condoms with your partner*" provides some suggestions.

Activity

3.4b *Teaching condom use*

Plenary – 30 minutes.

Materials: Condoms, penis model, poster or model of female anatomy, oranges or mangos;
tissue for cleaning hands
PowerPoint 3.4b: Condoms. (Optional)

Facilitator...

...introduces:

a) Condom demonstration:

Ask for a volunteer to demonstrate putting a condom onto a penis model.
Check for expiry date and damage to package.
Demonstrate how to open package without damaging the condom.

Demonstrate use of female condom. (Use anatomical diagrams to explain the positioning of the inner and outer rings.)

Ask participants:

- What precautions should be taken to ensure the condom is not damaged?
- Name four consequences that can be prevented by using a condom.
- What kind of myths are there around condom use in your community? How can you address these myths?

...notes:

- Condoms can be damaged by heat, fingernails, oil-based lubricants like cooking oil, Vaseline and body lotions. To lubricate, use water-based lubricants like egg white, glycerin, KY jelly or saliva. The lubricant should be used on the outside only.
- Condoms can prevent the following: unwanted pregnancy; HIV; many STIs; infertility from STIs.
- Myths: unhealthy for the man; condom can get lost inside the woman's body; etc.
- Male and female condoms should not be used together as this may result in weakening and tears of the latex and plastic.

b) Condom over fist:

Hand out condoms. Ask participants to put a condom over their fist. This helps to get them used to handling condoms and also demonstrates the condom's stretch quality and sensitivity to fingernails.

c) Condom game:

Each small group gets three condoms. Compete to see which group can fit the most oranges/mangoes into a condom in 5 minutes. In some cultures, it may be more appropriate and effective to place men and women into separate groups for this excercise.

Note: Examples of novelty condoms (e.g., colored, flavored, ribbed, etc.) can be shown. Alternately, this could be used as an ice breaker or energizer. These may not be appropriate in some cultural contexts.

3.5 Conclusion

- Overview of the day with link to Day 4
- Suggested reading
- Post-test
- Daily evaluation

DAY 4

- Universal precautions
- Mother-to-child transmission
- Stigma

Day 4 examines the two remaining transmission routes: the blood route and the mother-to-child route. Universal precautions and occupational exposure are discussed, and issues around mother-to-child transmission are debated. The main focus is on prevention, but aspects of care are also introduced. The day concludes with a session on stigma, which further links prevention and care, and thus provides a bridge to Day 5.

Learning objectives

By the end of Day 4, participants will be able to:

- Understand the risks of HIV transmission in health care settings and through traditional practices
- Describe universal precautions
- Have an awareness of the management of occupational and rape-related exposure, including post-exposure prophylaxis
- Describe mother-to-child transmission
- Analyze options for preventing mother-to-child transmission
- Explain the meaning of stigma, prejudice and discrimination
- Analyze causes of stigma
- Propose approaches for reducing stigma

Resource materials

Manual:

- International Rescue Committee. (2003) Protecting the Future: HIV Prevention, Care and Support among Displaced and War-Affected Populations. Chapters 11, 12 & 13.

Handouts:

- Course notes: Universal precautions.
- Course notes: Management of occupational exposure.

Additional resources:

- EngenderHealth. (2001) Infection Prevention Online Course www.engenderhealth.org/ip/about/ip.pdf
- Centers for Disease Control and Prevention. (2001) Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis. MMWR 2001; 50 (No. RR-11). www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm
- UNAIDS. (2001) Counseling and voluntary testing for pregnant women in high HIV prevalence countries. http://data.unaids.org/Publications/IRC-pub01/JC245-Couns_Test_en.pdf
- WHO/UNICEF/UNAIDS. (1998) HIV and infant feeding: a guide for health care managers and supervisors. http://www.who.int/nutrition/publications/HIV_IF_guide_for_healthcare.pdf
- Understanding and challenging HIV stigma – a toolkit for action. (2003) Facilitator's guide. The CHANGE project. www.changeproject.org/technical/hivaids/stigma.html
- WHO/UNHCR. (2002) Clinical Management of Survivors of Rape - A guide to the development of protocols for use in refugee and internally displaced person situations. http://whqlibdoc.who.int/publications/2004/924159263X.pdf
- Asia Pacific Network of People Living with HIV/AIDS. (2004) AIDS-related Discrimination in Asia. http://www.synergyaids.com/documents/Asia_AIDSDiscrimination.pdf
- Engender Health. (2004) Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers, Trainer's Manual and Participant's Handbook. http://www.popline.org/docs/273667

Teaching materials

PowerPoint:

4.2b Blood route facts
4.2c Implementing universal precautions
4.2d Accidental exposure
4.2f Managing accidental exposure
4.3a MTCT
4.4b Illustrating stigma
4.4e Fighting stigma
Teaching aids Day 4

Audio-visual:

Make the following to use with presentations and on wall display:

- Audio: CD Track 07 and 08

- Video: Mother-to-child transmission
- Video: A fighting spirit

Posters:

Blood route	(Show with PowerPoint 4.2b)
Universal precautions: Make poster of 7 points	(Make from text 4.2b)
Managing occupational exposure	(Make from text 4.2f)
MTCT/PMTCT	(Make from text: 4.3a & b)
PMTCT poster by Kenya participants	(Show as introduction to debate 4.3e)
"What is stigma?"	(Show with 4.4a)
Stigma quotations	(Make from text: 4.4d)

Miscellaneous materials

- PEP kit

DAY 4 - Session plan

Time	Topic	Materials
30 min	**4.1 Introduction**	
	4.1a Presentation: **Introducing the blood route and the mother-to-child route**	HIV/AIDS tree
	4.2 Universal precautions	
35 min	4.2a Activity: **Developing awareness of HIV transmission through the blood route**	Case studies
15 min	4.2b Presentation: **Blood route facts**	PowerPoint; Posters: Blood route, Universal precautions
40 min	4.2c Activity: **Challenges & solutions to implementing universal precautions**	Flipchart; PowerPoint
30 min	Break	
10 min	4.2d Presentation: **Accidental exposure**	PowerPoint
15 min	4.2e Activity: **Management of accidental exposure**	Flipchart
20 min	4.2f Presentation: **Management of occupational exposure**	PowerPoint; Poster: managing occupational exposure; PEP kit
	4.3 Mother-to-Child Transmission	
20 min	4.3a Presentation: **What is MTCT?**	Audio CD; PowerPoint; Poster: MTCT/PMTCT
20 min	4.3b Presentation: **How can MTCT be prevented?**	Poster: PMTCT; HIV/AIDS tree
45 min	4.3c Activity: **Examine issues relevant to PMTCT**	Video: Mother-to-Child
45 min	Lunch	
30 min	4.3d Activity: **Identifying challenges to PMTCT**	Flipchart
30 min	4.3e Activity: **Debating PMTCT**	PowerPoint poster: PMTCT by Kenya participants
	4.4 Stigma	
10 min	4.4a Activity: **What is stigma?**	Flipchart; Poster: What is stigma?
10 min	4.4b Presentation: **Illustrating stigma**	PowerPoint photo; flipchart
20 min	4.4c Activity: **Examining why HIV/AIDS is stigmatized**	Flipcharts
	4.4d Activity: **Examining the consequences of stigma**	Flipcharts; Posters: stigma, prejudice and discrimination quotations
15 min	Break	
20 min	4.4c&d Activity: **Feedback**	HIV/AIDS tree
15 min	4.4e Presentation: **Addressing stigma**	PowerPoint; Audio CD
30 min	4.4f Activity: **Tribute to a man who fought stigma**	Video: A Fighting Spirit
5 min	4.4g Activity: **Personal commitment**	
20 min	**4.5 Conclusion**	

4.1 Introduction

- Brief overview of previous day with review of wall displays. Feedback on pre- and post-tests and evaluations
- Select host team for the day
- Pre-test
- Overview of the day

4.1a PRESENTATION: *Introducing the blood route and mother-to-child route*

Presentation – 2 minutes.
Materials: refer to HIV/AIDS tree

On Day 1, we identified three HIV transmission routes:

- sex
- blood
- mother-to-child transmission

On Day 3, we focused on the sex route, examining three aspects of prevention: STIs, VCT and condoms. We emphasized that prevention and care are linked. Today we focus on the blood route and the MTCT route, looking at interventions involving prevention and care. We also address stigma, which has important implications for both prevention and care.

4.2 Universal precautions

Activity

4.2a *Developing awareness of HIV transmission through the blood route*

Small groups.
Preparation – 15 minutes. Feedback – 20 minutes.
Materials: Case studies written on flipchart sheets; Flipcharts

"But why?" exercise:

Facilitator...

...introduces:

Case studies: (Facilitator should adapt case studies to local context.)

1. Blood transfusion

Jane is 20 years old and pregnant with her second child. She delivers the baby at home in her village, assisted by a traditional birth attendant. After the delivery, Jane has moderately severe vaginal bleeding. She is taken to the hospital where she receives a blood transfusion. At age 27, Jane dies after a long period of weight loss and weakness. *Why did Jane get HIV?*

2. Contaminated injection needles

Amina is a 5-year-old girl living in a refugee camp. She develops an abscess on her leg and her mother takes her to the camp clinic. The health worker drains the abscess and gives Amina an injection. At age 10, Amina dies from AIDS-related pneumonia. *Why did Amina get HIV?*

Activity 4.2a cont'd

3. Contaminated sharps in cultural practices

At age 12, Moi is circumcised during a traditional ceremony. When he is 16 years old, after repeated chest and skin infections, a doctor recommends an HIV test. The test is positive. Moi has never had a sexual partner. *Why did Moi get HIV?*

...concludes:

There are complex layers of factors underlying why people are infected with HIV through the blood route. As in the sex route, these factors can be grouped into the three vulnerability areas: behavioral, power and health services issues.

4.2b PRESENTATION: *Blood route facts*


Presentation – 15 minutes.

Materials: PowerPoint 4.2b: Blood route facts
Posters: Blood route (Example: PowerPoint: Teaching aids Day 4)
Universal precautions (Make from text)

The blood route

The HIV virus lives in the blood, therefore any blood-to-blood contact with a person who has HIV carries a potential risk of transmission. We know that HIV can also be found in urine, feces, semen, vaginal fluids, breast milk, saliva, tears and other fluids inside the body. However, blood is the only fluid that has been associated with transmission in health care settings.

HIV transmission through the blood route can occur through: *(Show blood route poster)*

1. Blood transfusions, blood product transfusions (e.g., clotting factor for hemophiliacs) or organ transplants.
   Transfusion with infected blood or blood products carries an estimated risk of HIV infection of almost 100 percent. Five to 10 percent of new infections worldwide are estimated to be the result of unsafe transfusions. WHO estimates that every year 13 million units of transfused blood are not screened for HIV or other infections. "...Despite all the technological marvels that humanity is experiencing, a reliable and safe blood supply is still out of reach for untold millions of people around the world..." (Gro Bruntland, WHO Director General, World Health Day, 2000)

2. Shared needles
   Injecting drug users may share needles, or health workers may use the same needle on more than one patient. WHO estimates that each year up to 16 billion injections are given in developing and transitional countries. Ninety percent of these are given for curative purposes (i.e., not for immunization). Up to 96 percent of people seeking care from a primary health care provider receive an injection, of which over 70 percent are unnecessary or could be given as an oral formulation. WHO recently estimated that each year, the reuse of injection equipment may cause 20 million infections with hepatitis B virus and 250,000 infections with HIV worldwide.

3. Shared cutting instruments
   Health care workers or traditional practitioners may use the same cutting instruments on different clients without proper sterilization. This risk is notable when procedures are done in quick succession, for example, during ceremonies for circumcision or female genital cutting.

4. Needle stick injury
   A needle stick injury or occupational injury occurs when health care workers accidentally injure themselves with needles or other equipment used on a patient. The risk of a health care worker acquiring HIV after a needle stick injury from an HIV-positive person is less than 1 percent.

5. Contact of open sores with infected blood
   This may occur if a health worker's skin has a sore or cut, providing an opening for infection to get into the body. No cases of transmission through intact skin have been documented.

6. Mucous membrane exposure
   A splash of infected blood comes into contact with mucous membranes in eyes or mouth.

7. Sharing implements
   Some implements may have traces of blood on them, e.g., toothbrushes, razor blades.

The first three situations carry high risks. The last four carry smaller but definite risks.

Although health care procedures are responsible for a small number of all infections, they represent a highly preventable source of HIV infection. Protection of health workers is essential, both for their own safety and to prevent any discrimination against HIV-positive patients. Health workers need to understand what does and does not constitute risk.

How can health workers protect themselves and their patients? By implementing universal precautions.

What are universal precautions? *(ask participants)*
Universal precautions are simple infection control measures that reduce the risk of transmission of infections through exposure to blood or body fluids.

Why are they called universal precautions? *(ask participants)*
1. All blood and body fluids from all people should be considered as infected with HIV or other infectious agents, regardless of the known or supposed status of the person.

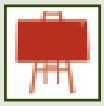
2. HIV is not the only infection we must worry about. Other infections can also be transmitted through blood and other body fluids, e.g., hepatitis B and hepatitis C and syphilis through blood; shigella and other diarrheal disease pathogens through feces. The risk of developing hepatitis B infection after a needle stick injury can be as high as 20 to 30 percent. (Compare this with the less than 1 percent risk of acquiring HIV through a needle stick injury.) Hepatitis B has been shown to survive in dried blood at room temperature on environmental surfaces for up to one week. Thus, even if HIV did not exist, we must follow universal precautions.

3. Appropriate infection control practices are part of good quality and ETHICAL health care practice and should be followed when caring for *all* patients, in *all* places, at *all* times. This includes home care settings and traditional practices.

What do universal precautions consist of? *(Universal precautions poster)*
1. Safe blood transfusions
2. Safe injections
3. Safe surgical procedures
4. Safe technique
5. Safe processing of instruments
6. Safe environment
7. Post-exposure prophylaxis

Activity

4.2c *Challenges and solutions in implementing universal precautions*



Work in small groups, by organization.
Discussion – 20 minutes. Feedback – 20 minutes.
Materials: Flipchart sheets
PowerPoint 4.2c

Facilitator...

