



Training Manual on Economic Empowerment and HIV Vulnerability Reduction

HIV and AIDS Train the Trainer's Manual
and Facilitator's Guide

Prepared under the ILO-Sida Project on Economic
Empowerment and HIV Vulnerability Reduction
along the transport Corridors in Southern Africa

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HIV and AIDS Train the Trainer's Manual and Facilitators Guide

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
ART	Anti-retroviral Therapy
CBOs	Community Based Organizations
CEEP	Corridor Economic Empowerment Project
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization MDGsMillennium Development Goals
MTCT	Mother to Child Transmission
NGOs	Non- Governmental Organizations
OIs	Opportunistic Infections
PLHA	People Living with HIV and AIDS
Pos	Partner Organizations
SADC	Southern Africa Development Community
SEOs	Social Economic Organisation
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Programme
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

DEFINITION OF TERMS

Antibody: A protein produced by B lymphocytes (B cells) in response to an antigen. Antibodies bind to and help destroy antigens.

Antibiotic: A drug used to kill or suppress the growth of microorganisms, such as bacteria and fungi.

Antigen: Any substance that is foreign to the body and triggers an immune response. Antigens include bacteria, viruses, and allergens, such as pollen

Bacterium: A single-celled microorganism. Bacteria occur naturally almost everywhere on earth, including in humans.

Baseline: An initial measurement used as the basis for future comparison.

Cardiovascular: Relating to or involving the heart and blood vessels.

Co-infection: When a person has two or more infections at the same time.

Communicable Disease: An infectious disease that is contagious.

Community-Based Organization (CBO): A public or private non-profit organization that provides services to local community members of an identifiable group, such as people living with HIV.

Concordant Couple: Sexual partners in which both partners are infected with a sexually transmitted infection, such as HIV.

Coverage area: Size in which project activities are implemented

Dissemination: Is the process of spreading information

Dose: The quantity of a medication to be given at one time or the total quantity of a medication administered during a specified period of time.

Drug Interaction: A change in a drug's effect on the body when taken with other drugs, supplements, or food, or when taken in the presence of other medical conditions.

Drug Resistance: When a bacteria, virus, or other microorganism mutates (changes form) and becomes insensitive to (resistant to) a drug that was previously effective.

Embryo: In humans, an infant developing in the uterus (womb) from conception until about the third month of pregnancy.

Epidemic: A widespread outbreak of a disease in a large number of individuals over a particular period of time either in a given area or among a specific group of people.

Epidemiology: The study of the distribution, causes, and clinical characteristics of disease or health status in a population.

(XDR-TB): Extensively Drug Resistant Tuberculosis, which is a relatively rare type of multiple drug resistant tuberculosis (MDR-TB)

False Negative: A negative test result that incorrectly indicates that the condition being tested for is not present when, in fact, the condition is actually present. For example, a false negative HIV test indicates a person does not have HIV when, in fact, the person is infected with HIV.

False Positive: A positive test result that incorrectly indicates that the condition being tested for is present when, in fact, the condition is actually not present. For example, a false positive HIV test indicates a person has HIV when, in fact, the person is not infected with HIV.

Gender-responsive: The term 'gender-responsive' is usually encountered in conjunction with another word: gender responsive governance, strategies, treatments, budgets, etc. Its meaning is similar to gender sensitive.

HIV Incidence: In general, incidence is expressed as the estimated number of persons newly infected with HIV during a specified time period (e.g., a year), or as a rate calculated by dividing the estimated number of persons newly infected with HIV during a specified time period by the number of persons at risk for HIV infection.

HIV Intervention: is a way of mediating or dealing with a social problem in an effort to influence behaviour change and to reduce HIV Vulnerability

HIV-negative: A person who is HIV-negative shows no evidence of infection with HIV on a blood test (e.g. absence of antibodies against HIV). Synonym: sero-negative. The test result of a person who has been infected but is in the window period between HIV exposure and detection of antibodies will also be negative.

HIV-positive: A person who is HIV-positive has antibodies against HIV detected on a blood test or gingival exudate test. Synonym: sero-positive. Results may occasionally be false-positive, especially in infants up to 18 months of age who are carrying maternal antibodies.

HIV Prevalence: The number of persons living with HIV disease at a given time regardless of the time of infection, whether the person has received a diagnosis (aware of infection), or the stage of HIV disease. Although prevalence does not indicate how long a person has had a disease, it can be used to estimate the probability that a person selected at random from a population will have the disease.

Homosexual/homosexuality: It refers to people who have sex with and/or sexual attraction to or desires for people of the same sex.

Hot spot: is a location or area posing or recognised as a high transmission Area of HIV, STIS, TB, Substance abuse etc. within a community

Infertility: Infertility is "a condition of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse."... (WHO-ICMART glossary¹).

Implementation: Implementation is the carrying out, execution of project activities

Intersex: is an individual with both male and female biological attributes

Maternal mortality and maternal death: Refers to death of a woman during pregnancy, child-birth or within 42 days after delivery or termination of pregnancy, irrespective of the duration and site of pregnancy or its management...Population Council HIV infection in pregnant women is seen as one of the causes of maternal mortality UNICEF.

Mobility: The movement of people from one area, social group, class, or level to another

Serostatus: A generic term that refers to the presence/absence of antibodies for a specific virus in the blood.

Sexual orientation: The term 'sexual orientation' refers to each person's profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or both sexes.

Sex worker: The term 'sex worker' is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold.

Site facilitator: The one who monitor Peer Educators in a specific zone

Social facilities: Facilities in a community which everyone can access

Target group: Is a specific group of people within the community at which the services is aimed at.

Tavern: A place of business where people gather to drink

Topographical map: Topographic maps are maps that provide extensive close-up detail about a place.

Transgender: A transgender person has a gender identity that is different from his or her sex at birth.

Transvestite: A transvestite is a person who wears clothes associated with the opposite sex in order to enjoy the temporary experience of membership of the opposite sex.

Tripartite: Divided into or composed of three parts; having three corresponding parts or copies or made between or involving three parties

Vulnerability: Vulnerability refers to unequal opportunities, social exclusion, unemployment, or precarious employment and other social, cultural, political, and economic factors that make a person more susceptible to HIV infection and to developing AIDS.

Zones: Distinguished area from adjacent parts by a distinctive feature or characteristic.

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INTRODUCTION

The Corridor Economic Empowerment Project (CEEP)

The Corridor Economic Empowerment Project (CEEP) works across six countries, Malawi, Mozambique, South Africa, Tanzania, Zambia and Zimbabwe.

Background

Globally, poverty, gender inequalities, social and economic exclusions continue to pose major challenges to HIV prevention efforts. More than 30 years since HIV was discovered, AIDS has become one of the most devastating disease humankind has ever faced.

By the end of 2012, an estimated 35.3 million people globally were living with HIV, with 1.8 million AIDS-related deaths and 2.3 million new HIV infections. Sub-Saharan Africa is still the region most affected, with 69% of all people infected with HIV living within the region. Women are the most affected by HIV accounting for 58% of new HIV infections. According to the 2009 UNAIDS report in Sub-Saharan Africa young women aged 15-24 years are 3-5 times more likely to be HIV positive than their male peers. This has highlighted the importance of relational dynamics such as economic and power imbalances, which in turn influence women's vulnerability to HIV and AIDS. A fundamental difference between AIDS and other diseases generally linked with poverty in Sub-Saharan Africa, such as tuberculosis or malaria, is that its primary route of transmission is sexual intercourse. It has been argued that the economic vulnerability of women increases their vulnerability to HIV and AIDS by keeping them dependent on men and constraining their ability to refuse sex, negotiate the use of a condom, discuss fidelity with their partners, seek out treatment or leave risky relationships. Women comprise almost two-thirds of the world's illiterate people and are often denied property rights or access to credit. They earn 30-40% less than men for the same work, and most of those who are working are employed outside the formal sector in jobs characterized by income insecurity and poor working conditions.

ILO and SADC HIV AIDS Economic Empowerment Programming

The International Labour Organization (ILO) implements different initiatives that support the SADC development agenda of controlling and reversing the impact of HIV and AIDS. From 2007-2010, the ILO supported the National Department of Transport, Employers and Workers in the transport sector under a previous intervention. This project achieved a number of results, including assisting the Transport Sector to develop policies, systems and programmes on HIV, AIDS, STI and TB in the workplace; the formation of Transport Sector HIV, AIDS, STI and TB coordinating committee in 2007.

Upon recognition of the project achievements, the ILO in consultation with SIDA extended the project to vulnerable groups along the transport corridors and communities, leading to implementation of the project on HIV vulnerability reduction through economic empowerment focusing women, men, young girls and boys.

The immediate objectives of the project with focus on the macro, meso and micro levels are detailed below:

Immediate Objective 1: To support Policy makers and promoters to make evidence-based decisions to mainstream the economic empowerment model into HIV and AIDS regional and national agendas.

Immediate Objective 2: To economically empower targeted men and women along selected transport corridors by increasing the availability of economic services to prevent and mitigate the impact of HIV and AIDS in selected transport corridors.

Immediate Objective 3: To reduce HIV vulnerability by increasing access to effective HIV and AIDS prevention and impact mitigation and social services provided by targeted operators (members organizations such as cooperatives, informal associations, MSMEs) along selected transport corridors.

Understanding the picture

The Corridor Economic Empowerment Project draws on a systems approach to understand and address the spread of the HIV pandemic. The project focuses on reducing people's vulnerability to HIV and AIDS.

What do we mean by “Reducing vulnerability to HIV and AIDS”?

“Reducing vulnerability to HIV and AIDS” is a phrase that is used to encompass two aspects:

- ✓ The primary focus of CEEP is on the reduction of HIV vulnerability through a combination of HIV prevention strategies. These strategies include economic empowerment, behavioural strategies (e.g. reducing the number of partners and making correct and consistent use of condoms), biomedical strategies (e.g. medical male circumcision, prevention of mother to child transmission, voluntary counselling and testing), advocacy with national, provincial and local structures as well as the implementation of HIV workplace programs.
- ✓ The second area that the reduction of HIV vulnerability refers to the mitigation (or reduction) of the effects of HIV and AIDS on the individual, families and communities. Through the economic empowerment, HIV sensitization and referral to appropriate services, CEEP is able to reduce HIV and AIDS impact for people infected and or affected by HIV and AIDS.

How do we approach HIV vulnerability?

The ILO-through CEEP makes use of a systems model to understand issues including HIV vulnerability. Drawing upon the latest understandings from the countries national strategic plans, key drivers of HIV vulnerability have been identified. These have been organised into the systems model from a micro, meso and macro level.

The **macro level** considers the broad factors that influence a person's vulnerability to HIV and AIDS. This includes the way in which groups of people relate to each other and the social and cultural norms that influence these interrelations and behaviours. At this level the drivers focus on:

- Poverty and Economic disempowerment
- Gender norms that are adopted within society
- Stigma and discrimination
- Alcohol and drug use
- Local, provincial, national and regional governmental responses. This can include policy frameworks on Economic Empowerment (and poverty reductions strategies) and HIV & AIDS that speak to ensuring individuals have access to primary health care services, e.g. condoms and contraception's, TB or STI clinics, HIV treatment clinics, HCT services and sexual reproductive health.

The **meso level** focuses on the interactions between people and focuses on the communities/groups/family norms and values that influence an individual's behaviours. At this level these drivers have been identified as key:

- Migration
- Group and family norms (including business support structures)
- Local cultural practices

At a **micro level** we consider the individuals themselves and the factors that increase or decrease their vulnerability to HIV and AIDS. At this level we consider:

- Knowledge of HIV, AIDS, TB and Other STIs

- Behaviours, including:
 - Age of sexual debut
 - Number of sexual partners
 - Transactional sex
 - Intergenerational sex
 - Correct and consistent condom use
- Bio-medical factors, including:
 - Knowledge of HIV status
 - Medical Male Circumcision
 - Family planning including maternal health and Mother to child transmission
 - STIs
 - Post Exposure Prophylaxis

While we have identified each factor individually, these factors are interrelated and may help or hinder a person's attempts at reducing their own vulnerability to HIV and AIDS. Below is a diagrammatic representation of these drivers:

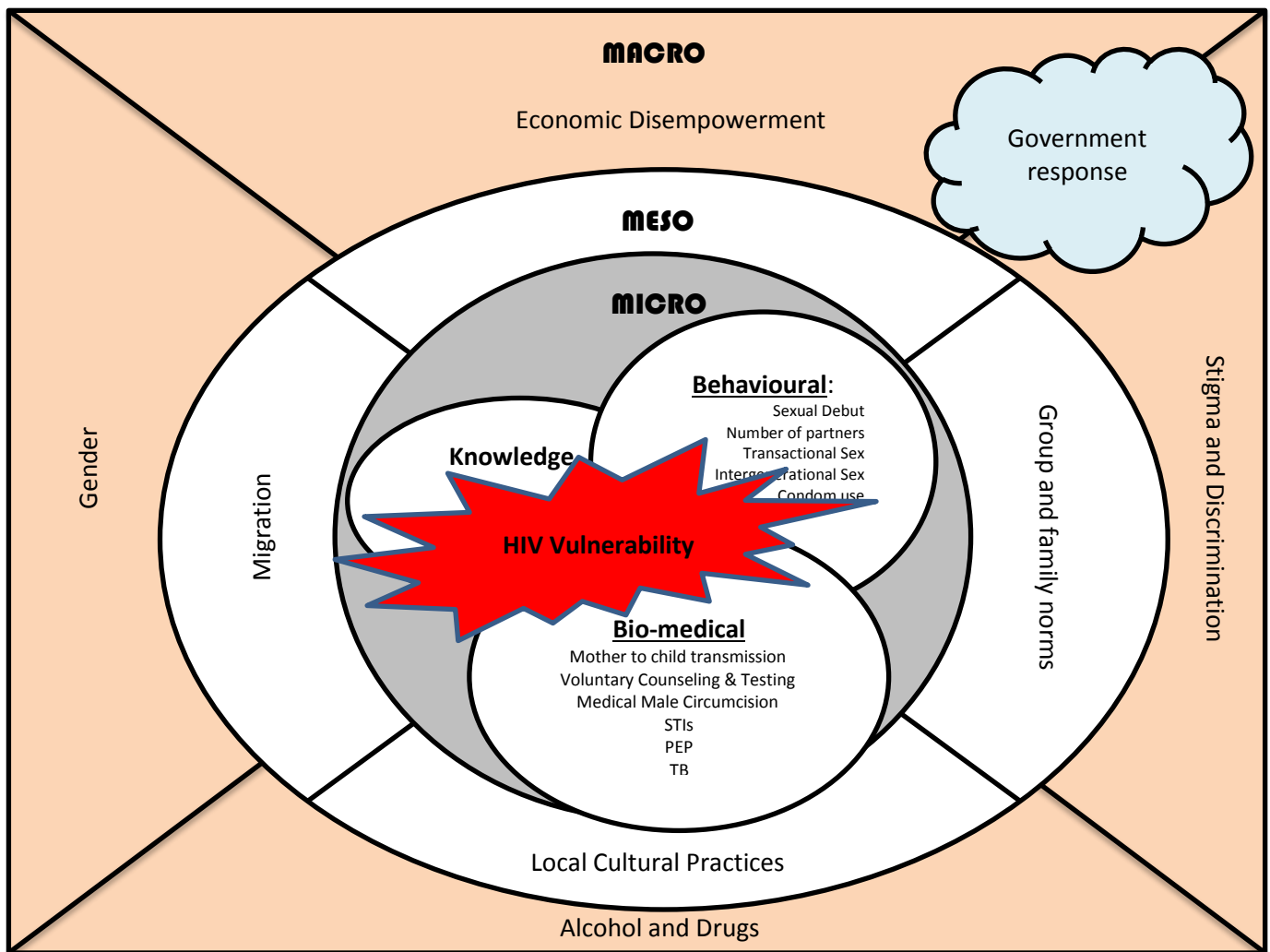


Figure 2: Diagrammatic representation of the key drivers of HIV and AIDS pandemic

Purpose of the manual

The manual offers an outline of a five-day training workshop which aims at providing CEEP trainers with the necessary tools for planning, designing, and conducting effective HIV training-of-trainers (TOT) workshops. The aim of the training is to build up the technical capacity of HIV peer educator trainers within the CEEP program to enhance the peer education training and to integrate HIV and gender inequalities into economic empowerment training. The manual has been designed for use by the facilitator in conjunction with the resource pack.. Facilitators will use the initial needs assessments to guide the selection of topics from the manual to prepare and conduct the workshop. The expectation is that participants will use the model as a basis for developing training they will deliver within the context of the CEEP project.

This training manual is a resource for strategies and programmes that can be put in place to address vulnerability to HIV as a result of gender and economic disempowerment. The manual has been divided into three parts:

PART 1 – TRAINING TOOLS

PART 2 – UNDERSTANDING HIV AND AIDS VULNERABILITY

PART 3 – ADVANCED BUSINESS TOOLS

Ideally the facilitators should check (assess) the knowledge that the participants have regarding the subject, in order to plan properly for the workshop. However one may not have had time to check each participant's knowledge about the subject. However, if the workshops are planned well they can be a valuable resource for participants. In any workshop participants often present with different levels of knowledge, this might be the case in workshop for integrating HIV and gender into economic empowerment. Some participants may not be well informed with regard to policies, processes and programmes that are in place, and some aspects and complexities in the approach. Others may already be aware and may have received some information. This training manual provides the facilitator with tools for balancing the needs and expectations of both new and existing trainers and educators involved with HIV initiatives.

Learning Objectives

At the end of the workshop, participants should be able to:

- Explain their own HIV and AIDS vulnerability
- Empower beneficiaries to take action to reduce this vulnerability (skills)
- Provide or refer beneficiaries to appropriate resources to effect change
- Foster a climate of change by sharing these skills and resources onto their families, friends, communities and businesses.
- Assess and develop a needs based training session for the trainers of peer educators.

Outputs:

- A vision journey for the next 5 years

Methodology

The participatory curriculum design model of the workshop outlined in this manual is based on principles of adult experiential learning. The underlying principle is that much of the content will come from the participants and that the workshop will serve as a framework for drawing out their experiences. Participants and facilitators commit themselves to engage in a process of mutual teaching and learning. The emphasis is on practical application and the development of strategies for action. Continued reflection and evaluation are central to the learning process. Transformative learning theory underpins the workshop content and process.

Target audience

This training manual has been developed to be used to train HIV peer educators' trainers i.e. training of trainers (TOT) manual. Preparing for a successful workshop requires advance planning, organization and focus, so that the workshop can address the needs and expectations of participants

Training Resources Needed

General resources

- Attendance registers
- Name tags
- Flipchart stand, paper and markers for facilitators
- Prestik
- A4 white paper for each table of participants
- Additional flipchart paper for each table of participants
- Permanent markers on tables for participants

Trainer's materials

- Training of Trainers HIV and Business manuals
- SIYB Intake forms
- Decision Trees
- Attendance Register
- Daily Evaluation Forms
- Pre and Post Workshop Questionnaires
- CEEP Baseline Questionnaires

Planning and Conducting a Workshop

Training situations vary greatly; therefore, the materials provided in this manual should be viewed as a guide to conducting a TOT workshop for peer educator trainers. The level of experience of the facilitator, the knowledge and skills levels of participants, and the training context are all factors that you will need to consider when planning your own workshop. A minimum of 10 and a maximum of 30 participants are recommended in order to maintain the integrity of the training design. However, the content and activities can be modified to accommodate smaller groups. Some guidelines and suggestions for planning and conducting an effective workshop are provided below.

PART 1: TRAINING TOOLS

This section of the manual considers training tools the trainers should have at their disposal to conduct trainings with trainers. In order to develop the peer educators; trainers will take participants through peer education as a strategy, mapping and zoning, how to work with individuals, how to work with groups, make appropriate referrals, monitoring and evaluation.

Module 1.1: PEER EDUCATION AS A STRATEGY FOR ADDRESSING HIV AND AIDS

“Education is the most powerful weapon which you can use to change the world.”

Nelson Rolihlahla Mandela

These famous words from South Africa’s and the world’s icon, Nelson Mandela, underlie one of the key principles of peer education programmes. We will examine this principle and peer education programmes within this module. The aim of the module seeks to develop the participants understanding of the role of peer education within CEEP’s Economic empowerment and gender equality as HIV and AIDS vulnerability reduction strategy.

Objectives of this module

- To locate the peer education and the training of trainers within a matrix of HIV and AIDS vulnerability reduction responses,
- To examine the definitions of peer education,
- To clarify the qualities, roles and responsibilities of peer educators and trainers,
- To explore the limits of peer education, peer educators and reasonable actions that can be taken and
- Explore the support offered to peer educators

Topic 1: Locating Peer Education

Time: 10 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ To understand that peer education is one resource that is drawn upon to address the HIV and AIDS vulnerability.
- ✓ To describe peer educators
- ✓ To identify the qualities of peer educators

Materials and equipment needed

Flip chart and koki pens

Activity 1.1.1: Locating peer education in the continuum of HIV Care and support

Trainer Instructions:

Brainstorm with the large group all the ways in which governments, Non-governmental organisations and communities have responded to reduce individual’s vulnerability to HIV and AIDS. Ask participants to consider prevention and treatment care and support responses/activities.

Write these responses on a flip chart paper.

Facilitator notes:

- What will emerge is that there have been a myriad of responses conducted by a range of people.
- Peer education is one of these valuable and important strategies that has been shown to be successful and is widely used amongst many groups.
- Peer education **does not exist by itself**; there are many other resources to draw on.
- The group/s may require a little prompting about what programmes exist within their communities.
- Although not a comprehensive list these may be the kinds of responses received:
 - Prevention:
 - Economic Empowerment Programmes
 - Condom distribution
 - School programmes
 - **Peer education programmes**
 - Gender programmes
 - Community outreach events
 - Media advertisements and programmes
 - Government announcements
 - Door-to-door campaigns
 - Individual counselling
 - Couple counselling
 - Voluntary Counselling and Testing
 - Prevention of Mother to Child Transmission
 - Medical Male Circumcision
 - Treatment, care and support:
 - Economic Empowerment Programmes
 - Individual counselling
 - Couple counselling
 - Support groups
 - Positive Living programmes.
 - Treatment clinics at hospitals and within the communities
 - Health talks within the clinics
 - Media advertisements and programmes
 - Government announcements
 - Support groups
 - Directly observed TB treatment support

Topic 2: Defining Peer education

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ To understand peer education as a strategy
- ✓ Clarifying the main aim of peer education allows beneficiaries to make informed decisions
- ✓ Identify the three main roles of peer education
- ✓ Identify the advantages and disadvantages of peer education

Materials and equipment needed

Flip chart and koki pens

Activity 1.1.2: Defining Peer education

Trainers Instructions:

Write the word “peer educator” on a flip chart page. Ask participants, in the big group, a selection of the questions below:

- What is a peer?
- What is education?
- What is peer education?
- What do peer educators do? (roles)
- What do trainers do? (roles)
- What are the advantages of peer education?
- What are the disadvantages of peer education?

Facilitator Notes:

1. Definition/s

Below is the definition that is used within these trainings:

***Peer education** is a strategy that works with individuals and groups in order to open or spark discussions around selected topics through respectful facilitation, providing information and resources/referrals to allow targeted individuals to make informed decisions.*

There are seven key elements to this definition that trainers need to impress on the peer educators:

- a) Peer education allows **participants to make informed decisions**
 - a. Peer educators provide discussions, information and resources (referrals) so that individuals can decide the best course of action for themselves. In order to respect a person’s human right of autonomy peer educators do not tell people what to do. Keep in mind if you do tell someone what to do this could be the wrong course of action for them and could even endanger them, e.g. if you tell a woman in an abusive relationship she has to use condoms, her partner could find this offensive and this can place her in danger. Of course we can challenge people and show them the benefits of one course of action (e.g. testing for HIV) but we cannot tell them what to do

- b) Peer education is a strategy/method for a targeted audience:
- c) This is **one method** among many others (see exercise 1.1.).
- d) Peers are those with similar ages, interests, values and locations. In order to ensure that peers are actually peers we need to ensure that those selected match the target group that we would like to focus on. That means we cannot expect people with different interest, ages or values to be peers, e.g. a person who is 35 is not a peer of a target group whose average age is 20. Peers need to match the selected target audience.
- e) Peer education works with **individuals and groups**
- f) Peer education **sparks discussions** (through respectful facilitation)
 - a. As we have seen above the main aim of peer education is to allow people to make informed decisions as such we are not telling people what to do but rather sparking discussions on a topic and then guiding or challenging people to think about the benefits or harms of a particular course of action.
- g) Peer education **provides information**
 - a. Peer educators provide accurate up-to-date information on selected topics
- h) Peer education **provides resources/referrals**
 - a. Peer education is one strategy among others and form part of a network or matrix of prevention, care and support services. This means that we don't have to do everything ourselves and there may be people in a better position to offer other services.
- i) **Empowering beneficiaries** with problem solving models for beneficiaries and peer educators.

2. The roles of peer educators:

There are **three primary roles** of peer educators:

- a) **Providing the most up-to-date information** to members of the community or peer group so that the individual is able to make an informed decision about the best action/s towards reducing their HIV and AIDS vulnerability.
- b) **Modelling** positive health seeking behaviours. A lot of learning (including behaviours) occurs through modelling from other people. By modelling we mean the behaviours, values and attitudes that we observe in others. We observe the way in which our parents, leaders and peers behave and adapt our behaviours based on the success or the values attributed to these behaviours.

Peer educators are well positioned to know the norms and behaviours that are valued by a particular group. This places them in an advantageous position to know how to address or reinforce these positive health seeking behaviours.

This means that peer educators themselves are in a position to show others what positive health seeking behaviours are.

The key question here is what have you done to reduce your vulnerability to HIV and AIDS? And what else can you do?

c. Refer, refer, refer

As we discussed above peer educators are not alone, there are other services and organisations that seek to support people who are vulnerable to HIV infections and AIDS impact. As such peer educators need to:

- a. Know that one does not need to be a super-hero and try to deal with everything alone!!!
This is a receipt for burn out and depression.
- b. Remember that they have trainers and their other peer educators to talk to
- c. Ensure that they have an up-to-date and active referral list
- d. Know their own limits and refer if you are not feeling comfortable

Benefits of Recruiting from target group

- ✓ Easier access to targeted groups.
- ✓ Confidentiality can be maintained.
- ✓ Communication is easier since language, social context and culture is the same between Peer Educator and the audience. This is especially important in addressing sensitive and culture specific information.
- ✓ Messages are repeated to the same audience.
- ✓ The Peer Educator and the participants (audience) are empowered. Relationship between the community and the organization is promoted; thereby creating acceptance by the community
- ✓ It increases community participation in prevention of HIV; thereby initiating Behavioural Change patterns.
- ✓ The number of Peer Educators recruited will be based on the number and size of zones in the project catchment area, as well as available funding.

Topic 3: Qualities of a peer educator

Time: 25 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ To identify the preferred qualities for a peer education

Material and equipment needed

Flip chart and koki pens

Activity 1.1.3: Qualities of a Peer Educator

Trainers Instructions:

Divide the big group into 4 – 5 smaller groups and ask each group to consider the qualities that are required from a peer educator. Give each group 10 minutes to discuss, at end of 10 minutes get back to the large group for feedback.

Write up these answers and develop one comprehensive list on the flip chart

During the feedback assess why these qualities are important.

Facilitator Notes:

Whilst these is not a complete list, here are some key qualities:

- Open-minded
- Non-Judgmental
- Trust worthy – ability to keep private information private
- Patience
- Compassionate
- Interested
- Supportive
- Positive attitude
- Encouraging
- Focused
- Truthful
- Assertive

Topic 4: **Knowing your limits and referring**

Time: 60 minutes

Knowing your limits is an important part of your training. These present barriers which you cannot and at times should not have to try to cross. Within this session we will explore some of your limits so that you will know when to refer.

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Reflect on their personal limitations in relation to what they can and can't do.
- ✓ Help clients access available support for identified needs Describe the importance of referring within peer education

Materials and equipment needed

Flip chart and koki pens

Activity 1.1.4: Knowing your Limits and Referrals

Trainers Instructions:

Frame the exercise by saying that we are going to take time to make a list of services we would need to refer for and the kinds of people or groups which you would have difficulty working with. As a group we will consider which groups of people the group has the most difficulty working with.

Task:

Write down on a piece of paper 4/5 kinds of people or groups of people that you would struggle to work with. Next to each group highlight some of the reasons for this difficulty and what we are going to do about it. After that think of services that might be needed by your clients that you would need to refer for and where in your community could you refer to. (10 minutes)

Step 2: Group feedback

Ask for volunteers to share which kinds of groups would be difficult to work with. Reasons need not be shared. Highlight the importance of identifying and respecting our limitations beforehand and coming with ways of overcoming them. Wrap up the session by facilitating a group discussion of the range of services that might be needed by our clients and the places they can be referred to in our communities.

Facilitator Notes

Be sensitive to people's limits and do not judge them for these limits but if there are strong commonalities highlight this for the group.

Step 3:

Ask the bigger group what should happen to these people on this list?

Is there any support that can be offered to them? And by whom?

Facilitator Notes:

The key here is referrals.

We assume that everyone has universal human rights and as such should be helped. We don't expect peer educators to do it all as the attempts may be insincere but the peer educator takes on the responsibility to refer those whom they cannot help.

Topic 5: What support is offered to peer educators?

Time: 10 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the support needed by peer educators and who provides this support

Materials and equipment needed

Flip chart and koki pens

Activity 1.1.5: Support for a Peer Educator

Trainers Instructions:

Ask participants to work in pairs and plan a support programme for peer educators involved in CEEP – their plan should consider the following

- Who should support peer educators
- What form should the support be – (face to face; telephonic)
- How often the support should be provided (intervals)

Give participants 10 minutes to develop the plan, at the end of 10 minutes ask participants to get to the large group and facilitate a discussion of the support, ask volunteers to give feedback and the rest of the group to add any points that have not been raised or if they have different view for the group to discuss.

Facilitator Notes:

There are different combinations of support that is offered to peer educators, the trainer needs to find out what is available to this batch of peer educators. Some of these are listed below:

Ongoing Weekly trainings (weekly or ad hoc trainings)

Should also run throughout the year, weekly training meetings are the activity nerve centre and are important for both the project coordinator and Peer Educators. They strengthen group unity, assist in management & maintaining the motivation of community volunteers while providing keys to ensure programme quality.

Meetings held regularly between coordinator and peer educators allow problems and other issues to be discussed, strategies formulated, the development of new training content and key lessons to be learned from other peer educators. Benefits of Weekly Training:

- Reinforcing all training topics given during the initial training;
- Identification and planning of other training needs or topics;
- Sharing of experiences and skills;
- Rehearsal of participatory approaches including new topics.
- Weekly Management Meetings
- Giving reports, quality and statistical assessments;
- Planning for the coming weeks meetings;
- It helps strengthen group unity;
- Collecting of materials e.g. condoms & pamphlets;

Benefits of Peer Educator Support:

- Solving of any problems;
- Motivation and support;
- Sharing of personal problems – one to one, peer to peer counselling, debriefing;
- Specifically inviting other professionals in during training times to provide emotional, social or spiritual support.

This support might not be formalised or evident in some cases. Here it may be up to the peer educators to find additional support for them and their fellow peer educators.

Alternative exercises

Activity 1.1.6: Case Study: Elements of a good peer education program:

A study of 21 peer education and HIV prevention and care projects in 10 countries in Africa, Asia, Latin America, and the Caribbean (AIDSCAP) revealed that peer education has been an effective strategy in the prevention of HIV/AIDS. Study findings documented the need for initial and reinforcement trainings, ongoing follow up, support, supervision; clear understanding of the role of peer educators and continued incentives and motivation techniques. The study also documented that peer educators must broaden their understanding of HIV to include care of people living with HIV and family planning. *The final output of the review was a handbook of guidelines from which future peer education programmes could be designed, entitled "How to Create an Effective Peer Education Project" (Flanagan and Mahler 1996).*

A comprehensive and participatory assessment of HIV peer education programmes was recently conducted in several clusters (regional HIVNGO networks) in Tanzania (Hooks et al. 1998). The results of this assessment stated that:

1. Community involvement and ownership is critical for the continuity and sustainability of a peer education programme.
2. Ongoing capacity building and supervision are important for the maintenance of quality in the programme.
3. One should capitalize and build on the knowledge, creativity and energy of peer educators, through their involvement in programme planning.
4. The reach of peer education should be increased through more training of trainer programmes in new geographical areas.
5. Both financial (such as access to credit and compensation for expenses) and non-monetary (such as bicycles, T-shirts and materials) incentives are important to motivate peer educators.
6. Reproductive health and other topical areas, as identified by communities, should be included in the scope of peer educators (Hooks et al. 1998).

Questions

- ✓ To what extent does each one of these findings apply to your own project or area? Give examples that will support your answer.
- ✓ If you are in disagreement, also give reasons why things are different in your project, community or country

a. Developing a peer education training programme

Activity 1.1.7: Case Study: New boy in training room

You have been selected to be a new trainer by your organisation to conduct trainings in another part of the country, you have experience in this field but new to the way trainings has to be conducted for this particular programme. A few weeks from now, peer educators implementing in that area from different sites are supposed to receive training on Peer Education as a Strategy and the benefits of running a peer education programme within that area. As the new trainer, you are scheduled to do one of the trainings for a group of 25 peer educators between the ages of 20 years to 45 years, among them a few can speak English the rest are coming from mixed tribes which speaks different language.

Questions

- ✓ How would you ensure proper planning prior the training?
- ✓ Draw a proper training curriculum with topics that you would train.
- ✓ What training methods would you use to train this particular group of peer educators?
- ✓ What challenges do you foresee encountering during this training?
- ✓ How would you solve them?
- ✓ Draw a fact sheet containing 20 facts as to what is peer education and the benefits of a peer education programme within that particular area

Key messages: Peer Education

- Peer education helps people make informed decisions
- Peer education is one method within a network of prevention, care and support services
- Peer educators need to be aware of their limits and refer where possible
- Peer educators:
 - Provide information
 - Model positive behaviours
 - Provide referrals
- Peer educators model positive health seeking behaviour – what have you done to show this?
- Peer educators require ongoing support, supervision or mentoring
- For the rest of this part of the training we will consider the tools that a peer educator needs to complete their jobs effectively. These include:
 - a. Mapping and Zoning
 - b. Working with individuals
 - c. Working with groups
 - d. Referral networks
 - e. M&E tools

Module 1.2: MAPPING AND ZONING

This module is intended to provide trainers with an understanding of mapping and zoning as an essential tool for the implementation of an effective peer education programme. It outlines the mapping and zoning process, identifying coverage area for the programme and identifies what gets mapped.

Objectives of the module

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

- ✓ Define “Mapping and Zoning”
- ✓ Identify places where maps can be procured and the types of map to be used
- ✓ Describe the process of mapping and zoning
- ✓ Demonstrate the ability to map and zone a community project

Topic 1: Mapping and Zoning an Introduction

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain mapping and zoning
- ✓ Identify what gets included in the mapping and zoning exercise
- ✓ Describe the process of mapping and zoning

Materials and equipment needed

Flip chart and koki pens

An Introduction to Mapping and Zoning

Trainer Instructions

Step 1

Present the information on mapping and zoning, to the large group by engaging participants in the discussion and asking for examples to make sure that they are fully engaged and following the discussion.

The presentation should cover the following topics – detailed information is available under key information for this session:

- ✓ Introduction
- ✓ Define mapping
- ✓ Define Zoning
- ✓ The mapping process
- ✓ What do we map?
- ✓ Where to procure maps
- ✓ Benefits of community mapping and zoning

If the trainer has an example of a chart that has been mapped and zoned this could aid the understanding.

