HIV/AIDS behaviour change communication

A toolkit for the workplace

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Preface

As part of its global programme on HIV/AIDS and the world of work, the International Labour Organization (ILO) has entered into a partnership with the United States Department of Labor (USDOL) to develop workplace HIV/AIDS education programmes in a number of countries. The ILO Code of Practice on HIV/AIDS and the world of work (see www.ilo.org/aids) establishes the framework for action. These programmes have two overall development objectives: firstly reduced level of employment-related discrimination against persons living with HIV/AIDS, and secondly, reduced HIV/AIDS risk behaviours among workers.

To address the second objective, the ILO has collaborated closely with Family Health International to build upon FHI’s expertise and experience to develop a Toolkit on behaviour change communication adapted to the dynamics of the workplace. Behaviour change communication (BCC) is an interactive process that helps to understand the target population, develop a focused strategy, and produce tailored messages, which are delivered using a variety of communication channels to promote positive behaviour.

The Toolkit provides a step-by-step approach, emphasizing prevention through education, gender awareness and practical support for behaviour change. Its intended users are government authorities, employers’ and workers’ and their organizations, businesses, ILO/AIDS National Project Coordinators, national BCC consultants and collaborating NGOs. It is designed for those with little or no experience in communications planning. As explained in the introduction, it is divided into several pull-out booklets that can be used either separately to learn more about different elements of BCC, or jointly to design and implement a comprehensive BCC programme at the workplace.

The ILO/FHI ‘HIV/AIDS behaviour change communication: A toolkit for the workplace,’ is now ready as a working draft: we see it as ‘work in progress.’ Thus, an action programme has been developed for its immediate utilization to implement BCC programmes in enterprises, which have signed memoranda of cooperation with us. We will introduce changes in the Toolkit once we have received feedback from those who have used it. We are also hoping to collect some case studies to give examples of good practice or as a way of sharing lessons learnt. We will decide in March 2006 how the Toolkit will be revised, packaged, printed and disseminated.

For the immediate future, however, the Toolkit will only be available in electronic form. To provide more information about the Toolkit, Booklet I is placed on the ILO/AIDS website (www.ilo.org/aids) and FHI website (www.fhi.org). In order to keep track of its utilization, we are kindly asking those interested to submit a request if they wish to receive the entire Toolkit.

I wish to take this opportunity to acknowledge the valuable input by ILO and FHI colleagues who have contributed to the development of this Toolkit both at Headquarters and in the field.

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Overview of HIV/AIDS
Behaviour Change Communication Programming for the Workplace

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Introduction: Why this toolkit?

This Behaviour Change Communication (BCC) Toolkit is designed to help users develop, implement and evaluate workplace programmes for behaviour change tailored to workplaces. The kit aims to operationalize key aspects of the ILO Code of Practice on HIV/AIDS and the world of work, which provides internationally recognized guidelines for the development of comprehensive HIV/AIDS workplace policies and programmes. The Code of Practice is based on ten key principles:

- The recognition of HIV/AIDS as a workplace issue
- Non-discrimination
- Gender equality
- Healthy work environment
- Social dialogue for the successful implementation of HIV/AIDS policy and programmes
- No screening for purposes of exclusion from employment or the work process
- Confidentiality
- Continuation of the employment relationship
- Prevention
- Care and support.

The HIV/AIDS workplace BCC programme is part of a comprehensive workplace effort to inform workers about HIV/AIDS, promote behaviour changes that will reduce the spread of the virus, reduce discrimination and support workers who are living with HIV/AIDS.

“Workplace information and education programmes are essential to combat the spread of the epidemic and to foster greater tolerance for workers with HIV/AIDS. Effective education can contribute to the capacity of workers to protect themselves against HIV infection. It can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace and bring about attitudinal and behavioural change. Programmes should be developed through consultations between governments, employers and workers and their representatives to ensure support at the highest levels and with the fullest participation of all concerned. Information and consultation should be provided in a variety of forms, not relying exclusively on the written word and including distance learning, when necessary. Programmes should be targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. They should be delivered by trusted and respected individuals. Peer education has been found to be particularly effective, as has the involvement of people living with HIV/AIDS in the design and implementation of programmes.”