...introduces:

Read the summary of universal precautions given as a handout. Then:

1. Identify three challenges to implementing universal precautions in your setting (other than problems with supplies and logistics).
2. Suggest some simple, practical measures using existing resources that your organization could take as a first step to improving the situation (excluding improvements in logistics).

Handout: Summary of universal precautions:

1. Safe blood transfusions:

A: Provide safe blood

- Screen all blood to be transfused.
- Establish standardized procedures for blood transfusion.
- Try to recruit low-risk donors.
- Avoid payment of blood donors.
- Screen donors using a checklist.
- Try to establish a stored blood supply which then reduces the need to use potentially high-risk donors in an emergency.
- Ensure appropriate supply of HIV tests and other screening tests.
- Ensure staff members are trained in using HIV tests and other screening tests.
- Ensure appropriate record keeping.
- Establish quality control systems with monitoring and supervision.

B: Reduce the need for transfusion

- Establish guidelines for blood transfusion to avoid unnecessary transfusions *(Refer to p161 in "Protecting the Future").*
- Consider the use of volume expanders.
- Prevent and treat anemia.
- Train staff in transfusion guidelines and the use of plasma expanders.

C: Educate the public

- Create a demand for appropriate quality services.
- Educate to dispel misconceptions surrounding blood donation and work at instilling a culture of blood donation.

2 & 3. Safe injections and other procedures involving cutting or piercing skin:

- Only give injections when absolutely necessary.
- Always use new single-use disposable injection equipment (needles and syringes) and blades for each procedure.
- If using reusable equipment, apply appropriate sterilization techniques.

4. Safe technique:

- Wash hands before and after examining each patient.
- Wash hands before and after any procedures.
- Wash hands after handling any potentially contaminated item.
- Wash hands after removing gloves.

Activity 4.2c cont'd

- Limit skin contact with blood or other potentially contaminated material by wearing gloves.
- Cover any sores with a waterproof dressing. Do not undertake procedures if you have a weeping rash.
- Wear a gown or apron for procedures when there might be splashes of blood or body fluids.
- Wear a mask and goggles for procedures where blood may splash, e.g., dentistry, surgical procedures and deliveries.
- Use aseptic technique for procedures: do not touch a clean area with anything that has been in contact with a potentially contaminated area.

5. Safe processing of instruments/other equipment:

Cleaning, disinfecting and sterilizing are different processes carried out for different reasons. It is essential that health workers understand the differences. (The following reference provides an excellent overview that can be used to train staff on infection prevention: EngenderHealth. (2001) Infection Prevention Online Course.)

6. Safe environment:

- Keep floors and other surfaces clean.
- Manage soiled linen safely.
- Dispose of all used sharps immediately in appropriate (puncture proof) containers. Do not walk around carrying a used needle or blade. Never put needles in with general waste. Do not re-cap needles, or remove them from the syringe after use.
- Bury or incinerate sharps.
- Burn or bury other medical waste (at least 20 meters away from water sources).

7. Post-exposure prophylaxis:

Discussed in next section.

...concludes (PowerPoint 4.2b cont):

It can be frustrating to try to maintain high standards when equipment and supplies are lacking. However, a lot can be done even when resources are limited, including in conflict-affected settings. Furthermore, many of the problems around universal precautions are related to behaviors of health staff rather than lack of supplies.

1. Establish standard procedures for infection prevention in health facilities: develop a procedure manual or file; develop wall charts to serve as reminders.
2. Train staff and ensure that procedures are understood.
3. Ensure that staff have the appropriate equipment and adequate supplies to implement precautions.
4. Supervise and support staff to ensure they implement the procedures.
5. Ensure staff have reasonable working hours and working conditions, because people who are stressed and tired may make mistakes or be tempted to cut corners.

Example from a conflict-affected setting:

The International Rescue Committee implemented a project in two hospitals in the Bas-Congo region of the Democratic Republic of Congo to reduce HIV transmission in health care settings. The project included:

- Training of health care workers on universal precautions.
- Provision of supplies to implement universal precautions.
- Provision of supplies for syphilis, HIV and hepatitis B screening of blood for transfusion.
- Training of laboratory personnel in the use and storage of supplies and equipment.
- Conducting supervisory visits in collaboration with hospital administration to ensure implementation of universal precautions.

An important lesson learned from this project was the need for support from hospital administration which resulted in a higher level of accountability among staff to adhere to universal precautions.

4.2d PRESENTATION: *Accidental exposure*

Presentation – 10 minutes.
Materials: PowerPoint 4.2d: Accidental exposure

Health care workers can be exposed to HIV infection through contact with infected blood, body fluids or tissues.

Types of exposure in health care settings (occupational exposure):

- percutaneous (penetrating the skin)
- mucous membrane
- non-intact skin
- intact skin

All exposures do not carry the same risk for infection. Factors affecting risk:

1. Type of exposure to HIV-infected body fluid:

- percutaneous: risk of infection about 0.3 percent
- mucous membrane: risk of infection about 0.09 percent
- non-intact skin: risk of infection not quantified but estimated to be less than for mucous membrane exposure
- intact skin: no cases of infection documented

2. Exposure to blood carries a higher risk than exposure to other body fluids or tissues.

3. Risks are higher when a large amount of blood from the source person is involved, for example:

- apparatus visibly contaminated with the patient's blood
- procedure involved a needle being placed directly into a blood vessel
- deep injury
- hollow bore needles

4. Risks are also higher when the source person has end-stage HIV/AIDS, possibly because of high viral loads.
After an accidental exposure to potentially infected blood in an occupational setting, e.g., a needle stick injury, there are measures that can be taken to reduce the risk of acquiring HIV infection. Similar measures can also be taken in the event of exposure to HIV through rape.

The first step in managing accidental exposure, however, is prevention. Prevention of accidental exposure to HIV in health care settings involves the effective implementation of universal precautions. Staff should also be educated about prevention of sexual exposure and provided with condoms.

Activity

4.2e *Management of accidental exposure – agency capacity*

Plenary – 15 minutes.
Materials: Matrix on flipchart

Facilitator...

...introduces:

Ask each agency to enter answers on a matrix:

a) Do all staff members receive health education on HIV/AIDS at your workplace?
b) Are condoms available at your workplace?
c) Does your organization have any policies or guidelines in place for management of accidental exposure? (needle stick injuries or related to sexual violence)
d) Have you received any training or information on the management of accidental exposure, including post-exposure prophylaxis?

...concludes:

Many workplaces have by now introduced policies on accidental exposure, both for occupational exposure and for rape. If your organization has not done so yet, it is important for you to raise the issue with your supervisors.

4.2f PRESENTATION: *Management of occupational exposure*

Presentation – 20 minutes.


Materials: PowerPoint 4.2f: Managing accidental exposure
Poster: Managing occupational exposure (make from text)
PEP kit

Systemic infection does not occur immediately after the HIV virus enters the body. A brief period (possibly a few hours to a few days) exists before the infection becomes established, during which time antiretroviral therapy may modify or prevent viral replication. PEP is short-term ARV treatment to reduce the possibility of HIV infection after potential exposure. Similar ARV treatment is given for occupational and rape-related exposure, but the approach to patient management is clearly different. Comprehensive care of rape survivors is well described in the document: WHO/UNHCR (2002) Clinical Management of Survivors of Rape - A guide to the development of protocols for use in refugee and internally displaced person situations. (Refer to additional resources.)

This session will focus on the management of occupational exposure.

After an occupational exposure, a number of steps should be followed: (Make a poster "Managing occupational exposure" summarizing the points for the wall display.)

1. Immediate first aid:
   - Wash wounds and skin with soap and saline solution or water.
   - Flush mucous membranes with water.
2. Assess the risk associated with the exposure:
   - Type of fluid (e.g., blood, visibly bloody fluid, other body fluids) or tissue.
   - Type of exposure, e.g., percutaneous injury, mucous membrane or non-intact skin exposure, or human bites resulting in blood exposure.

3. Evaluate the source for likelihood of HIV infection:
   - Assess the source patient using available information.
   - Counsel the source patient and do HIV test if consent is obtained. Maintain confidentiality and ensure appropriate care and referral.

4. Provide counseling and clinical assessment for the exposed worker:
   - Counsel on the implications of exposure.
   - Counsel on the need for and implications of PEP.
   - Obtain informed consent before proceeding with clinical examination and baseline HIV test.
   - A thorough history must be taken concerning pregnancy, illnesses and medications that could affect decisions about drugs used for PEP.

5. Provide PEP when appropriate.
   Details in next section.

6. Advise the exposed worker to use precautions to prevent secondary transmission during the follow-up period (i.e., abstain from sex or use condoms; do not donate blood).

7. Educate on risk reduction through review of the sequence of events leading to exposure.

8. Complete an exposure report.

9. Perform follow-up HIV testing for at least six months post exposure: at baseline, six weeks, three months and six months after the incident.

10. Provide counseling over the six-month period, regardless of whether or not the exposed worker has PEP.

Providing PEP

The exposed worker must be appropriately counseled prior to administering PEP. Antiretroviral drugs have potential adverse reactions. Because most occupational HIV exposures do not result in HIV infection, the potential toxicity of drugs must be carefully weighed against the risk of infection. The worker should also be aware that while administration of PEP is associated with a lower risk of HIV infection, treatment failure may occur. To date, information on percentages and circumstances of treatment failure of PEP is limited. It is important that the worker completes the full course of treatment. S/he should also be informed of potentially unpleasant side effects.

PEP should be started as soon as possible after the exposure – ideally within 2 to 4 hours. In some cases PEP has been given up to 2 weeks after the incident. However, it is believed to be more effective when given as soon as possible after exposure.

Combination therapy with two or three drugs is recommended for a minimum of 2 weeks and maximum of 4 weeks. WHO recommended regimens, in the absence of known resistance to zidovudine or lamivudine in the source patient, are:

Zidovudine 250-300mg twice a day
Lamivudine 150 mg twice a day

If a third drug is to be added:
Indinavir 800 mg 3 times a day or Efavirenz 600 mg once daily (not recommended for use in pregnant women.)

The exposed person taking PEP should be evaluated within 72 hours after exposure and monitored for drug toxicity for at least 2 weeks.

If the source person is already on ARVs, expert consultation should be sought.

In order for an organization to provide PEP appropriately, certain conditions should be in place:
(Ask participants)

- Prevention - Implementation of universal precautions
- Organizational protocols for management of occupational exposure
- Training of staff on management of occupational exposure
- Counseling capacity
- Supplies, including HIV tests and PEP kits
- Access to medical care (possibly specialist follow-up)

4.3 Mother-to-Child Transmission

4.3a PRESENTATION: *What is mother-to-child transmission?*

Presentation: 20 minutes.
Materials: Audio CD Track 07
PowerPoint 4.3a: MTCT
Poster display: MTCT

Introduce with CD – 5 minutes.

Since the beginning of the AIDS epidemic, over 5 million infants are estimated to have been infected with HIV. Ninety percent of these infections were acquired through the mother-to-child route. The remaining 10% were caused by sexual abuse, blood transfusion and other exposures to infected blood.

As the immune systems of young children are not yet fully developed, they usually develop AIDS much sooner than adults do. Many die within one to two years of birth. In Africa, half will have died by the age of five years.

Sometimes the term "parent-to-child transmission" (PTCT) is used, sometimes "mother-to-child transmission" (MTCT) and sometimes "vertical transmission". They all refer to the same process: the transmission of the virus from an HIV-infected mother to her baby. However, the term PTCT is used to emphasize the role and responsibility of both parents in the transmission process and avoids blaming the woman if the child is infected.

The HIV virus is transmitted from an HIV-positive mother to her baby in three possible ways:

- during pregnancy
- during labor and delivery
- during breastfeeding

The rates of mother-to-child transmission have been found to vary under different circumstances, but on average 35 out of every 100 HIV-positive pregnant women will transmit the virus to their babies. Of these, about 7 will become infected during pregnancy, about 15 during labor and delivery and about 13 during breastfeeding (mostly during the early weeks). *(Diagram Protecting the Future p155)*

Therefore, it is important to realize that most babies (two-thirds) will **not** contract HIV from their HIV-positive mothers. The reasons one baby will become infected and another will not are not yet fully understood, but there are some factors that may increase the risk. We call these the biological risk factors associated with the MTCT route: *(HIV/AIDS tree)*

Make a wall display summarizing risk factors and interventions during pregnancy, delivery and breastfeeding, using a different color for each stage. *(See example in Teaching aids Day 4: MTCT wall display)*

Biological risk factors for MTCT

Factors associated with pregnancy:

- Infection of the mother with the HIV virus during pregnancy. There are higher levels of virus in the blood (viral load) at the time of infection. (*Phases of HIV/AIDS poster*) The risk is also higher if the mother is pregnant when in an advanced stage of HIV/AIDS illness, when the viral load increases again.
- The presence of some STIs, which may affect the placenta, making it easier for HIV to cross to the baby.
- Malaria during pregnancy may also affect the placenta and facilitate transmission of HIV.
- Poor nutritional and general health status of the mother.

Factors associated with delivery:

- Obstetric procedures, such as amniocentesis, early rupture of membranes and episiotomy, increase the chance of the baby coming into contact with the mother's blood.
- Blood transfusions.
- Unsterile procedures (i.e., not observing universal precautions).

Factors associated with breastfeeding:

- Infection of the mother with HIV during breastfeeding (high viral load).
- Breast conditions (e.g., cracked nipples, mastitis, breast abscess).
- Non-exclusive breastfeeding. Breast milk substitutes may result in damage to the lining of the baby's gastro-intestinal tract, thus allowing an entry point for the virus when the baby receives breast milk. Mixed feeding (alternating breast milk with formula and/or other foods and fluids) appears to carry the highest risk.
- Duration of breastfeeding (i.e., higher risk with longer duration).
- Sores in the mouth of the baby (e.g., thrush) can provide an entry point for the virus.

4.3b PRESENTATION: *How can MTCT be prevented?*

Presentation – 20 minutes.
Materials: PMTCT wall display

The rate of transmission of HIV from mothers to babies can be reduced through a number of prevention methods.