Facilitator Notes

Introduction

When setting up an intervention program it is important to be clear of what your limits are. Limits help us understand the scale of projects and what we can do effectively. A project that tries to do everything will do nothing well. There are various limits to a project including number of staff, size of financial resources, and reach of the project. It is this last aspect, the reach of the project that mapping and zoning helps us to clarify.

Definition of Mapping:

Mapping is simply a process of demarcating your project coverage area. It is vitally important to ensure demarcation of your project coverage because if demarcation is not performed, it is very difficult to plan and manage implementation of field activities by peer educators.

Definition of Zoning:

Zoning is the partitioning of the mapped area into manageable units. The main objective is to outline information needed to design an intervention programme, such as recruitment of peer educators, which should be conducted based on zoned areas within the coverage area, to enhance cost effectiveness and accessibility to assistance by targeted community members.

Mapping and zoning follows the initial research (formative assessment) that is conducted into the nature and scope of the issue being focused on. Formative Assessment is conducted in order to learn the legal status of the targeted group/s. It is vital to know the laws regarding the targeted group/s, e.g. sex workers (SWs), how and when they are enforced, as this will influence one's approach to the assessment and intervention. Once the target area is established, a mapping and zoning exercise is necessary.

Once the general area of intervention has been identified, the site/s should then be mapped, using a suitable map, to indicate the different areas, types of settlements and availability of services such as transport, and to set the exact catchments area of the project. The mapped area can be divided in manageable zones to determine the feasibility of initiating interventions or selection of smaller sites.

Identifying your coverage area

We map in order to learn about the boundaries of an area, size, approximate population and dispersion of an area. Sub divisions in an area including major target areas e.g. sex work neighbourhoods, truck stops, schools, clinics etc. also needs to be mapped. Mapping also assist us in knowing the possible size of different target groups, area, major stable and mobile target groups and the relevant size of each. Through mapping, potential interactions in the area e.g. between stable and mobile populations can be ascertained. Commerce particularly related to HIV transmission, including sources of employment, night clubs, bars etc. are observed.

Focus demands sacrifice!

What to consider:

Social problems and challenges encountered by the community are often examined geographically by considering the following:

- Where are the targeted groups situated in terms of their location?
- Where do the sex-workers operate from and other high transmission areas?
- What mode of transport does youths in school use to get home after school and what are the threats in

between.

- Where do youths in and out of school hang around the most, and what other activities posing as drivers to HIV transmission do the youth get involved in? e.g. drug and alcohol abuse etc.
- Where and how dispersed are the clinics, hospitals, schools, truck stops, police stations, NGOs, CBOs, FBOs, Government Departments, trade markets and the border post etc.?
- How big is the coverage area and how dispersed are the areas where intervention activities need to be implemented.
- Where do cross border migrants reside or do they further travel to other towns.
- How vulnerable are they to the social drivers leading to HIV transmission
- What kind of support structures are needed to enhance behavioural change.
- Current use patterns of developed land and identification of land available for development
- What are the growth projections for the community (information can be obtained from census data.
- Who are the other community service providers e.g. police, schools, hospitals and utilities?

These are the kinds of questions which are often answered by looking at a map that contains more than just the location of towns, roads, water, and political boundaries such as province, region, district, constituency lines, state borders, etc.

The Benefits of Community Mapping and Zoning

- Identifies the size of hotspots/ targeted areas
- Helps with assessing the costs of targeted interventions, e.g. transport costs
- Helps identify the accessibility of community resources and referrals – are they near or far?
- Helps to identify other potential strategic partners, e.g. there may be a small shop that is located near a hotspot that could be a resource for condom distribution – with the owner's buy in of course
- Recruitment is the second step after Mapping and Zoning a coverage area. Peer educators are recruited from the target group based on whom the organization sets its project to target, e.g. Sex workers (SWs), Youth in and out of school, and SME Community etc. Peer Education strategy is effective when they have been recruited from the community and target community.

Topic 2: Practical exercise of Mapping and Zoning

Time:

30 Minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Mobilize resources and prepare for a mapping and zoning exercise
- ✓ Demonstrate mapping and zoning skills
- ✓ Discuss the benefits of conducting Mapping and Zoning exercise.

Resources needed

Flip chart and koki pens

Transport

Trainer Instructions

Step 1

Working with the bigger group discuss the process of mapping and zoning

Facilitator's Notes

The Mapping Process:

Select people who are accustomed to the area and are enthusiastic to share their knowledge and expertise. Depending on the vastness of the area recommendations may be to work in groups or individually, remember to consider this when preparing material and tools required for the mapping exercise.

Together with the selected group of people study the map and decide what the map or maps should show, e.g. hot spots, target group mobility, social facilities available etc.

Obtain topographic template maps of the catchment area for practical mapping exercise, and copies for transferring the data collected and indicated on the practical maps to be kept by the organisation for programme activity planning and for developing funding proposals.

Prepare materials such as the topographic map template, mighty markers, pencils, and adhesive labels of different colours and shapes to symbolize different programme areas as identified during the practical mapping exercise.

Drive slowly throughout an area, familiarizing ourselves with the site and noting major features. During this drive, we also develop a plan to map the site in greater detail, by sub-dividing it into smaller, more manageable units and identifying focal points for further mapping.

Armed with our maps, we then either walk through the site, if it is small enough, or drive to focal points, then walk through the site. During our walk/drive, we map the major features noted above.

We then develop a detailed key for each of the features mapped

We then transfer our rough practical mapping onto a new map, complete with a key and a full list of all sites.

During the practical mapping exercise, we also note the following, which will influence intervention development and relevant activity planning for programme implementation.

Some key questions include:

- What is the latest estimate of the population of the project area?
- How geographically dispersed is the project area?
- What proportion of the project area consists of informal settlements? In general, infrastructure, health and educational facilities are more limited in informal settlements.
- How safe is the entire project area and its sub-areas? If violent crime is common at night, this will reduce night intervention design and delivery.
- How good is public transport, both during the day and at night?
- On the basis of this mapping information, we begin to examine whether it is feasible to initiate interventions in the entire site, or whether we must limit ourselves to sub sites.

Step 2

Brainstorm with the larger group the kinds of things that need to be identified within the mapping and zoning exercise:

Time:

10 minutes

Facilitators Notes:

What do we map?

- Health, education, social and NGO services in an area.
- Security and crime in an area.
- Provisional zones or discrete sub-divisions in an area.
- Potential interventions.
- Approximate resources required for interventions
- Major industrial areas
- Major commercial areas
- Major agricultural centres
- Major uniformed services bases
- Upper-income residential areas
- Lower-income, formal-housing, authorized, residential areas
- Lower-income, informal-housing, unauthorized, residential areas
- Major migrant worker settlements or transit points
- Major highways and public transportation arteries. Sexual risk behaviour is often more common along such routes
- Border posts
- Sex work neighbourhoods and residential areas, stations, Colleges and School
- Social services, youth centres, NGOs and Religious centres

Step 3: Practical Exercise

Split the group into teams of 3 or 4 people and ask them to complete the mapping and zoning exercise from their area. Ideally the group participants should be from the same area

Time:

1 – 2 hours

(Ideally make this part of homework for the group also keep in mind that you will need to build in time to give the participants time to present their maps)

Alternative Exercise:

Questions for the case study: Nyautungwe

Split the group into teams of 3 or 4 people and allocate each component as their task. They should read the case study below and answer all the questions in each category and present their answers to the rest of the group.

1. As the National Project Co-ordinator of the organisation that has been established to implement HIV prevention, explain how you would mobilise for a mapping and zoning exercise. (10mins)
2. Draw up an imaginary map indicating the facilities and places mentioned in the case study. (30mins)
3. How would the mapping and zoning exercise assist your project towards reduction of new HIV infections, STIs and TB?

Case Study

The Border Town Of Nyautungwe

Nyautungwe is a border town whose population is largely made up of a poverty stricken community. A primary school and secondary school, a small shopping mall, a bus terminus, a small low density area, high density residential area and informal settlement make the important features of this town. The border town of Nyautungwe was growing and so were new expansions of informal resettlements taking place next to the high density areas of the town.

The influx of the trucks had increased and the truck drivers queued for longer hours, accumulating to days due to slow immigration processes. A truck stop had formed, consequently commercial sex work became rife. Due to poverty, both women and young girls in and out of school began to frequent the truck stop as commercial sex workers. Truck parking space also became a problem, which resulted in truck drivers finding anywhere to park, especially next to the informal settlements, where some commercial sex-workers had built informal structures for sexual activities.

Community members from high density area were pushing to make a living by trading various commodities to make a living. Traders competed to strike a sale; as a result many women resorted to commercial sex work to make a living, which left them vulnerable to HIV transmission or re-infection. Informal traders sold their commodities from bus stations, border post gates, truck stops, high density and informal settlement areas.

The only clinic within the town had reported a high number of TB and STI cases especially from informal settlement residents. Most clients would be referred to the nearest mission hospital for further treatment. An increase in teenage pregnancy was also reported, which resulted in young girls dropping out of school.

An organisation was established to intervene through peer to peer education for HIV transmission and re-infection, targeting informal traders and youth in and out of school around Nyautungwe. The question was how the organisation was going to implement the programme to reach out the intended beneficiaries and to monitor effectiveness of the activities and make impact.

Where to procure maps?

This may differ from one country to another, however the list below may help as a guide as to where topographic maps can be procured

- ✓ Department of land affairs
- ✓ Surveyors office

- 
- ✓ Local government
 - ✓ Census bureau
 - ✓ Universities, archives or public libraries
 - ✓ Development agencies e .g water and rural and urban development organizations working in the area.
 - ✓ Private corporations working in an area, especially mines, plantations and agro- industrial companies, who may have their own cartographers.
 - ✓ Aerial photograph agencies, such as mineral and agricultural surveyors.
 - ✓ Satellite mapping agencies. These are often more up-to date than hand drawn maps

Key Messages: Mapping and Zoning

- Mapping and Zoning are vital for project planning
- Mapping allows us to assess the size and scope of the project and what can be done effectively – gives us focus
- Mapping and Zoning helps us to identify where the hotspots or target areas should be
- Mapping and Zoning allows us to identify the resources and referrals that can be drawn upon for the project

Module 1.3: CLIENT REFERRAL AND FOLLOW UP SYSTEMS

Setting up an effective and efficient referral system can be a significant step for improving quality of services for people infected and affected by HIV and AIDS. This module explores the types of services that are available and needed for a comprehensive referral network, how to establish and monitor a referral network, and how to make a referral.

Objectives of this module

By the end of this module participants should be able to:

- ✓ Identify the range of HIV and AIDS related services
- ✓ Demonstrate ability to start or strengthen a referral network
- ✓ Demonstrate knowledge of how to make and follow-up clients
- ✓ Have a preliminary referral directory available for use and completion after the training.

Topic 1: What is a referral & Why refer?

Time: 10 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Discuss the importance of referral

Materials and equipment needed

Flip chart and koki pens

Activity 1.3.1: Referral: defined and functions

Time: 10 minutes

Begin with brainstorming with the larger group to answer the following questions:

- What is a referral?
- Why make a referral?

Facilitator Notes

A referral can be described as:

The process by which immediate client **needs** for comprehensive HIV care and supportive services are assessed and clients are helped to **gain access to services**, such as promoting available services, setting up appointments or giving directions to facilities. Referral should also include reasonable **follow-up** efforts to facilitate contact between peer educators and to solicit clients' feedback on satisfaction with services.

Within this broad definition there are some important aspects to emphasize:

1. The referral process seeks to empower the client to make an **informed decision** to seek out these services as such; part of the process is to provide information about the kinds of services that could be helpful for the client.
2. Referrals are **based on the needs** of the clients or individuals with whom we are working
3. Referrals seek to ensure that the **client gains access to these services**

4. The referral is complete when there is **follow-up** or feedback from the client on the nature and satisfaction of the service that has been offered.

Why Refer?

As has been mentioned above there are limits to the support that we can offer. In order to ensure the best quality of support offered to the people with whom we are working it is better to refer them to people who can provide good services rather than try to do everything ourselves. Also some support requires professional or medical care that we may not be qualified to complete.

Topic 2: Types of services that make up a comprehensive referral network

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the types of services that make up a comprehensive response to HIV and AIDS
- ✓ Provide the framework for developing referral directory

Material and equipment needed

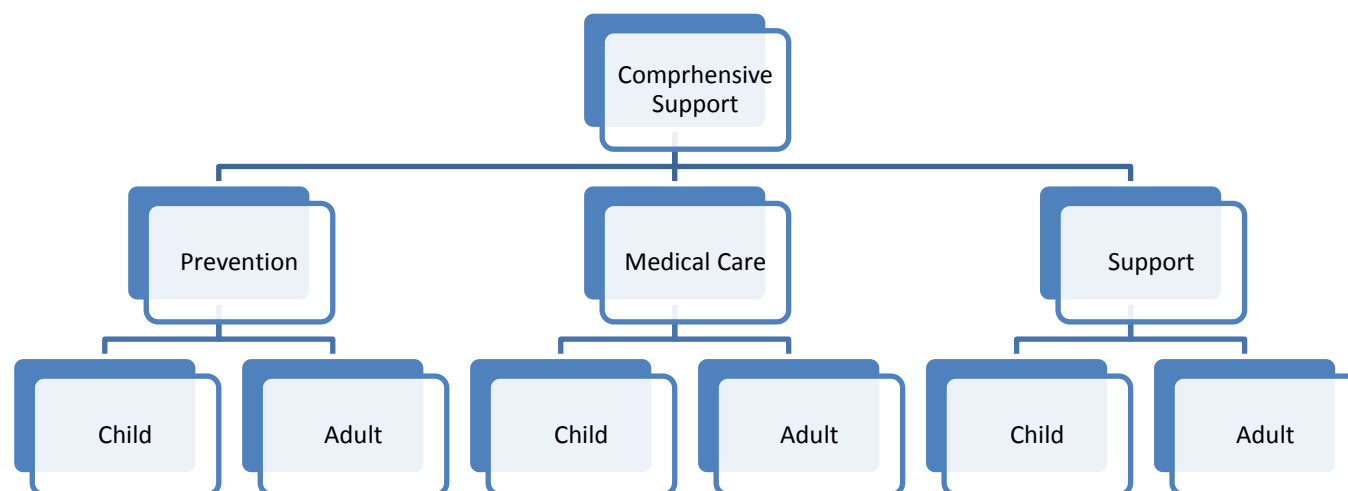
Flip chart and koki pens

Activity 1.3.2: The Range of HIV Services Available

Instructions to the trainer

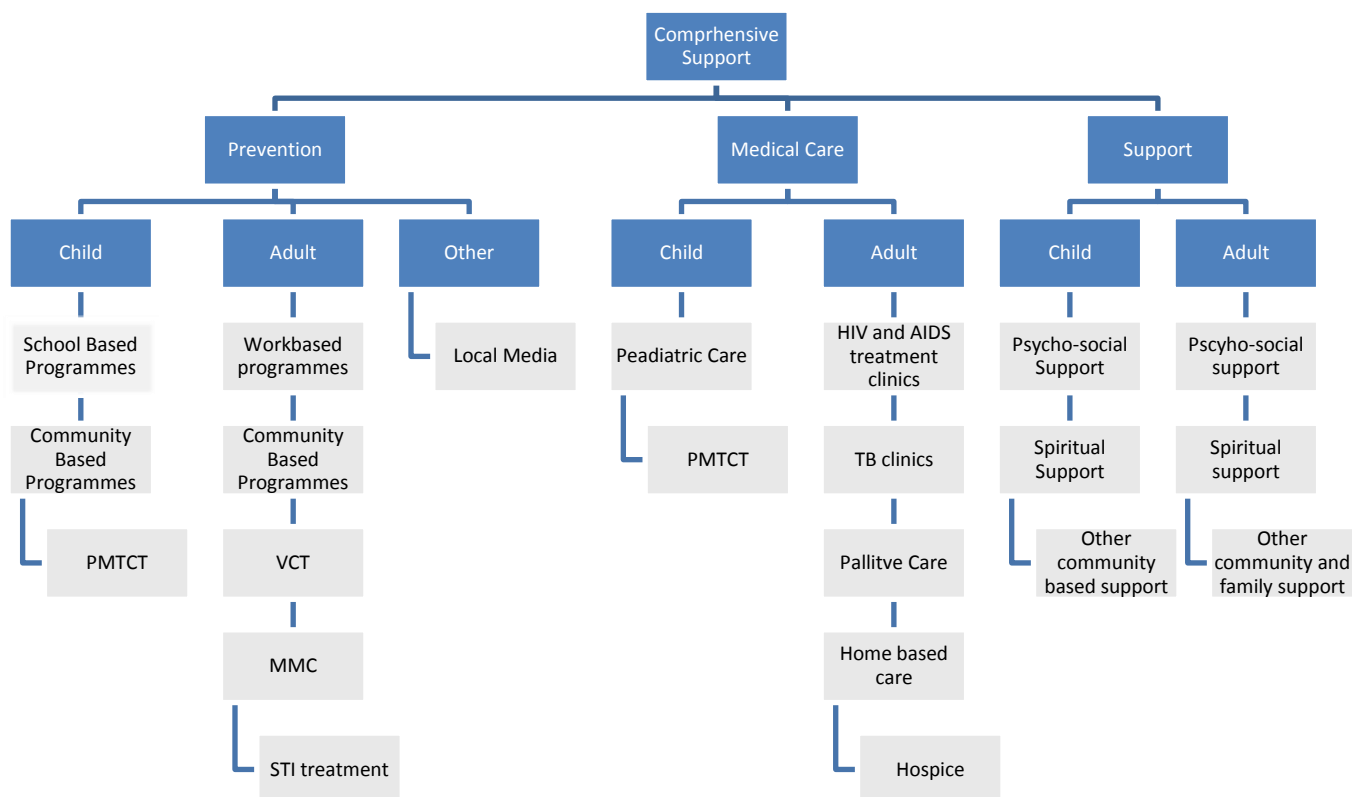
Step 1

Ask participants to think back on the range of services that were discussed when locating peer education. We are going to list the kinds of services that are available and the sites where they are on offer. On a piece of flip chart draw the framework outlined below



Facilitators Notes

An example of a completed diagram could look like this:



Below are some definitions of these services:

PMTCT:

The Prevention of Mother to Child Transmission is a medical service whereby Anti-retrovirals are given to a pregnant HIV positive mother before and during child birth to reduce the chances of passing the virus onto the new born baby. This topic will be discussed more in Part 2: HIV and AIDS Vulnerability Reduction Content.

VCT

Voluntary Counselling and Testing is the only way that a person can know their HIV status. Before administering an HIV test the patient is counselled to ensure that they are able to make an informed decision about taking the test. This topic will be discussed more in Part 2: HIV and AIDS Vulnerability Reduction Content.

MMC

Medical Male Circumcision is a procedure that is seen to reduce a man's risk of contracting HIV from a sexual



partner. The complexities of this procedure will be discussed more in Part 2: HIV and AIDS Vulnerability Reduction Content.

STI Treatment

The treatment of Sexually Transmitted Infections has an advantage for prevention of HIV (reduces entry points for the virus) and for treatment of HIV and AIDS (the treatment of STIs will support the immune system by reducing the strain on the immune system). This topic will be discussed more in Part 2: HIV and AIDS Vulnerability Reduction Content.

Psychosocial support

PLHIV whose symptoms are under control from a medical point of view may still face significant challenges due to HIV-related stigma and discrimination. Often, the challenges to treatment adherence; preventing and treating side-effects; and maintaining good follow-up with medical centres are not related to the patient's medical condition at all. Psychosocial support is critical to ensuring positive outcomes for PLHIV who face these challenges in different ways. Therefore, effective community structures with both group and individualized approaches to psychosocial support need to be linked seamlessly to health centre- and community-based medical care services. This topic will be discussed more in Part 2: HIV and AIDS Vulnerability Reduction Content.

Home-based care, including palliative care

Community- and home-based care deliver services that respond to the continuing care needs of a PLHIV outside the health centre.

Community- and home-based care programmes: function as entry points for HIV testing and counselling, as well as identifying eligible candidates for ART; follow-up patients who are discharged from a health centre or hospital but who still require direct monitoring and need active care; provide continuing care so that families and communities handle some patient care needs; strengthen the chronic-care approach to HIV treatment, care and prevention by supporting structures close to home where decisions are made about adherence, prevention and side-effect management.

In addition, these programmes help to offset the financial and human capacity constraints of any health centres. These centres benefit from the additional resources offered, as well as providing support for quality community- and home-based care programmes. There are several models of how community- and home-based care programmes can be structured and linked with health centres.

Care, support and treatment

Care, support and treatment are based on an active concern for the well-being of others and ourselves. People directly affected by HIV need care. People living with HIV, their families and communities are also involved. They all need support to face the challenges of illness and meet the needs that arise. The aim of comprehensive HIV care, support and treatment is to provide quality services to improve the quality of life of people with HIV, their families and communities. Comprehensive care, support and treatment are important because they enhance efforts to prevent further spread of HIV.

Topic 3: How to Start or Strengthen a Referral Network

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the process through which comprehensive referral networks can be created
- ✓ Identify the process through which they can complete their referral directories.

Materials and equipment needed

Flip chart and koki pens

Activity 1.3.3: Starting or strengthening a Referral Network

Instructions to the trainer

Step 1

Using the information provided below in facilitator's notes, prepare a presentation on the process of creating an effective referral network. Facilitate a discussion of the process using the presentation and engaging participants.

(This is a content heavy session and the facilitator will need to make it as interactive as possible, e.g. through the use of brainstorming with the bigger group or dividing the group up into smaller groups to discuss each step.)

Facilitators Notes

Starting a new referral network or strengthening an existing one is a multi-step process involving many players and stakeholders. The main steps are described below.

Step 1: Arrange an initial stakeholders' workshop

The first step in creating or strengthening a referral network is to identify and bring together the various stakeholders to initiate a community dialogue, seek input on creating a formal referral network and generating "buy-in" for the activity. Stakeholders to invite include PLHIV, support group representatives, district (government) health staff, key staff from health facilities at all levels (from tertiary to community level), social welfare office representatives, local NGOs and CBOs, and faith-based organizations.

Step 2: Conduct a participatory mapping exercise

The point of a mapping exercise is to generate a list of all organizations and facilities providing HIV-related services within the geographic area that might be included in the referral network. The mapping should identify key entry points (that is, how a client gets into the referral network), potential barriers to access and how the network will be linked to existing comprehensive care and support services in health facilities and community-based organizations. The mapping exercise should identify community resources, including the traditional authority structures that can be tapped to strengthen and expand the referral network. PLHIV will be an excellent resource in this activity and should play an active role. As part of the process, a directory of services can be created showing all clinical and social service agencies and NGOs that might assist HIV-positive

clients and their families in the catchment area.

Step 3: Put systems in place to develop and support the referral network

Identify and train an organization to serve as the coordinating organization. This can be either a health facility or a CBO. Identify and train key contacts within each organization in the network. Determine the roles and responsibilities of each organization within the referral system, including potentially developing a Memorandum of Understanding between organizations. Hold sensitization meetings with stakeholders and staff of participating organizations to achieve consensus on operating principles, such as ensuring that all referrals are honored. Supervisors in the network's organizations should ensure that staff understands the referral network and how it works and support staff at all levels (clinic- or community-based) in providing referrals as necessary. Establish agreed-upon guidelines to address the issue of confidentiality within the referral network. There should be a discussion about confidentiality, stigma and the potential for "shared confidentiality" and what that means to the community.

Outline an appropriate mechanism for referral, including referral forms and registers to document the process for the referrals and follow-up. Create and distribute standardized forms, tools and procedures and train all organizations in the network to use them. Encourage and help providers at all levels to nurture personal contacts within the network to facilitate referrals and follow-up. Monitor the network's activities and use findings to improve the system.

Step 4: Mobilize the community to use and support the referral network

Collaborate with PLHIV, their families and their caregivers to develop a referral network that will respond to their needs and engage them in its implementation. Undertake intensive community mobilization and promotional and public awareness activities to build demand for services. Seek the support of church and education leaders, medical providers and policymakers to use their influence to increase community support for the referral network.

Persons living with and affected by HIV have a wide range of needs spanning multiple dimensions of life: physical health, psychosocial well-being, human rights, food resources, economic security and spirituality. These needs vary depending on many factors, including the age and gender of the person. Also, over time and with disease progression, the needs of PLHIV, their caregivers and their families change.

Rarely can a single facility, agency or community group deliver all of the services to meet these needs. A well-established referral network is vital to meeting the needs of PLHIV and maintaining or re-establishing contact with clients and families who need on-going care and support. As different organizations provide prevention, care, treatment and support services, a system is required to link these agencies so they can provide HIV-infected and affected persons with access to needed services across the continuum of care.

The referral system entails a process of coordinating service delivery to ensure the.

- ✓ Confidentiality is maintained
- ✓ Referrals between the organizations in the network can be tracked.
- ✓ Access to needed services is expedited.
- ✓ Referrals and their outcomes are documented.

A feedback loop informs the organization initiating the referring organization that the requested service has been delivered and has met the needs of the client.

Gaps in services can be identified and steps taken by organizations in the network to bridge them.

Topic 4: How to make a referral

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify elements of making an effective referral system
- ✓ Discuss referral process in relation to the facilitation approach used when working with individuals, i.e. respecting informed consent

Materials and equipment needed

Flip chart and koki pens

Activity 1.3.4: Making a referral

Trainer Instructions

Step 1

Ask people to share their experience of referrals, it can be about them or somebody they know. Ask them to share about:

- ✓ How did they feel about being referred?
- ✓ Did they have any document to take with them to the referral point
- ✓ Did they get to the point where they were referred?
- ✓ How was the service at the other point where they were referred?

Step 2

Ask the group what steps or considerations need to be taken into account when making a referral. Facilitate a discussion of these points and use the information below to make sure that all the important points are covered.

How to Make a Successful Referral

- ✓ Work with clients to decide what their immediate referral needs are. Focus on a client- centred approach, as clients take on their role as the primary manager of their own chronic disease. This is an empowerment approach that aligns with the informed consent discussions above
- ✓ Outline the health and social service options available and help the client choose the most suitable in terms of distance, cost, culture, language, gender, sexual orientation and age. In some environments there will be limited resources and this will require a bit of problem solving accessing these resources.
- ✓ In consultation with the client, assess which factors may make it difficult for the client to complete the referral (e.g., lack of transportation or child care, work schedule, cost, stigma) and try to address them.
- ✓ Discuss confidentiality with clients and support them as they decide with whom they want to share their HIV status.
- ✓ Make a note of the referral in the client's file – if applicable
- ✓ Ensure follow-up and monitor the referral process.
- ✓ Document the referral in the organization's referral register.
- ✓ Give the client a list of other available services with addresses, telephone numbers and hours of operation.
- ✓ Ask the client to give feedback on the quality of services to which he or she is referred

Alternative exercise

Activity 1.3.5: Case Study: Referring to St Mary's Hospital

Trainer Instructions

Step 1

Ask participants to work with the person next to them, so that they work in pairs. Give each pair the case study below and ask them to read through the case study and answer the question below. Once participants have all had gone through the questions on the case study, facilitate a discussion in plenary, going through the different components of a referral. Link back to the 'build a character' in module 1 – the different services needed by their characters, who provides these in the community and how to make sure that there are linkages between different service providers.

Case Study

Client Referral Process at St Mary's Hospital

St. Mary's Hospital in Mumias, Kenya, provides HIV prevention, care, treatment and support services through its Comprehensive Care Center (CCC), which includes VCT, PMTCT, home-based care and clinical care (including managing opportunistic infections and other HIV-related conditions, prophylaxis for opportunistic infections, TB management and antiretroviral therapy). Facility-based services also include nutritional support and PLHIV group support. The CCC refers clients for other HIV-related services to organizations throughout the Butere Mumias District.

Two facility-based clinicians, a community nurse and a public health technician who are part of the CCC team, manage the referral system in addition to coordinating the hospital's HBC program. They also serve as the focal point for linkages between the health facility-based services and District residents, with community health workers (CHWs) from the HBC project functioning as intermediaries. The referral coordinators have created a Referral Network Guide Sheet (a type of directory of services) that details available services and contact persons. A referral form has also been developed that:

- ✓ Directs patients to the needed service
- ✓ Provides basic information for the service provider on the patient and reason for the referral.
- ✓ Documents the referral.

The form is retained by the referral coordinators at the hospital as documentation of the referral. While several features of this referral system contribute to its operational effectiveness, the following are particularly important: This district-wide system forges a close collaboration between health facilities and community members through a clearly defined referral process. The referral coordinators are members of the HIV care team at the hospital. They work collaboratively with other team members who recognize their work as an essential component of comprehensive patient care. The referral coordinators interact frequently with patients, CHWs, hospital staff and staff of other services in the community.



Key Messages: Referrals and Follow-ups

- There are limits to the role that that peer educator and trainer can provide. At times the best quality services can be provided by others therefore we can refer
- There are different types of services that are on offer for reducing HIV and AIDS vulnerability, these include:
 - Prevention services
 - Care and treatment services
 - Support services
- Mapping and Zoning helps us to identify these resources and develop a resource directory
- A resource directory is a vital tool for all peer educators and trainers
- Making a referral involves:
 - Clarifying the needs of the client based on their informed decisions
 - Identifying the best organization or person to provide these services
 - Identifying the barriers to obtaining this support and seeking some solutions to these
 - Developing a system for feedback
 - Setting a time frame for contact with the service provider to be completed
 - Obtaining follow up or feedback on the service that was offered.



Module 1.4: WORKING WITH INDIVIDUALS

Objectives of this module

By the end of this module participants should be able to:

- ✓ Identify elements of working effectively with individuals
- ✓ Clarify the qualities of a peer educator
- ✓ Demonstrate ability to implement active listening skills
- ✓ Confidently draw on referral lists to ensure beneficiaries get the best support possible.

Earlier we defined peer education as:

*Peer education is a strategy that works with **individuals** and groups in order to open or spark discussions around selected topics through respectful facilitation, providing information and resources/referrals to allow targeted individuals to make informed decisions.*

Within this section we will focus on facilitation or working with individuals and helping them to make informed decisions. Clearly what will be provided within this training manual will be an overview and peer educators are encouraged to gather and read more resources on this topic.

Topic 1: The Secret

Time: 20 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the kind of environment and responses that make individuals open up and share their experiences and issues with another person

Materials and equipment needed

Flip chart and koki pens

Small pieces of paper

Activity 1.4.1: What does it take to share your deepest darkest secret?

Trainer Instructions

Step 1

Ask individuals to take a moment to think about their deepest darkest secret, one that they have never shared with another person. Provide participants with a piece of paper and ask them to write down a list of qualities within another person that would allow them to share this secret with this person. They should also consider the way in which they you would like the other person to respond (10 minutes).

Ask the group to collect a list of what these qualities would be and note then on a flip chart page.

Facilitators Notes

Some of these qualities can include:

- Trustworthy
- Can keep a confidence/secret
- Be a good listener
- Is respectful
- Be open
- Be non-judgemental

How do these relate to the peer educator qualities mentioned earlier?

Topic 2: **Process of facilitation with an individual:**

Time: 120 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Discuss a simple model of respectful problem solving with the individuals with whom we are working.
- ✓ Empower beneficiaries by highlighting one method to sort through problems

Materials and equipment needed

Flip chart and koki pens

Activity 1.4.2: Facilitation with Individuals

Trainer Instructions:

Step 1

On a flip chart write down a list of the phases of problem solving presented below:

- a. Listening to the issue and collecting information
- b. Brainstorming solutions
- c. Assisting the individual in selecting the best solution for them (making the informed decision)
- d. Follow-up

Discuss each of these using the information provided below.

Phase 1: Listening

Within this phase the main objective is to gather as much information about the situation that presents itself as possible. The idea here is to open up the discussion and keep the person talking while you gather vital clues. In order to achieve this; the use of active listening is important.



Active Listening:

Active Listening is a skill that anyone can learn and is the cornerstone for any workshop and individual discussion.

What is active listening?

In this section we are going to consider what makes up active listening.

Role Play: Active Listening

Divide the group into threes. Within each subgroup select a person who will tell a story (narrator) and a listener. The third member of these sub-groups is the observer; who will feedback on this session. Ask the narrator to tell a story of an embarrassing moment – one that is not too traumatic but is more humorous. Then ask the listener to actively not-listen to the story being told. Give them 3 minutes for the exchange, (make sure that the observer does not hear this instruction given to the listener).

Thereafter switch roles and now ask the listener to tell a story (again of a funny embarrassing moment) and ask the initial narrator to actively listen to the story being told, (make sure that the observer does not hear this instruction given to the listener). Again restrict this story telling to 3 minutes.

Bring the group back together and consider the following questions:

1. Get general feedback from the group on the experience, i.e. what happened?
2. Ask the observers how they knew that the listeners were not listening?
Consider:
 - a. The cues/signs of their attention
 - b. Their body language
 - c. What they said
3. Ask the observers how they knew that the narrators were listening?
Consider:
 - a. The cues/signs of their attention
 - b. Their body language
 - c. What they said
4. Get some feedback from the participants on how it felt to be heard or not heard.

Summarize and close:

From these discussions define active listening and the manner in which we show that we are paying attention and it helps to open up the discussion.

Facilitators Notes

Components of Active Listening

For our purposes we will divide the section into non-verbal and verbal parts.

Drawing on the previous exercise highlight these parts by clustering the answers into non-verbal and verbal parts. Below is an example of how this clustering may work:

Non-verbal:

Body language:

- F – facing the other person
- L – leaning slightly forward
- O – having Open posture
- R – being Relaxed
- E – maintain eye contact when this is respectful

Other Non-verbal actions:

- Nodding of head
- Using verbal noises like yes, um, mmph

Typically non-verbal cues, especially body language is culturally specific and these guidelines need to be taken into consideration.

Verbal:

- Asking relevant questions (probing)
- Summarising what has been said

What is important to realise is that these active listening skills open the conversation! It keeps it going. Do not rush to the solution seeking (brainstorming phase rather take time here to unpack the story, this can be achieved by probing and summarising)

It is worthwhile spending some time on the definitions and nature of the verbal cues, which are probing and summarising.

Probing:

Questions are a great way to not only show that one is listening but also to find out more information about a scenario – recall that we are looking for personal resources and strategies that people use to solve or deal with issues.

Probing: Group work

Ask the group what questions people can ask about a story. Possible answers include:

- Who – who was involved?
- What – what happened?
- Where – where did this happen?
- When – when did this happen?
- What happened there after?
- How did this make you feel?

Summaries:

Summaries are an important tool for active listening. Summarising a story shows that you have been listening. This is not an exact retelling of a story but rather a brief description of the main events and results.

Summary: Group work

Step 1:

At this point ask the observers from phase 1 activity to summarise one of the stories that they heard.

Step 2:

Ask the other participants if this was a good summary and was there any important information that was left out.

Remember:

From the facilitation perspective, summaries are also important to the facilitation process as it provides the opportunity to highlight what the objectives of a session was, the road that was taken to get there and importantly what the key messages for the session was. Every session **MUST** end with a summary.

The summaries provide you with a framework from which to identify what the main points are.

Step 3:

Phase 2: Brainstorming

Brainstorming is a skill that assists with the solution to an issue.

Once you have summarised what the main issue is, it could be time to try to find a solution. Be wary however as at times people are not really seeking a solution but are rather talking to someone for the first time about an issue that is bothering them. At times this service is enough, however if you feel that you offer assistance or suggest some solutions then this is the way to do it. Remember that the person we are seeking to help needs to make an informed decision and take action.