Section 6 of the ILO Code of Practice on HIV/AIDS and the world of work
The intended users of the toolkit are stakeholders responsible for HIV/AIDS programming at all levels in the world of work, with a particular focus on the workplace. They include staff and members of workers’ and employers’ organizations, representatives of management and workers, workplace HIV/AIDS focal points, members of workplace HIV/AIDS or health and safety committees, and peer educators to be recruited from the workforce. In some countries factors common to different enterprises within an economic sector, such as mining or transport, mean that a sectoral programme may be appropriate and useful. The toolkit is also relevant for ministry officials with workplace-related responsibilities, and in particular for the government as an employer, to help it develop programmes for its own staff and public servants such as teachers and health workers.

In the framework of technical cooperation, the kit will provide HIV/AIDS focal points in ILO field offices and national project coordinators with a comprehensive tool for developing BCC programmes in the target sectors, in partnership with national non-governmental organizations and community-based organizations.

The kit is designed for people with little or no experience in communication planning. It consists of seven sections which can be used separately to learn more about specific elements or jointly to design and implement a comprehensive BCC programme at the workplace.
1 Overview of Behaviour Change Communication Programming for the Workplace – an overview of the contents of the toolkit, with an outline of the eight steps to follow in developing a BCC programme. It includes a case study from Kenya that illustrates the steps involved in the BCC process and shows how the toolkit can be applied in a specific workplace/sector.

2 Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace – a step-by-step guide to collecting the information needed to design BCC programmes (‘formative assessment’), tailored to the needs and interests of the target group, including a generic protocol for data collection.

3 Designing a Behaviour Change Communication Strategy – a detailed facilitators’ guide to developing a strategy based on the formative assessment.

4 Developing Materials for a Behaviour Change Communication Programme for the Workplace – how to develop a range of materials to support the BCC programme.

5 Guide to Conducting Peer Education at the Workplace – a guide to training workers to carry out BCC and other prevention activities with co-workers. It includes tips for peer educators and sample training exercises.

6 Tools for Monitoring and Evaluation of the Behaviour Change Communication Programme for the Workplace – includes tools to monitor progress and evaluate the impact of BCC objectives.

7 Training in the Use of the HIV/AIDS Behaviour Change Communication Toolkit for the Workplace – provides facilitators with a guide to training BCC implementers on the use of the toolkit.
1. What is behaviour change communication?

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

In the context of HIV and the workplace, BCC is an essential part of a comprehensive programme that includes services (e.g. care, counseling), commodities (e.g., condoms, drugs), and policies that promote non-discrimination and trust.

Before individuals and communities can reduce their level of risk or change their behaviours, they must first understand the basic facts about HIV and AIDS, assess and modify their attitudes, learn new skills, and gain access to appropriate products and services. They must also perceive their environment as supportive of behaviour change and the maintenance of safe behaviours.

To be effective, BCC programmes need to be tailored to specific target populations. In the context of the world of work, this entails communicating with workers in homogeneous groups, based on factors such as economic sector, type of job, education, gender. It also entails developing specific messages and approaches that will most effectively resonate with a particular workplace group.

Theories of behaviour change offer insights into certain aspects of health-related behaviour and can be useful in strategic planning in terms of understanding the target audience, development of messages, and allocation of resources.

The following is a practical model that combines ‘stages of change’, focusing on individual behaviour change, with enabling factors that support behaviour change. People may need different messages and information resources at different stages of change.
A framework for BCC design

Effective behaviour change communication can:

- increase knowledge of HIV/AIDS;
- stimulate social and community dialogue;
- promote essential attitude change;
- improve skills and sense of self-effectiveness;
- reduce stigma and discrimination against people living with HIV/AIDS;
- create a demand for information and services;
- advocate an effective response to the epidemic; and
- promote services for prevention, care and support of vulnerable populations.
2. Steps for developing an HIV/AIDS BCC programme at the workplace

The overall goal of an HIV/AIDS workplace programme is to reduce the prevalence and impact of HIV in the workforce and the wider community. The toolkit is designed to achieve that goal through a process that may be summarized in the following eight steps:

Step 1: Advocacy and stakeholder involvement
Step 2: Identification and segmentation of target populations
Step 3: Formative assessment for BCC
Step 4: Development of a BCC strategy
Step 5: Development of communication support materials
Step 6: Implementation of the BCC programme
Step 7: Monitoring and evaluation
Step 8: Feedback and revision

Step 1: Advocacy and stakeholder involvement

Government, businesses and trade unions exercise great influence over the lives of workers and society in general; for this reason, they have a unique opportunity to make a difference in the fight against HIV/AIDS. The impact of HIV/AIDS has placed a tremendous burden on the private sector and the national economy of many countries.