Prevention of MTCT has two aims:

- primary prevention: prevention of HIV infection in women
- secondary prevention: prevention of transmission of the virus from an HIV-infected mother to her baby

The majority of HIV-positive women do not know that they are HIV positive:

- they may not know about HIV
- they may not know about antenatal VCT
- they may not have access to antenatal VCT
- they may prefer not to be tested for HIV, or
- they may not be in a position to decide to get tested (e.g., when husbands or extended families make health care decisions)

Therefore, it is important to focus on and allocate resources to prevention strategies that **do not depend on testing during pregnancy**. These strategies include general measures that promote the health of all women. There are also a number of specific strategies aimed at women who are aware of their HIV-positive status.

General strategies:

Pregnancy:

- Prevent unwanted pregnancies by increasing access to information and contraception.
- Encourage couples when planning a pregnancy to consider VCT.
- Discuss the option of postponing pregnancy in any woman with a chronic illness.

- Prevent infection of the mother during pregnancy (primary prevention):
  - Provide condoms during pregnancy
  - Educate the community and help men to see their role in protecting their families
  - Treat STIs promptly
  - Practice universal precautions
  - Minimize blood transfusions

  (Refer to AIDS tree: removing the sex and blood roots will automatically remove the MTCT root.)
- Improve the health and nutrition of pregnant women, e.g., micronutrient supplementation.
- Treat any infection during pregnancy promptly.
- Use intermittent presumptive malaria treatment during pregnancy in malaria areas.

Delivery:

- Avoid unnecessary obstetric interventions, especially artificial rupture of membranes, episiotomy and use of forceps.
- Avoid unnecessary blood transfusions.
- Implement universal precautions.

Breastfeeding:

- Encourage breastfeeding mothers to use condoms.
- Provide training for mothers and health care workers on appropriate breastfeeding practices to minimize breast problems.
- Promote exclusive breastfeeding for all babies. The advantages of breastfeeding are well known; there are disadvantages associated with formula feeding and the introduction of other fluids and foods too early. Exclusive breastfeeding has been shown to reduce the risk of HIV transmission to babies. (This will be discussed in more detail later.)
- Treat infant thrush.

Many of these activities may be components of existing health programs. However, recognition that they make an important contribution to the prevention of MTCT of HIV can help to justify investment of increased resources, and can also give health workers a sense that they can take positive steps to help reduce MTCT, even in the absence of antiretrovirals.

Specific strategies:

For women who have chosen to know their HIV status, a number of options may be available. However, it is important that women be given the choice to either opt in or opt out of VCT and PMTCT interventions. Mothers should be given full access to information, but should never be pressured into HIV testing or into joining a PMTCT program.

Pregnancy and delivery:

- Antiretroviral therapy (ART)

  ARVs work by lowering the viral load in the mother's blood and by preventing the HIV infection from becoming established in the newborn. Although some side effects have been observed, ARVs are generally safe, with the benefits of the drugs outweighing the risk of side effects. Two drugs are commonly used for PMTCT:

Zidovudine (AZT):

AZT tablets are taken twice a day by the mother from 36 weeks onward, and then more often when labor starts. This can reduce transmission to the baby by up to 50 percent. However, AZT is less feasible in developing countries because of high costs and the fact that many women may present for the first time only when they are in labor.

Nevirapine (NVP):

Nevirapine also reduces transmission by almost half. Here the mother takes a single dose orally at the onset of labor and a single dose of syrup is also given to the baby within 3 days after birth. Nevirapine costs about $4 per mother and child pair, making it much more affordable than AZT. Nevirapine also has the advantage of being simple to use: the mother can be given a tablet to take at home when labor begins and there is a time space of three days to take the baby for treatment after birth.

Delivery:

- Planned caesarean section before the onset of labor
  This minimizes exposure of the baby to maternal blood and mucous and has been shown to reduce transmission by up to 66 percent. However, caesarean section is not feasible in many settings and also increases risks to the mother associated with surgery (e.g., anesthesia, bleeding, infection, etc.).

Breastfeeding:

- Avoidance of breastfeeding
  Breast milk substitutes (formula) or modified breast milk (wet nurse; heat-treated milk) may be used. If these are used, it is best to use them exclusively, i.e., not to alternate breastfeeding with substitute feeds.
- Exclusive breastfeeding
  The baby is given nothing but breast milk for 3 to 6 months, then abruptly weaned. This includes avoiding sips of water and other weaning foods traditionally given to babies.

There have been numerous studies assessing the effectiveness of various interventions to prevent MTCT. Results have varied considerably and research is ongoing. In industrialized countries, combinations of ART, caesarean section and replacement feeding have reduced MTCT rates to less than 4 percent.

Activity

4.3c *Mother-to-child – the story of two women and their babies*

Materials: Video: Mother-to-child – 45 minutes.

This video follows two HIV-positive pregnant women and their babies. It illustrates technical, social and emotional issues relevant to PMTCT. Some participants may find the video emotionally draining. Allow time for thought and spontaneous discussion afterwards.

Activity

4.3d *Identifying challenges to reducing MTCT*

Three groups.
Discussion – 10 minutes. Feedback – 20 minutes.
Materials: Flipchart

Facilitator...

...introduces:

Interventions to reduce MTCT using ARVs and breast milk substitutes have been very successful in some countries. However, implementation of these interventions is not simple and requires careful consideration. Conflict-affected settings pose further challenges. If such programs are introduced into the settings in which you work, identify some of the potentially challenging issues that need to be considered in relation to:

- the mother
- the baby
- the health care system

Are there factors associated with the impacts of conflict and/or displacement that could affect PMTCT (either positively or negatively)?

Each group analyzes and discusses one topic. (Tip: Think about health, social and resource issues)

Activity 4.3d cont'd

...notes:

Mother:

If her HIV status becomes known, the mother may suffer the consequences of stigma. She may be blamed if she is found to be HIV-positive and seen as the one who brought HIV into the family. She may suffer violence and/or abandonment. Therefore, she may be reluctant to go for testing.

If she has a caesarian section, there are potential complications of anesthesia and surgery.

If she does not breastfeed:

- Not breastfeeding may reduce uterine contractions post-delivery, with an increase in post-partum bleeding.
- Not breastfeeding may reduce the mother's bonding experience with baby.
- Breastfeeding delays return of fertility after pregnancy and without another method of contraception, she may soon become pregnant again. This is particularly important in relation to HIV-positive mothers, as another pregnancy very soon may negatively impact her health.
- Not breastfeeding may be unacceptable in some cultures; the woman may feel she is a bad mother if she does not breastfeed, and others may criticize her.
- Costs may be prohibitive. For example, free formula may not be available and water must be boiled resulting in fuel costs. The costs of the 22kg of formula required for the first six months is more than the annual income of many families.
- There is an added burden of time and effort to prepare formula feeds.

If exclusive breastfeeding:

- This may be difficult in some cultures, where traditionally other foods are introduced after a few weeks.
- There is physiological stress on mothers who are malnourished or unwell.
- It may not be practical for working mothers.

Baby:

- Mother's milk is the best form of nutrition for newborns.
- Breast milk protects against infections. Studies in Africa have indicated that children without HIV infection who receive replacement feeding have a 2.5 to 5 times greater risk of dying from any cause before the age of 12 months than breastfed children.
- Formula feeds are associated with infection risks, e.g., unhygienic preparation, lack of clean water.
- There is a risk that the baby may receive unsuitable foods, e.g., incorrect choice of formulas, incorrect dilution.
- Not breastfeeding may impact bonding and result in reduced stimulation of the baby.

Health care system:

- The health system must have the capacity to provide VCT and support services, ARVs and breast milk substitutes.
- Issues include resources, technical capacity, organizational capacity and confidentiality.
- Is it ethical to only provide treatment for babies, and not for mothers (and fathers)?
- Even though services, including ARVs, may be available, women may choose not to use them.

Other issues:

- Use of formula may impact on general promotion of breastfeeding.
- HIV may be used as an excuse for unethical promotion of breast milk substitutes.
- In conflict-affected settings, there is the possibility of flight or return to an area where formula or treatment are not available.
- Ethics of provision of ARVs and formula to refugees when these options are not widely available to the host population.

Activity 4.3d cont'd

...concludes:

PMTCT is an important means for combating the spread of HIV. However, sufficient recognition should be given to the factors influencing any potential interventions. These factors must be researched in detail. In addition, medical aspects as well as social needs must be considered. The mother's needs as well as the baby's needs must be addressed. Risks and benefits must be carefully weighed. The balance of risk will vary in different settings. Weighing the risks has been difficult in resource-poor settings because little is known about safe, feasible and affordable alternatives to breastfeeding. In humanitarian settings exclusive breastfeeding for four to six months followed by early weaning is likely to be a much safer option overall for the baby than avoidance of all breastfeeding. However, UN guidelines recommend supporting the mother in her own choice based on information about risks and her personal, cultural, social and economic circumstances.

Activity

4.3e *Debating PMTCT*

Two groups.
Preparation - 15 minutes. Debate - 15 minutes.
Materials: Introduce with PMTCT poster: "PMTCT by Kenya participants" (In PowerPoint: Teaching aids Day 4)

Facilitator...

...introduces:

"...Put yourself in my position as an HIV-positive mother. I would do anything to stop my baby becoming infected, anything. And I have needs, too – I want to survive so that I can see my child grow up..." (HIV-positive activist, South Africa)

"...Of course I want to protect my baby, but I am afraid to find out my status. I suspect I am already infected. What can I do? I will have to breastfeed anyway, nothing can make any difference; so why should I find out? It will only cause pain and worry..." (Pregnant urban woman, Zimbabwe)

Debate:
Access to ARVs for PMTCT as well as breast milk substitutes should be provided and promoted by the government on a large scale throughout the country as soon as possible. One group argues for access and the other group argues against.

If participants are working in refugee settings:
Access to ARVs for PMTCT as well as breast milk substitutes should be made available for all refugees as soon as possible. One group argues for access and the other group argues against.

...concludes:

The factors impacting MTCT will vary from country to country and setting to setting. The decision to initiate a PMTCT program is complex and should be made in collaboration with relevant authorities and communities. This is not a decision a non governmental organization can make independently. Appropriate emphasis should be given to interventions that improve the health of *all* mothers and babies, regardless of HIV status.

- Example from a conflict-affected setting:
  In Kakuma refugee camp in Kenya, the International Rescue Committee offers Nevirapine treatment to HIV-positive mothers and their infants. A recent report showed that over 2,700 pregnant women had accepted VCT. This represents 99 percent of antenatal care clients. Of those who tested positive, 80 percent accepted Nevirapine therapy.

PMTCT has also been introduced in other refugee settings, e.g., refugee camps in Tanzania.

4.4 Stigma

Activity

4.4a *What is stigma?*


Plenary – 10 minutes.
Materials: Flipchart
Poster: What is stigma? (Make from text)

Facilitator...

...introduces:

What are the meanings of the words "prejudice," "discrimination" and "stigma"?

...notes:

Prejudice:	intolerance, one-sidedness
Discrimination:	set apart, separate, judge
Stigma:	disgrace, shame, reproach, blemish, stain, spoiled identity

Ask participants: On Day 1 we identified some things that people say about PLWA and about refugees. Do any of these represent stigma?

Almost all of the phrases will probably contain some degree of stigma.

Make poster for wall display "What is stigma?":

> ..."Stigma is prejudice and discrimination against a set of people who are regarded by others as being 'flawed, incapable, morally degenerate, or undesirable' and who are treated in a negative way. Prejudice is an attitude, while discrimination is overt behavior..." (*Singhal, A & Rogers EM. (2003) Combating AIDS*)

4.4b PRESENTATION: *Illustrating stigma*

Presentation – 10 minutes.
Flipchart; PowerPoint photo (4.4b Illustrating stigma)

Four examples of what stigma can do:

Read to participants, with accompanying PowerPoint photo:

- In 1996, Govend Singh, a 25-year-old migrant worker, left the village of Churcher in the Indian state of Uttar Pradesh to find employment in Mumbai. Like many of his fellow migrant workers, he slept with commercial sex workers (CSWs). In 1999, when he began to feel tired and to lose weight, he went to Mumbai's Lash Deep Hospital for a checkup. He was HIV-positive. Govend Singh's fellow migrant workers, many of whom came from the same village, wrote home to their families that Govend had AIDS and that nobody should touch, talk with or see him. Too weak to work, when Govend returned to his village in April 2000, seeking shelter and care, he was shunned by his neighbors and family members, including his wife. Villagers dragged him into a pen where cattle and goats were kept. His captivity became a center of attraction for the villagers, who peeped into the enclosure, and teased him about his promiscuity. Twice a day they threw food into the enclosure. As Govend became weaker, he lay on the floor and was often stepped on by animals. On July 5th 2000, Govend was found dead in the enclosure. Since his death, his wife and two children have become social outcasts in the village. (Adapted from: Singhal, A & Rogers, EM. (2003) Combating AIDS.)

- On World Aids Day, December 1st, 1998, Gugu Dhlamini, a 36-year-old woman living in Durban, South Africa, disclosed her HIV status in a radio broadcast. A few days later she was stoned and stabbed to death by a gang of boys from her own neighborhood.

- *"My foster son, Michael, aged 8, was born HIV-positive and diagnosed with AIDS at the age of 8 months. I took him into our family home, in a small village in the south-west of England. At first, relations with the local school were wonderful and Michael thrived there. Only the head teacher and Michael's personal class assistant knew of his illness. Then someone broke confidentiality and told a parent that Michael had AIDS. That parent, of course, told all the others. This caused such panic and hostility that we were forced to move out of the area. The risk is to Michael and us, his family. Mob rule is dangerous. Ignorance about HIV means that people are frightened. And frightened people do not behave rationally. We could well be driven out of our home yet again."*
  ('Debbie' speaking to the National AIDS Trust, UK, 2002 - UNAIDS Epidemic update 2003)

- *"There is a strong potential for stigmatization of the HIV victims in the camps. Wherever we have gone to sensitize, some refugees tell us to show them who is infected in the camp so that they can avoid contamination."*
  (UNHCR staff member. UNHCR news report on UNHCR website. December 3, 2003)

Four kinds of stigma were identified by PLWA at a workshop in Kenya: (*Write headings on flipchart and ask participants for their interpretation of each heading and for examples of stigma towards people living with HIV/AIDS in their contexts. Ask how conflict and displacement may impact stigma.)*

1. Self-stigmatization:
People feel they are being judged by others; they isolate themselves. There may be self-hatred, depression and playing the role of sick person. This has a negative impact on mental well-being and in turn on physical well-being.