Brainstorming is a method whereby a problem is presented and solutions are sought. These solutions can be wild, bazaar or impractical. Within the first phase we do not censor or evaluate the possible solutions but rather are gathering as many ideas as we can.

During this phase there is the **opportunity of the peer educator providing information** (based on their key messages) to the client that presents some possible solutions that the individual could explore. This is a time to highlight the benefits of a certain course of action as well as some of the limitation. **IT IS NOT A TIME TO TEACH OR PREACH!!!**



Activity 1.4.3: Group work: Brainstorming

Step a:

In order to show the process of brainstorming ask the group:

How do we create world peace?

Ask them to think creatively and give you an answer.

Perhaps go around and allow each person to provide one answer.

Remember at this stage we are not assessing the worth of the suggestion, so just write it down.

Step b:

In the second stage go through all the suggestions and consider the pros and cons of each

Step c:

At the third stage eliminate those that are not attainable or are outrageous.

Step d:

At the fourth stage, have a look at the solutions that are left and note:

1. There should be more than one
2. These solutions may consider different levels towards one goal
3. The solutions may take time to implement

Step 4:

Activity 1.4.4: Phase 3: Selecting the solution/s

Once a person has brainstormed a range of possible solutions it is time to assess them and select one or some that are actionable. Within the assessment; facilitators need to highlight the pros and cons of each solution. In this way we can see which one yields the highest benefits.

A quick word on solutions:

Solutions are never absolutely ideal or ever completely finished.

There are pros and cons to any decision or course of action.

We assume people would select the ones that offer the most benefit, however this is not always the case at times they will select solutions that maintain the status quo and this may be frustrating for the facilitator but you need to remember that change is a process and there are many steps that people take before they change and we can merely assist them to realise that there are other options and that they are not as stuck as they may think. Be patient

Sometimes there are a few steps or solution that can be taken for each problem or issue.

At this stage drawing on the key messages and referral lists is important

Also, don't forget:

"I am because WE are and, since we are, therefore I am." John S. Mbiti

Another important aspect to realize in assisting people is that they are connected and interconnected with others. Getting a person to draw on their social networks is important. Helping them to identify someone within their family, friends, community (e.g. a pastor or school teacher) or business with whom they can talk is important

Step 5:

Phase 4: Follow-up

Before you say good bye to the person ask if you can follow up with them in an acceptable time period.

Activity 1.4.5: Step 6: Role Plays

Divide the group into threes, one beneficiary who wants to talk, one facilitator to listen and one observer. Allow individuals in the groups to select these roles and one of the case studies below. Group members will take turns to play the different roles and give each other feedback. The facilitators should go around the room and spend time with each group to observe and guide them. In giving feedback the observer should use the sandwich approach – start to tell facilitators what she or he did well, what needs to improve and finish with one other thing the facilitator did well.

Case Studies

1. After workshop, the facilitator is approached by a quiet young woman (17). She tells the facilitator that her boyfriend is cheating on her. She is visibly upset.
2. Before workshop a young man (19) tells the facilitator that he is scared that he is HIV positive.
3. During a session on facilitation skills workshop Y tells you that they want condoms



Key Messages: Working with Individuals

- In order to respect individual's human rights of autonomy; a facilitator helps to move the individual towards making an informed decision.
- To do this the facilitator does not tell a person what to do but rather provides information on the possible options that lie ahead.
- A critical aspect of facilitation with individuals is active listening
- Active listening opens the conversation up and includes verbal and non-verbal cues
- In developing summaries of stories and helping to identify the way forward, make use of the key messages
- The process to follow includes listening, brainstorming, selecting a solution and follow up
- Do not rush out of the listening phase to find a solution, rather unpack the story more.
- No solution is complete and final. Solutions and change is a process – help the individual take the first important step.
- Always draw on the person's social networks with whom they can share this burden and gain support
- Provide information of the benefits and limitations rather than preaching about what to do
- Remind the individual about other services available in the community that they might need to be referred to, if needed.

Module 1.5: WORKING WITH GROUPS

***Peer education** is a strategy that works with individuals and **groups** in order to open or spark discussions around selected topics through respectful facilitation, providing information and resources/referrals to allow targeted individuals to make informed decisions.*

Objective of this module

Facilitation with groups builds on the skills that are used for individuals and adds to these skills. Again the process is about enabling people to make informed choices. Information and issues are however discussed within the group which usually provides a greater opportunity for people to learn from one another.

We will explore the issue of working with groups through focusing on three topics, that is, facilitation with groups, the workshop structure and some participatory teaching methods.

Objectives of the module

- ✓ Understand how to facilitate a group
- ✓ Note the differences between individual and group facilitation
- ✓ Feel comfortable with drawing on the groups experiences as a key resource for learning
- ✓ Describe the different types of participatory health teaching methods.
- ✓ Demonstrate the ability to prepare for an outreach activity

It should be noted that the use of ice breakers and energisers is beyond the scope of this manual, in order to gain some ideas on these types of exercises visit:

<http://www.residentassistant.com/games/icebreakers.htm>

Topic 1: Common Participatory Health Education Methods used in groups

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- Describe the different participatory health teaching methods
- Describe key principles of facilitating a group discussion
- Describe the differences between individual and group facilitation
- Demonstrate ability to use common participatory health education methods

Materials and equipment needed

Flip chart and koki pens

Step 1:

Introduce the topic of facilitating with a group using a presentation; explain to the participants that this session will be looking at facilitation within a group, the structure of a workshop and participatory methods used within a group.



HOWEVER, we are going to start with the participatory methods first. The reason is that the other two topics will be presented by smaller groups to the main group. In order to tap into the participant's creativity and energy we are going to discuss some methods that can be used in delivering and sharing this information.

Activity 1.5.1: Participatory Methods: An Introduction

Trainer Instructions

Step 1

To introduce participatory methods our first step is to get the group thinking about why and when we use these methods. In order to do this, ask the group: How do you prepare for an outreach activity?

[jot the answers down on the flip chart paper]

You will need to lead the discussion and consider issues related to participatory methods including:

- ✓ Know your target group/audience and select an appropriate topic for the target group. Consider the groups' age, gender, cultural context and latest trends and fashions. Recall that you are a peer educator as such should have some ideas to these questions.
- ✓ Collect up to date information on the subject, select and prepare visual aids where possible.
- ✓ List down the important points you want to say or communicate to the target audience.
- ✓ Know your venue and time (book the meeting).
- ✓ Choose an appropriate participatory method for that target audience.

Some Common Teaching Methods include:

- A. Group Work and small group work
- B. Incomplete Role Plays
- C. Participatory Games
- D. Picture Code and Videos
- E. Songs
- F. Drama

Step 2

In a presentation in the larger group discuss:

- Each of the type of teaching methods
- Ask the group for personal examples where they have participated in these kinds of activities.
- Find out how they felt about these types of teaching methods

Facilitators Notes:

A. Group work and small group work

These are some of the main methods that are used with groups. The facilitator can lead discussions with the larger group or break the large groups into smaller groups.

Large group discussions – This method can be used when there is a large amount of content to move through. The advantage is that through good facilitation and good participation the group members can learn from each other and the facilitator can monitor the time closely. Some disadvantages include the need for good facilitation of the whole group or one or two people can dominate the discussions. This method is not recommended after

lunch when the group's energies naturally wane.

Small group discussions – This method can be used as another way to explore a range of topics. Each group can be assigned a topic or question to explore in a given time period. Each group will require a scribe and someone to feedback the answers of the group. This method is advantageous as participation of members of the small groups is higher than within the large group. Some disadvantages include the amount of time needed for feedback to the bigger group. It is a good idea to restrict the time for feedback per group and if the groups have the same questions then ask them merely to add new points to what has already been presented otherwise it can become repetitive and boring. Another disadvantage is that if the smaller group discussions are not monitored then they can become side tracked and the discussions can focus on issues not directly related to their questions.

B. Role-play

A role-play is an activity which participants act out roles around a problem in order to help them gain insight into people's behaviours, thoughts, feelings and attitudes. Role plays are the cornerstone of the participatory package, because they can be performed with a small number of participants, they are robust, easily transportable, do not require special equipment, are easily audible and visible to large groups and are often enjoyable for peer educators to develop, rehearse and perform. They help peer educators to develop confidence and communication skills

Sometimes a one minute, incomplete role play is used. This raises an important social issue, and leaves it unresolved, hanging, frozen at a dramatic, emotionally engaging moment. The cast then turn to the audience and ask them to discuss the issue. A vigorous discussion then usually ensues.

How to conduct a role- play:

A role play does not take much time to rehearse.

Be sure that everyone can see and hear well enough to follow the role play.

Watch carefully to see if the actors are raising issues which are appropriate to the main problem.

Take notes during the role-play then refer to your notes during the discussion, which will follow after.

Stop the role-play in suspense at an abruptly crucial point (freeze).

Questions to ask after a role-play

- Ask participants (actors) what they discovered by doing the activity.
- Ask participants how this is related to what they already know and how this information can help them in their daily lives.

Additional Questions

- What have you seen or heard?
- Does this happen?
- If it does what may be the cause?
- What are the problems faced?
- How can we solve these problems?

C. Participatory Games

Participatory games are an excellent way of ensuring audience attention and participation. If the

audience are fully involved and answer questions throughout each game, the game can also be an effective learning tool. Simple prizes or IEC materials may accompany games.

When these games have been well developed they can engage people and mirror what happens in reality. A good example of such a game is the Start Your Business Game that has been developed by the ILO. The disadvantages include being costly to develop, and they require a lot of time to run effectively.

D. Picture codes

Picture codes are materials that are used to stimulate a discussion about specific issues like behaviour which puts people at risk of HIV infection. The picture code has a photograph on one side showing people in different situations and on the other side has questions for the outreach worker to ask to stimulate a discussion. They usually tell a story of people in different situations that make different behaviour choices.

A picture code focuses attention on one issue or theme, and it has clear illustrations that combine to make a picture, which conveys a snap shot of a story. They are different to posters because they pose a problem not a solution. Picture codes do not have any wording and the picture should depict only one idea and should be simple.

They are used in group situations to:

- Generate discussion
- Stimulate interest
- Help people to analyse and solve their problem

Questions that can help guide the discussions:

- What do you see happening here?
- Does this happen?
- What are the various things that lead to this?
- What is the STI/HIV connection here?
- What problems are caused?
- What problems can follow?
- What would you suggest, how can we resolve this or what are the solutions?

Here are some examples that a picture code might depict:

- ✓ A middle-aged man sitting in his car, strokes the thigh of a schoolgirl in uniform. They are parked outside a short time place.
- ✓ A school-aged girl, in the early stages of pregnancy, walks past her old school. A group of students in uniform, about her age, are looking at her.
- ✓ A schoolboy is dropped off around the corner from an orphanage by a big man. The schoolboy's brand-name boots are obviously new.
- ✓ A schoolgirl in uniform is sitting in the office of a doctor known for performing abortions.
- ✓ A man is showing a condom to three youths.
- ✓ Four young men leave a party late, but stop to pick up a young woman waiting for a taxi on the road.
- ✓ A minibus pulls up. The driver invites the girl standing by the road to come sit in front. She is, as the song says, "a girl with a front-seat face."
- ✓ A mother discovers a sportswear outfit in her daughter's school bag.
- ✓ A woman is cleaning up and getting ready to do the wash. She finds a condom in her partner's pocket.



✓ A man in a police uniform is shouting at and threatening a woman. She is covering her face and crying.

E. Songs as a method of teaching

Songs and dance are used as crowd pullers. They are also used as entertainment in between other teaching methods. The message in the song should be accurate so that your audience can learn and remember it afterwards. The song should be short and appealing so that the audience does not get bored. Take caution not to use tunes that can easily be identified with certain beliefs or religious group as you might offend some people. Dance should be appropriate to the target audience or group. As much as possible, try to involve your audience.

F. Drama

A drama is a teaching method that allows participants, to act roles on problems that they face in everyday life, generating possible solutions. It is action oriented, and based on real life situations within a given community. It exposes reality and responds to current problems or issues on what people think about an issue e.g. sexual behaviour, STIs, HIV.

Step 3

It's now time for the new trainers to do some work. Divide the group into 4 smaller groups and give them each an activity sheet that they must present, in a creative and interactive manner.

Activity Sheet 1: Workshop Structure

Preparing for the Workshop

Facilitators will need to review the pre-training assignments (or information summaries prepared by the organizers). Particular attention should be paid to the needs and expectations expressed by participants and their level of knowledge and skills in training development, design, and facilitation. Facilitators will also need to become very familiar with the overall flow and content of the workshop; therefore, a thorough review of all activities and materials prior to the workshop is strongly recommended. The facilitator should also pay attention to the preparations that are needed for each day including the training tools that need to be prepared beforehand.

Suggested Seating of Participants

As the training is designed to be interactive, participants are to sit in such a way that they can work comfortably within their groups and simultaneously and see the facilitator(s) clearly. Usually this happens in a horse shoe formation

Preparing a Schedule for Your Workshop

The workshop as described in this manual is designed to take place over five days. A typical day begins at 8:30 or 9:00 a.m. and ends between 5:30 and 6:00 p.m. Suggested time frames for the modules and activities have been provided as well as a suggested daily breakdown of activities. It is important to remember that the time frames given are only guidelines; the number of activities and the time allotted can be adapted as appropriate to the needs of your participant group.

The schedule provided includes only the activities contained in the manual. You will also need to build time into the schedule for the following:

- o Recaps (30 min at the beginning of each day)
- o Morning and afternoon breaks (20 to 30 min each)
- o Lunch (45 minutes to 1 hour)
- o Debriefs (15 min at the end of each day)

Conducting the Workshop

The opening page of each module lists all the module activities and their times. A short description of the overall aim and content of the module is also provided. This should be reviewed with participants before beginning each new module. Clear procedural instructions are provided for each of the activities to help you structure your work with the participants.

Remember: Be flexible! If you believe it is necessary to make changes to activities in order to accommodate your particular training context or participant group, then feel free to do so. Engaging participants in the training process is an effective way to further build their skills during the workshop. You are encouraged therefore to provide opportunities for participants to take part in different aspects of the workshop delivery. Some of these include:

- Carrying out energizers and recaps
- Facilitating some of the activities and discussions during the workshop
- Preparing flipcharts and assisting in other aspects of the training
- Participating in the daily briefing/debriefing of facilitators
- Organizing evening events

Workshop Opening and Introductions:

- Begin the workshop by greeting participants.
- Introduce yourself and any other workshop staff working with you.
- If the workshop is being hosted by an organization, someone from that organization should make a few remarks to open the workshop and welcome participants.
- Facilitate an introductory session so that all participants are aware of who is in the room—names, organizations, work sites, and general information about each other's work. This can be accomplished with the two ice breakers outlined below. It should be noted that there are many ice breakers that trainers and peer educators can draw on.

Introduce your partner:

Ask the participants to pair up, you can ask each person to turn to the person sitting on the left with the person sitting next to them. Each person should briefly interview the other person, for 2- 3 minutes. You may give them some pointers as to what they should find out about the other person e.g. their name, where they come from, their likes and dislikes, what annoys them most, hobbies, pets etc. Once the first person has introduced themselves, the second person should get a chance to introduce themselves. Afterwards, everybody should get a chance to introduce their partner to the big group in a minute.

After everybody has had a chance to introduce their partner, highlight the skills that were used during this exercise such as questioning, listening and interpreting information and speaking in a large group of strangers. These skills will be in focus at least once during the training, so this is a relevant and helpful way to start any training session.

Group Bingo:

Ask participants to raise their hands if they (items selected here should speak to the target audience):

- Have their real hair
- Have more than 3 children/Have more than 3 siblings
- Have travelled more than 1000 kms to be at this training
- Have grandchildren/Have great grand parents
- Hates chocolate
- Has travelled to another country
- Is afraid of the dark
- Liked horror movies
- Has met the president
- Knows how to sing
- Loves soccer
- Have attended a gender training workshop before?
- Have attended a GBV training workshop before?
- Have attended a HIV and AIDS training before?
- Know someone personally who experienced domestic violence?
- Know somebody who is an entrepreneur in the area that they work in?
- Are a trainer?
- Have facilitated training on gender or GBV before?

Ask two people to indicate if they still remember who they shared similar experiences with. Indicate to participants that as a group, there will be differences and similarities, what is important is not to focus on our differences but focus on the common things that have brought us together.

Note to Trainers

For short workshops (a day or two) time will be limited, so introductions should be short (15 minutes). Participants will learn more about each other as the workshop continues.

For workshops three days or longer, introductions should take more time and involve more interactions between participants (45–60 minutes).

Expectations:

Step 1

- Ask participants to take 2 minutes to write down two expectations, two contributions and two worries / concerns they have about the workshop on the provided worksheet.
- Ask participants to discuss these expectations with their neighbours for 2 minutes.

Step 2

- Reconvene the group and ask participants to share their expectations.
- Write these on the flipchart paper prepared.

Step 3

- Explain which of the expectations will be met and which ones cannot be met by this training.
- For those expectations that will not be met, explain why and how interested participants can gain access to such knowledge.
- If there are other expectations of the workshop that were not mentioned by participants, explain these.

Step 4

- Introduce the poster “parking lot” and indicate to the participants that this will be a poster where they are allowed to write any points for discussion which are not part of the planned activities
- Indicate that the parking lot will be addressed at the end of the training

Objectives:

Step 1

- Immediately following the expectations session, hand out copies of the workshop objectives.
- Go through each objective, taking time to be sure participants understand the workshop purposes, objectives, and intended outcomes.
- Facilitate a discussion to clarify any questions or concerns.

Step 2

- Distribute the workshop agenda.
- Review the daily schedule with the participants, making sure to note any overall themes for given days, etc.
- Explain how the workshop sessions will build upon each other to achieve the workshop objectives.

Ground Rules

Facilitation and small group work are powerful vehicles of learning for participants. However managing groups can sometimes be a challenge. For groups to function effectively there needs to be trust and confidentiality in place (hence the need for creating “Ground Rules for Sharing” at the beginning of the training as advised in this manual). Group members need to respectfully listen to each other and allow people to have their say one at a time without being interrupted. When participants decide on their Rules for Sharing it creates shared ownership and responsibility in terms of how participants (and facilitator) act during the training. Sometimes people are not comfortable sharing in a large group but are happy to share in a small group and so this is a platform where much rich learning can take place for participants. None of us knows as much as all of us.

It is important to set a ground rule on how participation will be managed. Do you prefer for participants to raise their hands and be called on or for people to speak freely? Remember that some people -- especially those who tend to be introverted -- need more time to process thoughts and speak, so the latter option may exclude them from the discussion. Still, the formal process of raising hands to be recognized may detract from the collective atmosphere needed to discuss sometimes-controversial issues.

Strategies

- a. It is helpful to post the ground rules somewhere visible during the entire workshop.
- b. As a facilitator who may be with a group over an extended period of time, you can bring the list of ground rules (on news print or some other transportable medium) back to the group for every session or class period. They then can refer back to the list when they sense that participants are failing to follow one or more of the items.
- c. Challenge the participants on the ground rules early and often. If you do not set a tone of adherence to the items early in the process, it may become difficult to enforce them later.
- d. If you are using more than two or three ground rules, try focusing on particular items during appropriate activities or discussions. For example, if you are facilitating a discussion in a large group, state before the discussion starts that you would like to focus on active listening. Challenge participants to refrain from any side discussions. The same can be done if you are facilitating an experiential activity, by introducing it as a "silent" activity.
- e. You should model these ground rules in your own participation. This is especially true for an item such as Rule 2 (speak from your own experience). Be sure that your own language reflects ownership and responsibility by using as many "I" and "me" statements as possible.
- f. If a particular ground rule is routinely broken, bounce it back to the participants. A fruitful discussion can often arise from a close examination of why the participants are not adhering to particular items.

Steps:

Step 1

- Explain that in order for the training to go well; participants will have to follow certain rules.
- Ask participants to think about rules they would like to propose for the training

Step 2

- Ask participants to list the rules which might include the following
 - Turn off cell phones
 - Respect time—start on time, end on time
 - Be respectful of other participants and the facilitators
 - What is said in the group stays in the group – keep confidentiality about people who are sharing
 - Talk loud enough for all to hear
 - Talk one at a time
 - Participate!

- Write each ground rule on a flipchart and explain each as you write it
- Ask participants if there are any other rules they would like to suggest. Discuss and agree. Write these on the flip chart.
- Ask participants if they agree to abide by these ground rules
- Post the ground rule list on the wall in the training room.

Review the programme

Step 1

- Review the daily schedule—time for breaks and lunches.
- Inform participants of locations of toilets, break area, etc.
- **If relevant:** Review the workshop policies on seeking reimbursement for travel, how food and beverages will be handled (i.e., does the workshop provide these and pay for them directly, or does the participants pay for them and get reimbursed, etc.), and how accommodation will be paid.
- Set deadlines for receipt submission and announce when reimbursements will be distributed.
- Explain who from the workshop staff will be handling logistics and direct participants to contact her/him directly outside of the sessions.
- Explain that any housekeeping reminders will be posted on a paper in the back of the room.
(Post a flip chart paper at the back of the room, near the entrance.)
- Answer any questions.

Notes to Trainers

- For multi-day residential workshops, it is strongly recommended that there be someone other than the trainers serving as a logistics and support person. Participants will have many logistical needs and questions throughout the workshop, and trainers should be focusing on workshop content, not logistical details. If funding constraints do not allow for this extra staff person, then trainers should involve participants in helping with logistics. One idea is to ask for 2 volunteers each day to serve as a “host team,” to answer questions from participants and communicate any questions or problems they cannot answer to the trainers during a suitable break.

Facilitators’ Debriefing

At the end of each day, you should plan a debriefing session with facilitators and a selected group of participants. During the debrief, the facilitators, and participants invited for that day will discuss the issues, concerns or problems related to workshop content and process that were brought up during the end-of-day debriefing. As a group, decide on corrective actions to be taken or adjustments to be made. Once the debriefing is over, the facilitators will review the next day’s recap with the team of participants responsible for the recap.

A proposed agenda for the facilitators’ debriefing is as follows:

- Review of the day’s activities and events (20 min)
- Logistics information (10 min)
- Planning for the following day (20 min)

Activity Sheet 2: Activity Sheet 1. Points to consider when using participatory methods

It is important to understand the strengths and weakness of each participatory method e.g. in songs, is the message clear or is it being understood. Check the advantages and disadvantages and try to keep methodologies focused on objectives. Use the participant's experience in developing the participatory method always vary activities to avoid monotony.

Strengths of Participatory Teaching Methods

- The participants are actively involved during the discussion, so they are more likely to remember what was introduced during the discussion as they will draw from their real life experiences.
- Participatory teaching methods allow participants to discover principles for themselves and to develop problem-solving skills.
- Participatory learning methods are relevant for everyone within different levels of understanding.
- Participatory teaching methods involve everyone which makes teaching and learning easier. It makes people think for themselves and less dependent on the facilitator or information giver.
- They aid in concentration which makes health education more enjoyable and creates a close feeling between the facilitator and the audience.
- Participants build on knowledge that they already have.
- They focus on the whole person, behaviours and attitudes.
- They are innovative and creative
- It is a simple way to convince people to change behaviour and it gives people greater pride in what they can do for themselves by making the right choices.
- They are inexpensive and simple to use in a field setting.
- They are entertaining and able to attract and hold attention.

The Weakness of Participatory Teaching Methods

It is easy to lose focus:

- The audience will only pay attention if the content of the teaching is relevant to what they want to know about, is put across in an interesting way and uses a variety of teaching styles.
- Complicated and sensitive information should be introduced step by step, in a logical and organized way. People will learn more easily if the information presented to them is linked to their experiences and builds on what they already know.
- Always ask questions at the beginning to find out what people know, think and feel about the topic.
- If you lose focus draw on the key messages to guide the discussion back to the important details.

Entertainment can overshadow the value of the message

The audience may have enjoyed themselves and express appreciation, but may not have learned anything. The only way to find out whether learning has taken place is by obtaining some feedback either by asking questions or observing responses and lifestyles to see if they have changed. It is difficult to control large groups

Activity Sheet 3: Important considerations for the facilitator

- Take care not to overload the students with too many new ideas in one session, as there is a limit to the amount of information that can be absorbed at one sitting.
- Use a range of teaching approaches, such as talks, discussion, exercises and active learning methods.
- Build in frequent breaks between sessions where people can relax and stretch their legs. Twenty minutes at a time is probably the most people can keep up their concentration.
- Information presented in a teaching session is quickly forgotten. Some further input, either by the student's own reading or reminders by the teacher, is needed for the information to be retained in long-term memory.
- Opportunities should be provided for students to practice their newly-acquired skills in a safe, friendly and tolerant environment where they can make mistakes. People learn better if they are allowed to discover principles for themselves and if activities are built into the learning process and receive helpful criticism without feeling threatened.

Important Considerations

- Active learning - make students think and apply the knowledge through a task.
- Be clear - use visual aids, speak clearly, use simple language.
- Make it meaningful - explain in advance what you are going to teach, explain all new words and ideas, relate what you teach to participant's lives and work, give examples, summarize the main points at the end.
- Encourage participation - stimulate discussion and involve the group in the learning.
- Ensure mastery - check understanding and competence reached.
- Give feedback - tell the learners how far they have progressed.

Facilitation should have the following:

- Respect
- Language must be appropriate to your target audience
- Active listening
- Encourage questions, and if answer is not known, refer to the relevant person/organisation
- Reaching out at different levels
- Creating debate and controlling it
- Speaking audibly and clearly
- Paraphrasing
- Maintaining eye contact
- Use of names that are culturally acceptable for private parts
- No labeling of target audience or other groups
- A group of 10 to 12 people, which will be easy to manage. It will also allow meaningful discussion. Too large a group will be difficult to control.

Facilitation should NOT try to accomplish the following:

- Dominate the group
- Be involved in a lengthy discussion or debate with participants
- Take sides
- Be biased
- Jump into conclusions
- See self as an expert on the subject
- Create a lengthy dialogue with a particular participant
- Criticize on a personal basis
- Put participants on the spot
- Allow domination of discussions by some participants

Do and don'ts of a facilitator

A good facilitator does not

- Talk too much or interrupt, not allowing the group to participate.
- Talk too quickly, and not check understanding
- Argue, become emotional about people's responses, or use sarcastic or critical remarks.
- Ignore a speaker or filter what they say through selective listening.
- Humiliate or discourage members of the group.

A good facilitator does

- Listens well and with interest when it is time for the group to share.
- Offers eye contact and focused silence, gives full attention.
- Maintains focus on the learning point. Summarises, reflects, emphasises and repeats the discussion.
- Is warm, approachable, friendly and energetic. Asks for and encourages different points of view.
- Responds positively to people's viewpoints if possible or

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- | | |
|---|--|
| <ul style="list-style-type: none"> • Express shock or be domineering • Give advice, unless requested and appropriate. • Seem rehearsed and, therefore, insincere • Present questionable information. No information is better than the wrong information. | <p>else respectfully corrects them.</p> <ul style="list-style-type: none"> • Encourages participation by asking for specific examples and questions from the group. • Keeps asking probing questions and allows the group to reach the conclusion themselves if possible. • Guides the process and lets the discussion unfold. • keep the momentum going, but isn't a tyrant. • Stays neutral accepts people's input and emphasizes the positive. |
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Activity Sheet 4: Facilitation within a group

- Facilitation is leading a group through learning in a way that encourages participants to be involved and engaged with the facilitator, with each other and with the learning activities. This approach assumes that participants have valuable experience and knowledge to contribute to the training. The facilitator's role is to draw out knowledge and ideas from participants, to encourage them to learn from each other and to think and act together in learning activities.
- Traditional teaching shares information mostly in one direction, i.e. from teacher to student. Facilitation involves information being shared in quite a few directions – between the facilitator and the group, among the members of the group and between the group and the facilitator.
- It is the responsibility of the facilitator to allow participants to share thoughts and ideas, but simultaneously keep the training on track both in terms of achieving its outcomes/content (don't allow participants to go off topic too much) and keeping to time (don't allow participants to take too long with activities).

Goals of a facilitator:

- Facilitate task accomplishment
- Ensure the overall development of the group and group processes
- Provide a safe but stimulating workshop climate
- Provide a global view of the group and its processes
- Serve the group in whichever ways are needed to help it be successful in its assignment
- Take in group energy and emotions and re-channel these to help the group stay productive
- Track conversations - bringing the group back into focus when the conversation strays too far off topic
- Provide information needed by the group to complete its assignment
- Encourage participants to share knowledge with others outside of the session

Tips on Good Facilitation Skills

- **Active Listening** to the individual or the group: this is the most important skill for a good facilitator to learn. Recall that the experiential learning and training recognises that each individual and group has their own resources and abilities to sort out their own issues. As a trainer or peer educator your role is to empower the participants to seek solutions to the situations that they are facing. In order to complete this process effectively one needs to listen to the individual or group to find out where their strengths, resources and weaknesses lie.
- **Be well prepared:** know the content that will be covered in the training, know the training activities and how you will present them. Be clear on what instructions are to be given and when. At the same time, be flexible when necessary and adjust activities or the timing of activities based on feedback you get from the group during training. Keep to timing, but don't be driven by it at the sacrifice of learning happening.
- **Set ground rules/rules for sharing** - ask participants to agree on some rules for their interaction with each other so that they feel comfortable to share their thoughts. For example participants may decide to respect different views and opinions, keep cell phones switched off, don't interrupt a colleague etc. This creates shared ownership and shared responsibility to ensure rules for sharing are adhered to, so that there is a structure to their interactions.
- **Go through the programme upfront** with participants so that they know what will be covered in the training. This creates a map for participants of the journey that they are about to go on.
- **Share the planned outcomes and purpose** of the training with participants and then ask a few of them to share what their expectations of the training are so that you can see whether they are on the same page as you in terms of what they will get out of the training. Explain to participants, which of their expectations will be able to be met in the training, which weren't planned for, but you think you can include and which will need to be addressed in another forum. At the end of the training, refer back to the expectations you listed on flip chart paper and see whether participants agree that they have been achieved.
- **Give clear input/instructions.** It is important that participants understand what you are saying. This involves communicating concisely and clearly, checking with participants to see whether they have understood you, listening carefully to participants and summarising at different points in a training to pull information together for participants e.g. what we just covered involved....., now we are going to look at.....
- **Divide the large group into smaller groups** to encourage shy members to participate and allowing group members to learn from the wealth of knowledge and experience carried by their colleagues.
- **Use group discussions** and other activities to allow participants to be actively engaged in the learning process. Invite small groups to present and share information using flip charts, drawings or other visual aids.
- Remember, **it is important to manage people's feelings.** For example, create a safe space so that participants feel confident to ask questions – e.g. tell them that there are no stupid questions, that you are together to learn and that making mistakes is ok. Handle any conflict by respecting and valuing different opinions and referring back to the rules for sharing.
- **Encourage humour** and respect among participants and role model this as a facilitator

Tips for Working with Groups

- Never pick on a person to answer a question, ask for volunteers.
- If the group is large, make sure that everyone can hear you and their colleagues when they speak.
- Microphones may be needed to make this possible. If the group is larger than 25, then ideally two facilitators should be present. Repeat/reframe instructions to ensure that all participants have heard.
- Sometimes the same person wants to speak often. If this is the case and others also want to speak, then kindly thank the participant and say that you have noted their hand, but that you would like to give others a chance to speak.
- When groups are quiet, introduce an ice breaker to help participants feel comfortable. Use humour to help them relax. Try to encourage involvement through asking questions.
- When you have a participant that is making things very difficult, don't challenge him/her in front of everyone and embarrass him/her, take the participant aside during a tea break and ask them why they are behaving as they are and address the cause.
- Sometimes you cannot address things that come up in a talkative group, as there is not enough time, acknowledge the participant's comment and ask them to park the issue for the moment and say that you will come back to it later if there is time. The Parking Lot can be used for this.
- Stick up a flip chart labelled "Parking Lot" on the wall and explain that the purpose of a parking lot is for questions or thoughts to be parked at the current time in the training when:
 - It is not appropriate or
 - There is not enough time to deal with the question. The participant is asked to write their question in the parking lot during tea time.
 - The intention is that the facilitator will then address it later, when a suitable opportunity arises. This enables the facilitator to protect the flow and timing of the training.
 - Ensure the parking lot is addressed before the training finishes.
- The group will also help keep each other focused. If you are concerned about time, remind participants that if they want to finish on time, that you need to move on.
- If the group is resistant, it may help for people to change seats e.g. you can number them 1-4 and ask all the "1's" to sit together etc. Identify what the problem is, get it out in the open and see if it can be resolved. Invite participants to come up with suggestions.
- As facilitator, listen for the key points in discussions and reflect these back to the group through summarising in order to reinforce the key messages. Also correct any inaccurate information – not by telling the participant that they are wrong, but rather by thanking them for their input and offering factual and accurate information.
- Remember that while it is optimal for everyone to have space to share, time does not always permit this.
- Often as a facilitator you need to take direction to keep participants happy. Participants need you to lead them, you are responsible for ensuring the right environment is created for their learning – for example, they may not realise that they are talking excessively and yet they trust you to ensure that they get through all the learning and still finish on time.

Alternative Exercise

Activity 1.5.2: HIV and AIDS summary presentations

HIV presentations – would be useful after basic HIV and AIDS information has been imparted.

Ask participants to work in 4 groups, each group to focus on one of the topics from the previous day's topics. Give each group 20 Minutes to prepare their presentations. Ask participants to create an entrance song, situational and educational entertaining or joyful song based on the specific topic of choice using any of the methods of teaching: Picture Codes, Drama and Participatory Games and Role-play. Ask participants to create a presentation which carries HIV messages based on the same topic of choice as above. Each group must select a facilitator who will facilitate the discussion while other participants should pretend to be the audience which will respond to the presentation in discussion. Ask each group to present their participatory approaches and give each group 30 minutes to prepare and 10 minutes to present. As a facilitator note any areas not covered or wrongly presented and assists appropriately

Example of a Training programme

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
Workshop Opening Introduction to training team, CEEP and participants Setting Ground rules Participant Expectations (1 hour)	Warm Up Exercises Feedback on Day 1 Energiser/Icebreaker	Warm Up Exercises Feedback on Day 2 Energiser/Icebreaker	Warm Up Exercises Feedback on Day 3 Energiser/Icebreaker	Warm Up Exercises Feedback on Day 4 Energiser/Icebreaker
Peer Education as a strategy (1h 45 mins)	Working with Individuals (2h 20 mins)	HIV and AIDS 101	Sex ,Gender and HIV and AIDS Vulnerability	Vision Journey (3 hours)
Mapping and Zoning (1 hour & Homework)	Working with groups (2h 30 mins)	HIV and AIDS 101	Sex ,Gender and HIV and AIDS Vulnerability	
Referrals and follow-up (1h 25 mins)	Monitoring & Evaluation (30min) Homework Practice Role-play How HIV works	HIV and AIDS 101 (6 hours) Homework prepare for presentations	Sex ,Gender and HIV and AIDS Vulnerability (6 hours) Homework Vision exercise	



Key Messages: Working with Groups

- Groups provide another forum in which individuals can move towards making informed decisions
- Facilitation is leading a group through learning in a way that encourages participants to be involved and engaged with the facilitator, with each other and with the learning activities.
 - This approach assumes that participants have valuable experience and knowledge to contribute to the training.
 - The facilitator's role is to draw out knowledge and ideas from participants, to encourage them to learn from each other and to think and act together in learning activities.
 - Remember highlight the benefits and limitations don't preach!
- When selecting an approach or participatory method it is important to know your target audience
- **Some Common Teaching Methods include:**
 - Group Work and small group work
 - Incomplete Role Plays
 - Participatory Games
 - Picture Code and Videos
 - Songs
 - Drama
- A structure of a typical workshop includes:
 - Introductions
 - Clarifying expectations
 - Outlining the objectives
 - Establishing ground rules
 - The modules or topics required
 - Debriefings at the end of the day

Module 1.6: MONITORING AND EVALUATION

The purpose of this module is to provide participants with basic understanding of monitoring and evaluation (M&E). Its importance and relevance are explored as well as some of the means in which it occurs.