Enterprises with a workforce impacted by HIV/AIDS have to bear higher costs associated with health insurance, retirement funds, recruitment and training of new staff, widespread absenteeism and sick leave, and the loss of qualified staff. It is in the best interests of employers to take proactive steps to minimize the impact of HIV/AIDS on their staff and operations.

The loss of human capital is a consequence of the HIV epidemic that businesses, the public sector, and workers’ organizations have to face on a daily basis. All can play an active role by adopting workplace policies and programmes that curb the spread and impact of the disease. This is necessary not only because it affects the workforce, but also because the workplace, as part of the local community, has a broader role to play in limiting the spread and effects of the epidemic.

Effective HIV/AIDS workplace behaviour change communication programmes, supported by practical measures, can significantly reduce HIV-related anxiety and stigmatization, minimize disruption at the workplace, and bring about changes in attitudes and behaviours among the workforce and surrounding communities. Successful programmes are targeted and tailored to the age, gender, sexual orientation, sectoral characteristics and behavioural risk factors of the workforce and its cultural context. Peer education has been particularly effective in workplace HIV-prevention programmes.
Step 2: Identification and segmentation of target populations

To effectively develop BCC programmes, it is important to understand who needs to be reached. The first step is to identify the different groups of people at a workplace and to consider those that may be most at risk. The target population can then be divided into subgroups that have commonalities, or according to ethnicity, language and education. Groups that have an influence over those who are most at risk must also be examined.

To be most effective, HIV/AIDS BCC programming for the workplace must work with primary and secondary target populations:

- **Primary target populations:** the main group of individuals whose behaviour we would like to influence and support. For example, in the transport sector, the primary target population could be truck drivers, because they are away from home for long periods of time and more likely to engage in risky behaviour.

- **Secondary target populations:** those who can affect the BCC activities or be affected by them, even though these BCC activities were not designed to reach them directly. They are often people whose support or neglect determines whether or not the primary audience responds to communication messages. They can include opinion leaders (such as government officials), gatekeepers (such as police officers and brothel owners), and policy-makers. In the case of truck drivers, the secondary target populations may include the owners of the vehicles. They may also be vulnerable or at risk, as a result of their association with the primary audience, but they are not necessarily the main beneficiaries of HIV/AIDS programming efforts. The wives and girlfriends of men who frequent sex workers might fall into this category. There are often several secondary target populations around one primary target group, requiring different communication approaches and messages.
Assessing the HIV/AIDS prevention, care and support needs of potential target populations is crucial. This information, as well as more practical information on the available human, financial and material resources and capacities, will guide decisions about:

- the objectives of the communication strategy;
- the communication approach;
- the content of the communication; and
- stakeholders.

Whether they are primary target populations or secondary populations, all of these people have a stake in the outcome of our programmes and thus constitute our stakeholders. The more we understand them, include them and involve them, the more successful and sustainable our communication interventions will be.

It is also important to segment or subdivide the target population(s) once the programme has identified the appropriate group or groups to work with. Groups that appear similar often have many differences. A group of truck drivers may appear to be similar, but the formative assessment may find that they differ in age, marital status, sexual partners, income etc. Programmes can therefore be more focused and effective if the truck drivers are divided into subgroups.

### Step 3: Formative assessment for BCC

Assessing target groups is vital to the success of a BCC programme. The assessment allows programme staff and stakeholders to become aware of the realities of the target. This ensures that when the BCC programme is developed the messages, themes and channels resonate with the target group. If no BCC assessment is conducted, it is likely that the target group will misunderstand or reject the BCC messages and proposed activities. The assessment process also provides an opportunity to start involving the target group.

The formative BCC assessment will:

- identify opportunities and resources for BCC intervention;
- gather in-depth information about different target populations' behaviours, attitudes, hopes or fears about the future, likes and dislikes;
- define their social networks and their risk settings (environments in which they may be at risk of contracting HIV); and
- identify means to increase HIV/AIDS health-seeking behaviour.