2. Stigma from health care workers:
Unethical behavior: apathy in providing services, judgmental attitudes; breach of confidentiality; compulsory disclosure of HIV status; denial of treatment; sterilization without informed consent. For example, in Thailand 40 percent of a group of PLWA interviewed said their HIV status had been revealed to someone else without their consent. In a survey of 1,000 health workers in Nigeria, 10% admitted having refused to care for an HIV/AIDS patient or denied them admission to hospital and 20% felt that PLWA had behaved immorally and deserved their fate.

3. Representation and communication:
Careless language and unclear terminology used by the media, social leaders and society in general may result in misrepresentation of PLWA as people who are dying rather than living positively. For example, the negative term "AIDS victim" is frequently heard. Misconceptions are also presented about the behavior of PLWA, particularly their sexual behavior.

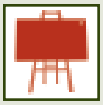
4. Social and work environments:
Hostility, violence, silence and denial about HIV/AIDS; exclusion of PLWA. People may lose jobs, be evicted from housing, denied loans and insurance. The children of PLWA may be ostracized at school and in the community.

PLWA in conflict-affected settings may experience all of the above. In addition, they may be stigmatized in similar ways because they are refugees, thus carrying a double burden. They may be blamed for bringing HIV into the host country and for being an additional burden on host country resources. Further examples of discrimination include possible mandatory HIV testing and denial of resettlement on the basis of HIV status.

Activities 4.4c and 4.4d are run concurrently in different groups.

Activity

4.4c *Examining why HIV/AIDS is stigmatized*



Work in small groups.
Discussion – 20 minutes. Feedback - 20 minutes, together with activity 4.4d.
Materials: Flipchart

Facilitator...

...introduces:

Why is HIV/AIDS stigmatized? i.e., Why are people with HIV/AIDS considered "undesirable"?

...notes:

- HIV/AIDS is associated with subjects that are often taboo: sex, disease and death.
- In the early stages of the epidemic, HIV/AIDS was associated with CSWs, men who have sex with men and injecting drug users. These groups were already stigmatized. When HIV was added, the prejudice increased.
- HIV is associated with behavior regarded as immoral or "sinful," such as premarital sex, extramarital sex and paying for sex.
- HIV causes fear resulting from ignorance and misconceptions about ways of transmission. Fear may be irrational: prejudice and discrimination are emotional matters, not based on facts; the fact that HIV is incurable raises the level of fear.
- People do not want to admit that an incurable disease acquired through "immoral" behavior could be spreading through their community – this labels their society as "bad."

Activity

4.4d *Understanding the consequences of stigma*

Work in small groups.
Discussion - 20 minutes. Feedback 20 minutes, together with Activity 4.4c.
Materials: Flipchart
Posters: Stigma, prejudice and discrimination quotations

Facilitator...

...introduces:

Explain the following statement. How does stigma result in the points raised here?

Poster:

Stigma and discrimination: *"Together, they constitute one of the greatest barriers to preventing further infections, providing adequate care, support and treatment, and alleviating the epidemic's impact..."* (UNAIDS, AIDS Epidemic Update 2003)

...notes:

- People are afraid of being stigmatized. Stigma drives the problem underground, making it more difficult to address, because people are afraid to go for testing and afraid to seek care.
- People may be afraid to take preventive measures, such as insisting on condom use, for fear that others will assume they are infected.
- Because of stigma, it is difficult to speak openly, thus myths and misconceptions are easily perpetuated.
- Because HIV is not talked about, it is easier for people to deny its existence.
- Stigma can create a false sense of security among the general population that undermines prevention efforts. People associate HIV with groups that are already marginalized, such as CSWs, or men who have sex with men and therefore do not perceive themselves to be at risk.

Activity 4.4d cont'd

...concludes:

Make posters for wall display:

"Prejudice kills during life...such a death is worse than real death" (Herbert Daniel, HIV-positive Brazilian writer)

"AIDS attacks the body
Prejudice attacks the spirit
One is caused by a virus.
One is caused by ignorance.
Both can kill."
(Berer M and Ray S. Women and HIV/AIDS. In: Jackson H (2002) AIDS in Africa)

HIV/AIDS tree: prejudice, discrimination and stigma = water which helps the HIV/AIDS tree to grow

4.4e PRESENTATION: *Addressing stigma*


Presentation – 15 minutes.
Materials: PowerPoint 4.4e: Fighting stigma
Audio CD: Track 08

Fighting stigma

It is not easy to remove stigma. Three broad approaches can be taken:

- Communication
- Measures to protect PLWA against discrimination
- Care of PLWA

These three approaches reinforce each other.

Communication

1. Addressing misconceptions:
Increase public awareness. Provide accurate information from respected sources. Get people talking about HIV/AIDS. Create opportunities for them to address fears and misconceptions. Some ways of raising taboo subjects include:

- Providing "safe spaces" for people to talk, e.g., telephone hotlines (anonymous, non-judgmental). In 2001 in Brazil, a telephone hotline received about 8,000 calls per day. Eighty percent of callers asked about HIV and 20 percent about STIs. In Thailand, people often talk to their barbers about personal matters, so barbers were trained to counsel on HIV/AIDS.
- Involvement of religious leaders. Religious leaders have a lot of influence in many cultures. Many people go to religious leaders for advice. If they set an example and start talking about HIV, it is easier for their followers to do the same.
- Using symbols: Symbols speak without using words. For example, the red ribbon has come to symbolize HIV/AIDS and support for those living with AIDS throughout the world.
- Using humor, e.g., condom bus T-shirt.
- Public figures supporting PLWA, e.g., Nelson Mandela.

2. Disclosure by PLWA:

- Shows that anyone can be affected, e.g., ex-President Kenneth Kaunda of Zambia disclosed that his son died of AIDS.
- Shows that PLWA are the same as everyone else; helps people to identify with them; gives HIV/AIDS "a human face", e.g., Nkosi Johnson, a young AIDS activist from South Africa; UWC student group.

(Audio: Track 08)

- UNHCR arranged for a number of PLWA to visit a refugee camp: "...Dr. Dieudonne T.S. Yiweza, UNHCR's Regional HIV/AIDS Coordinator for Central Africa, explained his decision to organise the session. 'We thought that by having infected persons from outside visit the camp, skeptical refugees could realize that AIDS does exist, while at the same time we protect infected refugees from stigmatization.'" (From UNHCR news report on UNHCR website: For AIDS day, Dec 3, 2003.)

3. Remembering people who died of AIDS and acknowledging that they died of AIDS.

- Memory boxes: these are cardboard boxes created by PLWA that are usually opened at their funeral by relatives and friends. They decorate the boxes with pictures of themselves with friends and family, and put personal items like clothing, diaries, letters, etc., inside, to help others remember them.
- Grieving publicly: People grieve together and allow others to grieve with them, e.g., AIDS funerals, AIDS quilts, candle-light vigils.

4. Advocacy

(Ask participants what they understand by the term "advocacy.")

"Advocacy is a method and a process of influencing decision makers and public perceptions about an issue of concern, and mobilizing community action to achieve social change, including legislative and policy reform, to address the concern." (NGO Steering Committee. Code of Good Practice for NGOs Responding to HIV/AIDS – Unedited draft for consultation. March 15, 2004)

Groups of people, including PLWA, actively fight for the rights of PLWA, e.g., Phumla January. In South Africa a group called the Treatment Action Campaign (TAC) played a major role in pressuring the government into providing ARVs, using human rights protections in the constitution. (At the same time, it is very liberating for those affected to fight for the cause.)

Audio: 1.5 minutes

5. Personal commitment of politicians and other community leaders

- President Museveni of Uganda made a point of mentioning HIV in his speeches during the time Uganda was working to reduce its HIV rate.

Measures to protect PLWA against discrimination

1. As part of their Declaration of Commitment on HIV/AIDS, drawn up at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, Member States agreed to:

..."by 2003, enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by, people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, inter alia, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic (paragraph 58) " (UNAIDS AIDS Epidemic Update 2003)

e.g., Brazil became one of the first countries in the world to mandate universal and free access to HIV care.

2. Organizations must have workplace policies to promote non-discrimination and train their staff on adhering to them. Health staff in particular need training on issues such as confidentiality and informed consent to testing and treatment. *(Ask participants what is in place in their organizations.)*

3. PLWA need to know about their rights and should be supported to take action against discrimination. For example, human rights should be emphasized in BCC activities; complaint mechanisms should be in place at health facilities; PLWA should be assisted in accessing legal aid.

Care of PLWA

Treating opportunistic infections and using ART turns HIV/AIDS into a manageable chronic illness rather than a death sentence. Two communities in Haiti and Khayelitsha, South Africa where ARV programs were successfully introduced, reported reductions in stigma around HIV/AIDS. (This will be discussed in more detail on Day 5.)

To conclude this session, ask participants to stand up and stretch. Do some arm stretches together, ending with pointing both hands toward themselves. Then ask where the fight against stigma begins: **the fight against stigma and discrimination begins with us, here, today.**

Activity

4.4f *Tribute to a man who fought stigma*

Video – 30 minutes.
Video - A fighting spirit

Ask participants for their impressions.

Activity

4.4g *Making a personal commitment to fight stigma*

Individual. 5 minutes. No feedback.

Write down two things that you are going to do to fight stigma against HIV/AIDS and PLWA.

4.5 Conclusion

- Overview of the day with link to Day 5
- Suggested reading
- Post-test
- Daily evaluation

DAY 5

◎ Care of People Living with HIV/AIDS

Day 5 focuses on people living with HIV/AIDS. The impacts of HIV/AIDS on individuals, families, communities and societies are explored. A holistic approach to care of PLWA is presented, addressing lifestyle, emotional, practical and medical needs. In addition, the role of support groups is examined, using a group of university students as a case study. At the end of the session, participants are provided the opportunity to write messages of encouragement to the student group. The course concludes by summarizing approaches to HIV/AIDS using the HIV/AIDS tree as a model.

Learning objectives

By the end of Day 5, participants will be able to:

- ◎ Explain the term "PLWA"
- ◎ Analyze the impacts of HIV/AIDS
- ◎ Describe the components of comprehensive care
- ◎ Understand issues impacting treatment options
- ◎ Appreciate the value of support groups for PLWA
- ◎ Acknowledge the role of PLWA in addressing HIV/AIDS

Resource materials

Manual:

- International Rescue Committee. (2003) Protecting the Future: HIV/AIDS Prevention, Care and Support among Displaced and War-Affected Populations. Chapters 10 and 14.

Handouts:

- Course notes: Experiences of managing a support group.
- From: EngenderHealth. (2001) HIV and AIDS online minicourse. Common side effects of antiretroviral drugs. http://www.engenderhealth.org/pubs/courses/about-hiv-aids-minicourse.php

Additional resources:

- Food and Agriculture Organization. (2002) Living well with HIV/AIDS. http://www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM
- WHO. (undated) Caregiver booklet: A guide for patients, family members and community caregivers. www.who.int/entity/3by5/publications/documents/en/IMAI_Caregiver.pdf
- WHO. (2002) Community home-based care in resource-limited settings. A framework for action. http://www.who.int/hiv/pub/prev_care/en/isbn9241562137.pdf
- UNAIDS. (2001) Best practice collection. Reaching out, scaling up: Eight case studies of home and community care for and by people with HIV/AIDS. http://data.unaids.org/publications/irc-pub02/jc915-reachout_en.pdf
- AIDSCAP. (2003) HIV/AIDS care and support projects: using behavior change communication techniques to design and implement care and support projects. http://pdf.usaid.gov/pdf_docs/PNADH527.pdf
- WHO. (2004) Scaling up antiretroviral therapy in resource-limited settings: treatment guidelines for a public health approach. www.who.int/entity/3by5/publications/documents/arv_guidelines/en
- UNAIDS. (2000) AIDS: palliative care. Technical update. http://data.unaids.org/publications/IRC-pub05/jc453-pallicare-tu_en.pdf
- International HIV/AIDS Alliance. (2000) Care, Involvement and Action: Mobilising and supporting community responses to HIV/AIDS care and support in developing countries. http://www.popline.org/docs/171373
- Family Health International. (2003) HIV/AIDS Care and Treatment: A Clinical Course for People Caring for Persons Living with HIV/AIDS. http://www.fhi.org/en/HIVAIDS/pub/guide/careandtreatmentclinicalcourse.htm
- WHO. (2003) Saving Mothers, Saving Families: the MTCT-Plus Initiative. http://www.who.int/hiv/pub/prev_care/en/Saving_Mothers_E.pdf
- WHO. (2003) Antiretroviral Therapy in Primary Health Care: Experience of the Khayelitsha Programme in South Africa. www.who.int/hiv/pub/prev_care/en/South_Africa_E.pdf
- International HIV/AIDS Alliance. (2003) Building Blocks: Africa-wide briefing notes, a series of booklets on psychological support, health and nutrition, economic strengthening, education and social inclusion, for communities working with orphans. http://hivaidsclearinghouse.unesco.org/file_download.php/Education.pdf?URL_ID=2459&filename=10579185481Education.pdf&filetype=application%2Fpdf&filesize=335071&name=Education.pdf&location=user-S/.