Objectives of the module

By the end of the module participants will be able to

- ✓ Explain monitoring and evaluation in the broad sense
- ✓ Define “Monitoring” and “Evaluation” separately
- ✓ Explain basic concepts of Monitoring and Evaluation
- ✓ Apply the process of monitoring and evaluation within a CEEP workshop
- ✓ Demonstrate the ability to work with data gathered through Monitoring and Evaluation based on the project data collection forms.

Topic 1: Monitoring and Evaluation an Overview

Time: 15 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ List basic principles of M&E
- ✓ To identify the potential effect of monitoring and evaluation of a programme.

Materials and equipment needed

Flip chart and koki pens

Activity 1.6.1: “If it is not documented it never happened”

Trainer Instructions

Step 1

Write down on a flip chart paper the following sentence:

“If it is not documented it never happened”

Ask the bigger group what they understand by this sentence.

The **key points** here to emphasize include:

1. Broadly speaking **M&E is about telling a story**. We are documenting what happened. M&E provides the framework to tell the story and allows us to make use of consistent story telling methods across various activities.
2. M&E is particularly interested in describing **what we did** and **what effect this had**. This allows us to assess the success of the project. At the beginning of a project we set targets and through the M&E system we can see if we have achieved this.

Step 2:

Divide the group up into smaller groups and give them the following questions to answer:

- What is **monitoring**?

- What is **evaluation**?
- What are the activities that are related to the HIV and AIDS project?
- What are the activities that we complete in the CEEP project? What are the questions that would be important to us about these activities?
- What effects are we looking for? Differentiate these by short term and long term effects.

Feedback the answers of the smaller groups and facilitate the discussion also bring in personal examples where applicable

Facilitator's Notes:

This provides a framework from which to discuss M&E:

Monitoring is looking at what we did

Evaluation are the effects that we saw (can be short term or long term). Here we consider what has changed as a result of what we did

Activities of HIV and AIDS programmes have been discussed earlier (see page 20).

The **Activities of CEEP** include:

- Peer education program training – number of people trained (gender break down)
- Peer education outreach – number of people reached (gender break down)
- Referrals – number of referrals made (gender break down)
- Monitoring and evaluation

Short term effects

- Increase in HIV and AIDS knowledge
- Change in attitudes of peer educators and beneficiaries
- Increase in positive health seeking behaviours
- Strong referral networks
- Positive up take of VCT and other related health services
- Available activity and program reports

Long Term Effects

- Reduction in HIV prevalence
- Reduction in HIV incidence
- Improved quality of life

Topic 2: CEEP Monitoring and Evaluation

Time: 15 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain in brief the components of CEEP's M&E
- ✓ To discuss the monitoring of trainings.

- ✓ To clarify the follow-up questionnaire process

Materials and equipment needed

Flip chart and koki pens

Activity 1.6.2: CEEP Forms

Step 1

This is a presentation that describes the forms that are used during the trainings. The trainers need to be familiarised with these forms and understand how they link together.

Monitoring forms:

These forms tell us that the training did happen and how many people attended the training. These forms allow us to differentiate age and gender of the beneficiaries:

1. SYIB intake form
The intake form provides us with the essential demographic information of the participants and it is used to decide on the type of training that is selected. These decisions are made by using the Decision Tree.
2. Daily attendance register
The daily attendance register keeps track of the number of beneficiaries that are present each day and this is fed into the final report (SYB Activity Report)

Monitoring and Evaluation forms:

Recall here we are looking for the effects of the project and training. These forms include:

Short term effects:

1. Daily Evaluation forms
These forms assess the beneficiaries' satisfaction with the training in general. These should be assessed on a daily basis throughout the training so that any issues that arise can be dealt with quickly and effectively.
2. Pre-Workshop and Post-Workshop Questionnaires
These questionnaires assess changes in knowledge and attitudes from the beginning to the end of the workshop.

Longer term effects:

1. Baseline and Follow-up questionnaires
In order to assess changes in economic empowerment, HIV and AIDS attitudes and practices as well as the impact of the gender component on beneficiaries, at the intake stage, all beneficiaries are given a baseline questionnaire. This questionnaire provides a starting point from which to assess changes of the project.

The follow-up questionnaires record these changes. Follow-up questionnaires are given twice a year.

Reports that are submitted:

There are three forms that are submitted as a completion of training and these include

1. End of To(P)E Evaluation Forms
2. End of Seminar Worksheet
3. Activity Report

Key Messages: Monitoring and Evalutaion

- If it's not documented it never happened
- M&E is about telling a story
- Monitoring considers what happened, what were the project activities?
- Evaluation considers what effects or changes occurred as a result of the project activities.
There are:
 - Short term effects
 - Long term effects
- CEEP's training monitoring and evaluation forms include:
 - SYIB intake forms
 - Daily Attendance Register
 - Daily evaluation forms
 - End of training evaluation forms
 - Activity report
 - Pre and Post Workshop Questionnaires

PART 2: UNDERSTANDING HIV AND AIDS VULNERABILITY

Within this part of the manual we will explore HIV and AIDS Vulnerability. This is a key concept to CEEP and trainers and peer educators need to be well versed in these issues as well as steps that can be taken to reduce HIV and AIDS vulnerability. In order to foster this understanding the following steps will be considered:

- Module 2.1: HIV and AIDS the basics (including TB)
- Module 2.2: HIV, Sex and Gender
- Module 2.3: HIV and AIDS vulnerability & reduction strategies

Throughout these discussions we will consider a systems approach of the effects of these topics. That is, the guiding principle will be to consider the effects on the individual, their families and friends, their communities and their businesses. This approach is linked to the idea that we exist as people through others. What affects us, affects others and what affects others, affects us.

Module 2. 1: HIV, AIDS AND TB: The Basics

This module is intended to set the tone of the rest of the training by reminding the peer educators of the elements of HIV and AIDS which will form the basis for discussions on HIV and AIDS vulnerability in Module 2.5, specifically focusing on the information that is needed by peer educators in engaging with community members during health education. The activities will be interactive and draw on the existing knowledge about HIV, the use of the resource pack to find out more information about HIV and exploring that information to draw conclusions.

Objective of this module:

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

- ✓ Explain the difference as well as the link between HIV and AIDS
- ✓ Differentiate between myths and facts about HIV and ways to address myths within the communities
- ✓ Describe the progression of the illness
- ✓ Outline the ways in which HIV can be transmitted and prevented
- ✓ Clarify issues on treatment, care and support
- ✓ Explain how stigma can affect HIV and AIDS prevention, treatment and care
- ✓ Highlight the effects of HIV and AIDS on individuals, families, communities and businesses

Preparations for this module:

Topic 1: Re-capping on our understanding of HIV and AIDS

Time: 20 minutes

Objectives of the session

By the end of this session participants should be able:

- ✓ Correctly describe what HIV and AIDS are
- ✓ Correctly describe the link between HIV and AIDS
- ✓ Identify how HIV is spread
- ✓ Identify HIV and AIDS myths common in their community and ways to argue against these myths

Materials and equipment needed

Flip chart and koki pens

Resource pack

Preparations for the session

The facilitators should also read the relevant resource pack (Part 2) that deals with HIV and AIDS. For this session the facilitator should be ready to discuss all components of HIV and AIDS and lead a discussion with the trainers.

Also prior to this session ask for 9 volunteers for a role play.

Trainer Instructions

Step 1

- Prior to this session identify 8 volunteers
- Ask the larger group what HIV and AIDS stand for. Write these out on the flip chart.
- Now ask what HIV does to the body. This sets stage for the role play

Step 2

Activity 2.1.1: How HIV works: Role Play

Divide the volunteers into 4 germs that cause different conditions (say TB, measles, common cold and thrush, etc.), 2 immune system cells, 1 HIV virus, 1 ARV and 1 Opportunistic infection medication.

Set the scene: Inside the body

Step 3

Let the germs introduce themselves: their likes, dislikes, how they are transmitted

Let the immune system cells introduce themselves. Their functions, likes and dislikes.

Let the ARV introduce itself

Let the Opportunistic Infection Medications introduce themselves

Step 4

Role-play the germs partying in the body with no care in the world.

There comes the immune system cells and they make the germs sit down and tidy up their mess. In fact one or two are even sent home or away.

Thereafter introduce the HIV.

These are sneaky viruses/germs as they get through the immune systems defences and attach the immune system directly. In the play they make the immune system cells lie down and they are unable to move

This means that the germs jump up and carry on with their party as there is nothing to stop them.

But there comes the ARV which restrains and confuses the HIV and wakes the immune system cells up. They are then able to restrain the other germs.

Step 5

Facilitate the discussion around the role play and highlight:

- What is HIV?
- What is AIDS?
- How HIV causes AIDS?
- How treatment works?
- What it means that HIV is not curable but treatable?

Facilitators Notes

What is HIV?

HIV stands for the human immunodeficiency virus. After getting into the body, the virus kills or damages cells of the body's immune system. The body tries to keep up by making new cells or trying to contain the virus, but eventually the HIV wins out and progressively destroys the body's ability to fight infections and certain cancers.

The virus structure has been studied extensively, and this has helped scientists develop new treatments for HIV. Although all HIV viruses are similar, small variations or mutations in the genetic material of the virus create drug-resistant viruses. Larger variations in the viral genes are found in different viral subtypes. There are two types of HIV, HIV-1 and HIV-2. Both types of HIV damage a person's body by destroying specific blood cells, called CD4+ T cells, which are crucial in helping the body fight diseases. Currently, HIV-1 is the predominant subtype common among HIV positive people.

What is AIDS?

AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer - even decades - with HIV before they develop AIDS. This is because of "highly active" combinations of medications that were introduced which help boost the weakened immune system? Fig. 1 Below illustrates how HIV is transmitted.

Difference between HIV and AIDS

When infection occurs and the virus has entered the body the T-helper cells or CD4 lymphocyte are the targets. The virus will take over the cell, kill it and then reproduce, which will take a few days. As soon as the immune system recognizes the foreign presence it will begin to produce an HIV antibody and replace the T helper cells that the virus has destroyed.

Where did HIV come from?

Scientists identified a type of chimpanzee in West Africa as the source of HIV infection in humans. They believe that the chimpanzee version of the immunodeficiency virus (called simian immunodeficiency virus or SIV) most likely was transmitted to humans and mutated into HIV when humans hunted these chimpanzees for meat and came into contact with their infected blood. Over decades, the virus slowly spread across Africa and later into other parts of the world.

Topic 2: Myths of HIV and AIDS

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ To explore some of the common myths that surround HIV
- ✓ Develop comprehensive counters for these myths

Materials and equipment needed

Flip chart and koki pens

Myths of HIV and AIDS

Activity 2.1.2: HIV and AIDS Myths

Trainer Instructions

Ask the participants to get back to their seats.

- ✓ Write the word myth on a flip chart and ask the participants what they understand by this term – discuss this term to make sure that everybody understands what it means.
- ✓ Ask the participants to get into pairs; they can just turn to their neighbour.
- ✓ In pairs ask participants to think of one myth that they have heard of in their community about HIV and AIDS. Once they have identified the myth they have heard ask them to come up with argument to counter that myth. Give each pair 5 minutes for discussion.
- ✓ At end of 5 minutes ask the participants to stop discussion and get back to the bigger group. Ask for volunteers to feedback to the bigger:
 - Which myth did they identify – ask if any other pairs had identified the same myth
 - How could they counter this myth – ask the other pairs to share how they had prepared to counter this myth.
- ✓ Give all participants a chance to feedback
- ✓ Wrap up the session by adding any myths that have not been discussed or add to the points raised as arguments in countering the myths. Indicate to the participants that they can use their resource pack to get additional information. Ensure that the following myths are covered:
 - HIV is caused by supernatural causes
 - HIV is passed by mosquito

Facilitators Notes:

Myth	What we know
1. I can get HIV by being around people who are HIV-positive	HIV can only be transmitted through bodily fluids that contain high dosages of HIV, i.e. blood, semen, vagina fluids and to lesser extent breast milk. In addition there needs to be an available entry point for the virus to enter another person's body, e.g. cuts, grazers or micro-lesions. As such hugging or kissing a person HIV positive provides no risk to either party. Sharing utensils, door handles, toilet seats and exercise equipment pose no threat.
2. Mosquitoes can transmit HIV from one person to another	Blood sucking insects are not considered a threat to spread HIV as the fluids that are injected into a person before sucking commences are HIV free. Also HIV has been shown to live a very short time before it is digested by the insect concerned.
3. HIV is a death sentence	In the early years of the epidemic AIDS related deaths were high. These days, ARVs and HIV treatments are seen to extend one's life. The road to health may require a life-style change
4. Homosexuals and drugs users are most at risk of contracting HIV and AIDS	In Sub-Saharan Africa, the most common method of transmission is through heterosexual sex.
5. My partner tested negative for HIV, therefore I must	The only way for you to know your status is to have an HIV test. At times there are discordant couples, that is two partners with different statuses. There are several factors that influence transmission from one person to another, and it may be that the chances of spreading from HIV is low but a

be negative as well.	person is still infected and can still pass on the virus to another person
6. Faithful and loving partners do not spread HIV	The main reason that this can be considered problematic is that HIV progression to AIDS can take years and a person may be infected even before a relationship starts and there may be no signs and symptoms. The only way to know is to test and then
7. To stop the spread of HIV, people simply need to stop being promiscuous and stop using drugs	There are many reasons why a person can be at risk of contracting HIV. Some of these reasons are beyond their control, e.g. transactional sex used as a means to survive on a daily basis. Also a lot of women contract HIV from their husbands and children contract HIV through their infected mothers.
8. HIV can be cured!	There have been many people who have claimed that they can cure HIV. At present there is no cure only treatment for management of HIV.
9. AIDS is the result of witch craft, curses or other supernatural means.	HIV causes AIDS. There is no supernatural cause for HIV, nor is it a punishment on an immoral generation. A lot of the people who are infected are not aware that they have been infected or may be infected due to reasons beyond their control.

Topic 3: Understanding HIV transmission

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able

- ✓ Identify the biomedical strategies for HIV prevention
- ✓ Identify the behavioural strategies for HIV prevention

Materials and equipment needed

Flip chart and koki pens

Activity 2.1.3: High, medium and low risk activities

Preparations for the session

Draw a table on a flip chart page, with 3 columns. Label each column with 1 High risk; 2 low risk 3 no risk.

Prepare small cards (small enough for people to hold but big enough to be visible to a group of 30 when placed on a floor in front of them). On each card write one activity HIV spread – include high risk, low risk and no risk activities for HIV transmission. The main list of activities should include:

- Vaginal Intercourse
- Blood Transfusion
- Masturbating alone
- Anal sex
- Kissing
- Vaginal Intercourse using condom
- Sharing Needles
- Masturbating your partner
- Sneezing on somebody
- Oral intercourse on a man using a latex condom
- Being in contact with urine
- Delivering a baby
- Anal sex with a condom
- Sharing a toilet
- Oral sex
- Being Heterosexual
- Donating Blood
- Anal sex with a condom with adequate lubrication
- Two uninfected persons having intercourse without a condom

Prepare a flip chart page which shows high risk, low risk and no risk activities for HIV transmission. Prepare another flip chart page with two columns showing biomedical and behavioural strategies for HIV prevention.

Trainer Instructions

Step 1

Place the flip chart page on the floor and ask the participants to stand in a circle around the flip chart page, everybody should be able to see that flip chart. To distribute the cards, place all the cards in a container and ask participants to pick up one without looking. If there are not enough cards for all participants, ask volunteers to pick a card until all the cards have been taken.

Step 2

Ask each person with a card to indicate whether the activity in their card is high risk, low risk or no risk for HIV transmission. Once they have decided they should put the card in the column corresponding to their answer. When all the cards have been placed on either the High, Some or Low Risk sheets, ask the participants if there are other actions they wonder about and make cards for these, then ask the participants where they should be placed. The group is asked to figure out if HIV could be transmitted by the actions on the cards. Ask the participants where they think the cards belong.

Step 3

Ask the participants to indicate why they placed their cards in the columns they chose. After the activity, discuss the difference between High Risk (i.e. actions that involve contacts with blood, semen, and vaginal discharge), some risk (very low) and No Risk.

The table should look like something like this:

High risk activities	Some/ low risk activities	No risk activities
Vaginal Intercourse	Blood Transfusion	Masturbating alone
Anal sex	Kissing	Vaginal Intercourse using condom
Sharing Needles	Masturbating your partner	Sneezing on somebody
	Oral intercourse on a man using a latex condom	Being in contact with urine
	Delivering a baby	Sharing a toilet
	Oral sex	Being Heterosexual
	Anal sex with a condom	Donating Blood
		Anal sex with a condom with adequate lubrication
		Two uninfected persons having intercourse without a condom

Step 4

Ask participants to divide into small groups of 3

Divide up these activities among the groups (one high and one low risk activity) and let them discuss ways to lessen the risk of transmission for the activity they have selected.

At the end of 5 minutes bring participants back to plenary and ask each group to give present in 1 minute (they can present where they are sitting and not come to the front).

Step 5

Once all the groups have presented wrap the session by showing a slide or flip chart page with list modes for HIV transmission and another one showing biomedical and behavioural strategies for HIV prevention.

Facilitators Notes

Summary of modes of transmission

1	Unprotected sexual intercourse with an infected person. The virus is introduced into the body through sexual intercourse by way of blood, vaginal fluids or semen. The easiest way to prevent this from occurring is to use a condom. Both female and male condoms provide protection from HIV, sexually transmitted infections and even pregnancy; if used properly.
2	Sharing needles, syringes for steroid or drug abuse, or other injection equipment with someone who is infected. If needles are not sterilized after being shared with an HIV infected individual, the virus is introduced into the bloodstream of persons using the needle.
3	Mother-to-child transmission. Babies born to HIV-positive women can be infected with the virus before or during birth, or through breastfeeding after birth. More information about HIV and pregnancy can be found in the training manual. The new-born baby of an infected mother will <i>not necessarily</i> be born with HIV.
4	Transmission in health care settings. Healthcare professionals have been infected with HIV in the workplace, usually after being stuck with needles or sharp objects containing HIV- infected blood or body fluids. As for HIV positive healthcare providers infecting their patients, there have only been six documented cases, all involving the same HIV-positive dentist in the 1980s.
5	Transmission via donated blood or blood clotting factors. However, this is now becoming rare in most countries around the world where blood transfusion samples are properly monitored and screened for HIV antibodies.

Whilst there are many sexual practices that people engage in a lot which are not covered here. When thinking about the level of risk first consider the bodily fluids that are involved, that is exchanged as well as what barriers can be used.		
Kissing (No risk) While saliva is exchanged during kissing it has been shown that saliva contains very little HIV virus and cannot cause infection, even if it came into contact with one's blood.	Blood transfusion (Some risk) If a person is given blood that has been tainted by the HIV virus, there will be little of the virus to have the person to become infected. However, almost every country in the world now screens donated blood supplies so that there is virtually no chance of this happening.	
Vaginal intercourse (high risk) Semen, vaginal discharge and blood are all possibly present here so there is very high risk of transmitting the virus from one person to another	Self-Masturbating (No risk)	
Vaginal Intercourse using condom (No risk – some risk)With correct condom use ,there is little risk of transmission because of the strength of latex condoms	Sneezing on somebody (No risk) HIV is not transmitted in this manner	
Sharing needles (High Risk) Sharing needles with an infected person is a way of introducing one's into another person. Needles should be correctly disposed of after use. When visiting a hospital, ensure that the needle is a new one and has been taking out of a sealed package	Insect bites (No risk) Insects cannot carry the virus and transmit it from one person to another.	
Masturbating your partner (No risk – some risk) This depends on the circumstances. Unless there are cuts on the person's hand where discharge can enter, there is no risk.	Swimming Pool (No risk) Chemicals in swimming pools are strong enough to kill any bacteria or virus	
Being in contact with urine (No risk) Urine does not have virus in it and cannot be a risk unless if it contains blood.	Sharing Utensils or a cup (No risk) Saliva cannot transmit HIV and HIV cannot be passed through touching	
Oral intercourse on a man using a latex condom (No risk -some risk) If there is a barrier used, then the virus cannot be transmitted. If the condom breaks and the semen leaks into the partner's mouth, HIV will be transmitted.	Sharing a toilet (No risk)	
Two uninfected persons having intercourse without a condom (No risk) If both partners do not have the virus and have been tested to prove this, unprotected intercourse will not spread HIV.	Delivering a baby (Some risk) For the doctor/nurse or traditional midwives or anyone delivering the baby, if they do not use protective gloves and the mother has HIV there is risk of transmission	

Breastfeeding (Some risk - high risk) Mother to Child Transmission can occur through breastfeeding. The use of antiretroviral can sometimes reduce the risk of the baby contracting HIV.	Being Heterosexual (No risk) It is not about who a person is but it is rather about what a person does and what kind of acts they participate in.
Being Homosexual (No risk) It is not about who a person is but it is rather about what a person does and what kind of acts they participate in.	Donating Blood (No risk) A sterilized needle must be used in this instance
Tears (No risk) It has been researches that there are no traces of HIV in tears	Unprotected Anal sex (High Risk) This is a high risk activity as the anus does not naturally produce lubrication as such the chances of micro lesions forming are high which would provide entry points for HIV.
Anal Sex with the use of condoms and lubrication (Low Risk) Assuming that there is the correct and consistent use of condoms as well as the use of adequate lubrication the risk of contracting HIV is low. The condoms create a barrier and the lubrication reduces the production of micro lesions	Anal Sex with a condom (Low risk) The issue here is that there may be tearing in the condom as the anus has no natural lubrication

HIV CANNOT BE SPREAD THROUGH THE FOLLOWING:



TEARS OR SALIVA - While there is an extremely small amount of HIV found in both of these fluids, it is so low that it is not possible to be infectious.



INSECTS - HIV stands for "*Human* Immunodeficiency Virus" and thus can only be spread from one human to another. Even if a mosquito were to bite an infected individual the biology of the insect destroys the virus.



SWIMMING POOLS - The chemical concentration in pools will kill the virus.



ANY SORT OF CASUAL CONTACT - HIV cannot be spread through kissing, shaking someone's hand or by sharing utensils, towels or the toilet with an infected person.

Topic 4: **Progression of the illness:**

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Describe the progression from HIV to AIDS
- ✓ Explain the importance of the viral load and CD4 counts
- ✓ Understand the dangers of the window period and the acute phase

Materials and equipment needed

Flip chart and koki pens

Activity 2.1.4: Progression of the illness

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the Stages of the progression of HIV infection
- ✓ Explain the key aspects about each stage of HIV infection

Materials and equipment needed

Flip chart and koki pens

This is a content heavy section as such facilitators need to find a way to make it interesting and lively. The use of smaller group work may be useful here.

Step 1:

Introduce the topic of the progression of HIV infection.

Remind the group of the idea that being infected with HIV does not mean that you have AIDS. AIDS is the acquired syndrome that develops at the last stage of infection. How do we move from being HIV positive to having AIDS?

Step 2:

Draw the following diagram on the board or on the flip chart:

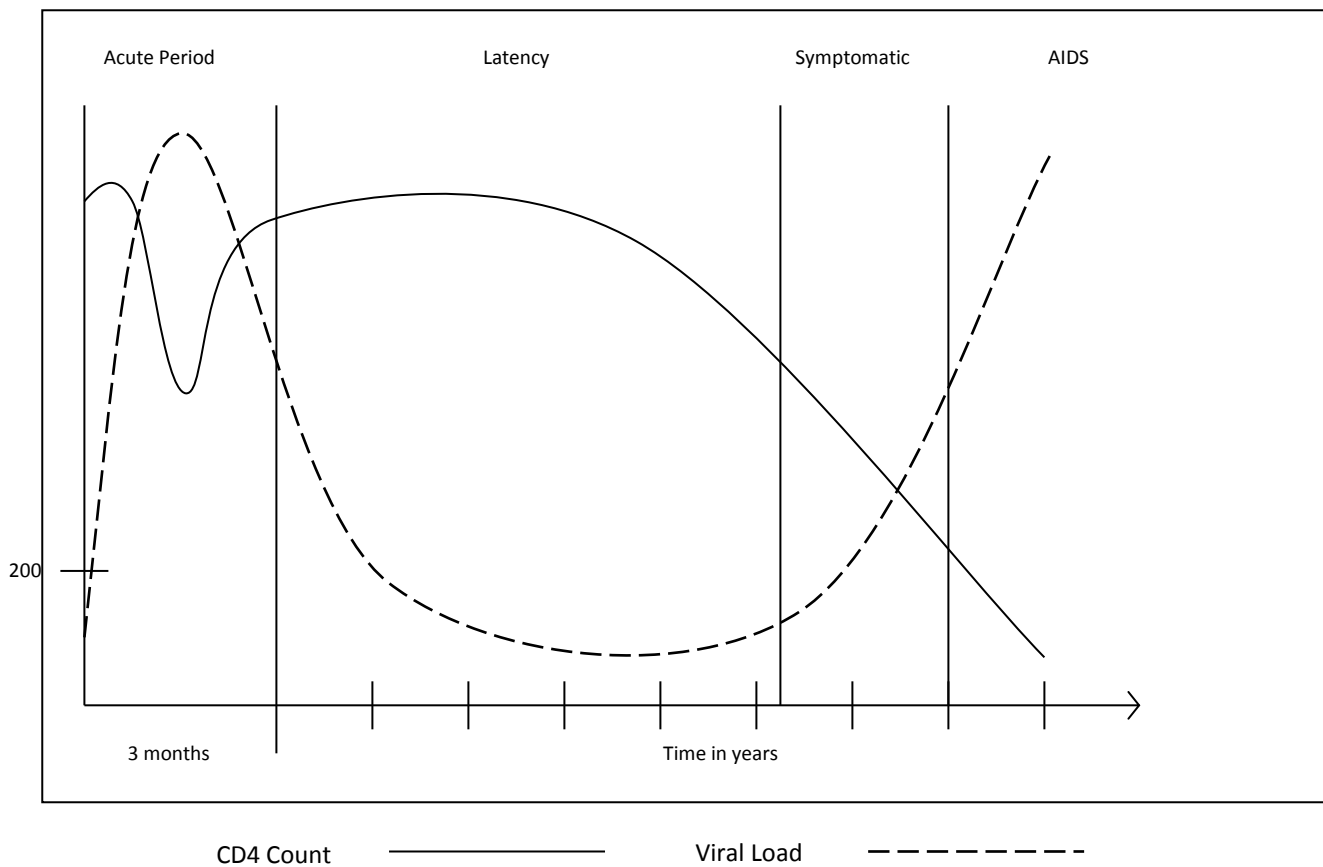


Figure 1: Progression of the HIV illness by CD4 count and viral load – without treatment

This is a diagram that all trainers and peer educators need to know very well.

To understand the progression of the illness we need to first consider what is meant by viral load and CD4 counts:

- The **viral load** is the amount of the HIV virus in the body. The higher the viral load, the more virus particles are in the body infecting and destroying the white blood cells.
- The **CD4 count** considers the number of white blood cells that are in a person's body to fight off germs and prevent disease. The average healthy CD4 count is between 500 and 1200 (cells per mm³). When the CD4 count drops below 500, the immune system is compromised and opportunistic infections set in. The clinical definition of AIDS is generally when the CD4 count falls below 200.

It is important to note that as the viral load increases, so the CD4 count drops.

With this understanding of viral load and CD4 counts we are able to outline the progression from HIV positive to AIDS; this is a similar course in most people who are not on treatment:

- The Acute Phase or the Window Period
- Latency
- Symptomatic
- AIDS phase

Step 3:

Divide the group up into 4 smaller groups and assign a period to each group. Remind the participants that the resource pack will be useful here. Each group needs to answer the following questions about their selected stage:

1. What is the stage?
2. What is happening to the viral load?
3. What is happening to the CD4 count?
4. What is the important point to remember about this stage?

Step 4:

Allow the groups to feedback their discussions to the wider group, watching the time will be important. The important points are contained in the facilitator's notes below.

Facilitators notes

Acute Period

This is the time from infection until antibodies are developed by the body to suppress the virus. Upon initial infection the body is not familiar with the virus and it takes time to start producing antibodies (2 weeks up to 3 months). As there is nothing to stop HIV from reproducing the viral load shoots up. It remains high until the body is able to co-ordinate an effective response to bring the virus under control. **It is important to keep in mind that when the viral load is high, during this period and later in the progression of the disease, a person is highly infectious to other people (key point).**

Currently, rapid tests used for HIV testing look for HIV antibodies, and at this stage antibodies are still developing, therefore a person testing for HIV at this stage may get a negative HIV test result, although they are infected. This is called the window period and it can take up to three months before antibodies are detected by the rapid test.

Latency

This is the time when there is a constant battle between the virus and the immune system on a daily basis. The immune system is able to contain the virus reproduction and attacks. During this time a person will be exposed

to the variety of other germs that will make them sick but like anyone else they will recover as their immune system is still strong. A person is infectious to others during this time even though the viral load has dropped. A person infected with HIV will live a healthy and productive life, and it is not possible to tell who is HIV positive and who is not just by looking at people. Additionally, nobody will know that they are infected with HIV unless they have been tested.

How long does this period last differs from person to person and can be as short as two years or longer. For example, some women in underdeveloped or developing countries, who are malnourished, regularly pregnant and often ill, develop AIDS much quicker than more privileged people in better socio-economic conditions. **This is one of the reasons that CEEP seeks to address economic empowerment, to prolong the latency period (key point and how to do this).** The latency period can be affected by many factors such as:

- ✓ Access to treatment,
- ✓ Life-style (including smoking and drinking),
- ✓ High levels of stress can also suppress the immune system response
- ✓ Socio-economic status,
- ✓ Disease management strategies,
- ✓ A person's health at the time of infection and
- ✓ The amount of times a person is exposed to the virus, e.g. through re-infection.

Symptomatic stage

After a while the immune system gets weaker and is not able to sustain the constant bombardment from the HIV. As the immune system and the body become weaker, the virus is able to reproduce more and the viral load increases again. With a weakened immune system, the ability to protect the body from other illnesses drops, resulting in an increase in infections that attack the body. These are called opportunistic infections and will be discussed in more details in another section below. **The key thing to recall is that the earlier one gets treatment of opportunistic infections the better as this will support the immune system**

Acquired Immune Deficiency Syndrome - AIDS

Finally, the body becomes severely weakened by the attacks from the opportunistic infections. At this stage a collection of infections is common, they attack the body and there is no immune response to stop it. **This stage is reversible with treatment but if treatment is not sought the infected person could die from any of these opportunistic infections (key point).** The most common opportunistic infection that results in death of people living with AIDS is TB, other common opportunistic infections include:

- ✓ Pneumonia
- ✓ Toxoplasmic Encephalitis
- ✓ Extra – pulmonary Tuberculosis
- ✓ Bacterial respiratory infections
- ✓ Herpes Simplex
- ✓ Hepatitis C
- ✓ Candidiasis (thrush)
- ✓ Varicella Zoster virus (shingles)

During this time a person may also be confined to bed for more than 50% of the time, have night sweats, chronic diarrhoea and lose weight.

What are Opportunistic Infections?

People with advanced HIV infection are vulnerable to infections and cancers that are called 'opportunistic infections' (OIs) because they take advantage of the opportunity offered by a weakened immune system. Almost any disease can become an HIV opportunistic infection when the immune system is weak. Some are more

common than others, though, and some are more likely to occur at certain levels of CD4 counts than others. Here are some of the more common HIV opportunistic infections:

Common Opportunistic Infections	Description
Candidiasis (Thrush)	Is a fungal infection of the mouth, throat, or vagina signified by reddening of the mouth, throat and vagina.
Cytomegalovirus (CMV)	Is a viral infection that causes eye disease that can lead to blindness
Herpes simplex	Blister like sores on the mouth, genital area or on the body caused by herpes simplex virus
Malaria	Condition caused by mosquitoes in malaria infested areas, Any person in Malaria infested areas can be sick of Malaria, however people with HIV have more severe symptoms due to lowered immunity
Mycobacterium avium complex (MAC or MAI)	Is a bacterial infection that can causes recurring fevers, general sick feelings, problems with digestion, and serious weight loss
Pneumocystis pneumonia (PCP)	Is a fungal infection that can cause a fatal pneumonia.
Toxoplasmosis (Toxo)	Infection of the brain caused by protozoa
Tuberculosis (TB)	Is a bacterial infection that attacks the lungs, brain and any part of the body.

Table 1: Common Opportunistic Infections Descriptions

Men are eight times more likely to develop a cancer called Kaposi's sarcoma. Women are more likely to develop bacterial pneumonia and herpes simplex infections. Women are also more at risk for certain infections that can lead to cancers of the reproductive system.

How to prevent Opportunistic Infections

The best way to maintain good health is to live a positive lifestyle, this can be achieved by accepting the HIV positive status, disclosing to a supportive person and seeking help where needed. Most of the germs that cause OIs are quite common, with a strong immune system some people may be living with the germs without noticing. To reduce the risk of new infections one can:

- ✓ Ensure good personal hygiene
- ✓ Reduce or avoid using drugs, alcohol, smoking
- ✓ Eat healthy food and exercise
- ✓ Seek spiritual and emotional support
- ✓ Avoid known sources of the germs that cause OIs, e.g. keep your living environment clean
- ✓ Consider using a condom everytime you have sex, its helpful to discuss this with your partner

Avoid severe complications and suffering by taking prescribed medications that will prevent the development of active disease, known as prophylaxis. In case where a person has an OI, it is important to take treatment correctly as instructed by the health provider.

Topic 5: Biomedical Prevention:

In this section we will consider bio-medical prevention strategies.

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain different bio-medical prevention strategies
- ✓ Explain Tadvantages and disadvantages of each

- ✓ Identify the barriers to the use of these methods

Materials and equipment needed

Flip chart and koki pens

Condoms (male and female)

Dildo

Tissues

Refuse bag

Activity 2.1.5: Biomedical prevention

Instructions to the Trainer

Step 1:

Divide the group up into 5 groups. Each group will be assigned a topic. Drawing on the participatory methods above the groups will present to the larger group.

The topics are:

1. Correct and Consistent Condom Use
2. Prevention of Mother to Child transmission
3. Medical Male Circumcision
4. Voluntary Counselling and Testing
5. STI treatment, Post-Exposure Prophylaxis and Early HIV and AIDS Treatment

During their presentations beneficiaries need to highlight:

1. What this method is
2. How it works (process)
3. Where to access it
4. The benefits of the method
5. The disadvantages of the method
6. The barriers to people accessing these methods and some suggested solutions.