Booklet 2, Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace, outlines specifics steps on how to:

- define assessment objectives based on what we already know and what we need to discover;
- select assessment activities relevant to the specific workplace setting, such as key informant interviews, in-depth interviews, or focus group discussions;
- conduct the assessment using in-depth interviews, key informant interviews, and other qualitative methods;
- process the results to provide the basis for developing the BCC strategy.
Step 4: Development of a BCC strategy

Moving from information-gathering to a BCC strategy is a critical step. A participatory workshop is the ideal context for developing a strategy. Booklet 3, Designing a Behaviour Change Communication Strategy, is a facilitators’ guide for conducting a five-day BCC strategy-development workshop. It is also possible to develop a BCC strategy with the help of a BCC practitioner working with target populations for a longer period.

The following elements are essential for the development of a BCC strategy.

A description of the target population. General knowledge about the target population, combined with BCC formative assessment findings, provide the basis for a description of the target populations and their environment. A target population profile should include current and desired behaviours; hopes, fears and dreams; and factors that influence behaviours. These factors might include their preferred TV or radio programmes; the magazines and newspapers that they read; literacy level; health-care-seeking behaviour; and relationship to family, friends, community, religion, services and the broader society. It is important to clearly identify their current behaviours and the improved/desirable/feasible safer behaviours that the BCC programme seeks to promote (such as condom use, seeking information on HIV and other sexually transmitted infections, or opposing the stigmatization of fellow workers with HIV). The resulting profile is the starting point for the development of a comprehensive HIV/AIDS BCC strategy for the workplace.

Behaviour change objectives: Behaviour change objectives specify new behaviours to be adopted or maintained over a specific time period. Objectives should be SMART: Specific, Measurable, Achievable, Relevant and Time-based.

Behaviour change communication objectives: BCC objectives specify a communication activity that may change knowledge or attitudes, which will contribute to the adoption of a specified behaviour. Adoption of that specified behaviour constitutes a behaviour change objective.

BCC objectives, if accomplished, support and promote behaviour change in the target population.

The matrix below provides examples of behaviour change and behaviour change communication objectives and highlights the difference between the two:
<table>
<thead>
<tr>
<th>Behaviour change objectives</th>
<th>Behaviour change communication objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase the use of condoms among long-distance truck drivers by 35% within one year of the start of the BCC programme</td>
<td>• Achieve a 60% increase in the number of long-distance truck drivers who believe that condoms are an effective or a very effective means of protection against becoming infected;</td>
</tr>
<tr>
<td>• Achieve reduction of 25% in the number of sexual partners among the miners, within one year of the start of the BCC programme</td>
<td>• Achieve a 50% increase in the number of miners who believe that abstinence and fidelity protect them against becoming infected with HIV, within one year of the start of the BCC programme</td>
</tr>
<tr>
<td>• Reduce construction workers’ use of sex workers at the site by 30% within two years of the start of the BCC programme</td>
<td>• Achieve a 50% increase in the number of construction workers who believe that commercial sex services place them at a high or very high risk of becoming infected with HIV within two years of the start of the BCC programme</td>
</tr>
</tbody>
</table>

**Strong messages:** A message is the information conveyed to the target population with the aim of motivating them to change, stimulating dialogue or promoting a product or service. A good message contains two parts: a desired behaviour and a benefit for the person adopting those behaviours. It is tailored and appropriate to the target group, as opposed to generic population-wide public health messages. To develop effective messages, one should do the following:

- **Identify barriers.** There are very often barriers to adopting a new behaviour. These could include lack of knowledge, distance to a health facility, lack of access to commodities, etc. Identification of the barriers will guide the development of messages and interventions.

- **Identify key benefits.** Finding out what could help to motivate a person or a community to change is an important step in developing an effective and convincing message. Data from the formative assessment and target population profile, including information about their hopes and fears, are used to develop key benefit statements. A key benefit statement is used with a statement of desired behaviours to form a message: “If I do X, I will get Y.”

- In Guyana, minibus drivers and conductors often discriminate against people living with HIV/AIDS or those perceived to be HIV-positive. Most people see the drivers and conductors as disreputable characters, but the drivers and conductors actually crave respect. In a campaign in Guyana, minibus drivers and conductors have been involved as change agents in the community and are receiving training on issues relating to HIV/AIDS and stigma. The message “Give Respect, Get Respect” provides the key benefit for minibus drivers and conductors: being seen as people with knowledge and as role models for the community.