Teaching materials

PowerPoint:

5.4a Medical care of PLWA
5.4c Antiretroviral therapy
5.4d(i) Introduction to debate
5.4(ii) ARVs in resource-poor settings
Teaching aids Day 5

Posters:

- Infected and affected (In PowerPoint: Teaching aids Day 5)
- Holistic approach (Make from diagram in text: 5.4a)
- AIDS is not a death sentence (In PowerPoint: Teaching aids Day 5)
- Mandela's speech (In PowerPoint: Teaching aids Day 5)

Audio-visual:

- Audio CD: Tracks 09 to 16
- Video: A red ribbon around my house

Other:

- Case studies from "A Broken Landscape"
- Research on drug availability in local setting – by a participant or facilitator

DAY 5 - Session plan

Time	Topic		Materials
30 min	**5.1**	**Introduction**	HIV/AIDS tree; Flipchart
10 min	5.1a	Presentation: **Linking prevention and care**	Flipchart
	5.2	**Care of people living with HIV/AIDS**	
5 min	5.2a	Activity: **Who are PLWA?**	Flipchart; Poster: Infected and affected
	5.3	**What are the impacts of HIV/AIDS?**	
45 min	5.3a	Activity: **Understanding the impacts of HIV/AIDS**	Case studies from "A Broken Landscape"; Flipchart; HIV/AIDS tree
	5.4	**Addressing the needs of PLWA**	
30 min	5.4a	Presentation: **A holistic approach to care of PLWA**	Posters: Holistic approach; AIDS is not a death sentence; Audio CD; PowerPoint
30 min	Break		
15 min	5.4a	Cont.	
10 min	5.4b	Activity: **Assessing the availability of treatment options other than ARVs**	Flipchart; Research on local drug availability
15 min	5.4c	Presentation: **Antiretroviral therapy**	PowerPoint
30 min	5.4d(i)	Activity: **Debating the introduction of ARVs**	PowerPoint
	5.4d(ii)	Presentation: **ARVs in resource-poor settings**	PowerPoint
	5.5	**Support group case studies**	
25 min	5.5a	Activity: **UWC student group on support group**	Audio CD; Flipchart
15 min	5.5b	Activity: **UWC counselor on support group**	Audio CD; Flipchart
10 min	5.5c	Activity: **Messages to UWC group**	
60 min	Lunch		
	5.5d	Presentation: **How can we control the HIV/AIDS tree?**	HIV/AIDS tree; poster: Mandela's speech
	5.5e	Activity: **Profile of a woman living with HIV/AIDS**	Video: A red ribbon around my house
	5.5	**Conclusion**	
		Closing ceremony	

5.1 Introduction

- Brief overview of previous day with review of wall displays. Feedback on pre- and post-tests and evaluations.
- Select host team for the day
- Pre-test
- Overview of the day

5.1a PRESENTATION: *Linking prevention and care*


Presentation – 10 minutes.
Materials: Flipchart

So far, we have primarily discussed ways of preventing the spread of HIV. (Point to wall displays.) Today, we are going to focus on the care of people living with HIV/AIDS. However, prevention and care are closely linked. *(Ask participants what they see as the links.)*

Examples:

- BCC initiatives can lead people to access VCT services. Through VCT, if they are HIV-positive, people can access services for care and support. If they are HIV-negative, going through the VCT process may increase their sense of vulnerability and responsibility, and therefore may lead to safer sexual behavior.
- Well-designed BCC activities can reduce the fear and stigma surrounding HIV/AIDS, and can thus increase people's desire to know their status. Reduced stigma makes disclosure of their HIV status easier for PLWA and improves their quality of life as they become more accepted and understood in their families and communities. PLWA who have disclosed their status and are living productive lives, can have a powerful impact on increasing awareness and reducing stigma.
- Treatment of opportunistic infections and treatment of HIV using ART results in longer, healthier lives for PLWA. The fact that positive measures are available to PLWA is a powerful motivating factor for HIV testing. If HIV/AIDS is no longer seen as a "death sentence," but rather as a manageable chronic illness, stigma and fear are also reduced.
- Early diagnosis and treatment of infectious diseases that are common among HIV-infected people, e.g., STIs, TB, results in increased protection of both PLWA and the rest of the community.
- If women learn that they have HIV/AIDS through BCC programs and VCT services, they can access information and services that will reduce the chance of passing on HIV to their unborn or new-born children.
- Increased availability of care and increased visibility and acceptance of people with HIV/AIDS can make the broader population more aware of HIV/AIDS and can promote discussion and openness which in turn can increase safer behavior.
- Care and support keeps PLWA healthier longer, thus keeping families socially and economically stable and reducing the vulnerability of women and children.

An example of how prevention and care are mutually reinforcing:
In Khayelitsha, a poor neighborhood of Cape Town, South Africa, Médecins sans Frontières (MSF) provides care for PLWA through treatment of opportunistic infections and provision of ART. A recent survey of nine sites around South Africa found that Khayelitsha had the highest rates of HIV testing, and the highest levels of condom use. In the district, VCT uptake increased from fewer than 1,000 HIV tests in 1998 to more than 12,000 in 2002. The number of HIV support groups in Khayelitsha also increased dramatically from 4 in 1998 to 22 in 2002.

HIV/AIDS tree: Add prevention and care sections to HIV/AIDS tree.

5.2 Care of people living with HIV/AIDS

Activity

5.2a *Understanding the range of people impacted by HIV/AIDS*


Plenary - 5 minutes.
Materials: Flipchart
Poster: Infected/affected (In PowerPoint: Teaching aids Day 5)

Facilitator...

...asks:

Who are PLWA?

Those infected and those affected.

Who are those infected?

- People who have been diagnosed with HIV or AIDS. (Some may find the test result or clinical diagnosis so difficult to accept that they do not believe it.)
- People who have not been diagnosed but think they may be HIV positive, e.g., their partner is diagnosed with HIV; or they become ill and know enough about HIV/AIDS to suspect that this could be the cause.
- People who have no idea they have HIV. This is most people.

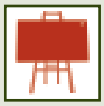
Who are those affected?

- Partners
- Children
- Family
- Friends
- Colleagues
- Care givers (community workers, health care workers, social workers)
- Wider community/nation
- **You and me**

5.3 What are the impacts of HIV/AIDS?

Activity

5.3a *Understanding the impacts of HIV/AIDS*


Work in small groups.
Discussion - 15 minutes. Feedback - 30 minutes.
Materials: Case study handouts
Flipchart

Case studies from "A Broken Landscape": pp. 46-47; 50-51; 60-61; 90-91; 98-99; 100-101; 104-105; 110-111; 114-115; 134-135; 152-155; 172-173.

Distribute case studies among groups.

Facilitator...

Activity 5.3a cont'd

...introduces:

Read the case studies and draw on the issues described, as well as your own knowledge and experience, to identify:

- Impacts of HIV/AIDS on emotions and mental health.
- Impacts of HIV/AIDS on families.
- Impacts of HIV/AIDS on communities and society.

Note any factors that could be particularly significant or perhaps different in conflict-affected situations.

...notes:

- **Impacts on emotions and mental health:**
  Stress, sadness, guilt, wanting to die, denial, hopelessness, anger, frustration, fear of illness and death, fear of stigma and rejection, fear about future of partner and children, fear of infecting others.
- **Impacts of AIDS on families/communities/society** (adapted from Actionaid webpage: www.actionaid.org)

Income:

- Increased consumption needs for food, medication, transport and care.
- Depleted household assets: items are often sold to pay for treatment.
- Decrease in income as people become too sick to work.
- Problems for economy with loss of workforce and productivity. (According to the World Bank, if 10 percent of adults are infected, national income growth can shrink by one-third. A recent World Bank study predicted that South Africa will face complete economic collapse within three generations if the country does not take effective measures to combat AIDS.)

Nutrition and food security:

- People with HIV/AIDS have high energy requirements and need a high-quality diet.
- Illness and reduced incomes lower the productivity of subsistence agriculture and increase food insecurity.

Education:

- The supply of education is threatened by illness and death among teachers.
- Children drop out of school to care for sick relatives or to work to compensate for income lost through family illness.

Social:

- Relationships break down.
- Stigma, discrimination and rejection: PLWA may be cast out by families or lose jobs or be refused insurance or loans; family members of PLWA may be stigmatized and isolated.
- Women take on greater burdens of caring and face greater economic insecurity when wage earners fall ill.
- Due to some local laws or customs, women may lose house or land rights when their husbands die.
- Local customs may force women to marry their husband's brother, further spreading HIV.
- Older people are often left to care for dying family members and orphans.
- There are increasing numbers of orphans and children made vulnerable by HIV/AIDS. It is estimated that AIDS has orphaned at least 14 million children in Africa. Families and communities who care for them are strained, and there are increasing numbers of child-headed households and street children.
- Children are deprived of the care and opportunities to learn skills usually acquired in supportive family and community settings.
- Girls are more likely to be kept out of school to care for sick relatives or to go to work, entrenching existing gender inequities.

Health care:

- Health care facilities become overwhelmed by AIDS patients.
- Health systems experience loss of health care workers to burnout, illness and death.
- Increased health care needs result in increased costs to governments.

Activity 5.3a cont'd

Security:

- Poverty, hunger and high numbers of street children may lead to increased crime.
- National security may be threatened by lack of development, decreasing social support, loss of confidence in the government and increasing fear and hopelessness.

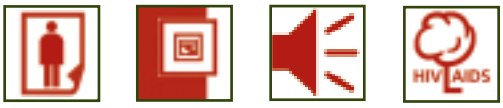
Conflict-affected situations:

- The HIV/AIDS epidemic is in itself a major crisis, undermining the strength of communities' traditional coping mechanisms. When further crises such as natural disasters, crop failures, conflict and displacement are added, coping mechanisms may be overwhelmed.
- People weakened by HIV/AIDS may not be able to flee disasters, or are an added burden to family members during flight.
- Displaced people often leave home with very few possessions and thus have very little for selling or bartering to ensure survival as well as covering the additional needs of sick relatives.
- Malnutrition is often associated with conflict and displacement and further weakens the immune system of PLWA.
- Stress, overcrowding and unhygienic conditions increase vulnerability to opportunistic infections.
- However, the presence of humanitarian aid as a result of disasters can also bring opportunities to assist people affected by HIV/AIDS.

HIV/AIDS tree: Branches of tree: layer above symptoms and signs = emotions;
next layer = impacts on families; top layer = impacts on society.

5.4 Addressing the needs of PLWA

5.4a PRESENTATION: *A holistic approach to care of PLWA*



Presentation - 45 minutes. (break for tea part of the way through)
Materials: Posters: Holistic approach; AIDS is not a death sentence
(PowerPoint: Teaching aids Day 5)
Audio CD: Tracks 09 and 10
PowerPoint 5.4a&c Medical care of PLWA

(Refer to AIDS tree).

So far we have seen that PLWA have medical needs - we identified symptoms and signs on Day 1 - but PLWA also have emotional needs and practical needs.

At present there is no cure for HIV/AIDS. However, much can be done to prolong and improve the quality of life of PLWA, and to support those who are caring for them. PLWA have different needs, depending on the stage of the infection and their individual circumstances. It is important to address the needs of the whole person, rather than focusing only on medical care.

We can summarize the components of care required by PLWA as follows:

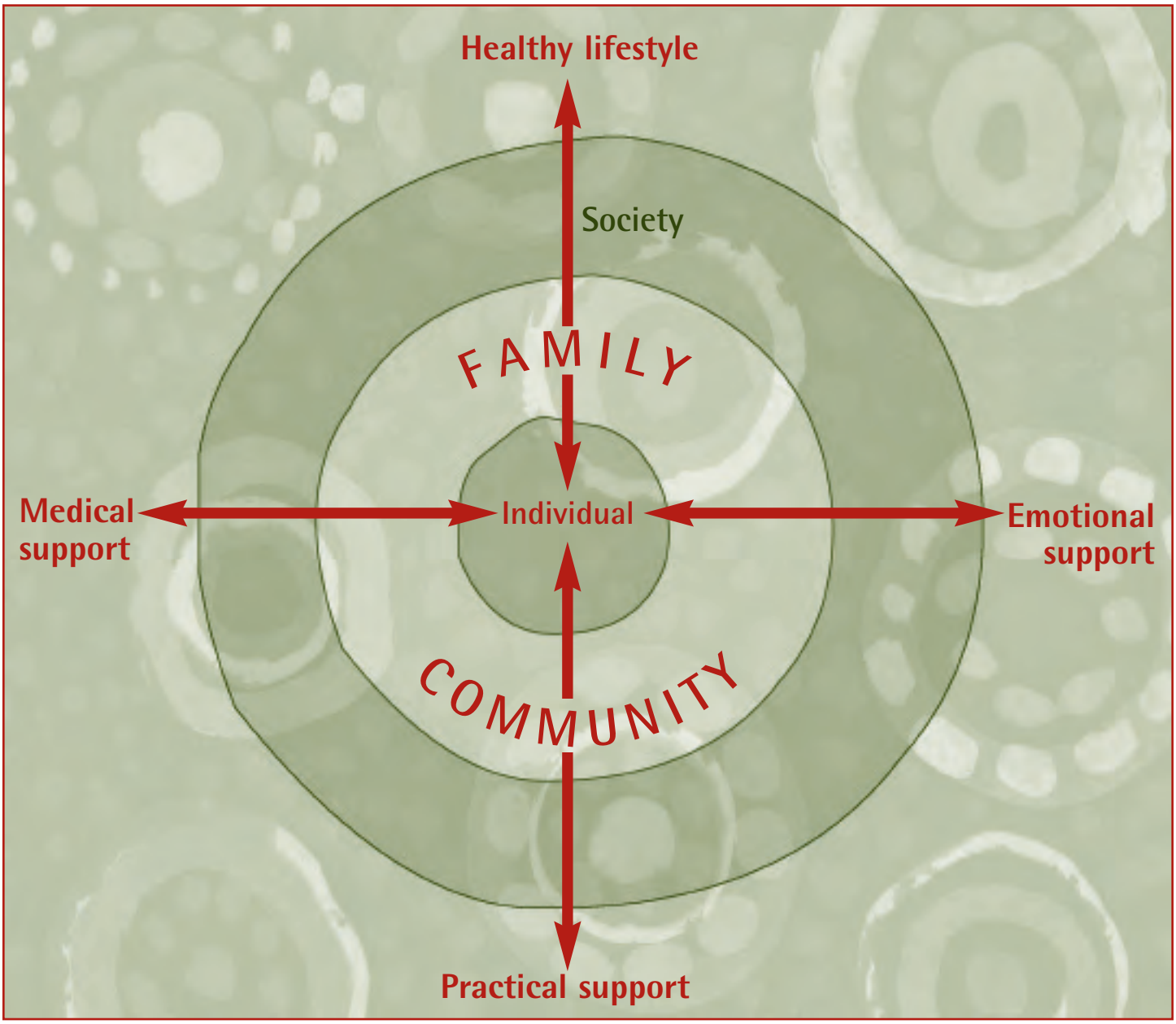
- A healthy lifestyle, including good food
- Emotional support
- Practical support
- Medical care

These components of care are necessary not only for PLWA, but for all people living with chronic illness or disability. Interventions should therefore focus on holistic care for all these groups. This reduces the possibility of stigma and also ensures care for all those in need.