Facilitator Notes

Key Messages: Correct and Consistent Condom Use

- **Correct and Consistent Condom use is a prevention strategy that can effectively reduce one's risk of contracting HIV**
- **Correct and Consistent Condom use is seen as a social norm and this needs to be encouraged**
- **Correct and Consistent Condom use requires skill to use it effectively and space to negotiate its use.**
- **Condom education should promote this product as well as attempt to increase women's ability and confidence in the use of condoms in any situation. Along with this developing partner support to always use condoms is equally important. We also need to advocate for availability of female condoms.**
- **Correct and Consistent Condom use along with contraceptive use is seen as the best way to prevent unwanted pregnancies and STIs**
- **Always use water based lubricants, as Oil based lubricants can break male condoms**

Condom Demonstrations:

How to use a male condom

One condom used the correct way, each and every time, during oral, vaginal or anal intercourse can protect one from getting HIV, STI and unplanned pregnancy.

- ✓ Talk to your partner about what kind of protection you want to use.
- ✓ Condoms are readily available in public and private health facilities, chemist and some workplaces.
- ✓ Latex condoms are preferable, but polyurethane condoms works, too, for people who are allergic to latex.
- ✓ Until you and your partner actually have sex, store the condoms in a cool, dry place.
- ✓ Don't store them in your pocket or wallet, since heat from your body can damage them.
- ✓ Before having sex (oral, vaginal or anal) open the package carefully (watch your finger nails) and remove the condom.
- ✓ Check the expiry date before purchasing or collecting the condoms to make sure they have not expired
- ✓ Squeeze the air out of the tip of the condom. This is important because if the air is not squeezed out, the condom could break.
- ✓ Open the condom using your hands not teeth or scissors
- ✓ Check to see which way the condom unrolls.
- ✓ Pull back the foreskin if the penis is uncircumcised.
- ✓ Place the condom on the tip of the erect penis and roll it all the way up.
- ✓ Have sex.
- ✓ After orgasm and ejaculation, hold the condom at the base of the penis and withdraw the penis.
- ✓ Carefully remove the condom from the penis, making sure that none of the semen seeps out.
- ✓ Wrap the condom in tissue, and throw it away. Don't flush the condom down the toilet; throw it away in the trash. Never use the same condom again.

Female condom

The female condoms, is made of polyurethane as opposed to latex like the male condom. This product is becoming increasingly popular so there are several advantages and disadvantages to consider before usage

How to use Female Condoms

- ✓ Open the Female condom package carefully; tear at the notch on the top right of the package. Do not use a scissor or a knife to open.
- ✓ The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.
- ✓ While holding the Female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow or makes a figure of eight - 8
- ✓ Choose a position that is comfortable for insertion – squat, raise one leg, sit or lie down.
- ✓ Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place
- ✓ Place, the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.
- ✓ The female condom is now in place and ready for use with your partner. When you are ready, gently guide your partner's penis into the condom's opening with your hand to make sure that it enters properly – be sure that the penis is not entering on the side, between the sheath and the vaginal wall.
- ✓ To remove the Female condom, twist the outer ring and gently pull the condom out.
- ✓ Wrap the condom in the package or in tissue, and throw it in the garbage. Do not put it into the toilet.

Key Messages: Prevention of Mother to Child Transmission (PMTCT)

- **The transmission of HIV from mother to child is preventable**
- **The transmission of HIV from a mother to a child is seen as the second biggest driver of the epidemic within Sub-Saharan Africa.**
- **The Prevention of Mother to Child Transmission occurs through medical and behavioural factors:**
 - **Medical:**
 - **Use of ARTs during pregnancy to reduce the mother's viral load, thereby reducing the risk**

- of passing the infection to the infant before birth
 - The use of quick natural birth methods to ensure that the child's exposure to potentially harmful bodily fluids is reduced
 - Provision of ART to the infant after birth is a form of Post Exposure Prophylaxis (PEP)
- Behavioural:
 - Exclusive Breastfeeding practices for the first four months
 - If a mother is negative during the antenatal check-ups it is vital for her to remain negative as the acute infection period just after infection places the infant at risk of contracting HIV
- People require better knowledge of PMTCT

Key Messages: Medical Male Circumcision (MMC)

- Medical Male Circumcision can reduce a man's risk of HIV infection by 60% and other STIs incl. Herpes Papilloma Virus (HPV)
- Whilst in some countries and areas there are high levels of circumcision, we need to keep in mind that there are different types of circumcision and these need to be considered when promoting Male Circumcision (MC) as a prevention strategy
- A man should not have sex for 6 weeks after the procedure as it can cause damage and provide entry points for the virus if this act is unprotected
- MMC is one prevention method but correct and consistent condom use is important as well
- MMC only reduces the risk of contracting HIV through vaginal intercourse only

Key Messages: Voluntary Counselling and Testing (VCT)

- VCT is seen as a vital prevention strategy as well as providing an important entry point into treatment, care and support
- Testing HIV positive is not a death sentence, rather VCT can be vital to refer people to good treatment, care and support
- Testing HIV negative does not mean that you will stay negative. If a person has been potentially exposed within three months of testing they will need to have a confirmatory test

Key Messages: Post Exposure Prophylaxis (PEP)

- PEP is an effective means of preventing HIV infection after exposure to the virus
- PEP needs to begin within 72 hours after exposure
- Little is known about PEP and this should be a focus area for programs

Key Messages: Sexually Transmitted Infections (STIs)

- The early treatment of STIs is seen as an effective method to reduce new HIV infections as this reduces the possible entry points for the virus

Key Messages: Early Treatment

- Treatment is seen to reduce the risk of new infections as this will bring the viral load down thereby reducing the exposure to the amount of virus per possible infection activity.

Topic 6: Behavioural factors that influence the use of biomedical prevention methods:

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain the value of bio-medical interventions in HIV prevention efforts.
- ✓ Explain how behaviour is influenced by social norms
- ✓ Explain steps that can be taken at this level to reduce a person's vulnerability to HIV and AIDS
- ✓ Clarify the barriers that prevent people from adopting these strategies and some of the ways to address these barriers.

Materials and equipment needed

Flip chart and koki pens

Activity 2.1.6: Behavioural Prevention Methods

There are some behavioural factors that are seen to help or hinder the spread of HIV, some of the pertinent ones will be considered in this section. We know that the underlying principle here is that the more exposure one has to high risk situations the higher the chances of contracting HIV.

Trainer Instructions

Step 1

Divide the group into 5 sub-groups. Assign each group a topic in which they:

- Define and describe the behaviour mentioned
- Assess the risks or benefits of each behaviour
- Identify factors that influence these behaviours
- Develop a media product to portray the desired behaviour to be used at a community level.
This media product could include a poster, a drama, etc. It is essential to identify a target group before the development of this media product – to whom is this topic and media product most applicable (refer to the resource pack for more clues). Don't forget to focus on the benefits!!

The behavioural topics are:

- a. Sexual Debut
- b. Sexual networks
- c. Transactional sex
- d. Intergenerational sex

Step 2:

Allow each group to conduct their presentations and consider the use of media (appropriate for target audience), the messages telling us what the benefits are and originality of the presentation and media used. A person who watches the time will be important here.

Facilitator Notes:

Here are the key messages that are associated with each of the above mentioned behaviours: _____

Key Messages: Early Sexual Debut

- Early sexual debut places people at risk of unwanted pregnancies, STIs (including HIV) and lower use of contraceptives and prevention strategies
- Women tend to have an earlier sexual debut than men but men have more partners
- Delay sexual debut

Key Messages: Sexual Networks

- The more sexual partners that a person has the more risk they are of contracting STIs (including HIV)
- The acute infection period ensures that people within a concurrent sexual network are at great risk in contracting HIV
- Reduce your number of sexual partners
- Multiple partners with low condom use is seen as driving the epidemic across a range of countries.
- Do you know the status of your lover's past lovers?

Key Messages: Transactional Sex

- Transactional sex is one of the key drivers of the epidemic
- This is one of the key drivers the Economic Empowerment approach seeks to address
- Transactional sex places an unequal power dynamic within a sexual relationship, where the buyer can set the conditions of the transaction
- Empowerment here means not only economic empowerment but also empowering people to set limits to activities that would place them at risk and reminding them that they do have power within these encounters.
- Unfortunately at times, due to poverty, families may condone this behaviour

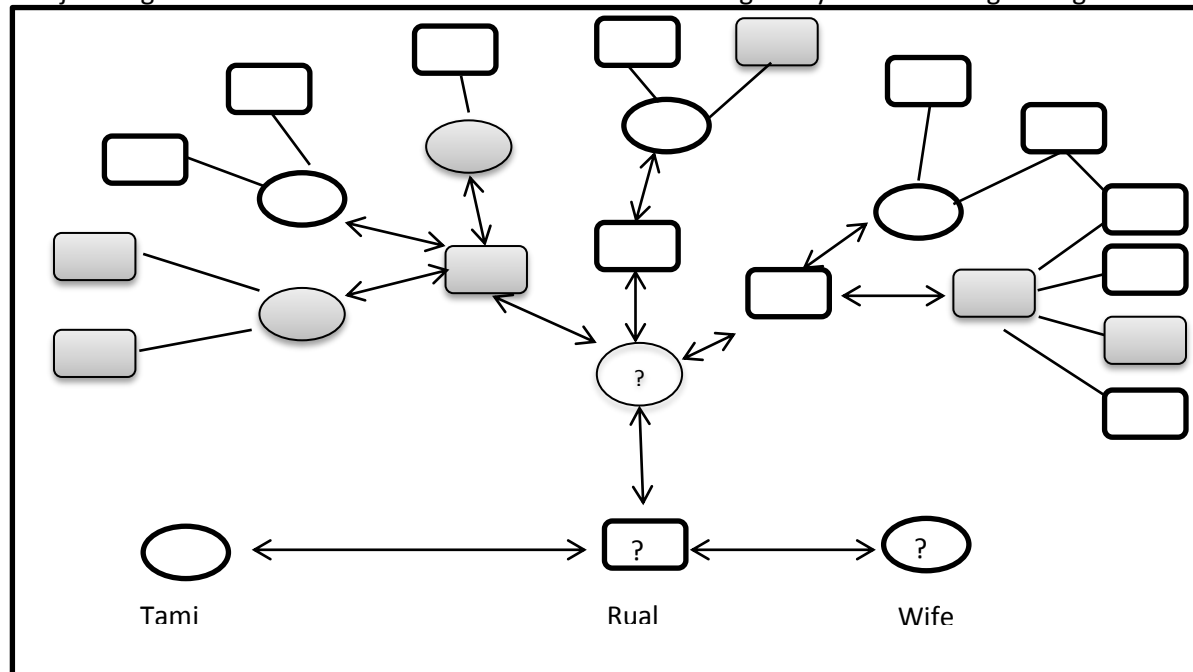
Key Messages: Intergenerational Sex

- Intergenerational sex is more common in some countries than others
- Intergenerational sex appears to have more potential dangers for women and girls including unwanted pregnancies, exposure to STIs and HIV
- Intergenerational sex creates an unbalanced power relations between partners where the one (usually the male) makes decisions about where, when and how sexual relations can occur – this includes condom use.
- Intergenerational sex is seen as one of the reasons for the high levels of HIV infection found in young girls and women and older men
- To address issues of intergenerational sex, we need to consider the male norms within areas, districts and countries

Activity 2.1.7: Sexual Networks:

Tami is a young smart and sassy 17 year old girl. She is in her final year at school and has begun a relationship with Rual (28 years) for the last 3 months. Tami trusts Rual as he makes her feel valuable and validated through the special gifts that he brings her and for saving her from that long walk home from school. She empathizes with Rual with his frustrations at being misunderstood by his wife but always insists that they use condoms. Recently, Rual has been complaining that condoms are stealing his mojo and he is placing a lot of pressure on Tami to stop using them, I mean they have been together for 3 months now and can trust each other.

Rual's sexual history before his wife is a shimmer in the past, he had one steady girlfriend though high school but they broke up before they finished college. Unbeknown to Rual, his ex-girlfriend's first partner has just begun ART. Neither he nor his wife has tested although they are discussing having another child.



Diagrammatic representation of sexual networks and their dangers

From the diagram ovals represent women and rectangles represent men. The shaded blocks indicate that the person is HIV positive, even if they are unaware of this and the question marks indicate that their status is unknown.

Group discussion:

What should Tami do?

Activity 2.1.8: HIV networks

Give a small piece of paper to every person. Before the activity starts, write the letter "C" on three of the pieces of paper. On one piece of paper write the letter "X". Everyone else will receive a blank paper. Make sure that you cannot see what is written on each paper, and then hand them out to each individual.

Get everyone to look at their paper and not show others. Ask them to stand up and walk around and shake hands with 3 other people. When each person has shaken hands with **ONLY** three others, they should go

back and sit down. Tell them to remember the faces of those they shook hands with.

Once everybody is sitting, ask the people with the letter X to stand up. These people should identify the people that they shook hands with and ask them to stand up. These people should identify the people that they shook hands as well; continue with this until everybody is standing up. Explain that the people with an X represent people who are infected with HIV. Shaking hands represents sexual activity, and only the people with the letter C had used a condom during the sexual intercourse. This exercise illustrates how sexual networks can ; lead to vulnerability to HIV infection.

Topic 7: HIV treatment care and support

Time: 90 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain what is meant by opportunistic infection
- ✓ Identify common OIs among people living with HIV and AIDS
- ✓ Explain the components of treatment, care and support for PLHIV

Materials and equipment needed

Build a character exercise instructions
Small group work instructions
Flip chart and koki pens
Resource pack

Note to facilitator

This is an intense session; it takes the participants through a long process. A lot of work is being done in groups. It is very important to keep track of the groups, keep the discussion focussed by going around and making sure that the groups are focussed. Encourage this group to do their own research – they can get more information on the resource pack.

Trainer Instructions

Activity 2.1.9: Build a Character for Treatment, Care and Support

Step 1 – 10 minutes

Ask participants to get into small groups of 4-5 people by counting from 1-5. Inform participants that all the people who were 1 when counting should get together, 2s together and so on, until everybody is in a group. Ask groups to find a space where they will work from. They must decide on the following:

- A name
- The sex
- The age
- Family make-up/composition
- Occupation (if applicable)

- Area that they live
- Successes
- Dreams
- Any other important information that we should know

Give them 3-5 minutes to build the fictional character. Give each group to introduce their character to the group.

Step 2 – 10 minutes

Inform all the groups that their character is afraid that he or she might have been exposed to HIV; they would like to know if you think they should test for HIV, if you think they should test – why should they test? Each group should list their reasons on a flip chart. This is their opportunity to promote VCT and provide reasons why they think community members should test for HIV.

Step 3

After VCT, their character has just been informed that he or she is HIV positive. Each group should list the emotions that they think their character is going through and the support they need to deal with this news.

Ask group to think of the different services that will be needed by their character. Guide them to think about what is needed for their physical and emotional health. Ask participants to think about the different role players who can provide care and support to their character. On a flip chart write the words below ask participants to discuss these terms in relation to their character

- ✓ Opportunistic Infections – what OI is their character likely to experience (resource pack)
- ✓ Care and support – what is meant by care and support
- ✓ Treatment – what treatment is available and when can their character expect to start treatment?

Step 4

Ask participants to prepare on a flip chart a 3 minutes presentation for their group. Assign a different topic for each group. The groups should select a presenter and all prepare a presentation on a flip chart paper. (This is based on their discussion that they already had, but they should now think as trainers and do a proper presentation of the information as trainers). Each group should select one person that will present on behalf of the group.

- ✓ Group 1: Pre and post-test counselling, ongoing counselling
- ✓ Group 2: Care and support for PLHIV
- ✓ Group 3: Opportunistic infection and treatment
- ✓ Group 4: HIV treatment
- ✓ Group 5: Positive Living

Step 5

All the groups get a chance to present to the bigger group. At the end of each presentation the facilitator should ask other members of that group to add if they have any additional points to add, then the other group members can add and ask questions for clarity. Once all the groups have had a chance to present, wrap up the session by highlighting all the different things that were discussed in this session and where they are found in the resource pack.

Topic 8: HIV treatment and adherence

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain what is meant by treatment adherence
- ✓ Identify barriers to treatment adherence
- ✓ Identify ways to support treatment adherence

Materials and equipment needed

Small group exercise instructions

Flip chart and koki pens

Resource pack

Activity 2.1.10: Treatment Adherence

Trainer Instructions

Divide the participants into 4 small groups, each small group should make a poster to educate people in the community about the topic they are given.

- ✓ Group 1 & 2: What is treatment adherence and why is it important for HIV management?
- ✓ Group 3: What are possible barriers to treatment adherence?
- ✓ Group 4: How to support treatment adherence?

Give each group 20 minutes to discuss and design their poster. Each group has 3 minutes to present their poster to the bigger group. Wrap up the session by highlighting the importance of on-going support for treatment adherence and the different role players in providing that support.

Topic 9: HIV and stigma

Time: 90 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explain what is meant by stigma
- ✓ Identify some feelings involved in being stigmatised

Materials and equipment needed

Small group exercise instructions

Flip chart and koki pens

Presentation on stigma (power point or flip chart)

Activity 2.1.11: The effects of HIV and AIDS Stigma

Trainer Instructions

Step 1 – 20 minutes

Ask participants to sit on their own, away from other participants. Then say “think about a time in your life when you were treated differently, isolated or rejected for being different from others –or a time when you saw

others treated this way?” (This example does not have to be related to HIV, it can be any form of isolation for being different)

- What happened?
- How did it feel?
- What impact did it have on you?

Ask participants to share with someone they are comfortable with. Invite participants to share their stories with the bigger group, ask volunteers to share.

Step 2 – 20 minutes

Then say “think about a time in your life when you treated somebody else differently, isolated or rejected them for being different –or a time when you saw others treated this way. (This example does not have to be related to HIV, it can be any form of isolation for being different)

- What happened?
- How did it feel?
- What impact did it have on you?

Invite participants to share their stories with the bigger group, ask for volunteers to share, don’t force anybody.

Step 3

Write on the flip chart the question “What is the meaning of stigma?”. Ask each participant to work on their own and write down their own definition of stigma. Ask participants to either explain stigma or give example of stigma. Wrap this session by explaining stigma and explaining the difference between internal and external stigma.

Step 4

Put the heading on flip chart papers: PLHIV, families of PLHIV; children of PLHIV; women; men; sex workers; gays
Put the flip chart on different areas around the room, divide participants into small groups, assign each group to a flip chart and ask them to go to the flip chart and brainstorm ways in which the group indicated can be affected by stigma, they must look at both immediate and long term effects. Give each group a minute, at the end of 60 seconds shout “change” and the groups should move to the next flip chart. Continue until all groups have contributed to all topics. When each group is back at the flip chart it started with, ask groups to select a person to present to the large group.

Step 4

Write on a flip chart “how does stigma affect up take of HIV related services?

Brainstorm in large group, discuss and add any information that does not come from the large group.

Topic 10: Testing

Ask the group how they are feeling about HIV and AIDS at this point. What are some of the thoughts and emotions that have been evoked?

End the session with the individual exercise hand out. These are questions that they should consider privately however if any wants to discuss these with you they should wait till after the session.

Activity 2.1.12: When last did you test for HIV? (Individual exercise)

Have you tested for HIV?

How long ago was your last test?

Are you at risk of having HIV? Consider the following:

- Have you had several sexual partners?
- Have you had sex with somebody whose HIV status you did not know?
- Of all your sexual partners, how many partners did they have?
- Did your partner/s always use protection with their other partners?
- Does our partner/s know the status of their ex-lovers
- Have you used injectable drugs or steroids and shared needles or other equipment during drug use?
- Have you had any sign of sexually transmitted infections, including smelly discharge, sore on private parts, pain during urination or sexual intercourse, lower abdominal pain in the last 6 months?
- Have you had sex for drugs or money?
- Have you had sex with someone who has a history of any of the above -- or with someone whose sexual history you don't know?

Topic 11: TB and HIV

It has been established TB and HIV are epidemics that feed off each other. TB is one of the most common opportunistic infections that cause deaths in HIV positive patients. TB/HIV co-infection is common, with Malawi reporting 78% co-infection rates¹, however the treatment programs tend to be implemented independently of each other.

Time: 90 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Discuss the signs and symptoms of TB
- ✓ Explain the importance of adherence to the medical treatment
- ✓ Identify TB infection control methods that can be used at home

Materials and equipment needed

Small group exercise instructions

Flip chart and koki pens

Presentation on stigma (power point or flip chart)

Activity 2.1.13: TB and HIV

¹ National AIDS Commission Malawi (2009) National HIV Prevention Strategy 2009 - 2013

Divide the group into 4 smaller groups and assign each group two topics on TB. Each group needs to develop a poster that can be used within the clinics and local communities to highlight their TB topics. The topics include:

- Signs and symptoms of TB
- Kinds of TB
- Treatment
- Link between HIV and TB
- Infection Control at home.

Facilitator Notes:

Facts about tuberculosis (TB)

- TB is curable!
- At least 50% of people living with HIV are also infected with TB, and 50% of those infected with TB also have HIV.
- If not treated properly, TB disease can be fatal and TB remains one of the world's top infectious killers.
- About 95% of TB deaths occur in low- and middle-income countries and it is among the top three causes of death among women aged 15 to 44.
- Tuberculosis typically attacks the lungs, but can also affect other parts of the body. It is spread through the air when people who have an active TB infection cough, sneeze, or otherwise transmit respiratory fluids through the air.
- Most infections are asymptomatic and latent, but about one in ten latent infections eventually progresses to active disease which, if left untreated, kills more than 50% of those so infected.

Typical Symptoms of TB disease

- A bad cough that lasts 2 weeks or longer
- Pain in the chest
- Coughing up blood or sputum
- Weakness or fatigue
- Weight loss
- Loss of appetite
- Sweating at night
- Fever

What is the link between TB and HIV?

- HIV, AIDS and TB are closely interrelated in the following ways
- TB suppresses the immune system, thus increasing vulnerability to HIV infection.
- HIV promotes the progression of latent TB to active disease and the relapse of the disease in previously treated patients.
- TB speeds up the HIV progression, so is HIV for TB, TB and is one of the leading causes of death among people infected with HIV.
- It also promotes both the progression of latent (inactive) TB infection in previously treated patients.
- TB is harder to diagnose in HIV positive people, and progresses faster.
- TB occurs earlier in the course of HIV infection than many other opportunistic infections.
- However TB is treatable even in people living with HIV.
- A person who has both HIV infection and TB disease has an AIDS-defining condition.

Classification of TB

Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and Active TB disease.

Latent TB Infection	Active TB Disease
• Latent /Silent TB occur when the bacteria are presents in the body, but this state is inactive and presents no symptoms. • Latent TB is not contagious; • The body is able to fight the bacteria to stop TB germs from growing. • People with latent TB infection do not feel sick and do not have any symptoms. • If a persons' immune system is challenge and becomes weaker, e.g. with age, or exposure to other illnesses that attack the immune system, e.g. HIV, then the TB bacteria becomes active in the body and multiplies. The person will go from having latent TB infection to being sick with TB disease. • Diagnosis of latent TB relies on the tuberculin skin test (TST) and/or blood tests. • It is importnat to stay healthy to prevent TB if infected	• When the TB bacteria become active and the immune system can't stop them from growing a person develops TB disease (active TB). • Active TB is the condition that can make one sick with symptoms, and it is contagious. • TB is curable • Without treatment, TB disease can progress from sickness to death. • The most common type of TB, affects the lungs. • Treatment is for 6 months and adherence is essential to prevent restistant TB • Diagnosis of active TB relies on X-Ray, or microscopic examination and microbiological culture of body fluids.

How can TB be prevented?

Personal hygiene is very important in preventing TB, such as:

- Use a tissue when coughing (cover your mouth)
- Wash your hands properly with soap and water
- Opening windows for fresh air to circulate (proper ventilation)
- Eating healthy diet that supports the immune system
- Getting a TB test regularly if you work, live in high risk environment
- Finishing TB medications
- Children to receive BCG treatment. The TB vaccine, (BCG) is given to children after birth to prevent TB including TB meningitis.
- Using medication as a preventive measure in high risk cases.
- Support people who are taking treatment to ensure compliance and increase cure rate.

TB Risk Factors

A number of factors make people more susceptible to TB infections. This is a particular problem in sub-Saharan Africa, where rates of HIV are high. Once a person is infected with TB bacteria, the chance of developing TB disease is higher if the person:

- –Has HIV infection;

- Has been recently infected with TB bacteria (in the last 2 years);
- Has other health problems, like diabetes, that make it hard for the body to fight bacteria;
- Abuses alcohol or uses illegal drugs; or
- TB treatment was not taken correctly in the past.
- Inhabitants and employees of locations where vulnerable people gather (e.g. prisons and homeless shelters), medically underprivileged and resource-poor communities, high-risk ethnic minorities, children in close contact with high-risk category patients, and health care providers serving these patients.
- Those who smoke cigarettes have nearly twice the risk of TB than non-smokers.
- Tuberculosis is closely linked to both overcrowding and malnutrition, making it one of the principal diseases of poverty.

Key Messages: HIV and TB

- **TB and HIV form a deadly duo that is known to kill most HIV positive persons**
- **TB is preventable**
- **TB is curable**
- **TB treatment is for 6 months**
- **Adherence is crucial not adhering leads to the possibility of TB becoming resistant to treatment and need for longer treatment period**

Module 2. 2: GENDER, HIV AND GENDER BASED VIOLENCE

This module is divided into two sections, the first considers Gender and HIV and the second considers Gender and Gender Based Violence. For the first section the aim is to build participants' understanding of the key concepts and principles behind gender norms and expectations. This will provide the foundation for discussions on how these gender norms make men and women vulnerable to HIV and AIDS. Another key factor that will be considered is that of gender based violence. These discussions will begin with an assessment of the participants' attitudes and values, a discussion on sex and gender, an exploration of social expectations of men and women, highlighting gender roles, gender issues and how these constructs relate to Gender Based Violence and HIV and AIDS vulnerability. The second section considers an exploration into the definitions and dynamics of Gender Based Violence, how this can increase a person's chances of contracting HIV and what can be done.

Section 1: HIV and Gender

Objective of this module

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

- Describe the nature of gender and how it relates to GBV and HIV and AIDS vulnerability
- Describe the difference between sex and gender
- Describe the key concepts and basic issues underpinning all forms of gender and gender issues.

Topic 1: Human rights

Time: 40

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify essential human rights that relate to Gender, HIV and AIDS
- ✓ Explain the foundation of the CEEP focus on GBV and HIV and AIDS Vulnerability

Materials and equipment needed

Flip chart and koki pens

Power point presentation or presentation prepared on a flip chart

Resource pack

Activity 2.2.1: Human Rights

Trainers Instructions

Step 1

- ✓ Write "Human Rights" on the flip chart. Ask participants, who has human rights and write their responses on the paper. Discuss the concept that everyone has human rights.
- ✓ Ask the respondents who or what grants human rights. Discuss the concept that nobody has to give these rights to you because you have them automatically from birth.

Step 2

- ✓ Ask participants for examples of human rights and write their responses on the paper.
- ✓ Ask how these human rights apply to HIV, Gender and Gender Based Violence.
- ✓ Discuss.

Key Information for this session

- ✓ Human rights are universal, inalienable, indivisible, interconnected and interdependent.
- ✓ Everyone is entitled to all the rights and freedoms, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.
- ✓ Prevention of and response to gender-based violence is directly linked to the protection of human rights.
- ✓ Acts of gender-based violence violate a number of human rights principles enshrined in international human rights instruments. These include, amongst others:
 - The right to life, liberty and security of person,
 - The right to the highest attainable standard of physical and mental health
 - The right to freedom from torture or cruel, inhuman, or degrading treatment or punishment
 - The right to freedom of opinion and expression, to education, to social security and to personal development

Human rights are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. These are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible. Universal human rights are often expressed and guaranteed by law, in the form of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups

Regardless of who we are, where we live or what we do, every human being has rights. They belong to everyone. Human rights address many aspects of our everyday lives from the right to food, shelter, education and health to the right to freedom of thought, religion and expression.

Topic 2: Understanding gender (optional)

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Explore why men and women are treated differently in society
- ✓ Examine the participants' attitudes and beliefs about gender
- ✓ Recognize the different groups that have power and the groups that are targeted for unfair treatment
- ✓

Materials and equipment needed

Four forced choice signs (Strongly Agree; Agree; Strongly Disagree; Disagree)

Flip chart and koki pens

Activity 2.2.2: Understanding Gender

Trainer Instructions

Step 1

Display the four choice signs around the room, leaving enough room around the sign for people to stand. Ask participants to come to the centre of the room. Explain the exercise to participants as follows:

- » There are four areas marked with AGREE or STRONGLY AGREE; DISAGREE or STRONGLY DISAGREE around the room.
- » A statement will be read out loud.
- » Each participant should think about how s/he feels about the statement and move to stand next to the page that best describes how they feel.
- » Participants should not analyze the statement or look at what other people are doing, they should think about what their reaction is to the statement and move to the corresponding paper immediately.

Step 2

Read the statements out loud and ask participants to move to one of following pages once the statement has been read: AGREE or STRONGLY AGREE; DISAGREE or STRONGLY DISAGREE (*Start with statements that are less threatening, e.g. a black cat crossing the road in front of you will bring you bad luck. Consider what is culturally appropriate and would be understood by the participants when you are making the statements.*)

Step 3

Ask a few people under each heading to share why they agree, disagree or strongly agree or disagree. Try to get everyone to participate in the discussion and share their views.

- ✓ As people explain why they agree or disagree with a statement, get people to think about what has informed their views, is it experience, what they were told or saw as they were growing up (socialization), something they read etc.
- ✓ Discuss the importance of realizing that our views are different and it is important not try to get everybody to have the same views as ours. (if everyone has the same opinion, play the devil's advocate by offering a different opinion).

List of statements:

- Friday the 13th is an unlucky day
- Every men deserved to have a son
- Good women take care of their household
- Men must make the decisions in the household
- Good children take after their fathers
- Self-respecting women do not go to shebeens or taverns
- Wives who respect their husbands have happy marriages
- Husbands are justified in beating their wives if she goes out without telling him
- Husbands are justified in beating their wives if she refuses to have sex with him
- Husbands are justified in beating their wives is she has an affair

Topic 3: Understanding sex and gender

Within this topic there are three possible exercises that can be used to explore the same issues. The selection of which exercise to use will be based on the target audience that is being trained.

Time - 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Differentiate between English words “sex” and “gender”
- ✓ Explore social and cultural expectations for males and females
- ✓ Illustrate the difference between those based on sex and those based on gender to highlight the seemingly natural gender inequalities.

Materials and equipment needed

Flip chart and koki pens

There are three optional exercises here:

Activity 2.2.3: Option 1: Listing the differences in biology and expectations between men and women.

Trainer Instructions

Step 1

- ✓ On the flip chart, write the word “sex” on the left side and “gender” on the right side.
- ✓ Ask participants to explain the meaning of these two words. Write their responses under the appropriate heading.
- ✓ Ask what the two words mean in their mother tongue (in groups that include people who speak English as a second language). Are there separate words that specifically mean sex and gender in the local language?

Step 2

- ✓ Explain the definitions of sex and gender, including the Key Discussion Points below.
- ✓ Write on another blank flipchart “Social/cultural expectations” and divide the sheet into two columns: one for Men/Boys and one for Women/Girls.
- ✓ Ask participants to tell you some social/cultural expectations for men and boys in their society.
- ✓ Repeat step above for women and girls.

Step 3

- ✓ For each expectation noted, discuss with participants if this expectation is based on sex or gender. For example, the expectation for women to have children is based on sex but the expectation for women to do the cooking for a family is based on gender.
- ✓ Explain to participants that you are almost ready to close this session. First, you want to verify that everyone is clear about the differences between sex and gender. Read a few of the following examples and ask participants to indicate whether the statement is based on sex or gender.
 - Women give birth to babies, men don’t (S)
 - Little girls are gentle, boys are tough (G)
 - Women can breastfeed babies, men can bottle-feed babies (S)
 - Most building-site workers in this country are men (G)
 - Men’s voices break at puberty, women’s do not (S)
 - According to UN statistics, women do 67% of the world’s work, yet their earnings for it amount to only 10% of the world’s income (G)

Activity 2.2.4: Option 2: Real men and Good women

Trainer Instructions

Step 1

In large letters on a flip chart write the phrase “REAL MEN...”

Ask the participants to complete this sentence and share their ideas about this means with a person sitting next to them. After two minutes ask the participants to share their discussion in large group. Draw a box on the flip chart and write down the responses inside the box, ask participants not to repeat what has been said already.

Step 2

In large letters on a flip chart write the phrase “GOOD WOMEN...”

Ask the participants to complete the sentence and share their ideas about this means with a person sitting next to them. After two minutes ask the participants to share their discussion in large group. Draw a box on the flip chart and write down the responses inside the box, as participants not to repeat what has been said already.

Activity 2.2.5: Option 3: The Sexy Relay²

This is a relay race in which participants are divided into two groups. Ideally each team has a range of ages and gender groups. Each participant gets a turn to partake in the race when they are tagged into the race by another participant. The first team with all the members completing their turn is the winner.

Place two flipcharts on the wall for everyone to see. Above one write “men” and above the other write “women”.

This is a drawing competition in which we are drawing a man or woman depending on which one the group has been selected to complete. The rule is that the person who is selected/tagged must run to the flipchart paper and can only draw one line. The next person can draw another until the picture is complete.

Get the race going and then announce that the clearest picture will win and that they need to highlight biological and social expectations of men and women, e.g. women have breasts, men may have beards, a baby on the woman’s back, hairstyles and clothes can also speak to these differences.

Once the teams are complete then call them back to the big group.

The facilitation of this exercise should focus on:

- General experiences of the exercise
- What the differences between the two drawings are
- The differences that have been identified, are these biological or social expectations? Highlight the biological in one colour and the social expectations in another.
- Where are the bigger differences biological or social expectations?
- Biological differences are carried by one sex only.
- Which roles can both men and women complete?

Now that the group has an idea of the differences between biology and social expectations and continue to highlight these differences:

- Women can get pregnant (s)

² This exercise is adopted from the ILO’s (2007) GET Ahead for Women in Enterprise: Training Package and Resource: African Edition.

- Women are responsible for the household and the children (g)
- Men have short hair and women have long hair (g)
- In this country, women earn less than men (g)
- Women are able to breastfeed (s)
- Women are traders and or accountants in some countries but these jobs are completed by men in other countries (g)
- Men usually have a lower voice than women when they sing (s)

Key Discussion Points

Sex

- ✓ Refers to the physical/biological differences between males and females
- ✓ Determined by biology
- ✓ Does not change (without surgical intervention)

Gender

- ✓ Refers to the social differences between males and females
- ✓ Determined by social factors—history, culture, tradition, societal norms, religion
- ✓ “Gender” in any given society involves the socialization for boys and girls, men and women that determines roles, responsibilities, opportunities, privileges, limitations, and expectations
- ✓ **Gender roles are learned, and can and do change – Important to emphasize!**

Gender is a neutral term, neither good nor bad, right nor wrong. For some, the word “gender” has become associated with women’s issues and women’s programs, feminists, and for some people gender has become a negative word that connotes exclusion or hatred of men. In fact, “gender” refers to both males and females.

The term “gender” is widely used in humanitarian aid programs. Surprisingly and unfortunately, many humanitarian workers do not understand its meaning. Gender is an English word; the meaning has changed over time. Twenty years ago, “gender” had the same definition as “sex.” The word does not translate easily into other languages. For each language, we must find a way to describe the concept of gender in ways that can be understood, not simply use the English word “gender.” It is useful to ask a few participants to translate “sex” and “gender” into local languages. Try to get the group to agree to use these translated definitions when talking about gender. Emphasize that inserting the English word “gender” into discussions in other languages is not an effective way to teach the concept of gender.