- The major concern of sex workers in Kamatipura, Mumbai, India is the future welfare of their children or having a child. So all desired behaviours, such as seeking treatment for sexually transmitted infections and using condoms, are associated with an assurance of future fertility and of having and taking care of healthy children.
In Kenya, many of the predominantly male workers in a sugar factory live apart from their families, have disposable income and, in their leisure time, have unprotected sexual encounters with women in the community. Peer education is a main component of the BCC strategy, supported by a mass media campaign, dubbed “kati yetu” – Kiswahili for “between us”. The overall theme of the campaign is “Question (our) Relationships”. This theme stimulates dialogue among workers, all of whom have relationships, both nearby and far away. Who are they interacting with? Are they relating to the right person, in the right way and at the right place and time?

**Characteristics of effective messages**

- Effective messages:
  - command attention;
  - are clearly stated;
  - communicate a benefit;
  - are consistently repeated;
  - reach the heart and the head;
  - create trust; and
  - call for action.

- Ensure that messages are consistent across multiple channels and target populations, to avoid confusion. Key messages can provide a framework for working with multiple target populations and form the entry point for discussions and BCC activities.

**Communication channels:** These are the vehicles that present, deliver and explain messages. Channels can range from face-to-face interactive activities to community-level interventions and mass media. It is important to choose the channels most readily available and acceptable to the target population and to keep cost-effectiveness in mind.

- At the workplace, interpersonal channels such as peer education have proven to be very effective and should be the main strategy used in workplace programmes: Mass media channels can raise awareness of specific issues, but more personal interventions (especially by peers) can have a greater impact on influencing behaviour change. Peer education is a process that involves members of a group or community learning informally together. Peers have similar backgrounds, values and jobs to others at the workplace, but are trained to provide information, education and even counselling. Peer-education initiatives generally focus on health education and prevention activities, and often aim to promote safer and healthier lifestyles. In the context of BCC, it means training members of the target group as key behaviour change communicators. The peer educator is the link between the programme and the target population. Peer education hinges on the idea that people are most likely to change their behaviour if people they know and trust encourage them to do so. Peer education is one of the most effective ways of inspiring behaviour change and conducting HIV/AIDS education at the workplace. Peer education:
  - breaks barriers to allow for discussion of sensitive matters without fear;
Overview of HIV/AIDS Behaviour Change Communication Programming for the Workplace

- brings about sustainable behaviour change in target populations;
- maintains confidentiality;
- is the most effective, informal way of sending the correct message to a specific target group;
- is less time-consuming than formal education activities or programmes;
- provides an open channel for on-going communication and problem-solving;
- costs very little.

Programmes can take advantage of other elements within the workplace to support and legitimize interpersonal channels. These might include newsletters, bulletin boards, company events, radio and print materials. Channels linked to workplace-based activities can also be useful: these include clinics, lunchrooms, basic and in-service training programmes, and organized recreational activities.

- **Identification of communication support materials:** Those involved in the BCC strategy-development process (whether in a workshop format, or by using a consultant or small team) need to identify the types of communication materials they should use to support the channels selected. These can include picture codes for peer educators (pictures that depict risky situations and can be used to initiate a discussion), client/provider support materials (such as flipcharts and pamphlets on various health-care services for HIV/AIDS), billboards, scripts for use in dramas, etc. Step 5 outlines specific strategies for the development of materials, which takes place after the development of the BCC strategy and with the close participation of target populations and skilled material-development practitioners.
**Step 5: Development of communication support materials**

Behaviour change communication materials should be based on the guidelines established by the BCC strategy for the workplace. The strategy will define an action plan, timeline, channels, and which materials to develop. Development of materials and messages should always correspond to the research conducted with the target population and through stakeholder consensus.

BCC budgets will need to take into account the development of support materials and the multiple steps linked to this process. BCC budgets often take into account only materials production, without considering the importance of other steps such as pre-testing (see below).