On Day 1, we said that a person does not exist in isolation: a person exists within a community and within a broader society. *(Refer to levels of influence in vulnerability areas poster.)* When looking at care of people living with chronic illness, we need to look at the person themselves, their family, their community and the broader society. As before, the different levels of influence will interact with and support each other.

Make poster of diagram; add details during presentation:

COMPREHENSIVE CARE – A HOLISTIC APPROACH



We do not have the time to examine all the components of care in detail, but a range of materials is suggested for further reading. In order to achieve comprehensive care (or a "continuum of care"), various sectors of a community must be involved: health care providers, social services, community members, families and PLWA themselves. In various parts of the world, communities have worked in different ways to provide comprehensive care. A number of examples are described in the document: "UNAIDS (2001) Best practice collection. Reaching out, scaling up: Eight case studies of home and community care for and by people with HIV/AIDS." (*Refer to additional resources.*)

In some conflict-affected settings, NGOs are coordinating comprehensive care for chronically ill people, including PLWA. For example, in Lukole refugee camp in Tanzania, chronically ill patients were responsible for 30% of bed occupancy in the camp hospital. Norwegian People's AID (NPA) then introduced a home-based care program, utilizing a multidisciplinary team. Elements of the home-based care program include clinical care, nutrition care and counseling (including spiritual care), as well as education of service providers, family members and neighbors. Referrals for care come from community-based volunteers, community health workers, and clinic and hospital.

As we work through the different components of comprehensive care, consider how each component is applied or could be applied in your work situation.

1. Healthy lifestyle and environment

Although health services play an important role in the care of people who have chronic illnesses, most of the time they are cared for at home by family members, sometimes assisted by community workers. People need to know how to take care of themselves and their caregivers need to know how to assist them. *(Refer to additional resources.)*

a) Nutrition

A healthy diet can help people maintain their strength and live longer. This does not necessarily mean buying special food. People need to know how to make the best use of locally available foods.

b) Exercise

Moderate exercise helps to keep the body strong.

c) Hygiene

PLWA are very vulnerable to infection. They need to keep their bodies, clothes and houses clean to help prevent infections. Well-ventilated houses help prevent respiratory tract infections. Ensuring that drinking water is clean and that food is hygienically prepared can help prevent diarrhea. Keeping clothes and bodies clean can help to prevent skin infections and good dental hygiene can help prevent mouth infections.

d) A positive attitude *(CD: UWC Interviews Tracks 09 and 10.; Poster: "AIDS is not a death sentence")*

The students interviewed exude optimism and a zest for life that is remarkable.

These are simple measures that can make a big difference. Paying attention to these issues can also give people living with chronic illness and their families a sense of control: they are actively working to stay healthy. Families of sick people, as well as communities in general, must be educated on these simple care measures. This should be included in BCC activities, including school curricula, and should emphasize that men also have a responsibility as caregivers.
(Ask participants if any community education on care of the chronically ill is taking place in their settings.)

2. Emotional support

We saw from the case studies that living with HIV is associated with a great deal of stress, e.g., the knowledge that you are going to die; the fear of rejection; problems of poverty, etc.

Emotional support and reduction of stress have been shown to improve the physical as well as emotional well-being of PLWA and are extremely important components of care. Where can people get this emotional support?
(Ask participants for examples from their settings.)

Examples:

- Family, friends, colleagues
- Trained counselors
- Health workers
- Peer support groups
- Religious groups. It should be remembered that many people take comfort and strength from their religious beliefs and many counselors encourage this. For example, Edna is a Kenyan woman living with HIV. She was asked how she dealt with rejection from other people when they found out she was HIV positive. "…She says that it was her faith in God that has helped her, because she knows that she is never alone and always loved. She laughs when she says that she does not care what people think of her anymore – she knows that she is following the path that God intends for her…"
  (From: Orr NM / Metropolitan. (undated) Positive Life. Empowerment Concepts. Nelspruit, South Africa. p8.)

Support for caregivers:

Caregivers are often under a great deal of stress. Taking care of a person with AIDS, especially in the terminal stage, is not easy. (Ask participants to suggest sources of stress.) Caregivers are mostly women, who may have to go out to work, do house-work and take care of children as well as care for a sick person. A person with AIDS may be difficult to nurse; s/he may be bedridden, have chronic diarrhea and may be confused. Caregivers may be HIV positive themselves and also in poor health. It is very stressful to care for a dying person, and even more stressful when you know that you may die in the same way.

Interventions to assist people living with chronic illness must therefore also consider the needs of caregivers and seek ways to support them. This could include training on care of the sick person, practical support in the home, respite care and counseling.

Caring for PLWA is also stressful for health workers who may feel overwhelmed and powerless. They must be trained in the care of PLWA and provided consistent support. For example, the Mildmay Center for Palliative HIV/AIDS Care near Kampala, Uganda, holds weekly interdisciplinary meetings to discuss patients. This is helpful in allowing staff to plan together on how best to address the patients' needs. It also provides an opportunity for staff to share their emotions about the situations they face. This has been found to be a useful technique in countering burnout. (Ask participants what is done to support health workers and other caregivers in their settings.)

3. Practical support

Measures should be established to identify and assist vulnerable families.
(Ask participants for examples of what is being done in their settings.)

Examples:

- Food and shelter
- Transport
- Assistance with basic household activities such as cooking, cleaning and childcare
- Financial support and access to income generation opportunities
- Parents may need assistance in planning for the future of their children
- People may need legal assistance, for example, in drawing up a will, or protecting a widow from losing her property
- Children orphaned or made vulnerable by HIV/AIDS (OVC) must be identified and assisted

4. Medical care *(Start PowerPoint 5.4a)*

In this section we are going to look at care of PLWA using medicines. It is important to remember that medical treatment is only one aspect of care for PLWA. Treatment must always be linked to and supported by other forms of care, such as emotional support, practical support and nutrition.

When we talk about treatment for HIV, ART is often the first option that comes to mind. However, there are other forms of treatment that can prolong life and improve the quality of life, in addition to or even without ARVs. It is particularly important to emphasize other forms of treatment in settings where ARVs are not yet available.

General aims of treatment using medicines:

Curative - curing or controlling disease either temporarily or permanently
Preventive - preventing disease from occurring or becoming worse
Palliative - treating symptoms to reduce discomfort and distress

Aims of treatment using medicines in people with HIV/AIDS:

1. Alleviating symptoms, e.g., pain, loss of appetite, nausea, diarrhea, dementia
2. Curing or preventing opportunistic infections
3. Curing or controlling cancers
4. Controlling the HIV virus

a) Relief of symptoms:

It is very important that a person who is severely ill be kept as comfortable as possible, as this helps him/her to maintain his/her dignity and reduces stress. Many symptoms can be relieved using simple and inexpensive medicines like lotion for itchy skin and loperamide for chronic diarrhea. Traditional remedies may also be helpful. *(Note example of traditional healer from "A Broken Landscape")* Mental problems like confusion and depression are common among people with HIV. Alleviating these conditions greatly improves the quality of life of PLWA and their families. About 50% of AIDS patients suffer from chronic pain, often as a result of peripheral neuropathies, but also from other causes such as pressure sores and infections. In a terminally ill patient, pain should be treated aggressively with strong painkillers. (Management of symptoms is described in detail in "AIDS Palliative Care – UNAIDS.")

b) Treatment and prevention of opportunistic infections:

This is a crucial part of the care of PLWA. As HIV/AIDS progresses and the immune system becomes increasingly weakened, the person becomes increasingly susceptible to infections. *(Refer to "timeline" poster.)* Many infections, for example pneumonia and candidiasis, can easily be treated with drugs that are widely available and relatively inexpensive. It is important to help PLWA and health workers understand that these options are available.

PLWA can also take medication to protect themselves against getting infections. A daily dose of the antibiotic cotrimoxazole has been shown to prevent many infections in PLWA, including PCP, bacterial pneumonia, toxoplasmosis and a variety of gastro-intestinal infections including shigella, nocardia, isospora and salmonella. Before the introduction of ARVs in developed countries, no single medial intervention had a greater impact on the health and survival of PLWA than the use of cotrimoxazole in people with CD4 counts below 200.

WHO recommends cotrimoxazole 800mg daily for HIV-positive adults in the following circumstances:

- CD4 count below 500
- Total lymphocyte count below 2000
- No CD4 count available: treat all PLWA who have TB or who have symptomatic disease (stages 2 to 4); also treat HIV-positive pregnant women in the third trimester.

Cotrimoxazole should be taken indefinitely, as long as there are no serious side effects.

In many developing countries, TB is the most common cause of death among PLWA. It is important for the patient and the community that TB is treated properly and promptly. People with HIV can also take an inexpensive anti-TB drug called isoniazid (INH) to prevent TB, if this is part of the national TB policy.

Activity

5.4b *Assessing the availability of treatment options other than ARVs*

Plenary – 10 minutes.
Materials: Flipchart
Research on local drug availability

Facilitator...

...introduces:

On Day 1, we identified some common medical problems associated with HIV/AIDS. Now we are going to look at what we have available to treat these problems or at least alleviate the suffering they cause. One of the facilitators/course participants has done some research on drug availability in her/his community. She/he went to some drug outlets and asked whether certain drugs were available, and what they cost.

The following are some common problems, and examples of drugs that can be used to treat them. Facilitator describes availability, form and price:

Skin problems: Itchy skin: aqueous cream; calamine lotion
Fungal skin infections: miconazole cream
Bacterial skin infections: erythromycin, penicillin, cloxacillin

Respiratory tract infections: cotrimoxazole; amoxycillin; doxycycline; ciprofloxacin; anti-TB treatment
Gastrointestinal system: oral candida: nystatin; chronic diarrhea: loperamide, codeine
Central nervous system: pain, e.g., shingles: paracetamol, NSAID, codeine
STIs: ciprofloxacin, doxycycline, metronidazole, benzathine penicillin, erythromycin

What was the point of this exercise? *(Ask participants.)*

...concludes:

With this exercise, we are emphasizing that many of the common problems experienced by PLWA can be treated with locally available and relatively inexpensive medications. Just because ARVs or other expensive medications are not available, does not mean that we cannot do anything to help PLWA. It is important that health workers and PLWA understand these components of care.

5.4c PRESENTATION: *Antiretroviral therapy*

Presentation – 15 minutes.
Materials: PowerPoint 5.4c

HIV is a retrovirus. Antiretroviral drugs (ARVs) are used to treat HIV/AIDS. They cannot completely remove the virus from the body, but they can reduce the levels of the virus in the blood by preventing the virus from multiplying. This gives the immune system an opportunity to recover to some extent. People on these drugs can remain well for many years and their life can be considerably prolonged.

There are three classes of antiretroviral drugs:
1) Nucleotide reverse transcriptase inhibitors (NRTIs)
2) Non-nucleotide reverse transcriptase inhibitors (NNRTIs)
3) Protease inhibitors (PIs)

The different classes of ARVs inhibit different parts of the lifecycle of the HIV virus. Guidelines for treatment of HIV recommend lifelong triple therapy, commonly two NRTIs with a PI or NNRTI. These combinations are called "highly active antiretroviral therapy" (HAART). WHO has recently included a number of ARVs in the WHO model list of essential medicines. These medicines are considered safe and effective and appropriate for use in developing countries. However, there are many more on the market and new medicines are constantly being developed.

Further details about ARVs may be found in: *(Refer to additional resources.)*

- WHO (2004) Scaling up ART in resource-limited settings: treatment guidelines for a public health approach.
- Family Health International (2003) HIV/AIDS Care and Treatment: A Clinical Course for People Caring for Persons Living with HIV/AIDS.

Challenges related to anti-retrovirals:

- They are expensive and although prices are coming down, they are not yet affordable for most developing countries. At present the cost of antiretroviral therapy in developing countries is between $300 and $1,200 per patient per year.
- In order to be effective, the drugs have to be taken correctly 95% of the time and they must be taken for life. Compliance may be difficult.
- Unpleasant side effects may impact compliance. Side effects of ARVs include: tiredness, anemia, headache, nausea and vomiting, diarrhea, weight loss, dry mouth, rash, peripheral neuropathy, hair loss, menstrual problems, allergic reactions, liver and kidney problems.
- As some of the side effects can be potentially serious, the patient's blood counts and liver and kidney functions should be monitored regularly.
- CD4 counts and/or viral loads should be measured at intervals to see if people are responding to treatment.
- Drug resistance is a significant issue. *(What is resistance? Ask participants.)*

Resistance:

Drug resistance (also called antimicrobial resistance) means that the organism is no longer sensitive to the drug and therefore continues to multiply in the patient. Drug resistance is a very important issue in relation to HIV/AIDS. It impacts antiretrovirals, anti-TB drugs and also some of the drugs used to treat STIs.

Resistance is influenced by two factors:

1. The characteristics of the organism: some organisms become resistant more easily than others.
2. When the drug is not taken in adequate doses, is not taken at the correct time intervals and/or is not taken for a long enough time period.

If a person is only partially treated, an opportunity is created for resistance to develop. The result of this is that drugs that were commonly used are no longer effective and that different, often more expensive, drugs are needed. This has already happened with gonorrhea. In some cases, multidrug resistance develops, so that a patient does not respond to a variety of drugs, as has happened with TB and other infections such as malaria in some parts of the world. Because the HIV virus mutates rapidly in the body, it becomes resistant rapidly. (This is also the reason why it has been difficult to develop a vaccine against HIV.) Using combinations of drugs (triple therapy in the case of HIV/AIDS) reduces the risk of resistance developing, but increases costs and the potential for side effects and toxicity.

VERY IMPORTANT :

When thinking about starting an HIV, TB or STI treatment program, it is essential to consider the possible factors that would influence whether or not people are going to be able to take the drugs appropriately and ways to address these factors. *(Ask participants what the factors could be.)* Where drug resistance is a concern, at population level, no treatment is better than incorrect or inadequate treatment.

Activity

5.4d *Debating the introduction of ART*

Two groups.
Preparation – 15 minutes. Debate – 15 minutes. Facilitator's conclusion – 5 minutes.
Materials: Introduce with PowerPoint 5.4d(i): Introduction to debate; Conclude with PowerPoint 5.4d(ii): ARVs in resource-poor settings

Facilitator...