Topic 4: Gender fishbowl

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Discuss and be heard about gender issues
- ✓ Develop a better sense of understanding and empathy for the opposite sex

Materials and equipment needed

Question for men and women

Activity 2.2.6: Experiences of Gender Norms

Trainer Instructions

Step 1

Divide the participants in two groups – men and women separately. Ask the women to sit in a circle in the middle of the room and the men to sit around the outside of the circle facing outside. Begin the discussion by asking women the question below. The men have to sit and listen to what is being said. They are not allowed to answer or speak out.

Step 2

Once the women have talked about 15 minutes, close the discussion. Ask the men to switch places with the women and lead a discussion with the men while women sit and listen. After both groups have had an opportunity, discuss the activity and highlight the lessons for both groups in the session. Highlight the fact that as trainers both groups are representing the community and they should look at the views expressed as a representation of the views of the community members.

Fishbowl questions for women

- ✓ What do you think is the most difficult thing about being a woman in your community / in your country?
- ✓ What do you think men need to understand better about women?
- ✓ What do you find difficult to understand about men?
- ✓ What is one thing you do not want to hear again about women?
- ✓ What rights are hardest for women to achieve in your country?
- ✓ What do you remember about growing up as a girl in your country? What did you like about being a girl? What did you not like? What was difficult about being a teenage girl?
- ✓ Who are some of the positive influence in your life? Why are they positive?
- ✓ How can men support and empower women?
- ✓ Do men need to be empowered as well? In what way/s?

Fishbowl questions for men

- ✓ What do you think is the most difficult thing about being a man in your community / in your country?
- ✓ What do you think women need to understand better about men?
- ✓ What do you find difficult to understand about women?
- ✓ What do you remember about growing up as a boy in your country? What did you like about being a boy? What did you not like? What was difficult about being a teenage boy?
- ✓ What are some of the positive female influences in your life? Why are they positive?
- ✓ Should women be empowered?
- ✓ How can men support and empower women?

- ✓ Do men need to be empowered? In what way/s?

Topic 5: Gender norms and HIV and AIDS vulnerability

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Examine how messages about gender roles influence human behaviour
- ✓ Describe how gender roles can lead to vulnerability to HIV and AIDS for both men and women

Materials and equipment needed

Flip chart and koki pens

Activity 2.2.7: Gender Norms and HIV and AIDS Vulnerability

Step 1

Divide the participants into four groups – two should look at women and the other two groups should look at men in relation to the questions below:

- ✓ How can the social norms or expectations of “act like a man” **increase** one’s vulnerability to HIV and AIDS?
- ✓ How can the social norms or expectations of “act like a woman” **increase** one’s vulnerability to HIV and AIDS?
- ✓ How can the social norms or expectations of “act like a man” **decrease** one’s vulnerability to HIV and AIDS?
- ✓ How can the social norms or expectations of “act like a man” **decrease** one’s vulnerability to HIV and AIDS?
- ✓ Can men and women live outside the box? Is it possible for men and women to challenge and change existing gender roles and expectations?

Ask participants write their responses on a flip chart page and prepare a presentation for the large group. At the end of 15 minutes ask the group to get back together. As there are two groups for each themes, ask the first of the two to present, the second group should only add what has not been covered by the first group. Wrap up this session by discussing the how gender roles can lead to vulnerabilities; refer participants to the resource pack for more information on this subject.

Facilitators Notes

Gender Norms-key risks and vulnerabilities of women and girls

- Sexual subordination is a common factor in relationships between men and women in traditional patriarchal societies. In these relationships, women are required to be ignorant about sexual issues and remain passive recipients of men’s sexual advances and domination. This expected subordination results in women being unable to negotiate where, when and how sexual interactions occur, this includes condom use and other forms of protection.
- Violence against women and girls is supported by the gender values and expectations whereby a women or girl can be threatened, beaten or worse if she does not conform to the social expectations for her gender. This violence can come from family members, partners, other women or acquaintances. This threat of _____

violence increases a women's vulnerability to HIV infection by removing the space for her to negotiate sexual-decision making, including negotiating safer sexual practices. Additionally, the threat of violence silences or disempowers women from seeking out testing services, disclosing their status and accessing treatment and support services.

- Economic disempowerment silences women from negotiating or setting boundaries on practices they disapprove of. Economic disempowerment results in women not having access to resources to get to health facilities and pay for health care services, inclusion in ART and VCT services. At times, women require permission of their male partner to access services, creating a barrier. In Tanzania it was found that 40% of women do not have the final say in decisions over their own health, the children's health as well as say over the household expenditure³
- In many instances women tend to be the care givers, as a result women carry more of the burden of the disease because they are required to care for the infected person within the family. Typically the time required for such care reduces their access to schooling or engaging in income generating activities.
- These vulnerabilities are made worse by poverty, in case of poverty resources within families are allocated to men first, which can lead to women and girls having no resources to access health care services. During hard times girls are sometimes removed from schools to support the family through work or worse child labour. Women may also be forced to engage in transactional sex, selling sex for food, shelter, transport, etc.
- Limited access to education and higher illiteracy rates amongst women and young girls means that they would struggle to access prevention and treatment information. Added to that, illiteracy and low levels of education limits the choices of employment women can access, maintaining their economic disempowerment even more. The kinds of work women do often do not offer any social protection e.g. lack of medical aids, pensions, etc. leading to further disempowerment.
- Some property, inheritance, custody, social and customary laws where assets are passed down through the male side increase women and girls' vulnerability to HIV and AIDS even more. In some cultures, women who are widows are abandoned leaving them vulnerable, or in some cases leading to engage in transactional sex to gain resources for food.
- HIV related stigma and discrimination can result in women being excluded from society and reduces their access to care and support services.

Gender Norms-key risks and vulnerabilities for men and boys

- Due to traditional patriarchal norms that men are socialised in, they too may be at risk of contracting HIV. Below are some of the ways in which these masculinities increase their risk of infection and progression of the disease:
- Norms, stereotypes and expectations about male behaviour affects men's knowledge of sex and expectations within relationships. Men may subscribe to the ideas that real men have multiple sexual partners, which is already known to be a risk for HIV infection especially if protection is not used consistently and correctly. Additionally, ideas about masculinities may be strongly linked with alcohol use and abuse which reduces risk assessments and increase risk of infection. Accessing treatment and care services may be hard due to the expectations that men are strong and if a man admits that he is sick and accepts help, he is considered weak. Men may be required to constantly prove their male powers and masculinity through violence even directed at women and girls sometimes.
- Some of the jobs such as transport, construction and mining sectors, which are dominated by men may results in man being separated from their families for longer periods of time increasing men's vulnerability to HIV infection. When men are separated from their spouses there is an increased risk of engaging in multiple sexual partnerships, and this might be done without using sexual protection.
- Men may also engage in sex with other men and this practice is often considered a taboo and abnormal.

³ Prime Minister's Office. 2013. Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013 - 2017)

Due to the stigma associated with this practice, it can lead to silence and result in this practice being kept hidden and reduces the chances that these men would access health information and services.

- Often at a policy and service provision level, treatment and care programs are designed and targeted at women, encouraging women to take up these services. This reinforces the idea that women are solely responsible for sexual and reproductive health. This can increase men's vulnerability as it may be harder to find male orientated services.

Key Messages: Gender and HIV and AIDS Vulnerability

- **Women are at more risk of contracting and being affected by HIV than men. This is not only as a result of biological differences but due to social expectations and norms of women. In traditional societies women are seen to be subservient to men because of socialisation and beliefs about a women's place, economic disempowerment, exposure to violence and lower literacy levels or education.**
- **Men are vulnerable to contracting HIV due to male norms of men's sexual prowess, e.g. number of sexual partners, alcohol and drug use. Men are also vulnerable due to them not accessing health services when they are at risk (e.g. testing) or sick. Types of work can also increase a man's vulnerability to HIV, e.g. migrant work**

Section 2: Gender and Gender Based Violence

The second section considers an exploration into the definitions and dynamics of Gender Based Violence, how this can increase a person's chances of contracting HIV and what can be done.

Topic 1: Definitions of Gender Based Violence

Time: 20

Objectives of the session

By the end of this session participants should be able to:

- ✓ Describe gender based violence
- ✓ Identify the different forms of gender based violence

Materials and equipment needed

Flip chart and koki pens

Flip chart page with different definitions of GBV or power point presentation

Activity 2.2.8: Gender Based Violence Presentation

Trainer Instructions

Step 1

- ✓ Remind the group of the concepts covered in the previous flipchart. List them on a flipchart, leaving space between them to write more words later in the session:
GENDER
POWER
VIOLENCE/USE OF FORCE
INFORMED CONSENT
- ✓ Ask the group to put those terms/concepts together to describe the meaning of "gender based violence." Discuss, writing a few key words on the flip chart under each concept (see key discussion points below).

Step 2

- ✓ Show flip chart with different definition of Gender Based Violence – use the key information below to prepare flip chart.

Step 3

- ✓ Prepare two flipcharts, listing types and sites of gender-based violence before the exercise. During the discussion, display only the flipchart listing major types of gender violence, leaving the one listing the sites of gender violence covered until the end of the discussion.
- ✓ Divide participants into pairs and allows them 10-15 minutes to discuss which major types of violence occur in the family, community/society, businesses and the ones perpetrated or condoned by the state.

Types of Gender Based Violence	Sites for Gender Based Violence
Physical abuse: ○ Battering ○ Sexual assault Psychological abuse: ○ Deprivation of liberty, ○ Forced marriage, ○ Sexual harassment Deprivation of resources needed for physical and psychological well-being (including health care, nutrition, education, means of livelihood) Trafficking in women and girls for sexual exploitation Rape Corrective Rape Ridiculing and humiliating a woman or a girl	Family One of the primary sites of gender violence. Prepares its members for social life, forms gender stereotypes and perceptions of division of labour between the sexes. It is the arena where physical abuses (spousal battering, sexual assault, sexual abuse) and/or psychological abuses occur. (Domestic violence can also take such forms as confinement, forced marriage of woman arranged by her family without her consent, threats, insults and neglect; overt control of a woman's sexuality through either forced pregnancy or forced abortion.) Violence within the family and household takes place in the home and is often seen as a 'private' issue and information about it is lacking. Community/Society As a group sharing common social, cultural, religious or ethnic belonging, it perpetuates existing family structure and power inequalities in family and society. Justifies the behaviour of male abusers aimed at establishing control over women in the family, and supports harmful traditional practices such as battering and corporal punishment Businesses Workplace can also be a site of violence. Either in governmental service or in a business company, women are vulnerable to sexual aggression (harassment, intimidation) and commercialized violence (trafficking for sexual exploitation). State Legitimizes power inequalities in family and society and perpetuates Gender-based violence through enactment of discriminatory laws and policies or through the discriminatory application of the law. Is responsible for tolerance of gender violence on an unofficial level (i.e. in the family and in the community). To the extent that it is the State's recognized role to sanction certain norms that individual life and dignity and maintain collective peace, it is the State's obligation to develop and implement measures that redress gender violence.

Key information for this session

Putting concepts together to explain the meaning of "gender-based violence":

- Gender **based** violence, violence that occurs based on gender roles, expectations, limitations, etc. GBV therefore affects females in most societies; males are also victims/survivors of GBV, but most gender discrimination occurs against females because they are disempowered in most societies as compared to their male counterparts.
- Power: GBV involves the **abuse of power**
- Violence/Use of force: GBV involves **some type of force**, including threats and coercion.

Force is not always physical force. Using the word “violence” implies physical violence, but the meaning is broader than that.

- Informed Consent: Acts of GBV are characterized by the **lack of informed consent**
- Human rights: Acts of GBV are **violations of fundamental human rights**.

The U.N. General Assembly defined gender-based violence and violence against women in its Declaration on the Elimination of Violence against Women in 1994. UNHCR headquarters developed the following definitions based on that Declaration.

Expanded Definition of Sexual and Gender-based Violence used by UNHCR and implementing partners, based on Articles 1 and 2 of the United Nations General Assembly Declaration on the Elimination of Violence against Women (1993): **...any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women because of being women and men because of being men, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life...shall be understood to encompass, but not be limited to the following:**

1. Physical, sexual and psychological violence occurring **in the family**, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation
2. Physical, sexual and psychological violence occurring **within the general community**, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution
3. Physical, sexual and psychological violence **perpetrated or condoned by the State and institutions**, wherever it occurs.

Definition of Violence against Women and Girls

“...Violence against women encompasses, but is not limited to, the following.....physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution².” ²Article 2 of the Declaration on the Elimination of Violence against Women (General Assembly resolution 48/104)

Definition of Gender-Based Violence

Gender-based violence is violence that is directed against a person the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty...³. While women, men, boys and girls can be victims of gender-based violence, women and girls are the primary victims.

Definition of Sexual Exploitation

Any abuse, harm or suffering done to a person who is in a position of trust, vulnerability or differential power for sexual purposes. Sexual exploitation includes, but is not limited to, profiting monetarily, socially or politically from another person. Acts of sexual exploitation often occur under coercive or deceptive circumstances or where the victim/survivor does not have the power or capacity to give consent or to make decisions to end the exploitation

Alternative Exercises

Activity 2.2.9: Gender Based Violence Case Studies (20 minutes)

Read the following examples to participants. Then ask each question and discuss before moving on to the next.

In a very traditional and patriarchal family, the father of a 19 year old girl tells her that he has arranged for her to marry a certain man. The girl does not know the man very well, he is much older than she is, but she agrees to the marriage.

- Do you think this kind of situation could happen?
- Did she give her informed consent to this marriage?
- Was there any force used in this incident?
- Who is more powerful in this example – father or daughter?
- What kind of power does this father have?
- What kind of power does the daughter have?
- How does power relate to choice in this example?

A refugee woman with 3 children approaches an armed soldier at a checkpoint. The woman has been separated from the rest of her family and community; she is seeking refuge at a town on the other side of the checkpoint. The soldier asks the woman for some money to pay the fee; then he will let her through the checkpoint (there is no fee – he is asking for a bribe). The woman explains she has no money and nothing of value to offer. The soldier tells the woman that he will let her through if she has sex with him. The woman agrees.

- Do you think this kind of situation could happen?
- Did she give her informed consent for sex? (No; this was rape)
- Was there any force used in this incident?
- Who is more powerful in this example—soldier or woman?
- What kind of power does this soldier have?
- What kind of power does this woman have?
- How does power relate to choice in this example?

Key Messages: GBV and HIV and AIDS Vulnerability

- GBV can be physical, sexual or psychological and it increases the chances of contracting HIV.
- PEP is an effective means of preventing HIV infection after exposure to the virus
- PEP needs to begin within 72 hours after exposure
- Little is known about PEP and this should be a focus area for programs

Module 2.3: HIV AND AIDS EFFECTS AND VULNERABILITY REDUCTION METHODS

This module will consider some of the ways in which people can reduce their vulnerability to HIV and AIDS. In this section we are going to explore some of the factors that influence the use of the bio-medical and behavioural prevention methods, mentioned above. We will consider the psycho-social behaviours that help or hinder the use of these biomedical prevention methods. In order to facilitate or tackle this issue we will make use of the systems model mentioned earlier.

Objectives of this module

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

- Discuss the effects of economic disempowerment, gender equality and HIV and AIDS
- Highlight the risk reduction strategies and know how to address the barriers to their implementation
- Demonstrate ability to apply these ideas to their present life circumstances

Topic 1: Effects of HIV and AIDS

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the effects that economic disempowerment, gender inequality and HIV and AIDS has on an individual, family and friends, on communities and on businesses.

Materials and equipment needed

Flip chart and koki pens

Activity 2.3.1: Build a Character and the effects of HIV and AIDS

Trainer Instructions

Step 1:

Divide the larger group into 4 smaller groups. Get each group to build a character. They must decide on the following:

- A name
- The sex
- the age
- Family make-up/composition
- Occupation (if applicable)
- Area that they live
- Successes
- Dreams
- Any other important information that we should know

Step 2:

Each group gets 3 minutes thereafter to present this to the group

Step 3

Tell each group that their character went for a test and the result has come back HIV positive.

Now assign each group a topic to explore the impact of economic disempowerment, gender inequality and HIV and AIDS – you may have to assign the groups carefully to ensure that they are relevant, e.g. don't give a scholar the group 4 task

Group 1: Effects on the individual

How does economic disempowerment, gender inequality and HIV and AIDS effect the individual? In your discussions consider the biological, psychological, economic and social effects.

Group 2: Effects on friends and family

How does economic disempowerment, gender inequality and HIV and AIDS effect friends and family? In your discussions consider the psychological, economic and social effects.

Group 3: Effects on the community

How does economic disempowerment, gender inequality and HIV and AIDS effect community? In your discussions consider the psychological, economic and social effects.

Group 4: Effects on businesses

How does economic disempowerment, gender inequality and HIV and AIDS effect businesses? In your discussions consider the psychological, economic and social effects.

Facilitator's notes:

These are some things that can be considered in answering these questions, it is recognised that these lists of effects are by no means complete and there are more that can be added.

Individual effects:

Biologically: (briefly highlight the main points from the progression of the illness mentioned above)

- After initial infection the person may be unaware that they have been infected. However at this acute stage they are highly infectious to others.
- The latency or asymptomatic phase is where there is an on-going battle between HIV and the immune system. Through good nutrition and exercise this stage can be prolonged
- The symptomatic stage is where the opportunistic infections may try to take hold and The key thing to recall is that the early treatment of opportunistic infections the better as this will support the immune system
- The final AIDS Stage is where the body is severely weakened and opportunistic infections become rife. This stage is reversable with treatment but if treatment is not sought the infected person will die from any of these opportunistic infections.

Psychological effects:

Consider the way the person would feel at each stage of the illness, where emotions include things like shock, guilt, depressions, self-blame

Social effects:

With a person's depression and stigma within the communities a person can become more and more isolated from others. This not only effects the depression which can speed up the progression and negatively affect life expectancy.

How does this affect their gender role expectations?

Economic:

Initially the person's ability to perform business activities is not affected by the illness but as the illness progresses there will be more time off from work, perhaps a loss of income as they get more and more sick.

Family and Friends effects:

- The effects on families and friends will be influenced by who is involved, i.e. parents, grandparents, children, spouses,

etc.

Psychological effects:

Consider the way the family could respond to the disease. Does the person tell the family or keeps quiet. If the person does disclose, does the family respond positively or do they try to hide it?

How do people feel at a personal level about finding out that a family member is infected?

How does this influence the way that they respond to the person infected?

Social effects:

How the family feels will influence the manner in which they respond socially to the illness and the infected person. Do they try to hide it? If so how do they cope when the person infected enters the AIDS stage?

How does this affect their gender role expectations?

Economic:

Initially the person's ability to perform business activities is not affected by the illness. However, as the illness progresses; there will be more time off from work, perhaps a loss of income as they get more and more sick. This could have big repercussions on the family, that is to lose a productive bread winner.

Community Effects:

Psychological effects:

Consider the way the community could respond to the disease. Does the person tell the community or keeps quiet. If the person does disclose, does the community respond positively or do they try to hide it?

Social effects:

How the community feels will influence the manner in which they respond socially to the illness and the infected person. Do they try to hide it? If so how do they cope when the person infected enters the AIDS stage?

How does this affect their gender role expectations?

Economic:

What would the effects be on the community if more and more people become infected.

Business Effects:

Psychological effects:

What would the effects be on the other workers if more of their peers become infected and get sick? How does the person feel if they become less and less productive.

Social effects:

How the family feels will influence the manner in which they respond socially to the illness and the infected person. Do they try to hide it? If so how do they cope when the person infected enters the AIDS stage?

Economic:

Initially the person's ability to perform business activities is not affected by the illness but as the illness progresses there will be more time off from work, perhaps a loss of income as they get more and more sick. Some of the cost implications at this level include (in order to calculate these costs see the Advance Business Tools section):

- Training of new staff
- Costs of time before new staff become 100% productive
- Recruiting new staff
- Funeral attendance costs to company
- Costs of absenteeism
- Health costs to the company
- Burial costs to the company
- Decrease in productivity to the business

As a final thought the idea is to mention that we are all affected by HIV and AIDS at various levels, its for these reasons that we seek a comprehensive response.

Topic 2: HIV and AIDS Vulnerability Reduction Strategies

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the HIV and AIDS Vulnerability Reduction Strategies for individuals, families and friends, communities and businesses.

Materials and equipment needed

Flip chart and koki pens

Activity 2.3.2: HIV and AIDS Vulnerability Reduction Strategies

Trainers Instructions

Step 1

Go back to the “Build a Character” Exercise. Let each group discuss prevention and mitigation strategies that could be applied at their focus level, i.e. individual, family and friends, community and business. These discussions should consider some of the barriers to the use of these strategies.

Note:

Not all individuals are doing things that are unhelpful, e.g. a lot of people are using condoms and GBV is not necessarily prevalent in all relationships

Individual:

HIV prevention:

- Economic empowerment – for example, If you are engaging in transactional sex consider other options that don’t place you at risk of contracting HIV
- Know your status
- Delay sexual debut
- Reduce the number of partners
- Correct and consistent condom use
- Get medically circumcised – males only
- Make use of PTMTC services if pregnant
- Get treated for STIs as early as possible
- Don’t engage in intergenerational sex

AIDS Mitigation”

These responses seek to reduce the impact of AIDS on a person:

- Economic Empowerment
- Get tested
- See if you qualify for the treatment regimens as soon as possible
- PMTCT
- Health living and life style
- Reduce the number of partners

- Correct and consistent condom use
- Seek support from social networks and access resources where needed

Friends and Family:

HIV prevention:

- Economic Empowerment to help
- Consider the norms and values that you are reinforcing for your son or daughter
- if you were to have a daughter or if you have one, what is one piece of advice you would give her about growing up as a female to help her fight unfair treatment”
- How can you foster access to bio-medical prevention methods

AIDS mitigation:

- Economic empowerment to reduce the effects
- How can you foster behavioural norms that would improve persons accessing HIV and AIDS services

Community:

HIV Prevention:

What community programmes are there that could assist here?

Youth based programmes, community outreach events, role models, media representations, behavioural norms, gender norms, etc.

What services are there that could be accessed here?

VCT, MMC, PMTCT, STI treatment

AIDS mitigation

What community programmes are there that could assist here?

Home-based care programmes, spiritual counselling, etc.

What services are there that could be accessed here?

VCT, HIV treatment programmes, STI treatment, treatment of other Opportunistic infections

Business:

HIV prevention

Workplace programmes

HIV and AIDS policies

Topic 3: Bringing it all together

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify their vision for the next five years as well as actions, opportunities and challenges that can affect their achievement of these goals.

Materials and equipment needed

Flip chart and koki pens

7 blank pieces of paper for each individual

Activity 2.3.3: The Vision Journey

Trainers Instructions:

Step 1:

Introduce the idea of a Vision Journey⁴ to the beneficiaries. In order to complete this exercise we are going to consider 5 steps.

In completing this exercise beneficiaries will be required to draw on all the lessons that they have learnt thus far.

Step 2: - This should be a homework exercise (ideally completed by a couple)

The Vision:

Ask participants to take a piece of paper and think about the next five years. On the piece of paper create a collage of where you want to be in the next five years.

What are you dreaming of?

There is no right and wrong as this is your dream/s so feel free to create whatever you desire.

Step 3:

Divide the larger group into smaller groups. Although the exercises below are individual in nature, beneficiaries will share their **Vision Roadmaps** and **Action Pathways** within the smaller groups.

The vision roadmap:

On another piece of paper draw three circles. These should go up diagonally (see the pic below).

The achievement journey:

In the first circle consider where you have come from. Draw or write down:

- Where you come from
- Some of the major events in your life
- Some of the biggest successes/achievements
- Some of the biggest challenges

Life Now:

⁴ Adapted from Women's Empowerment Mainstreaming and Networkinh (WEMAN), 2010, Steering Life's Rocky Road: Gender Action learning for individual and communities Manual for Field Testing and Piloting, support provided from Odfam Novib.

In the second circle draw or write down aspects of your present situation:

- Where are you now
- Your present strengths and weaknesses
- Present occupation or business
- Some things about your family
- Describe your health
- Your socio-economic status
- Resources

Now join these two circles with a path. Consider was this path straight or were there many bends and potholes?

A vision of the future:

In the final circle consider what are some of your goals for the next five years. To do this look at the 5 year vision that you developed and draw out 5 priorities for the next 5 years. One of these priorities, at least one should speak to your socio-economic status, one should focus on gender relations and one should focus on an HIV and AIDS goal.

Write down these goals as SMART goals. That is, they should indicate:

S – Specifics

M – Measurable

A – Achievable

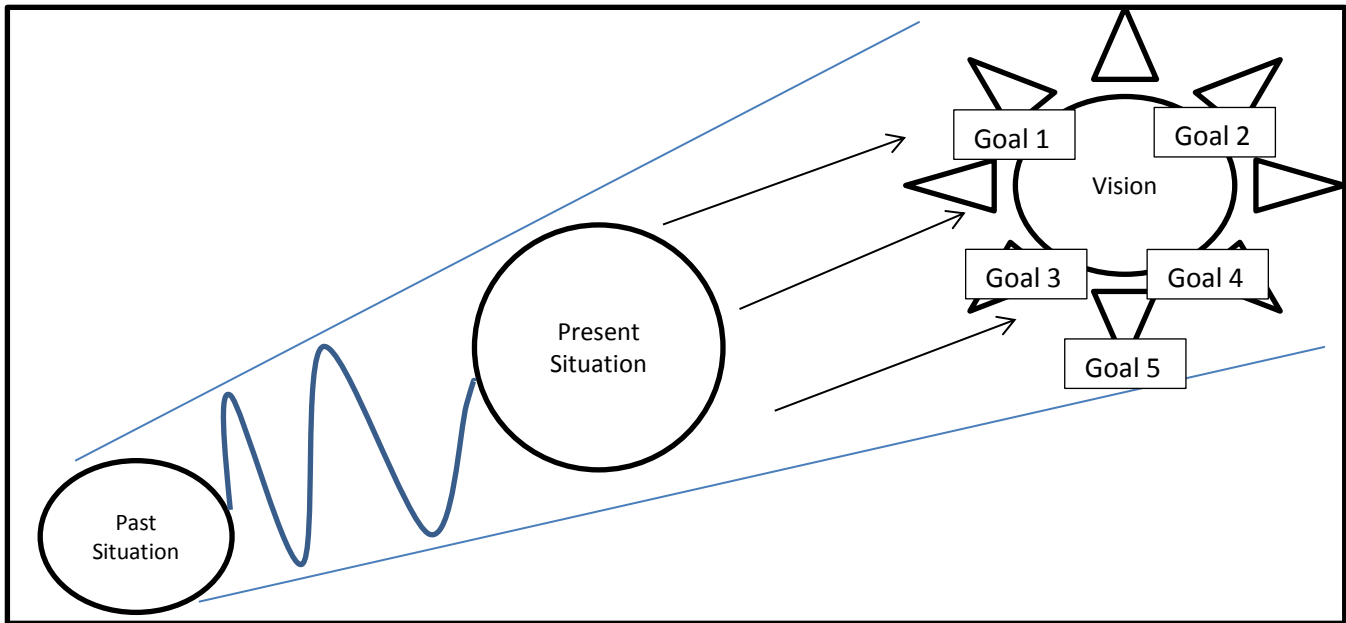
R – Realistic

T – Time bound

An example of a SMART goal would be:

- In five years' time (time), I will acquire a (measurable) blue Volkswagen GTI(specific)
- In five years' time, I will build a 4 bedroom house
- In five years' time, I will manage my HIV infection
- In five years' time, I will be HIV free

Join these last two circles with two straight lines.



Once this diagram has been completed share this within your smaller groups.

Facilitators Notes

An important aspect of this exercise is to highlight that people have come far and have overcome many challenges to get here. While we talk about the baggage that people bring, we often think that this is negative. Here is the chance to affirm the beneficiaries and remind them of their strength, loyalty, commitment, resourceful and passion. These are the kinds of characteristics that will carry them forward in the future towards success

Step 4: Group work

Action Pathways

Working in the smaller groups, beneficiaries will now consider the goals that they have identified in the Vision Journey Exercise. For each goal that has been identified beneficiaries will develop Goal pathways to have a look at how these goals can be achieved. The key question here is **how**?

On a piece of paper, draw a circle or square on the right hand side of the page. In this square, write down the goal that you have identified.

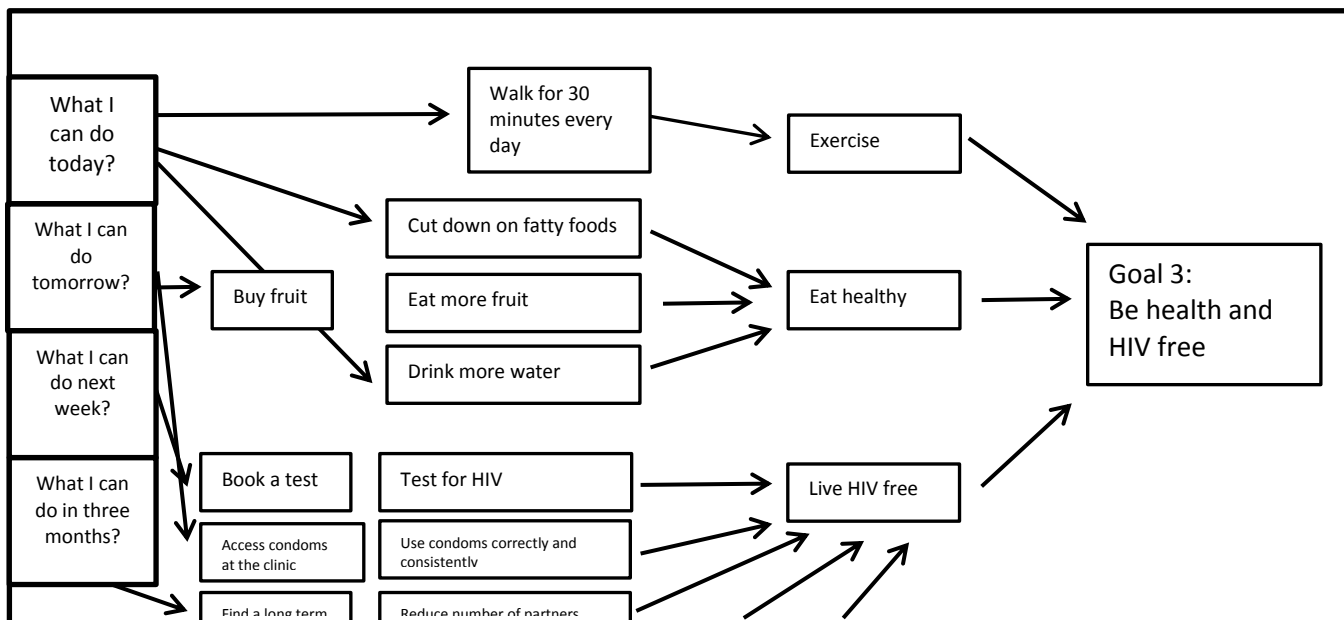
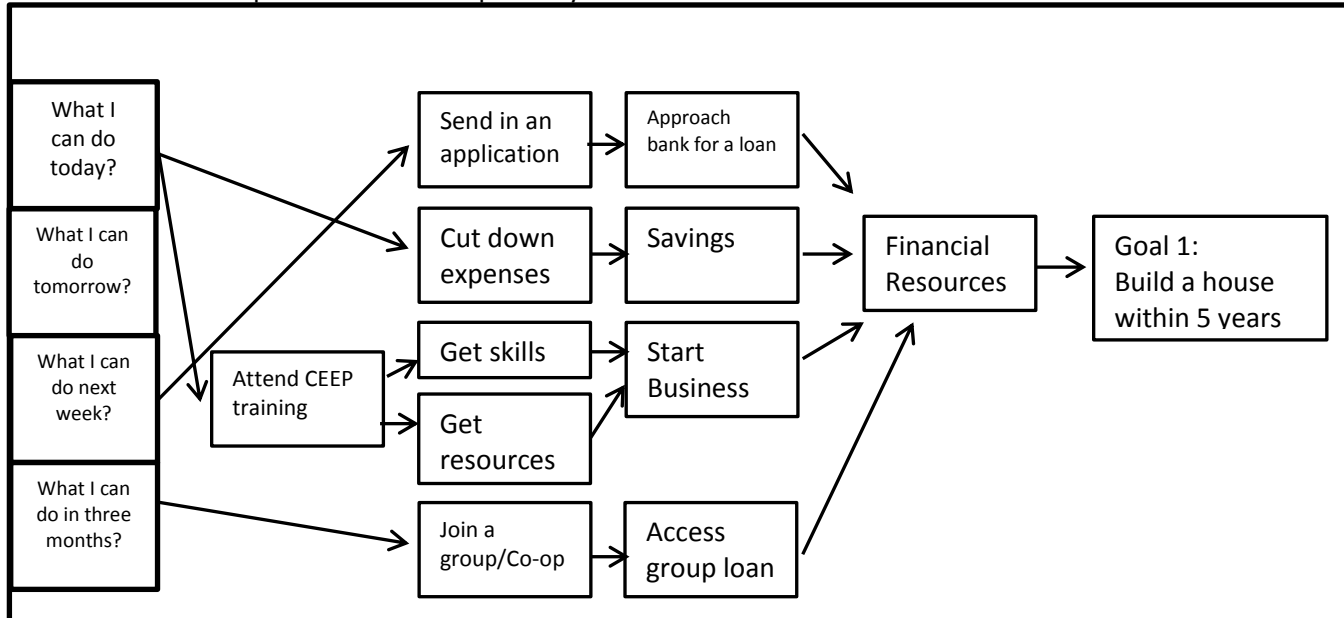
We are working backwards. Now draw a square or circle to the left of this initial goal. In this square consider one way in which or how this goal can be achieved. You need to note that there may be more than one factor that can lead to the achievement of this goal. For example, a straight forward relationship could be for a goal of "In the next five years, I will be buying a car" ... how?... "Build up financial resources". Or the relationship could be a little more complex for example for the goal "In the next five years I want to be healthy" there could be a few ways in which this could be achieved, e.g. "I will exercise"; "I will eat healthy"; "I will test for HIV"; "I will prevent myself from getting HIV", etc.

Once this second level of activities has been identified, take each activity and ask how you are going to achieve this. Remember that each activity can have one or more answers to the question of "How?". Keep asking this question and try to be as specific as possible.

Eventually you will not be able to ask “How?” anymore. The next step is to assign time frames to these actions. In this section consider the when these activities can take place: today, tomorrow, this week, in three months.

As this is group work, discussions among the members of the group will result in more options that the individual can think of.

Below are two examples of what these pathways could look like:



Step 5:

Ask the bigger group for a few 2-3 volunteers to walk us through their vision, their vision journey and their action pathways.

Facilitators notes:

These exercises are personal in nature and as such reinforcing sensitivity and the confidentiality ground rules is important.

If there are beneficiaries who are struggling emotionally with the exercise take them outside and let one of the facilitators talk to them

This is an exercise that could be completed by couples, which can be an advantage to the success of the project. However, we need to ensure that the one partner does not dominate the discussions and decisions or actions to be taken.

Emphasize that this exercise can be used for the achievement of many other goals in life. Working as a couple towards these goals will help to increase the chances of success. It is always advisable to have someone look at the plans as they might have other suggestions that we could miss.

Sometimes you will find that some of the goals can be linked. For example, "In the next five years I will buy a car"; "In the next five years, I will build a house", "In the next two years I will own a Television". All of these can be linked to building up financial resources.