Issues to consider when developing support communication materials include:

- hiring and working with advertising or public relations agencies;
- if working with vendors, giving them what they need and being as specific as possible so they do the job correctly;
- including stakeholders in the entire process;
- providing information that is clearly and simply stated in order to enhance the response;
- repeating your messages frequently;
- making your materials as specific as possible for the target population to understand, taking into account appropriate language, culture, dress, setting, etc.;
- being careful not to stigmatize people living with HIV/AIDS in the materials; and
- being careful not to select images and words that promote negative behaviours.

Once personal prototypes of the materials have been developed, they need to be pre-tested. Pre-testing is a process of determining an audience's reaction to, and understanding of, messages or behaviour change information before materials are produced in final form. Regardless of which channels you choose, you will confirm the effectiveness of what you have developed through pre-testing.

After developing, pre-testing and revising the materials, you will need to distribute and monitor them. Further revision and modification may be necessary at a later stage. Given the time, money and effort required to produce effective HIV/AIDS BCC materials, it is not uncommon for programmers to plan and budget insufficiently for distribution and effective monitoring of communication products.

Every type of item you plan to produce need to be pre-tested, assuming that various items will utilize the same basic design concept. For example, if you are producing banners and posters at the workplace and they are all targeting the same audience, you can pre-test just one image for them all. Once the materials have gone through the pre-testing and revision process often enough to ensure a good-quality product, you can produce and distribute the material on a larger scale.
Step 6: Implementation of the BCC programme

While implementation varies depending on the sector, specific channels and activities you have chosen, some common issues and challenges are frequently encountered.

Your planning should include the following key areas:
- Developing a workplan
- Sequencing programme elements
- Timing
- BCC Coordination and supervision
- Budgeting
- Interactivity and synchronicity of channels
- Planning for interactivity and synchronicity of channels

Developing a workplan: A detailed workplan is essential for translating a strategy into action. The workplan identifies activities, who will be responsible for each, and how the activity will occur. It also provides more information about where the activities will happen and what the expected outcomes are.

Sequencing programme elements: Sequencing is the order in which activities are implemented. Make sure you have a clear idea of the timing of all programme events to maximize their impact.

Timing: Timing means the scheduling of activities within your programme in relation to events happening in the broader context of a community, region or country outside of your project. It is important to remember that a programme is not taking place in a vacuum. Think ahead of time about other, unrelated events, such as holidays, celebrations or political events that could compete for time, attention of your target audience(s), broadcast space, or facilities.

BCC coordination and supervision: The best HIV/AIDS BCC programmes will have a specific person in charge of coordinating and supervising behaviour change communication. This person might be the HIV/AIDS focal point or a technical staff member, and will be responsible for ensuring that all BCC-related activities take place. Even if your programme is a team effort, one person should be responsible for coordinating the process. Effective coordination is crucial to ensuring the impact of multi-component BCC strategies and programmes. The key question to ask during the development and implementation process is, “Who can answer questions about the status of any part of the process?”

Budgeting: Promoting the budget that covers the costs of the entire HIV/AIDS workplace BCC strategy development process, in addition to the costs of developing and disseminating quality BCC products and activities, is an essential component of effective implementation planning. This requires expertise from BCC staff who have been through the process and can articulate in convincing terms exactly what should be involved, what it is likely to cost, and why. Consideration of the action steps provided later for each of the eight BCC programme-development steps can illuminate budget ramifications and make planning more accurate for the costs of each step. The primary task at this point will be to ensure that implementation stays within budget. Some planning tips to help make this more likely include the following:
Baseline and follow-up evaluations: Have you budgeted for both baseline and follow-up evaluations?

Distribution: Have you budgeted adequately for distribution? Programmes often underestimate the cost of distribution.

Quantity of materials: Have you briefed stakeholders/funders on the extent of materials production/mass media broadcasting, events, etc? They may make requests later on for wider distribution or broadcasting that could have an impact on your budget.

Unexpected incentives: Make sure that peer educators do not suddenly request ‘incentives’ for their work that you did not plan for.

Planning for interactivity and synchronicity of channels: A comprehensive HIV/AIDS BCC strategy for the workplace ensures that channels are truly interactive and promote consistent messages in a concerted fashion. The programme should say the same things at the same time though a variety of channels.

Collaboration: Effective collaboration means sharing ideas and experience, and effectively rationalizing resources. Without collaboration, BCC interventions can suffer from mixed or contradictory messages and duplication of interventions and services.