...introduces:

In September 2003, WHO declared lack of access to ARVs a global health emergency. On World AIDS Day in 2003, WHO and UNAIDS released a global initiative aiming to provide ART to 3 million people with HIV/AIDS in developing countries by the end of 2005. The costs involved in introducing ARVs are high and some have argued that these funds may be better used in other ways, for example, on prevention efforts. But, if people do not receive treatment, the ultimate costs to society could outweigh the costs of treatment.

Debate:

- Should the government provide ARVs free of charge to all PLWA?
  Alternately question, if most participants are working in refugee settings:
- Should NGOs/UNHCR provide ARVs to refugees?

...notes:

Are the following in place to allow safe and effective use of ARVs?

- VCT services
- Health workers trained in clinical management of HIV/AIDS and opportunistic infections
- Laboratory services to monitor CD4 counts and side effects of drugs
- Reliable supply system for providing drugs and laboratory supplies
- Strong social structures to help people maintain the treatment

Further points to raise:

- Feasibility issues: health system infrastructure; costs; equitable access
- Conflicting priorities: ARVs versus preventive interventions, e.g., improved STI treatment; intensive public awareness campaigns; HIV versus other health or development needs, e.g., education
- Consequences of not providing ARVs
- Refugee issues: equal treatment of refugees and host population; inclusion of refugees in host country plans to address HIV/AIDS; access to ARVs when refugees return home

...concludes: (Start PowerPoint 5.4d(ii))

There are significant challenges to providing ARVs in resource-poor settings. However, it can be done.

In Haiti, a community-based ARV program started in 1998 has been very successful. Community health workers visit patients in their villages on a daily basis to provide support and ensure that ARVs are being taken. This project has resulted in decreased mortality among PLWA as well as decreased stigma.

In Khayelitsha, an urban slum area of Cape Town, South Africa, a combined MSF/government initiative has provided ARVs since 2001. ARVs are provided through primary health care facilities and peer educators provide support to patients in their homes. The project has been very successful, with significant increases in CD4 counts, weight gain and reduction of opportunistic infections. Of an initial group of 288 patients, the median CD4 count before starting ARVs was 43. After six months on ARVs, the average increase in the CD4 count was 143. The average weight gain after 6 months was 6 kg. The incidence of TB and oral or esophageal candida decreased by two-thirds for the same group of patients when the period of treatment was compared to the same length of time before starting treatment.

5.5 Support group case studies

One of the most important aspects of care for PLWA, is involvement of PLWA themselves. PLWA have been very effective in raising awareness, in advocating for rights of PLWA, in organizing services for PLWA and in providing care and support for each other. Examples of successful PLWA organizations include the TAC (Treatment Action Campaign) in South Africa, TASO (The AIDS Support Group) in Uganda and the post-test club in Kakuma refugee camp, Kenya.

We are going to listen to perspectives from a group of people belonging to a support group at the University of the Western Cape (UWC) in Cape Town, South Africa.

Activities 5.5a to 5.5c are linked. Pauses are needed between activities for thought, questions and discussion. Participants may by now have developed an emotional involvement with the UWC group. This culminates in the writing of messages to the students. (Messages from pilot courses have been very well received by the UWC group. They feel that they are making a positive contribution to the fight against HIV/AIDS in a different part of the world.)

Activity

5.5a *UWC student group on support group*

Audio – 15 minutes; Feedback – 10 minutes.
Materials: Audio CD: Tracks 11 to 15
Flipchart

The UWC group discusses the benefits of the support group.

Participants are asked to note the most striking benefits.

Facilitator...

...notes:

The members of the group have formed strong bonds, supporting each other through problems and celebrations. They find acceptance and understanding in the group. Many of the members say that it is the group that has given them the strength to live positively.

Activity

5.5b *UWC counselor on support group*

Audio – 6 minutes; Feedback – 10 minutes.
Materials: Audio CD Track 16
Flipchart

A counselor for the UWC group discusses issues in managing a support group.
Participants are asked to note important issues impacting the functioning of the group.

Facilitator...

...notes:

Issues include:

- Confidentiality
- Group members taking responsibility for leadership themselves
- Limiting the size of the group
- Sharing a meal
- Some members of the group take on the burdens of others – they need additional support outside of the group.
- There is a need to monitor the emotional well-being of the group – someone with counseling expertise should be available to work with them.

Activity

5.5c *Messages to PLWA group*

Individual – 10 minutes.

Participants are given the opportunity to write messages of encouragement to the UWC group. The messages can be emailed to the Cape Town group at: tvergnani@uwc.ac.za

5.5d PRESENTATION: *How can we control the HIV/AIDS tree?*

Presentation – 5 minutes.
Materials: HIV/AIDS tree
Poster: Mandela's speech (In PowerPoint: Teaching aids Day 5)

We used the HIV/AIDS tree throughout this course as a model for describing and understanding the epidemic.
The tree illustrates the many dimensions of HIV/AIDS. In order to control the growth of this tree and ultimately kill it, we need to attack it in a number of ways:

- Cut the tree down (lifestyle, support, treatment).
- Kill the roots (transmission routes).
- Take away the fertilizers (biological risk factors).
- Change the soil that nourishes it (vulnerability factors).
- Block the water supply (stigma).

Activity

5.5e *Video - A red ribbon around my house.*

Video - 30 minutes.

This video of a dynamic woman living with HIV/AIDS provides a very positive ending to the course.

5.6 Conclusion

- Post-test and daily evaluation
- Overview of course
- Course evaluation: evaluation forms and plenary discussion
- Finalize participant objectives
- Closing ceremony


اول دسمبر روز جهانی ایدز
احمق نشوید
ایدز یک حقیقت است نه جادوگری


เอดส์ป้องกันได้

> *We learned more new technique and method to improve our course at the present... The tree gives us an idea and easy to use in our training to show participants to easily understand the HIV/AIDS problem... specific things with the picture like mother to child, blood routes... those pictures give us new idea to do during our coming training...*
>
> (Thailand)

> *It gives me more hope that it can be controlled with proper education. Therefore I am going to talk about this to everyone...*
>
> (Sierra Leone)

Evaluation tools

- Daily evaluation
- End of course evaluation
- Pre- and post-tests

Daily evaluation: DAY ___

Please tick the appropriate box and comment where relevant:

	Adequate	Not enough	Too much	Comments
Information				
Explanation				
Participation opportunities				
Breaks or Energizers				
Handouts				
Discussion time				
Question time				
Refreshments				

Do you feel that the outcomes for the day were achieved? If not, please explain.

Could the presentation styles be improved? Please explain.

Please suggest any other changes that could improve today's program.

Name one thing you learned today that will help you in your work and write one objective.

End of course evaluation

1 —— Please evaluate the content of what you learned:

TOPICS	Enough for my needs	Too much information	Too little information
1. HIV/AIDS - Basic facts			
2. A framework for HIV/AIDS interventions			
3. Behavior Change Communication			
4. Sexually transmitted infections			
5. Voluntary counseling and testing			
6. Condoms			
7. Universal precautions			
8. Mother-to-child transmission			
9. Stigma			
10. Care of people living with HIV/AIDS			

2 —— Where relevant, please explain your answers to the above.

3 —— Was the level of complexity of the course: too basic appropriate too scientific
If anything was too basic or too scientific, please explain.

4 —— Were you able to participate when you wanted to? If not, how could we make participation easier?

5 —— Was the time allowed for training: too little adequate too much

6 —— Were there enough breaks, energizers, etc.?

7 —— Were you comfortable with the group dynamics during the course, or is there anything that could have made it more comfortable?

8 —— Were the handouts you received (in addition to the manual) helpful? If not, what else would have been helpful?

9 Is there anything we could do to improve administration and practical arrangements?

10 How do you feel about running an introductory training on HIV/AIDS with your clients or colleagues?

Confident	OK	Not ready

11 How do you feel about developing a behavior change strategy with colleagues from your organization?

Confident	OK	Not ready

12 How do you feel about advising a young person about prevention of HIV/AIDS?

Confident	OK	Not ready

13 How do you feel about discussing the advantages and disadvantages of voluntary counseling and testing with a friend?

Confident	OK	Not ready

14 How do you feel about explaining care options for people living with HIV/AIDS to colleagues and clients?

Confident	OK	Not ready

15 Was the course relevant to the work you are doing at present? Please explain.

16 Did the course meet your expectations? If not, please explain what else would have been helpful.

17 Did the course change anything about the way you feel about HIV/AIDS or people living with HIV/AIDS? If so, please explain.

Pre- and post-test
DAY 1

1. Which cells in the immune system are specifically attacked by the HIV virus?

2. What is the term for infections that take advantage of a weakened immune system?

3. What is the difference between HIV and AIDS?

4. What is the most common cause of death among people with HIV/AIDS in Africa?

5. Explain the term "window period."

6. How long does the window period last in most people?

7. In developing countries, what is the usual time span between infection with the HIV virus and death from AIDS-related illness?

8. True or false:
It is possible to tell whether a person is infected with HIV by looking at them.

9. True or false:
Unequal power relationships between men and women can contribute to the spread of HIV.

POST-TEST ONLY:

10. Name three "socio-economic vulnerability areas."

11. Name three biological risk factors that increase the risk of HIV transmission.

Pre- and post-test DAY 1

ANSWER SHEET

1. Which cells in the immune system are specifically attacked by the HIV virus?
   CD4 cells

2. What is the term for infections that take advantage of a weakened immune system?
   Opportunistic infections

3. What is the difference between HIV and AIDS?
   HIV is a virus. When the virus gets into a person's body, the person is infected with HIV or "has HIV." AIDS is the group or syndrome of symptoms and signs, mostly caused by opportunistic infections, which results when the immune system is severely weakened.

4. What is the most common cause of death among people with HIV/AIDS in Africa?
   TB

5. Explain the term "window period."
   The window period is the time between infection with the HIV virus and a positive HIV test.

6. How long does the window period last in most people?
   About three months (twelve weeks)

7. In developing countries, what is the usual time span between infection with the HIV virus and death from AIDS-related illness?
   Eight to ten years

8. True or false:
   It is possible to tell whether a person is infected with HIV by looking at them.

9. True or false:
   Unequal power relationships between men and women can contribute to the spread of HIV.

POST-TEST ONLY:

10. Name three "socio-economic vulnerability areas."
    Unsafe behavior, power issues, health services issues.

11. Name three biological risk factors that increase the risk of HIV transmission.
    Viral load; receptive partner; young female; uncircumcised; damage to genitals; STIs.

Pre- and post-test
DAY 2

1. Name four ways in which people can protect themselves from getting HIV.

2. True or false:
People will always change their behavior if they are given the appropriate information about behaviors which could improve their health.

3. True or false:
Behavior change requires a personal decision and nothing else.

4. Explain the term "Behavior change communication."

5. Name two models or theories that attempt to explain the behavior change process.

6. True or false:
Fear is often an effective way of getting people to change their behavior.

7. True or false:
Communication can be a one-way or a two-way process.

8. Name three communication channels or media.

9. True or false:
All channels/media are appropriate for all messages.

10. True or false:
Peer education is always the best way to increase safer sexual behavior among adolescents.

POST-TEST ONLY:

11. Name the four components of the communication process.

12. Name two methods that help people to learn more easily.

Pre- and post-test DAY 2

ANSWER SHEET

1. Name four ways in which people can protect themselves from getting HIV.
   Abstain; Be faithful to one uninfected partner; Use condoms; Control damage and disease (treat STIs, avoid practices which cause damage to genitals.)

2. True or false:
   People will always change their behavior if they are given the appropriate information about behaviors which could improve their health.

3. True or false:
   Behavior change requires a personal decision and nothing else.

4. Explain the term "Behavior change communication."
   BCC is a process of working with individuals, communities and societies to:
   develop communication strategies to promote positive behaviors that are appropriate to their settings; AND
   provide an environment that will enable people to initiate and maintain positive behaviors.

5. Name two models or theories that attempt to explain the behavior change process.
   Stages of Change Model; Diffusion of Ideas Model.

6. True or false:
   Fear is often an effective way of getting people to change their behavior.

7. True or false:
   Communication can be a one-way or a two-way process.

8. Name three communication channels or media.
   Mass media, small media, dialogue-oriented approaches, participatory approaches.
   (Also correct if examples are named.)

9. True or false:
   All channels/media are appropriate for all messages.

10. True or false:
    Peer education is always the best way to increase safer sexual behavior among adolescents.

POST-TEST ONLY:

11. Name the four components of the communication process.
    The communicator, the receiver/audience, the message, the channel/medium

12. Name two methods that help people to learn more easily.
    People learn more easily when:
    - the new idea is linked with what they already know
    - they identify problems themselves and find solutions themselves
    - they go through a process of critical analysis and reflection

Pre- and post-test
DAY 3

1. True or false:
   Sexually transmitted infections can result in infertility in men and women.

2. True or false:
   The presence of an STI increases the risk of HIV transmission.

3. True or false:
   A person will always have symptoms if they have an STI.

4. True or false:
   The syndromic approach to STI management requires laboratory tests.

5. Name two advantages of knowing your HIV status.

6. Why is a confirmatory test needed if an HIV test is positive?

7. Name three important prerequisites for setting up VCT services.

8. True or false:
   Condoms can be damaged by oil-based lubricants.

9. True or false:
   Using both male and female condoms at the same time provides extra protection.

ANSWER SHEET

1. True or false:
   Sexually transmitted infections can result in infertility in men and women.

2. True or false:
   The presence of an STI increases the risk of HIV transmission.

3. True or false:
   A person will always have symptoms if they have an STI.

4. True or false:
   The syndromic approach to STI management requires laboratory tests.

5. Name two advantages of knowing your HIV status.
   - Can take responsibility for yourself.
   - Can plan for the future.
   - Can take steps to protect your health: diet, nutrition, rest, stress management, medical care.
   - Can be referred to appropriate services.
   - Can take steps to protect partners and unborn children.
   - Can make decisions about future pregnancies.
   - Can make decisions about breastfeeding.
   - Can protect yourself from re-infection, etc.

6. Why is a confirmatory test needed if an HIV test is positive?
   About 2 percent of HIV tests may be false positive.

7. Name three important prerequisites for setting up VCT services.
   - Buy-in from stakeholders (community leaders, religious leaders, health staff).
   - Education of community.
   - Appropriate venue.
   - Appropriate management systems.
   - Assured confidentiality.
   - Appropriate protocols.
   - Reliable supply of tests.
   - Staff capacity to do tests.
   - Staff capacity to counsel.
   - Means of monitoring quality of service (testing and counseling).
   - Appropriate links with other services for care.
   - Resources to sustain the services.