PART 3: ADVANCE BUSINESS TOOLS

Within this section there are tools that are useful for small to big businesses. The first set of tools considers the costs of HIV and AIDS to a business and the second section considers the manner in which businesses can develop workplace policies.

Module 3. 1: CALCULATING THE COST OF HIV TO BUSINESS

This module will look at how HIV and AIDS affect business financially by exploring topics such as budgeting for HIV activities; itemising a budget for HIV activities; drafting a budget and calculating the impact of HIV on the workplace.

Objectives of this module

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

- ✓ List the items for inclusion in the programme activity budgets
- ✓ Explain the benefits of calculating the cost of HIV to the business
- ✓ Draft a budget for an HIV activity
- ✓ Demonstrate ability to calculating the financial impact spread sheet

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Demonstrate understanding for the relevance of budgeting.

Materials and equipment needed

Flip chart and koki pens
Colour coded cards

Introductory presentation on calculating the costs of HIV and AIDS on small, medium and big businesses

Trainer Instructions

Step 1

Blow is some pertinent information on the impact of HIV and AIDS on businesses and spend some time going through this information with the wider group:

Introduction

One of the most important issues management has to consider in making a decision about how to handle HIV at the workplace is the financial risk HIV infection presents to the organisation. Managers are likely to want to see some kind of cost–benefit analysis to help them make informed decisions. To date, the costs of STIs and HIV to businesses, as well as the benefits of prevention, have been quite a challenge to estimate.

Determining the precise benefit or value of a prevention programme is still complicated and is likely to vary in relation to the quality and comprehensiveness of the programme, and the availability of other programmes in the community. This Module is intended to guide the facilitator through the process of calculating the cost of an HIV programme and the impact of HIV on a business.

Budgeting for HIV Activities

From the beginning of developing programmes addressing HIV in the workplace, it is necessary think of cost. Some of the questions that should be asked early in the process are:

- ✓ What are the rough costs of the activities?
- ✓ What about cost sharing and with whom?
- ✓ Is the budget limit affordable?
- ✓ Who else can support the programme?
- ✓ What public services can be accessed to minimise costs?
- ✓ What needs to be done first and what can be done at a later stage?

Who should be involved in budgeting?

The task of developing a policy rests with a committee or task force comprising both staff and management. The same team should facilitate costing of planned activities. Consultations should be made with staff, management, the board, stakeholders and service providers.

Issues to take note of

In budgeting it is necessary to bear in mind the following issues:

- ✓ The informal activities that will be carried out and that have cost implications
- ✓ Not everything has to be done at once and activities can be phased
- ✓ Looking beyond the workplace for support
- ✓ Whether the in-house skills are adequate to facilitate the process, and seeking support if they are not
- ✓ Whether the organisation is sufficiently financially stable for the activities to be sustained
- ✓ Funding according to priority
- ✓ Creating room for flexibility to accommodate any changes that may occur.

Step 2

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Demonstrate the ability to develop itemised budget.

Materials and equipment needed

Flip chart and koki pens
Colour coded cards

Itemising the budget

Trainer Instructions

Step 1

Ask participants to imagine an HIV programme in a medium scale enterprise. Ask them, 'As a member of the HIV task team, what costs do you envisage could go into the HIV budget?' Allow the list to be as wide as possible, involving activities for prevention, care, treatment, support and mitigation.

What costs could go into a budget for HIV?

Many activities will involve time rather than money. The activities that involve expenditure include:

- ✓ Information materials
- ✓ Refreshments
- ✓ Consultation and facilitation fees
- ✓ Travel and accommodation
- ✓ First aid kits

- ✓ Condoms
- ✓ Health packages, health care medicines and ARVs
- ✓ Counselling and testing fees
- ✓ Treatment fees
- ✓ Staff costs
- ✓ Legal fees

Step 3:

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Demonstrate the ability to develop itemised budget.

Material and equipment needed

Flip chart and koki pens

Colour coded cards

Developing and understanding of itemized billing

Trainer Instructions

Step 1

Using the sample below, ask participants to design a draft budget for workplace activities on HIV for their enterprise.

Ask one participant to volunteer to present their draft budget. Discuss with the rest of the group issues such as who, what, when, where and the costs.

Activity/Item	Unit Cost USD	No.	Total	Notes
Four half day workshops for staff on stigma and VCT	200	4	800	Refreshment
Fees for 2 facilitators	50	2	100	
Purchase DVD on stigma	20	1	20	For awareness creation
Single sex 1 hour discussions	50	6	300	Lunch provided
Supply condoms to staff –	2	2 Boxes	2,000	Course fees and travel allowances
1,000 male; 100 female (2 per box)	150	3	200	Refreshment
Total Cost			450	

Step 4:

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Demonstrate their understanding of assessing the cost of HIV on a business.

Materials and equipment needed

Flip chart and koki pens

Colour coded cards

Brainstorming the relevant areas that HIV and AIDS impacts on in a business

Trainer Instructions

Using a brainstorming exercise, ask participants to jot down on cards pieces of information that could be used in calculating the impact of HIV in the workplace. As each participant pins their card on the board, ask them to explain how that piece of information would be helpful in the calculation. Ask the other participants to discuss its relevance. Wrap up with a presentation of information given below.

There are several broad categories of data used in determining the economic impact of HIV (and other STIs) in the workplace. These can be plotted on a spread sheet against the staff categories in the organisation. The categories include:

The number of employees and average salaries

- ✓ Labour turnover
- ✓ Training
- ✓ Reduced productivity
- ✓ Funeral attendance
- ✓ Absenteeism
- ✓ Recruitment
- ✓ Annual health costs
- ✓ Burial costs and death benefits.

For the purposes of the analysis, employees are described in several broad categories, in each of which HIV will have a varying impact on the overall costs. These are:

- ✓ Secretarial or support staff (SecStf)
- ✓ Manual labourers (ManLab)
- ✓ Supervising managers (SupMgr)
- ✓ Technical professionals (TecPro)
- ✓ Senior managers (SenMgr).

If the staff categories in your organisation are substantially different, you can make modifications as necessary. If a company decides not to use the suggested employee categories, different categories could be used or they could simply include all the employees in one column.

Step 4:

Time: 30 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Calculate the impact of HIV. (This activity is suitable as a company or enterprise activity).

Materials and equipment needed

Flip chart and koki pens

Colour coded cards

Completing the HIV and AIDS costing spread sheet

Trainer Instructions

Having made a prior arrangement with a suitable organisation, visit the organisation as planned. Using information provided in this module, ask permission from the Human Resources department to extract information that can be fitted into this tool. Modify the columns as needed to fit the organisation, without losing the essence of the tool. Calculate the impact of HIV for that enterprise. Compare and contrast your findings with the example given at the end of this Module. For a worked example of the spread sheet see attachment at the end of the Module

Calculating the Impact of HIV in the Workplace

This is not an activity that can be undertaken by every organisation due to its complexity. Nonetheless, it will be helpful to have participants review the various categories of impact of HIV on workplace costs, as they are many and broad. For companies that wish to embark on the full analysis of costs, the additional material at the end of this module includes sample spread sheets and technical notes to assist them. A simpler tool – the ILO HIV and AIDS workplace data collection tool – is also provided at the end of

SUMMARY

- ✓ Information necessary for budgeting for a workplace programme includes human resources, materials, activities, support etc.
- ✓ Impact assessments will need the help of specialists in the field of Health Economics as external contractors.
- ✓ Consider cost-sharing as an alternative, when resources are limited.

SAMPLE SPREADSHEET TO DETERMINE THE FINANCIAL IMPACT OF HIV ON A WORKPLACE (See the worked example)

		Category of Employee*				
		SecStf	ManLab	supMgr	TecPro	Sengr
1	Employees/Salary					
A	Total number of employees in each category of staff					
B	Gross weekly salary of all staff in each category					
2	Labour turnover					
C	Number of weeks to hire new employees in each category					
D	Lost labour cost (C*B/A)					

		Category of Employee*				
		SecStf	ManLab	supMgr	TecPro	Sengr
3	Training					
E	Number of weeks trainer is training each staff category					
F	Trainer's gross wage per week					
G	Typical class size for training each staff category					
H	Trainees' time (number of weeks trainees are in training)					
I	Weekly training wage per trainee (% of gross weekly wage (B) paid to trainee)					
J	Training cost per employee ((E * F) / G)					
K	Total salary paid to employee during training (H * I)					
L	Total training cost (J + K)					
4	Reduced productivity					
M	Number of weeks after training before productivity reaches 100%					
N	Productivity immediately after training (% of normal)					
O	Percentage productivity lost (100 – N)					
P	Total wages paid to employee before productivity reaches 100% (M*B/A)					
Q	Total productivity cost (.5*O*P)/100)					
5	Funeral attendance					
R	Average number of paid leave days a worker takes to attend a co-worker's funeral					
S	Average number of workers who took paid leave to attend each co-worker's funeral this year					
T	Productivity loss per co-worker funeral attended (R/5*S*B/A)					
6	Absenteeism					
U	Average number of absent days for Employees					
V	Number of days during this year workers with AIDS were absent					
W	AIDS cost (B/A*(V-U)/5)					
X	Number of days this year workers with HIV were absent					
Y	HIV cost (B/A*(X-U)/5)					
Z	Number of days this year workers with STIs were absent					
AA	STI cost (B/A*(Z-U)/5)					
7	Recruitment					
AB	Recruitment cost per employee hired in each category					
8	Annual health costs					
AC	Total cost of all employee claims this year					

		Category of Employee*				
		SecStf	ManLab	supMgr	TecPro	Sengr
AD	Total number of employee claims this Year					
AE	Cost per claim this year (AC/AD)					
AF	Average number of health claims per employee with AIDS					
AG	Average number of health claims per employee with HIV					
AH	Average number of STI-related claims per employee					
AI	Health care cost per employee due to AIDS (AE*AF)					
AJ	Health care cost per employee due HIV (AE*AG)					
AK	Health care cost per employee due to STI (AE*AH)					
9	Burial costs/death benefits per employee					
AL	Cost of coffin (if paid for by organisation) plus other death benefits paid to family					
AM	Other costs (not paid to family), excluding lost labour due to funeral attendance					
AN	Total burial cost (AL+AM)					
10	HIV and AIDS Rates					
AO	AIDS prevalence (%)					
AP	HIV prevalence (%)					
AQ	STI prevalence (%)					
AR	AIDS cases (A*AQ/100)					
AS	HIV cases (A*AP/100)					
AT	STI cases (A*AQ/100)					
	Anticipated decreased revenues and increased expenditures Decreased revenue					
AU	Revenue for the organisation this year					
AV	Labour turnover (AR*D)					
AW	Training (AR*L)					
AX	Reduced productivity (AR*Q)					
AY	Funeral attendance (AR*T)					
AZ	AIDS absenteeism (AR* W)					
BA	HIV absenteeism (AS*Y)					
BB	STI absenteeism (AT*AA)					
BC	Decreased revenues in each category(sum of AV through BB)					
BD	Summary revenue impact of STI, HIV and AIDS across categories (sum of all categories in BC)					
BE	Total revenue with STI, HIV and AIDS (AU- BD)					
	Increased expenditures					
BF	Expenditures incurred by the organisation this year as reported					

		Category of Employee*				
		SecStf	ManLab	supMgr	TecPro	Sengr
BG	Recruitment (AR*AB)					
BH	Health care costs - AIDS (AR*AJ)					
BI	Health care costs - HIV (AS*AI)					
BJ	Health care costs - STI (AT+AK)					
BK	Total health care cost (sum BH to BJ)					
BL	Burial (AR*AN)					
BM	<i>Anticipated increased expenditures in each category due to STI, HIV and AIDS (BG+BK+BL)</i>					
BN	<i>Summary of anticipated expenditure impact of STI, HIV and AIDS across categories (sum of all categories in BM)</i>					
BO	<i>Total expenditure with STI, HIV and AIDS (BF+BM)</i>					

Summary of HIV and AIDS Impact on the Organisation		
Projected HIV & AIDS cases		
BP	AIDS cases this year (sum across AR)	
BQ	HIV cases this year (sum across AS)	
Distribution of costs		
BR	STI cases this year (sum across AT)	
BS	Organisation profits without STI , HIV and AIDS (AU-BF)	
BT	Organisation profits with AIDS (BE-BO)	
BU	Decrease in profits as a result of STI, HIV and AIDS (BS-BT)	

Distribution of costs		
Labour turnover (sum across AV)	\$	(sum across AV*100/BU) %
Training (sum across AW)	\$	(sum across AW*100/BU) %
Reduced productivity (sum across AX)	\$	(sum across AX*100/BU) %
Funeral attendance (sum across AY)	\$	(sum across AY*100/BU) %
AIDS absenteeism (sum across AZ)	\$	(sum across AZ*100/BU) %
HIV absenteeism (sum across BA)	\$	(sum across BA*100/BU) % STI
absenteeism (sum across BB)	\$	(sum across BB*100/BU) %
Recruitment (sum across BG)	\$	(sum across BG*100/BU) %
Health care (sum across BK)	\$	(sum across BK*100/BU) %
Burial (sum across BL)	\$	(sum across BL*100/BU) % STI/HIV
and AIDS impact per employee		

Topic 1: Technical notes for completion of impact spread sheet

The letters in the left-hand column correspond to the letters of individual lines found in the spread sheet

The technical notes describe the data needed for the individual lines and, in some cases, suggest where the data could be obtained.

I Employees/Salary

- A. The number of employees, by each employee category in the organisation, obtained from organisation records.
- B. This number is obtained by dividing the gross wage (including benefits) of all employees in each category by the number of employees in that category.

II Labour turnover

Labour turnover is treated as a loss in revenue since the number of weeks it takes to hire employees is a period of lost revenue (this cost may also represent increased expenditures if temporary workers are hired or existing employees must be paid overtime). The cost of training is treated as a decrease in revenue because new employees in training do not contribute to productivity

- C. The number of weeks it takes to hire an employee in each category. D. This number is obtained by multiplying line item B by line item C.

III Training

- E. The number of weeks a trainer/supervisor spends in training an employee, by each employee category. This is based on how long it takes to train this cadre of employees. F. The trainer's weekly wage is their weekly wage.
- G. This number represents the typical class size for trainees in each employee category. If training is predominantly on a one-to-one basis, the average class size should be set to 1.
- H. This is the length of time in weeks that new or promoted employees receive training, by each employee category.
- I. The gross wage of a trainee per week, in each employee category. It is assumed here that the trainee will be paid a certain percentage of normal weekly gross pay. That percentage is multiplied by the average gross weekly wage. For example, if the average weekly gross wage is X (obtained from line item B), and a trainee is paid 90% of that during training, then the pay would be $.9 \times X$.
- J. This is the training cost per employee, by each employee category. The number is obtained by multiplying E by F and then dividing the product by G (weekly salary paid to trainer divided by number of trainees).
- K. This is the total salary paid to employee while in training. This number is obtained by multiplying H by (weekly training wage per employee by the number of weeks spent in training).
- L. This number represents the total cost of training each employee, obtained by adding J to K (training cost per employee added to total salary paid to employee while in training).

Reduced productivity

Once an employee has been trained, they will begin working but at less than 100% productivity. The organisation will provide:

- M. Information on how long it takes before a trainee reaches 100% productivity. If the information is in percentage (e.g. 30% of the year), multiply this number by 52 weeks in a year and divide the product by 100 to get the number of weeks the trainee is not yet at full productivity.
- N. The organisation will provide information on the employee's level of productivity after training.
- O. This number represents the percentage productivity lost. It is obtained by subtracting N from 100.

- P. Total wages paid to employees before they reach 100% productivity. It is assumed that the employee will be paid the same salary as regular employees after training.
- Q. The total productivity cost is obtained by multiplying O by 0.5 and by P, and then the product is divided by 100.

Note that O through Q refers to the reduced productivity of new employees who have not reached a level of full proficiency. There is also reduced productivity due to absenteeism, but this is calculated elsewhere: AZ to BB, revenue loss due to HIV and AIDS absenteeism.

V Funeral attendance

Funeral attendance is seen as decrease in revenue, since those who attend a funeral take time off and do not contribute to productivity, thus resulting in a reduction in revenue generated by the organisation.

- R. The organisation provides the average number of paid leave days employees in each category take to attend each funeral.
- S. This is the average number of workers who took paid leave to attend each co-workers' funeral. The organisation provides the number of employees in each employee category.
- T. Productivity loss per co-worker funeral attended, obtained by multiplying T by R/5 and by B/A.

VI Absenteeism

Absenteeism because of STIs, HIV and AIDS is treated as a loss in revenue because absent employees do not contribute to productivity. Once again, depending on how the organisation responds to absenteeism, this cost may actually be an increased expenditure rather than lost revenue

- U. Average number of absent days for employees.
- V. The organisation provides information on the number of days during the year that employees with AIDS were absent. If not available, use 65 days.
- W. The cost of AIDS absenteeism to the organisation, obtained by multiplying the gross weekly wage of each employee category, i.e. B/A by (V-U) and then dividing the result by 5.
- X. The organisation provides information on the number of days during the year employees with HIV (but not AIDS) were absent. If not available, use 15 days. This represents the cost of HIV absenteeism to the organisation. This figure is obtained by multiplying (B/A) by (V-X) and then by dividing the result by 5.
- Y. The cost of HIV absenteeism to the organisation is obtained by multiplying the gross weekly wage of each employee category i.e., (B/A) by (X-U) and then dividing the result by 5.
- Z. The organisation provides information on the number of days during the year employees with STIs were absent. If not available, use 10 days. This represents the cost to the organisation of absenteeism resulting from STIs. The figure is obtained by multiplying (B/A) by (V-Z), then dividing the result by 5.

VII Recruitment

- AC The total cost of all health claims by employees in each category, this year. If not available, obtain the total number of claims made by all employees in all categories, this year. AD The total number of employee health claims made, by each employee category. If not available, obtain the total number of claims made by all employees in all categories, this year.
- AE This number is obtained by dividing AC by AD.
- AF This is the average number of AIDS - related claims made by employees during the year.
- AG This is the average number of HIV - related claims made by employees during the year.
- AH This is the average number of STI - related claims made by employees during the year.
- AI This is the health cost per employee due to AIDS, obtained by multiplying AE by AF.
- AJ This is the health cost per employee due to HIV, obtained by multiplying AE by AG.
- AK This is the health cost per employee due to STIs, obtained by multiplying AE by AH.

IX Burial costs/death benefits per employee

- AL The market price of a coffin this year plus benefits paid to the deceased's family, in cash or kind. If in kind, give cash value equivalent.
- AM The cost of organisational representation in funerals this year (excluding lost labour due to funeral attendance). Examples of this include transportation of employees to funerals, flowers, per diem, etc.
- AN This is the total burial cost, obtained by adding AL to AM.

X HIV and AIDS rates (assume the same for each category of employee unless specific information is available)

- AO To obtain AIDS prevalence (%), use the rates of the city/area/region where the organisation is located. If this information is not available, use the national AIDS prevalence.
- AP Use the same rule as in AO above to obtain HIV prevalence.
- AQ Use the same rule as in AO above to obtain STI prevalence.
- AR This number is obtained by multiplying the AIDS prevalence, AO, by the number of employees in each employee category, A. For example, if the AIDS prevalence is X and the number of employees in the support employee category is Y, the number of new AIDS cases will be obtained by multiplying X by Y and dividing the result by 100.
- AS This number is obtained by multiplying the HIV prevalence, AP, by the number of employees in each employee category, A, then dividing by 100. For example, if the HIV prevalence is X and the number of employees in the support employee category is Y then the new HIV cases is $X*Y/100$.
- AT This number is obtained by multiplying the STIs prevalence AQ, by the number of employees, in each employee category. For example, if the STIs prevalence is X and the number of employees in the support employee category is Y, then the new STIs cases in this category will be $X*Y/100$.

Anticipated decreased revenue and increased expenditures

- AU The organisation will provide the revenue figure for the year.
- A To calculate decreased revenue due to labour turnover, multiply D by AR. AW To calculate decreased revenue due to training, multiply L by AR.
- AX To calculate decreased revenue due to productivity loss, multiply Q by AR. AY To calculate decreased revenue due to funeral attendance, multiply U by AR. AZ To calculate decreased revenue due to AIDS absenteeism, multiply W by AR.
- BA To calculate decreased revenue due to HIV absenteeism, multiply Y by AS.
- BB To calculate decreased revenue due to STI absenteeism, multiply AA by AT. *Where the epidemic has hit some categories of workers especially hard, some companies have resorted to double hiring in anticipation of higher labour turnover due to HIV. Thus, the values in AV through BA will increase to reflect these costs.*
- BC To get total decreased revenue due to HIV, add AV through BB.
- BD To get total decreased revenue across all categories, add BC across all employee categories.
- BE To get total revenue in the presence of STIs, HIV and AIDS, calculate the difference between AU and BD.
- BF The organisation will provide the expenditure figure for the year.

- BG To calculate the increased expenditure for recruitment due to HIV, multiply AB by AR.
- BH To calculate increased expenditure due to AIDS, multiply AI by AR.
- BI To calculate increased expenditure due to HIV, multiply AJ by AS.
- BJ To calculate increased expenditures due to STDs, multiply AK by AT.
- BK To calculate the total health care cost, add BH to BJ.
- BL To calculate the increased expenditure due to burial, multiply AN by AR.
- BM To calculate increased expenditures due to HIV, AIDS and STIs in each category, add BG, BH, and BI.
- BN The summary of anticipated expenditure due to HIV, AIDS and STIs is obtained by adding BJ across all employee categories.
- BO Total expenditure in the presence of HIV, AIDS and STIs is the sum of BF and BJ.

Summary of HIV and AIDS Impact on the Organisation

- BP To get the total number of new AIDS cases in the organisation this year, add AR across all employee categories.
- BQ Total number of new HIV cases in the organisation this year is obtained by adding AS across all employee categories.
- BR To get the total number of new STI cases in the organisation this year, add AT across all employee categories.
- BS To calculate profits under the no-AIDS scenario, subtract the difference between AU and BF.
- BT To calculate profits under the AIDS scenario, subtract the difference between BE and BL.
- BU To calculate the decrease in profits due to AIDS, subtract the difference between BS and BT.

Module 3. 2: WORKPLACE HIV POLICIES AND PROGRAMMES

The purpose of this module is to outline HIV workplace policies and what they accomplish. The module will also explore the 10 key elements of an HIV policy, describe how to formulate workplace HIV policies and programmes and how to supporting labour legislation for workplace HIV policies and programmes

Objectives of the module

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

- ✓ Define a Workplace HIV policy
- ✓ Define a workplace HIV programme
- ✓ Outline the elements an effective workplace HIV policy
- ✓ Outline elements of an effective workplace HIV programme
- ✓ Demonstrate ability to formulate a Workplace HIV policy
- ✓ Explain basic communication strategies for implementing a workplace HIV programme
- ✓ Describe the legal framework that supports the proper implementation of workplace HIV initiatives.

Topic 1: Introduction to HIV and AIDS workplace policies

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify the basic components of an HIV workplace policy.
- ✓ Identify the basic components of an HIV workplace programme.

Materials and equipment needed

Flip chart and koki pens

Trainer Instructions

Step 1

Divide the participants in small groups of 5-6 people, distribute handout 1 & 2 to all participants and ask participants to read through the handouts and answer the questions below:

1. Based on the handouts on HIV workplace policy and HIV workplace programme, how would you go about formulating your HIV policies and programmes in workplace;
2. What pieces of legislation would be applicable in your own country

Give the groups 20 – 30 minutes to read through the information and then discuss, at the end of 30 minutes ask participants to feedback to the large group. Ask a group to volunteer and present and ask the rest of the groups to add any points that were left out by the first group.

Step 2

Facilitate a discussion regarding HIV workplace policy and programme using the information presented below. Use the same information on handout 1 & 2 to prepare a presentation that will be used to emphasise key points and wrap up this session.

Hand-out 1: HIV workplace policy

An HIV workplace policy makes provision for the basic framework for company/organisation action to reduce the spread of HIV and to manage its impact in the workplace. Developing an HIV workplace policy should be the initial step for any company in its commitment to address HIV. Such policies will clearly state the company's position on the issue and articulate a set of guidelines that management staff can follow in the future. HIV workplace policies also outline the responsibilities, rights, and expected behavior for management and employees.

What does a Workplace HIV policy accomplish?

- ✓ Makes an explicit promise for corporate action.
- ✓ Commits to confidentiality and non-discrimination for all employees.
- ✓ Ensures consistency with appropriate national laws.
- ✓ Encourages all employees (regardless of HIV status) to support an inclusive and non-stigmatizing working environment.
- ✓ Provides guidance to supervisors and managers.
- ✓ Explains to employees living with HIV the type of support and care they will receive, so they are more likely to come forward for counseling and testing.
- ✓ Helps stop the spread of the virus through prevention programs.
- ✓ Makes the policy available to all employees, in a format that is easily understood.
- ✓ Manages the impact of HIV with the ultimate aim of cutting business costs.

10 Key elements of an HIV Workplace Policy

The International Labour Organization (ILO) recommends that every workplace HIV policy should have the following key elements:

1. Recognize HIV as a workplace issue

HIV is a workplace issue because it affects workers and enterprises—cutting the workforce by up to 30 percent in some countries, increasing labor costs and reducing productivity. Recognizing the link between workplaces and the surrounding communities, business also has a role to play in the wider struggle to beat the epidemic.

2. Prevent discrimination

HIV should be treated like any other serious illness/condition in the workplace. There should be no discrimination against workers on the basis of real or perceived HIV status. The non-discrimination principle extends to employment status, access to health insurance, pensions, and other staff entitlements. Stigmatization and discrimination against people living with HIV actually inhibits prevention: if people fear the possibility of discrimination, they are less likely to undergo counseling and testing and seek out treatment. As a result, they may unknowingly pass HIV on to others. Additionally, those who are positive are more likely to conceal their status for fear of being shunned by their co-workers or fired.

3. Foster gender equality

The gender dimensions of HIV should be recognized. Women are more likely to become infected and more often adversely affected by HIV than men, for biological, socio-cultural, and economic reasons. HIV programs must therefore respond to the circumstances and needs of men and women separately, as well as together. Prevention, testing, and other support decrease the impact of the epidemic.

4. Forster healthy work environment

The work environment should be healthy and safe, as far as is practicable, for all concerned parties. This means employers are responsible for providing information on HIV transmission and appropriate first aid in the event of an accident. It does not, however, give employers the right to test employees for HIV in the interest of public health, because casual contact in workplace presents no risk of HIV transmission. In addition, a healthy work environment tries to accommodate all workers (in consideration of their physical and mental health) and thereby mitigate the impact of AIDS on workers and the enterprise.

5. Encourage social dialogue

Successful HIV policies require cooperation and trust between employers, workers and their representatives, as well as government, where appropriate. This is fundamental, as policies are more likely to be used effectively if they have been developed with the full participation of all concerned parties.

6. Prevent screening for purposes of exclusion from employment

Companies should not require HIV screening of new applicants or current employees. HIV screening not only violates the right to confidentiality, but is impractical and unnecessary. At best, HIV test results are snapshots of individuals' infection status today. It is no guarantee that they will remain HIV negative or that they will not become infected tomorrow, or next month. It is also important to remember that people with HIV are often healthy and are able to be productive workers for many years.

7. Provide for confidentiality

Companies are never justified in asking job applicants or workers to disclose HIV-related information. Nor should coworkers be obliged to reveal such information about fellow workers. Access to personal information of this type should be strictly bound by confidentiality provisions (e.g., managers and health personnel can sign confidentiality pledges to show their commitment to this principle). Violating employee confidentiality will erode trust, employee morale, and productivity as well as encourage possible legal action.

8. Provide for continuation of the employment relationship

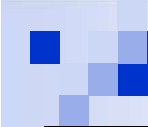
HIV infection cannot be a cause for termination of employment. Persons with HIV should be encouraged to work for as long as they are medically fit for available, appropriate work. This principle is based on the fact that being HIV positive is not the same as having AIDS and related opportunistic infections.

Reasonable accommodation to help people continue working can include flexible working hours, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work, and return-to-work arrangements. With the availability of antiretroviral therapy, ongoing employment is advantageous for both the employee and the employer.

9. Prevent HIV infection

HIV infection is preventable. Prevention of all means of transmission can be achieved through a combination of strategies: informational materials, participatory education classes (including personal risk assessment and life skills), practical support for behavioral change (such as condom distribution and encouraging family living situations among employees), and treatment for other sexually transmitted infections.

10. Provide care and support



Solidarity, care, and support should guide the response to HIV in the workplace. Prevention, care, and treatment should be seen on a continuum of workplace programming. Available treatment encourages confidential voluntary testing, which makes it easier to provide care and also encourage prevention. Care and support include voluntary testing and counseling; treatment for opportunistic infections, especially tuberculosis, and antiretroviral therapy, where affordable; workplace accommodation; employee and family assistance programs; and access to benefits from health insurance and occupational schemes.

Hand-out 2: H I V workplace programmes

An HIV workplace programme is an action-oriented plan that an organization can implement in order to prevent new HIV infections, provide care and support for employees who are infected or affected by HIV, and manage the impact of the epidemic on the organisation.

Key elements of an HIV Workplace Programme include:

- ✓ An impact assessment of HIV on your organisation.
- ✓ HIV awareness programmes.
- ✓ Voluntary HIV testing and counseling programmes.
- ✓ HIV education and training.
- ✓ Condom distribution.
- ✓ Encouraging health treatment for STIs and TB.
- ✓ Universal infection control procedures.
- ✓ Creating an open accepting environment.
- ✓ Wellness programmes for employees affected by HIV/AIDS.
- ✓ The provision of antiretrovirals or the referral to relevant service providers.
- ✓ Education and awareness about antiretroviral and treatment literacy programmes.
- ✓ Counseling and other forms of social support for infected employees.
- ✓ Reasonable accommodation for infected employees.
- ✓ Strategies to address direct and indirect costs of HIV.
- ✓ Monitoring, evaluation and review of the programme.

Workplace HIV Policy and HIV Workplace Programme

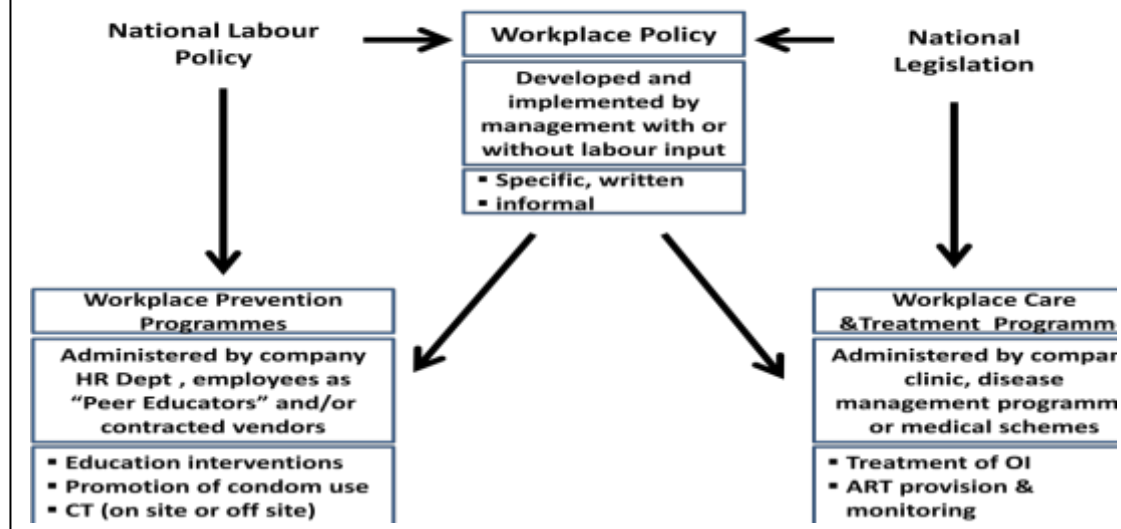


Fig. 1 Process for putting in place workplace processes and programmes

Topic 2: Discrimination in the workplace

Time: 45 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify discriminatory actions targeting PLHIV in workplace.

Materials and equipment needed

Flip chart and koki pens

Case study: Confronting HIV Discrimination in the Workplace

Trainer Instructions

Step 1

Ask participants to go back to their small groups, distribute case study 1 and give participants 20 minutes to read through the case study and answer question below. Bring participants to the large group and ask them to present, give each group 2 minutes to present their responses to the questions.

Step 2

Ask participants to write down on pieces of paper or cards the workplace policy on HIV that they know. Ask participants to hand over their piece of paper to the person next to them. Ask each participant to read out what they have on the paper and record on the flipchart. Allow discussions on all points recorded on the flipchart and let the whole group respond and move onto the next point until all have comments are addressed. Close this exercise with the following information on examples of workplace policies to be put in place in many organisations.

Case Study: Confronting HIV Discrimination in the Workplace

Even as the quarter-century mark in the HIV epidemic approaches, many HIV-positive employees experience job-threatening discrimination, especially if they do not “drive desks.” Cirque du Soleil, the premier acrobatic circus show, hired Matthew Cusick in 2002 and assigned him to the international company’s Las Vegas production, *Mystère*. In general health discussions with Cirque’s physiotherapy department at the beginning of his training, Cusick voluntarily disclosed his HIV status. At Cirque’s request, he twice visited doctors who assessed his HIV and judged him a “healthy athlete.” He was cleared for full performance activities with Cirque. Yet in the spring of 2003, fresh from several months of intense training, Cirque fired Cusick based upon fears of HIV transmission, claiming it was acting to protect other employees from “known safety hazards.” Shortly thereafter, Cusick came to Lambda Legal.

When Cirque refused to reconsider its decision, Lambda Legal filed a complaint under the Americans with Disabilities Act (ADA) with the Los Angeles office of the Equal Employment Opportunity Commission (EEOC). After the EEOC investigation supported Cusick’s allegations, conciliation talks between the parties eventually resulted in a groundbreaking settlement for HIV-related employment discrimination complaints

Question:

1. *What likely changes must have been implemented within the circus company that might have been triggered by the ruling to reinstate Matthew Cusick, in terms of*
 - a) *Regulatory framework and*
 - b) *Employee wellbeing programmes.*
2. *What remedies do you think were awarded to Matthew Cusick for unfair dismissal?*

Topic 3: Drafting an HIV and AIDS workplace policy

Time: 60 minutes

Objectives of the session

By the end of this session participants should be able to:

- ✓ Identify discriminatory action in workplace targeting PLHIV.

Material and equipment needed

Flip chart and koki pens

Case study 1

Questions for case study 1

Elements of an HIV and AIDS workplace policy

Trainer Instructions

Step 1

Divide participants into 4 groups and give each group 30 minutes and instructions as follows:

Part 1:

Ask participants, in their groups, to come up with a draft of a policy statement from the key principles discussed.

Outline the Specific guidelines to managers and employees on how they are to address HIV in the workplace

Give an outline of the HIV prevention education, care and support activities supported by the organisation.

Part 2: Participants' Action Planning and Dissemination

Ask participants, in their groups, to:

Develop a communication plan to inform all employees about the policy

Suggest appropriate initial messenger(s) and messages

Suggest a way of carrying out sequenced additional communication

Suggest how the policy could be implemented.

Ask each group to find a creative way to present their information to the rest of the group in 3 minutes. Give all groups an opportunity to present their work. Wrap up the session by highlight the key learning points for this session.

EXAMPLES OF ELEMENTS OF WORKPLACE PROGRAMMES

1. Education, Awareness and Prevention Programmes

Information, education and prevention programmes should be developed jointly by employers and employees and should be accessible to all at the workplace. Education on HIV/AIDS should where possible incorporate employee families. Essential components of prevention programmes are information provision, education, prevention and management of STDS, condom promotion and distribution and counseling on high risk behaviour. Workplace AIDS programmes should co-operate with and have access to resources of National AIDS programmes.