8. True or false:
   Condoms can be damaged by oil-based lubricants.

9. True or false:
   Using both male and female condoms at the same time provides extra protection.

Pre- and post-test
DAY 4

1. Name three ways in which HIV transmission can occur through blood.

2. Name three universal precautions.

3. Within how many hours after accidental exposure to HIV should a person begin post-exposure prophylaxis (PEP)?

4. Approximately what percentage of babies born to HIV-positive mothers will also be infected?

5. Name three ways in which the HIV virus can pass from an HIV-infected mother to her baby.

6. True or false:
Breastfeeding alone (exclusive breastfeeding) carries a higher risk for HIV transmission to a baby than alternating breastfeeding with formula feeds.

7. Name one drug that can reduce mother-to-child transmission.

8. Name three ways of fighting stigma.

Pre- and post-test DAY 4

ANSWER SHEET

1. Name three ways in which HIV transmission can occur through blood.
   - Blood transfusion
   - Shared injection needles
   - Shared cutting instruments
   - Needle stick injury
   - Open sores
   - Mucous membrane splash
   - Shared implements

2. Name three universal precautions.
   - Safe blood transfusions
   - Safe injections
   - Safe surgical procedures
   - Safe technique
   - Safe processing of instruments
   - Safe environment
   - Post-exposure prophylaxis

3. Within how many hours after accidental exposure to HIV should a person begin post-exposure prophylaxis (PEP)?
   Ideally within two to four hours

4. Approximately what percentage of babies born to HIV-positive mothers will also be infected?
   About 33 percent or one-third

5. Name three ways in which the HIV virus can pass from an HIV-infected mother to her baby.
   Pregnancy, delivery, breastfeeding

6. True or **false**:
   Breastfeeding alone (exclusive breastfeeding) carries a higher risk for HIV transmission to a baby than alternating breastfeeding with formula feeds.

7. Name one drug that can reduce mother-to-child transmission.
   Nevirapine; AZT

8. Name three ways of fighting stigma.
   - Get rid of misconceptions
   - Get people talking
   - Care of PLWA
   - Disclosure by PLWA
   - Remembering people who died of AIDS
   - Advocacy
   - Policies and personal commitment by national leaders
   - Laws against discrimination

Pre- and post-test
DAY 5

1. Name three ways in which HIV/AIDS impacts families.

2. Name three ways in which HIV/AIDS impacts societies.

3. True or false:
   Emotional support can improve the physical health of people living with HIV/AIDS.

4. True or false:
   Antiretroviral drugs are the only drugs that can help people with HIV/AIDS.

5. True or false:
   Drug resistance is a problem concerning antiretrovirals.

6. True or false:
   Antiretrovirals have to be taken for life.

7. What is meant by "a holistic approach" to care of people living with HIV/AIDS?

8. Who are people living with HIV/AIDS?

Pre- and post-test DAY 5

ANSWER SHEET

1. Name three ways in which HIV/AIDS impacts families.
   Facilitator's discretion

2. Name three ways in which HIV/AIDS impacts societies.
   Facilitator's discretion

3. True or false:
   Emotional support can improve the physical health of people living with HIV/AIDS.

4. True or false:
   Antiretroviral drugs are the only drugs that can help people with HIV/AIDS.

5. True or false:
   Drug resistance is a problem concerning antiretrovirals.

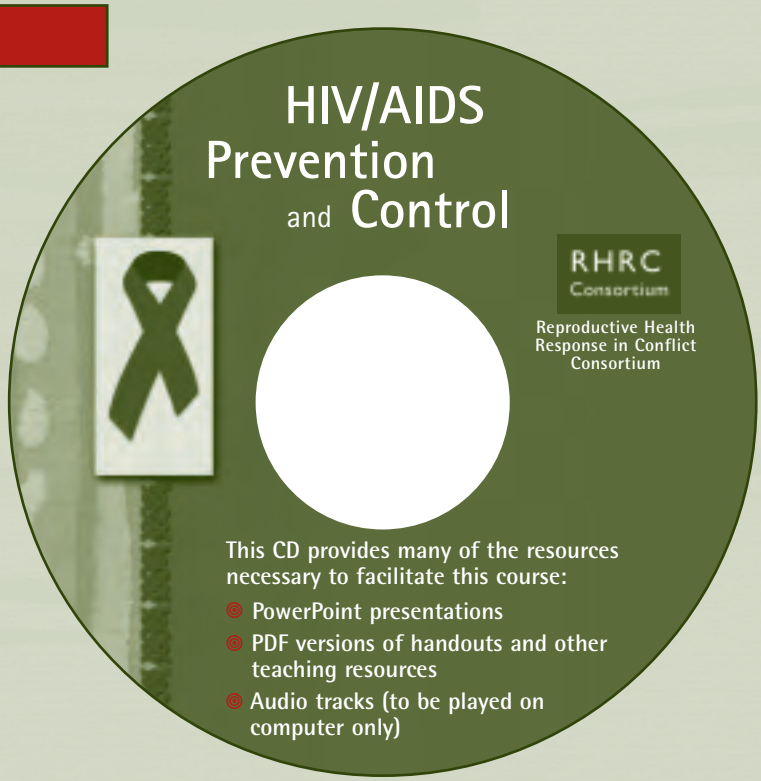
6. True or false:
   Antiretrovirals have to be taken for life.

7. What is a holistic approach to care of people living with HIV/AIDS?
   Care of the whole person: promoting a healthy lifestyle (positive attitude, nutrition, hygiene, exercise); emotional support; practical support; medical care.

8. Who are people living with HIV/AIDS?
   Those infected and those affected. All of us.

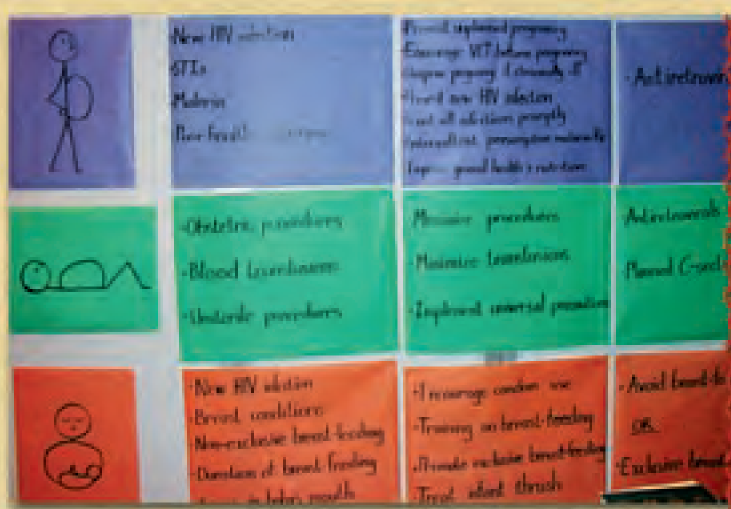
CD Contents

DATA CD

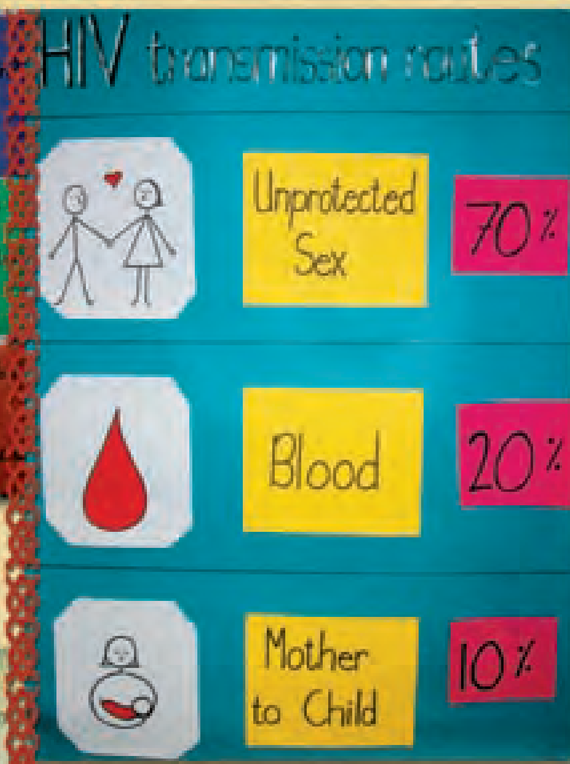


AUDIO CD

A theme of the course is the participation of a group of HIV-positive university students from Cape Town, South Africa. They tell their stories through interviews captured on this audio CD. (included for convenience on the DATA CD.)



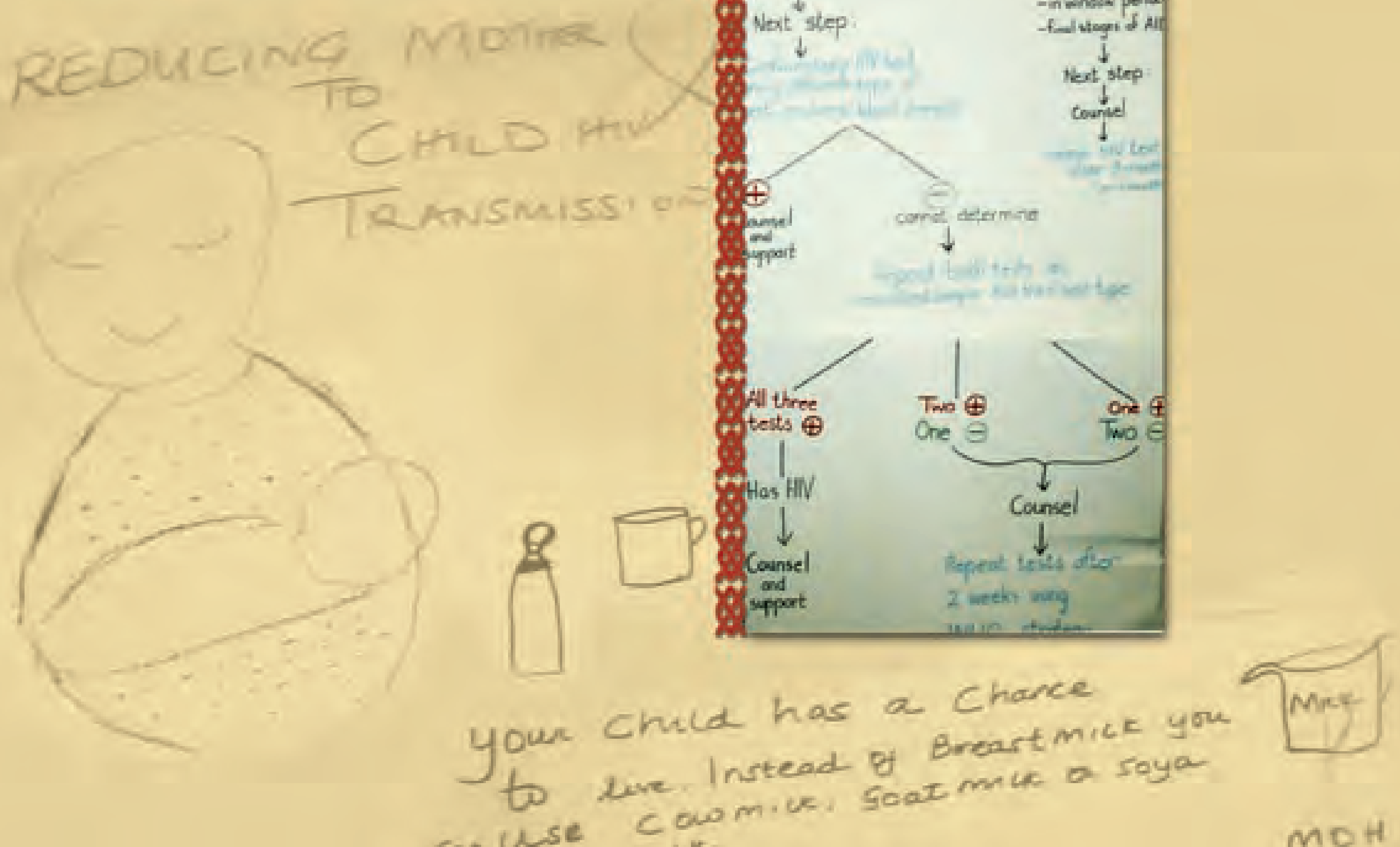
New HIV infection
STIs
Malaria
Obstetric procedures
Blood transfusions
Unsterile procedures
Minimize procedures
Minimize transfusions
Implement universal precautions
New HIV infection
Breast conditions
Non-exclusive breast-feeding
Duration of breast-feeding
Encourage condom use
Training on breast-feeding
Promote exclusive breast-feeding
Treat infant thrush
OR



HIV transmission routes
Unprotected Sex
70%
Blood
20%
Mother to Child
10%

INFECTION
DEATH
Health status
no symptoms
symptoms
AIDS
Viral load
0 – 12 weeks window period
± 3 years
± 5 years
± 2 years

HIV testing flowchart
Pre-test counseling
Possibilities
has HIV
false ⊕
Next step
Possibilities:
-not infected
Next step
Counsel
counsel and support
cannot determine
All three tests ⊕
Two ⊕ One ⊖
Two ⊖
Has HIV
Counsel
Counsel and support



REDUCING MOTHER TO CHILD HIV TRANSMISSION
YOUR CHILD HAS A CHANCE TO LIVE. INSTEAD OF BREAST MILK YOU USE COW MILK, GOAT MILK OR SOYA
MILK
MOH

Contact Us

For more information about the Reproductive Health Response in Conflict Consortium, please visit our website at www.rhrc.org

The *HIV/AIDS Prevention and Control: Short Course for Humanitarian Workers* is available online at www.rhrc.org or in print by contacting info@rhrc.org

RHRC CONSORTIUM

2004

ARC INTERNATIONAL · care · Columbia University MAILMAN SCHOOL OF PUBLIC HEALTH · RESCUE · JSI Research & Training Institute, Inc. · MARIE STOPES INTERNATIONAL · WOMEN'S COMMISSION for refugee women & children