2. Job Access

There should be no direct or indirect pre-employment test for HIV. Employees should be given the normal medical tests of current fitness for work and these tests should not include testing for HIV. Indirect screening methods such as questions in verbal or written form inquiring about previous HIV tests and/or questions related to the assessment of risk behaviour should not be permitted.

3. Workplace Testing and Confidentiality

There should be no compulsory workplace testing for HIV. Voluntary testing for workplace testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with informed consent of the employee in accordance with normal medical ethical rules and with pre-and post-test counseling. Persons living with HIV or AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment. An employee is under no obligation to inform an employer of his/her HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's written consent.

Confidentiality regarding all medical information of an employee or prospective employee should be maintained, unless disclosure is legally required. This applies also to health professionals under contract to the employer, pension fund trustees and any other personnel who obtain such information in ways permitted by the law, ethics, the Code or from the employee concerned.

4. Job Status

HIV status should not be a factor in job status, should promotion or transfer. Any changes in job status should be based on existing criteria of equality of opportunity, merit and capacity to perform the work to a satisfactory standard.

5. HIV Testing and Training

In general, there should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of non-discrimination between individuals with HIV infection and those without and between HIV/AIDS and other comparable health/medical conditions.

6. Managing Illness and Job Security

No employee should be dismissed merely on the basis of HIV status, nor should HIV influence retrenchment procedures. Employees with HIV related illness should have access to medical treatment and should be entitled, without discrimination, to agreed existing sick leave provisions. HIV infected employees should continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they cannot continue with normal employment, efforts should be made to offer them alternative employment without prejudice to their benefits. When the employee becomes too ill to perform their agreed functions the standard benefits and conditions and standard procedures for termination of service for comparable life-threatening conditions should apply without discrimination.

7. Occupational Benefits

Government employers and employee representatives should ensure that occupational benefits are non-discriminatory and sustainable and provide support to all employees including those with HIV infection. Such occupational benefits schemes should make efforts to protect the rights and benefits of the dependents of the deceased and retired employees. Information from benefit schemes on the medical status of an employee should be kept confidential and should not be used by the employer or any other party to affect any other aspect of the employment contract or relationship.

Medical schemes and health benefits linked to employment should be non-discriminatory. Private and public health financing mechanisms should provide standard benefits to all employees regardless of their HIV status. Counseling and advisory services should be made available to inform all employees on their rights and benefits



from medical aid, life insurance, pension and social security funds. This should include information on intended changes to the structure, benefits and premiums to these funds.

8. Risk Management, First Aid and Compensation

Where they may be an occupational risk of acquiring or transmitting HIV infection, appropriate precautionary measures should be taken to reduce such risk, including clear and accurate information and training on the hazards and procedures for safe work. Employees who contract HIV infection during course of their employment should follow standard compensation procedures and receive standard compensation benefits. Under conditions where people move for work, government and organizations should lift restrictions to enable them to move with their families and dependents. People who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimize the risk of infection including information, condoms and adequate accommodation.

9. Protection against Victimization

Persons affected by or believed to be affected by HIV or AIDS should be protected from stigmatization and discrimination by co-workers, employers or clients. Information and education are essential to maintain the climate of mutual understanding necessary to ensure this protection.

Where employers and employees agree that there has been adequate information and education and provisions for safe work, then disciplinary procedures should apply to persons who refuse to work with an employee with HIV/AIDS.

10. Grievance Handling

Standard grievance handling procedures in organisations, in labour and civil law that apply to all workers should apply to HIV related grievances. Personnel dealing with HIV related grievances should protect the confidentiality of the employee's medical information.

11. Information

Governments should collect, compile and analyse data on HIV/AIDS, sexually transmitted diseases and tuberculosis and make it available in the public domain. SADC Member States should co-operate in making available national data for monitoring and planning an effective response to the regional health, human resource, economic and social impact of the AIDS epidemic.

12. Monitoring and Review

Responsibility for monitoring and review of the code and its implementation should lie with the parties to the tripartite at national and regional level and with the SADC Employment and Labour Sector.

Topic 4: Presentation on Developing a Workplace HIV Policies

Developing a HIV and AIDS policy for your programme

Developing policies *before* implementing programmes enables enterprises to set programme parameters and address concerns and alternatives as part of a structured process. The resulting policies then guide programme development. Workplace policies can be HIV specific, as a part of overall policies addressing life threatening illnesses or disabilities. Collective bargaining agreements can also be general or specific with regard to HIV.

A HIV/AIDS policy states the company's position and practices for preventing the transmission of HIV and for handling HIV infection among employees. It is usually designed to establish consistency within the company and compliance with local and national laws, as well as setting standards of expected behaviour for all employees. In addition, the policy aims to provide guidance to employees on how to address HIV/AIDS and where to go for assistance.

The policy must:

- ✓ Have worker participation in its drafting;
- ✓ Be communicated to all concerned in simple and clear terms;
- ✓ Be reviewed and updated in the light of epidemiological data and the very dynamic therapeutic responses to the pandemic, as well as other scientific information;
- ✓ Be monitored for its successful implementation; and
- ✓ Be evaluated for its implementation and effectiveness.

The workplace policy on HIV/AIDS should address essential issues, including:

- ✓ Compliance with the laws and culture of the country;
- ✓ Prevention of discrimination against people with HIV or AIDS;
- ✓ Behaviour expected of staff towards a HIV-positive co-worker;
- ✓ Medical and educational services;
- ✓ Confidentiality and privacy;
- ✓ Benefits that can be expected by an employee (health benefits, sick leave etc.);
- ✓ Accommodation of employees with HIV and acceptable work performance standards;
- ✓ First aid practices and 'universal precautions';
- ✓ Conformity with other current policies and practices within the organization;
- ✓ Balance in the needs of the company, management, co-workers and the individual; and
- ✓ Resources, both within and outside the company, for information and services and HIV-prevention education in the workplace.

Steps in Developing and Implementing a Workplace HIV Policy

A workplace HIV-prevention education programme needs to: provide basic information about HIV and AIDS, on fair treatment of people living with HIV or AIDS, and on the enterprise's policy;

Discuss and promote prevention methods; emphasize regular and correct condom use, which is essential for the prevention of HIV and other sexually transmitted infections (STIs); if reliable and affordable condoms are not readily available, the company may consider providing condoms (free or at low cost) to its employees, through dispensing machines, company stores and clinics;

Promote safety awareness; design the programme to provide clear answers to staff members' concerns about working with people with HIV/AIDS, emphasizing that casual contact at the workplace carries no risk of HIV infection; and discuss occupational hazards of at-risk groups of workers, such as on-site medical staff and



laboratory technicians who are regularly exposed to human blood or blood products and should be provided with first aid training, details of universal precautions and protective equipment.

For a programme to succeed, it is strongly recommended that it be:

- ✓ Implemented during company time;
- ✓ Inclusive of top-level management;
- ✓ Offered in small group meetings;
- ✓ Mandatory for all staff;
- ✓ Structured to allow time for discussion and questions;
- ✓ Reinforced periodically by regular follow-up meetings; and
- ✓ Monitored to assess employee knowledge through pre- and post-programme surveys.

Checklist for developing a company policy and programme on HIV/AIDS in the workplace:

The ILO recommends a step-by-step approach to developing workplace HIV policies. The policy is based on consultation and collaboration amongst employers and workforce. While the guidelines suppose a medium sized or large workplace, even in a smaller enterprise where there may just be one person with responsibility to act on HIV, the same basic steps should still be adapted and followed. Similarly, in a collaborative arrangement between SME's, the same steps should be followed.

An HIV committee is set up with representatives of top management, supervisors, workers, trade unions, members of the human resources and training departments, the industrial relations unit, the occupational health unit, the health and safety committee, and persons living with HIV. There should be a representative balance between women and men. An existing committee may also be adapted and used or collaboration between small business leaders may form the committee. Ideally, selected representatives should have an interest in the work of the committee, rather than having membership forced upon them by virtue of their position. The committee decides it's terms of reference, and decision making powers and responsibilities. These must be approved by existing decision making bodies (e.g. a workplace committee or the executive board or regulatory body of an informal sector grouping).

10 steps for developing a company policy and programme on HIV/AIDS in the workplace:

1. Set up a HIV/AIDS committee with representatives of top management, supervisors, workers, trade unions, human resources department, training department, industrial relations unit, occupational health unit, health and safety committee, and persons living with AIDS, if they agree.
2. Decide terms of reference and decision-making powers and responsibilities.
3. Review national laws and their implications for the enterprise.
4. Investigate the needs of the company by carrying out a baseline study among the workers, and determining what health and information services are already available at the workplace and in the local community.
5. Formulate a draft policy to be circulated for comment before a revised draft is adopted.
6. Draw up a budget, seeking funds from outside the company. If necessary, identify existing resources in the local community.
7. Establish a plan of action, including a timetable and lines of responsibility, to implement policy.
8. Disseminate widely the policy and plan of action via noticeboards, mailings, pay-slip inserts, special meetings, induction courses and training sessions.
9. Monitor the impact of the policy.
10. Review the policy regularly in light of internal monitoring and external information about the virus and its workplace implications.



BASICS FOR SUCCESSFUL IMPLEMENTATION

Adherence to fair employment practices will ensure that the workplace provides a non-discriminatory environment that is reasonable for all employees, as well as supportive of those with HIV. Some of these principles are: complying with existing laws that regulate business practices in relation to those living with HIV, or general laws applicable to HIV, such as employment laws pertaining to disabled persons; making alternative working arrangements for employees with HIV/AIDS; treating a HIV/AIDS infection in a manner similar to other disabilities or life-threatening illnesses; respecting confidentiality of medical information; and providing voluntary screening for HIV/AIDS to encourage workers to determine their status and hence take appropriate measures.

In addition to these components, a number of practical issues need to be addressed to ensure a sustainable and effective response. These include the following:

Leadership, Structures and Partnerships

Experience has shown that for workplace programmes to be successful they need to be driven by senior management. Without the support of those who influence policy, practice, and resource distribution, initiatives are doomed to fail. A dedicated post, unit or working committee, or combinations of these, should be established to co-ordinate and drive the response. It is vital that such individuals or bodies are sufficiently senior and skilled in HIV and AIDS issues to lead the response, are given a proper mandate, are supported by senior management, are located where they can be most effective, and are given sufficient financial, technical, and human resources to fulfill their mandate. Such individuals or structures should be allocated a specific budget. This budget should be sufficiently large to allow the implementation of comprehensive programmes and activities. Forming partnerships with other institutions in the public, private, and non-governmental sectors can also help in sharing information, experience, skills, and resources.

Capacity Building

HIV and AIDS present new challenges and, with these, an increased need for training and capacity-building to enable institutions to develop, monitor, and evaluate responses to HIV and AIDS. To take on these new roles and responsibilities, workplaces ideally require a solid understanding of:

- ✓ The basic facts about HIV and AIDS;
- ✓ Prevailing attitudes towards HIV and AIDS and people living with HIV and AIDS;
- ✓ Relevant laws and policies;
- ✓ Knowledge of government and community level policy responses;
- ✓ Knowledge of government and community services available;
- ✓ Workplace prevention, treatment, and care and support options for employees infected and affected by HIV and AIDS;
- ✓ How to encourage and support openness concerning the epidemic;
- ✓ HIV and AIDS counseling skills;
- ✓ Establishing HIV and AIDS support groups;
- ✓ Occupational exposure policies and processes; and
- ✓ Monitoring and evaluating workplace HIV and AIDS programmes

Communication Strategies

For programmes and policies to be effective, their existence and content must be communicated to all employees. Mechanisms also need to be created to facilitate dialogue between stakeholders, to ensure that policies and programmes are owned by those they affect. This requires:

- ✓ Ensuring that employees and employers are aware of the HIV and AIDS policy and programmes and understand what they can offer them;

- ✓ Allowing all staff an opportunity to have an input and contribute to the development, maintenance, and review of policies and programmes;
- ✓ Making use of media and other forms of communication, such as drama, to put messages across to all employees.

Monitoring and Evaluation

Interventions need to be constantly monitored and evaluated to ensure efficiency and effectiveness. The process enables organisations to control what is going on, take timely action to deal with problems that arise and adjust work plans to improve the efficiency, effectiveness and relevance of the programmes.

Comprehensive monitoring and evaluation indicators must be developed and agreed upon by private companies, public organisations and National AIDS Council to ensure systematic monitoring; those include tracking provision of goods and services for the affected employees and their families, as well as prevention services. The indicators may include amount of resource allocated for HIV and AIDS activities, production of an HIV and AIDS policy at workplace, number of peer educators recruited and trained, and number of staff trained voluntarily; number of employees receiving treatment and counseling services

Levels of Monitoring and Evaluation

There are different levels of monitoring. Monitoring is done at input level, process (activity) level and output level.

- ✓ **Inputs:** the various resources needed to run the program. These include money, facilities, staff time, supplies and equipment.
- ✓ **Process:** Process monitoring tracks the set of activities that are used to produce the desired outputs to determine whether they are done on time and whether the inputs are being used efficiently. Examples of process monitoring would be the number of peer education workshops conducted.
- ✓ **Outputs:** the goods and services produced as a result of implementing the activities. Examples of output indicators used in workplace program include the number of peer educators trained, number of condoms distributed and the number of information, education and communication materials produced and distributed.

Evaluation is done at outcome and impact levels.

- ✓ **Outcomes:** are the intermediate results that occur at population level as a result of implementing project/programme activities.
- ✓ **Impacts:** are the long-term effects of the programme/project at population level which are attributed to the contributions made by the programme.

The following should be considered when delivering educational messages:

Explanation of the company's guidelines to all workers; use of staff members as peer educators or training facilitators; distribution of a brochure or pamphlet about HIV/AIDS to all employees; screening of a demonstration videotape, followed by a discussion; invitation to a person with HIV/AIDS, or an expert from either the local health department or HIV/AIDS organization, to give a presentation to employees; encouragement of employees to learn about HIV/AIDS on their own; and invitations to other companies to share their experiences, with the opportunity for employees to ask questions.

Care, support and treatment are fundamental elements of an effective response. To mitigate the impact of the HIV/AIDS epidemic in the workplace, counseling and other forms of social support to workers may be provided. Where health-care services exist at the workplace, appropriate treatment may also be provided, particularly for opportunistic infections. While some companies are providing treatment for STIs to reduce HIV infection rates, other companies and provides antiretroviral treatment to their employees with AIDS, thus helping to prolong their lives. Where health services are not available, workers should be informed about the location of available



outside services. Such linkages have the advantage of reaching beyond the workers to cover their families (particularly their children).

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Annexure A:

Activity Sheet 1: Workshop Structure

Preparing for the Workshop

Facilitators will need to review the pre-training assignments (or information summaries prepared by the organizers). Particular attention should be paid to the needs and expectations expressed by participants and their level of knowledge and skills in training development, design, and facilitation. Facilitators will also need to become very familiar with the overall flow and content of the workshop; therefore, a thorough review of all activities and materials prior to the workshop is strongly recommended. The facilitator should also pay attention to the preparations that are needed for each day including the training tools that need to be prepared beforehand.

Suggested Seating of Participants

As the training is designed to be interactive, participants are to sit in such a way that they can work comfortably within their groups and simultaneously and see the facilitator(s) clearly. Usually this happens in a horse shoe formation

Preparing a Schedule for Your Workshop

The workshop as described in this manual is designed to take place over five days. A typical day begins at 8:30 or 9:00 a.m. and ends between 5:30 and 6:00 p.m. Suggested time frames for the modules and activities have been provided as well as a suggested daily breakdown of activities. It is important to remember that the time frames given are only guidelines; the number of activities and the time allotted can be adapted as appropriate to the needs of your participant group.

The schedule provided includes only the activities contained in the manual. You will also need to build time into the schedule for the following:

- o Recaps (30 min at the beginning of each day)
- o Morning and afternoon breaks (20 to 30 min each)
- o Lunch (45 minutes to 1 hour)
- o Debriefs (15 min at the end of each day)

Conducting the Workshop

The opening page of each module lists all the module activities and their times. A short description of the overall aim and content of the module is also provided. This should be reviewed with participants before beginning each new module. Clear procedural instructions are provided for each of the activities to help you structure your work with the participants.

Remember: Be flexible! If you believe it is necessary to make changes to activities in order to accommodate your particular training context or participant group, then feel free to do so. Engaging participants in the training process is an effective way to further build their skills during the workshop. You are encouraged therefore to provide opportunities for participants to take part in different aspects of the workshop delivery. Some of these include:

- Carrying out energizers and recaps
- Facilitating some of the activities and discussions during the workshop
- Preparing flipcharts and assisting in other aspects of the training
- Participating in the daily briefing/debriefing of facilitators
- Organizing evening events

Workshop Opening and Introductions:

- Begin the workshop by greeting participants.
- Introduce yourself and any other workshop staff working with you.
- If the workshop is being hosted by an organization, someone from that organization should make a few remarks to open the workshop and welcome participants.
- Facilitate an introductory session so that all participants are aware of who is in the room—names, organizations, work sites, and general information about each other's work. This can be accomplished with the two ice breakers outlined below. It should be noted that there are many ice breakers that trainers and peer educators can draw on.

Introduce your partner:

Ask the participants to pair up, you can ask each person to turn to the person sitting on the left with the person sitting next to them. Each person should briefly interview the other person, for 2- 3 minutes. You may give them some pointers as to what they should find out about the other person e.g. their name, where they come from, their likes and dislikes, what annoys them most, hobbies, pets etc. Once the first person has introduced themselves, the second person should get a chance to introduce themselves. Afterwards, everybody should get a chance to introduce their partner to the big group in a minute.

After everybody has had a chance to introduce their partner, highlight the skills that were used during this exercise such as questioning, listening and interpreting information and speaking in a large group of strangers. These skills will be in focus at least once during the training, so it is relevant and helpful way to start any training session.

Group Bingo:

Ask participants to raise their hands if they (items selected here should speak to the target audience):

- Have their real hair
- Have more than 3 children/Have more than 3 siblings
- Have travelled more than 1000 kms to be at this training
- Have grandchildren/Have great grand parents
- Hates chocolate
- Has travelled to another country
- Is afraid of the dark
- Liked horror movies
- Has met the president
- Knows how to sing
- Loves soccer
- Have attended a gender training workshop before?
- Have attended a GBV training workshop before?
- Have attended a HIV and AIDS training before?
- Know someone personally who experienced domestic violence?
- Know somebody who is an entrepreneur in the area that they work in?
- Are a trainer?
- Have facilitated training on gender or GBV before?

Ask two people to indicate if they still remember who they shared similar experiences with. Indicate to participants that as a group, there will be differences and similarities, what is important is not to focus on our differences but focus on the common things that have brought us together.

Note to Trainers

For short workshops (a day or two) time will be limited, so introductions should be short (15 minutes). Participants will learn more about each other as the workshop continues.

For workshops three days or longer, introductions should take more time and involve more interactions between participants (45–60 minutes).

Expectations:

Step 1

- Ask participants to take 2 minutes to write down two expectations, two contributions and two worries / concerns they have for the workshop on the provided worksheet.
- Ask participants to discuss these expectations with their neighbours for 2 minutes.

Step 2

- Reconvene the group and ask participants to share their expectations.
- Write these on the flipchart paper prepared.

Step 3

- Explain which of the expectations will be met and which ones cannot be met by this training.
- For those expectations that will not be met, explain why and how interested participants can gain access to such knowledge.
- If there are other expectations of the workshop that were not mentioned by participants, explain these.

Step 4

- Introduce the poster “parking lot” and indicate to the participants that this will be a poster where they are allowed to write any points for discussion which are not part of the planned activities
- Indicate that the parking lot will be addressed at the end of the training

Objectives:

Step 1

- Immediately following the expectations session, hand out copies of the workshop objectives.
- Go through each objective, taking time to be sure participants understand the workshop purposes, objectives, and intended outcomes.
- Facilitate a discussion to clarify any questions or concerns.

Step 2

- Distribute the workshop agenda.

- Review the daily schedule with the participants, making sure to note any overall themes for given days, etc.
- Explain how the workshop sessions will build upon each other to achieve the workshop objectives.

Ground Rules

Facilitation and small group work are powerful vehicles of learning for participants. However managing groups can sometimes be a challenge. For groups to function effectively there needs to be trust and confidentiality in place (hence the need for creating “Ground Rules for Sharing” at the beginning of the training as advised in this manual). Group members need to respectfully listen to each other and allow people to have their say one at a time without being interrupted. When participants decide on their Rules for Sharing it creates shared ownership and responsibility in terms of how participants (and facilitator) act during the training. Sometimes people are not comfortable sharing in a large group but are happy to share in a small group and so this is a platform where much rich learning can take place for participants. None of us knows as much as all of us.

It is important to set a ground rule for how participation will be managed. Do you prefer for participants to raise their hands and be called on or for people to speak freely? Remember that some people -- especially those who tend to be introverted -- need more time to process thoughts and speak, so the latter option may exclude them from the discussion. Still, the formal process of raising hands to be recognized may detract from the collective atmosphere needed to discuss sometimes-controversial issues.

Strategies

- It is helpful to post the ground rules somewhere visible during the entire workshop.
- As a facilitator who may be with a group over an extended period of time, you can bring the list of ground rules (on news print or some other transportable medium) back to the group for every session or class period. They then can refer back to the list when they sense that participants are failing to follow one or more of the items.
- Challenge the participants on the ground rules early and often. If you do not set a tone of adherence to the items early in the process, it may become difficult to enforce them later.
- If you are using more than two or three ground rules, try focusing on particular items during appropriate activities or discussions. For example, if you are facilitating a discussion in a large group, state before the discussion starts that you would like to focus on active listening. Challenge participants to refrain from any side discussions. The same can be done if you are facilitating an experiential activity, by introducing it as a "silent" activity.
- You should model these ground rules in your own participation. This is especially true for an item such as Rule 2 (speak from your own experience). Be sure that your own language reflects ownership and responsibility by using as many "I" and "me" statements as possible.
- If a particular ground rule is routinely broken, bounce it back to the participants. A fruitful discussion can often arise from a close examination of why the participants are not adhering to particular items.

Steps:

Step 1

- Explain that in order for the training to go well; participants will have to follow certain rules.
- Ask participants to think about rules they would like to propose for the training

Step 2

- Ask participants to list the rules which might include the following
 - Turn off cell phones
 - Respect time—start on time, end on time
 - Be respectful of other participants and the facilitators
 - What is said in the group stays in the group – keep confidentiality about people who are sharing
 - Talk loud enough for all to hear
 - Talk one at a time
 - Participate!
- Write each ground rule on a flipchart and explain each as you write it
- Ask participants if there are any other rules they would like to suggest. Discuss and agree. Write these on the flip chart.
- Ask participants if they agree to abide by these ground rules
- Post the ground rule list on the wall in the training room.

Review the programme

Step 1

- Review the daily schedule—time for breaks and lunches.
- Inform participants of locations of toilets, break area, etc.
- **If relevant:** Review the workshop policies on seeking reimbursement for travel, how food and beverages will be handled (i.e., does the workshop provide these and pay for them directly, or does the participants pay for them and get reimbursed, etc.), and



how accommodation will be paid.

- Set deadlines for receipt submission and announce when reimbursements will be distributed.
- Explain who from the workshop staff will be handling logistics and direct participants to contact her/him directly outside of the sessions.
- Explain that any housekeeping reminders will be posted on a paper in the back of the room.
(Post a flip chart paper at the back of the room, near the entrance.)
- Answer any questions.

Notes to Trainers

- For multi-day residential workshops, it is strongly recommended that there be someone other than the trainers serving as a logistics and support person. Participants will have many logistical needs and questions throughout the workshop, and trainers should be focusing on workshop content, not logistical details. If funding constraints do not allow for this extra staff person, then trainers should involve participants in helping with logistics. One idea is to ask for 2 volunteers each day to serve as a “host team,” to answer questions from participants and communicate any questions or problems they cannot answer to the trainers during a suitable break.

Facilitators’ Debriefing

At the end of each day, you should plan a debriefing session with facilitators and a select group of participants. During the debrief, the facilitators, and participants invited for that day will discuss the issues, concerns or problems related to workshop content and process that were brought up during the end-of-day debriefing. As a group, decide on corrective actions to be taken or adjustments to be made. Once the debriefing is over, the facilitators will review the next day’s recap with the team of participants responsible for the recap.

A proposed agenda for the facilitators’ debriefing is as follows:

- Review of the day’s activities and events (20 min)
- Logistics information (10 min)
- Planning for the following day (20 min)

Activity Sheet 2: Activity Sheet 1. Points to consider when using participatory methods

It is important to understand the strengths and weakness e.g. in songs, is the message clear or is it being understood. Check the advantages and disadvantages and try to keep methodologies focused on objectives. Use the participant's experience in developing the participatory method always vary activities to avoid monotony.

Strengths of Participatory Teaching Methods

- The participants are actively involved during the discussion, so they are more likely to remember what was introduced during the discussion as they will draw from their real life experiences.
- Participatory teaching methods allow participants to discover principles for themselves and to develop problem-solving skills.
- Participatory learning methods are relevant for everyone within different levels of understanding.
- Participatory teaching methods involve everyone which makes teaching and learning easier. It makes people think for themselves and less dependent on the facilitator or information giver.
- They aid in concentration which makes health education more enjoyable and creates a close feeling between the facilitator and the audience.
- Participants build on knowledge that they already have.
- They focus on the whole person, behaviours and attitudes.
- They are innovative and creative
- It is a simple way to convince people to change behaviour and it gives people greater pride in what they can do for themselves by making the right choices.
- They are inexpensive and simple to use in a field setting.
- They are entertaining and able to attract and hold attention.

The Weakness of Participatory Teaching Methods

It is easy to lose focus:

- The audience will only pay attention if the content of the teaching is relevant to what they want to know about, is put across in an interesting way and uses a variety of teaching styles.
- Complicated and sensitive information should be introduced step by step, in a logical and organized way. People will learn more easily if the information presented to them is linked to their experiences and builds on what they already know.
- Always ask questions at the beginning to find out what people know, think and feel about the topic.
- If you lose focus draw on the key messages to guide the discussion back to the important details.

Entertainment can overshadow the value of the message

The audience may have enjoyed themselves and express appreciation, but may not have learned anything. The only way to find out whether learning has taken place is by obtaining some feedback - either by asking questions or observing responses and lifestyles to see if they have changed. It is difficult to control large groups

Activity Sheet 3: Important considerations for facilitator

- Take care not to overload the students with too many new ideas in one session, as there is a limit to the amount of information that can be absorbed at one sitting.
- Use a range of teaching approaches, such as talks, discussion, exercises and active learning methods.
- Build in frequent breaks between sessions where people can relax and stretch their legs. Twenty minutes at a time is probably the most people can keep up their concentration.
- Information presented in a teaching session is quickly forgotten. Some further input, either by the student's own reading or reminders by the teacher, is needed for the information to be retained in long-term memory.
- Opportunities should be provided for students to practice their newly-acquired skills in a safe, friendly and tolerant environment where they can make mistakes. People learn better if they are allowed to discover principles for themselves and if activities are built into the learning process and receive helpful criticism without feeling threatened.

Important Considerations

- Active learning - make students think and apply the knowledge through a task.
- Be clear - use visual aids, speak clearly, use simple language.
- Make it meaningful - explain in advance what you are going to teach, explain all new words and ideas, relate what you teach to students' lives and work, give examples, summarize the main points at the end.
- Encourage participation - stimulate discussion and involve the group in the learning.
- Ensure mastery - check understanding and competence reached.
- Give feedback - tell the learners how far they have progressed.

Facilitation should have the following:

- Respect
- Language must be appropriate to your target audience
- Active listening
- Encourage questions, and if answer is not known, refer to the relevant person/organisation
- Reaching out at different levels
- Creating debate and controlling it
- Speaking audibly and clearly
- Paraphrasing
- Maintaining eye contact
- Use of names that are culturally acceptable for private parts
- No labeling of target audience or other groups
- A group of 10 to 12 people, which will be easy to manage. It will also allow meaningful discussion. Too large a group will be difficult to control.

Facilitation should NOT try to accomplish the following:

- Dominate the group
- Be involved in a lengthy discussion or debate with participants
- Take sides
- Be biased
- Jump into conclusions
- See self as an expert on the subject
- Create a lengthy dialogue with a particular participant
- Criticize on a personal basis
- Put participants on the spot
- Allow domination of discussions by some participants

Do and don'ts of a facilitator

A good facilitator does not

- Talk too much or interrupt, not allowing the group to participate.
- Talk too quickly, and not check understanding
- Argue, become emotional about people's responses, or use sarcastic or critical remarks.
- Ignore a speaker or filter what they say through selective listening.
- Humiliate or discourage members of the group.

A good facilitator does

- Listens well and with interest when it is time for the group to share.
- Offers eye contact and focused silence, gives full attention.
- Maintains focus on the learning point. Summarises, reflects, emphasises and repeats the discussion.
- Is warm, approachable, friendly and energetic. Asks for and encourages different points of view.
- Responds positively to people's viewpoints if possible or else respectfully corrects them.

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| <ul style="list-style-type: none"> • Express shock or be domineering • Give advice, unless requested and appropriate. • Seem rehearsed and, therefore, insincere • Present questionable information. No information is better than the wrong information. | <ul style="list-style-type: none"> • Encourages participation by asking for specific examples and questions from the group. • Keeps asking probing questions and allows the group to reach the conclusion themselves if possible. • Guides the process and lets the discussion unfold. • keep the momentum going, but isn't a tyrant. • Stays neutral accepts people's input and emphasizes the positive. |
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Activity Sheet 4: Facilitation within a group

- Facilitation is leading a group through learning in a way that encourages participants to be involved and engaged with the facilitator, with each other and with the learning activities. This approach assumes that participants have valuable experience and knowledge to contribute to the training. The facilitator's role is to draw out knowledge and ideas from participants, to encourage them to learn from each other and to think and act together in learning activities.
- Traditional teaching shares information mostly in one direction, i.e. from teacher to student. Facilitation involves information being shared in quite a few directions – between the facilitator and the group, among the members of the group and between the group and the facilitator.
- It is the responsibility of the facilitator to allow participants to share thoughts and ideas, but simultaneously keep the training on track both in terms of achieving its outcomes/content (don't allow participants to go off topic too much) and keeping to time (don't allow participants to take too long with activities).

Goals of a facilitator:

- Facilitate task accomplishment
- Ensure the overall development of the group and group processes
- Provide a safe but stimulating workshop climate
- Provide a global view of the group and its processes
- Serve the group in whichever ways are needed to help it be successful in its assignment
- Take in group energy and emotions and re-channel these to help the group stay productive
- Track conversations - bringing the group back into focus when the conversation strays too far off topic
- Provide information needed by the group to complete its assignment
- Encourage participants to share knowledge with others outside of the session

Tips on Good Facilitation Skills

- **Active Listening** to the individual or the group: this is the most important skill for a good facilitator to learn. Recall that the experiential learning and training recognises that each individual and group has their own resources and abilities to sort out their own issues. As a trainer or peer educator your role is to empower the participants to seek solutions to the situations that they are facing. In order to complete this process effectively one needs to listen to the individual or group to find out where their strengths, resources and weaknesses lie.
- **Be well prepared:** know the content that will be covered in the training, know the training activities and how you will present them. Be clear on what instructions are to be given and when. At the same time, be flexible when necessary and adjust activities or the timing of activities based on feedback you get from the group during training. Keep to timing, but don't be driven by it at the sacrifice of learning happening.
- **Set ground rules/rules for sharing** - ask participants to agree on some rules for their interaction with each other so that they feel comfortable to share their thoughts. For example participants may decide to respect different views and opinions, keep cell phones switched off, don't interrupt a colleague etc. This creates shared ownership and shared responsibility to ensure rules for sharing are adhered to, so that there is a structure to their interactions.
- **Go through the programme upfront** with participants so that they know what will be covered in the training. This creates a map for participants of the journey that they are about to go on.
- **Share the planned outcomes and purpose** of the training with participants and then ask a few of them to share what their expectations of the training are so that you can see whether they are on the same page as you in terms of what they will get out of the training. Explain to participants, which of their expectations will be able to be met in the training, which weren't planned for, but you think you can include and which will need to be addressed in another forum. At the end of the training, refer back to the expectations you listed on flip chart paper and see whether participants agree that they have been achieved.
- **Give clear input/instructions.** It is important that participants understand what you are saying. This involves communicating concisely and clearly, checking with participants to see whether they have understood you, listening carefully to participants and summarising at different points in a training to pull information together for participants e.g. what we just covered involved....., now we are going to look at.....
- **Divide the large group into smaller groups** to encourage shy members to participate and allowing group members to learn from the wealth of knowledge and experience carried by their colleagues.
- **Use group discussions** and other activities to allow participants to be actively engaged in the learning process. Invite small groups to present and share information using flip charts, drawings or other visual aids.
- Remember, **it is important to manage people's feelings.** For example, create a safe space so that participants feel confident to ask questions – e.g. tell them that there are no stupid questions, that you are together to learn and that making mistakes is ok. Handle any conflict by respecting and valuing different opinions and referring back to the rules for sharing.
- **Encourage humour** and respect among participants and role model this as a facilitator

Tips for Working with Groups

- Never pick on a person to answer a question, ask for volunteers.
- If the group is large, make sure that everyone can hear you and their colleagues when they speak.
- Microphones may be needed to make this possible. If the group is larger than 25, then ideally two facilitators should be present. Repeat/reframe instructions to ensure that all participants have heard.
- Sometimes the same person wants to speak often. If this is the case and others also want to speak, then kindly thank the participant and say that you have noted their hand, but that you would like to give others a chance to speak.
- When groups are quiet, introduce an ice breaker to help participants feel comfortable. Use humour to help them relax. Try to encourage involvement through asking questions.
- When you have a participant that is making things very difficult, don't challenge him/her in front of everyone and embarrass him/her, take the participant aside during a tea break and ask them why they are behaving as they are and address the cause.
- Sometimes you cannot address things that come up in a talkative group, as there is not enough time, acknowledge the participant's comment and ask them to park the issue for the moment and say that you will come back to it later if there is time. The Parking Lot can be used for this.
- Stick up a flip chart labelled "Parking Lot" on the wall and explain that the purpose of a parking lot is for questions or thoughts to be parked at the current time in the training when:
 - It is not appropriate or
 - There is not enough time to deal with the question. The participant is asked to write their question in the parking lot during tea time.
 - The intention is that the facilitator will then address it later, when a suitable opportunity arises. This enables the facilitator to protect the flow and timing of the training.
 - Ensure the parking lot is addressed before the training finishes.
- The group will also help keep each other focused. If you are concerned about time, remind participants that if they want to finish on time, that you need to move on.
- If the group is resistant, it may help for people to change seats e.g. you can number them 1-4 and ask all the "1's" to sit together etc. Identify what the problem is, get it out in the open and see if it can be resolved. Invite participants to come up with suggestions.
- As facilitator, listen for the key points in discussions and reflect these back to the group through summarising in order to reinforce the key messages. Also correct any inaccurate information – not by telling the participant that they are wrong, but rather by thanking them for their input and offering factual and accurate information.
- Remember that while it is optimal for everyone to have space to share, time does not always permit this.
- Often as a facilitator you need to take direction to keep participants happy. Participants need you to lead them, you are responsible for ensuring the right environment is created for their learning – for example, they may not realise that they are talking excessively and yet they trust you to ensure that they get through all the learning and still finish on time.