### Step 7: Monitoring and evaluation

#### Monitoring

Measuring progress in achieving BCC objectives and determining whether the programme is on track require monitoring of activities and reactions. Once you have developed your BCC strategy and designed interventions, you will be ready to establish a monitoring plan. Monitoring must take place continually throughout the life of the programme. An effective and well-designed monitoring plan should have mechanisms in place to ensure that staff understand why monitoring is necessary and to help them see their hard work making a difference in the programme. The monitoring plan and tools are specific to the programme being implemented, and they are designed specifically for those who are collecting the data and for the target group. The tools should be simple enough to be understood by those implementing them. They should also be comprehensive enough to ensure that the information gathered is relevant and that the programme objectives are being met.

The monitoring plan should make sure that the information collected is used to improve the project. Monitoring results also provides a bigger picture of the programme, facilitating an understanding of its goals and objectives.

#### Evaluation

The monitoring process allows for evaluation—a critical component of HIV/AIDS BCC programming. Evaluation helps determine the effectiveness, relevance, reach and impact of BCC activities. It indicates whether the project is achieving its objectives, and it should be an integral part of the entire programme, not just a report at the end. It takes place at the beginning, when you conduct a formative assessment, when you develop BCC objectives, when you carry out pre-testing, and when you implement the programme in line with the envisioned process and output. Evaluation also serves to determine the outcome of the HIV/AIDS workplace BCC programme and the impact on the intended audience.
Measurable BCC objectives form the basis for evaluating BCC programmes. Outcome and impact evaluations form the basis for good evaluation.

**Assessing the outcome and impact of a programme**

Evaluation should answer the following questions: What outcomes are observed? What do the outcomes mean? Does the programme make a difference? For example, evaluation will help determine if a BCC objective, such as stimulating community dialogue on risk and stigma, was actually achieved. Evaluation will show if there is more open discussion on issues of risk and stigma in the community.

Questions asked should be based on, and refer to, behaviour change communication objectives and the behaviour change goals of the general programme.

People do not change their behaviour overnight. It takes time and it is often difficult to attribute the change to any one component of a comprehensive HIV/AIDS programme. However, it is possible to achieve qualitative changes in the short term, such as improved worker morale, increased comfort in discussing HIV/AIDS issues at the workplace, improved access to services that support behaviour change, and a sense that the employer is trying to create an environment that is supportive of safer, healthier behaviours.
Examples of HIV/AIDS BCC programme outcome evaluation questions:

- What has been the impact on the knowledge levels of the target/general population?
- What has been the impact on attitudes and beliefs about HIV/AIDS?
- What has been the impact on risky behaviours (e.g., sexual, drug abuse, needle-sharing) by the target/general population?
- What has been the impact on stigma associated with people living with HIV/AIDS?
- What has been the impact on discrimination against people living with HIV/AIDS?
- What has been the impact on service utilization (e.g., health, HIV/AIDS, legal, economic, social, psychological services)?

Basic steps in planning for an outcome evaluation:

- Determine when an evaluation is required
- Determine objectives of the evaluation
- Choose methodology
- Ensure that there is a budget for evaluation.

Section 6 provides guidelines and tools for monitoring and evaluating BCC programming at the workplace.
Step 8: Feedback and revision

HIV/AIDS BCC messages and approaches often need revision during the course of the programme. Sometimes messages developed at one point in time become irrelevant or simply stop having the desired impact. As the BCC workplace programme evolves, it may also become necessary to shift resources from one approach to another, or to change the programme theme.

Monitoring is a very effective tool that allows BCC practitioners to fine-tune messages once they have launched the programme. Monitoring should be a required item in the budgets and schedules of all HIV/AIDS workplace BCC programmes. Often the results of monitoring alert programme managers to problem areas in materials or messages. BCC materials and messages can sometimes become less effective following programme implementation. The needs of the target population change as they confront materials that lead them to seek other information.
3. Cross-cutting issues for implementation

There are several cross-cutting issues to take into account while implementing an HIV/AIDS BCC workplace Programme:

- **Involvement of people living with HIV/AIDS:** Effective BCC programming for HIV/AIDS at the workplace ensures that people living with HIV/AIDS are involved in every aspect of programme development and implementation.

- **Confidentiality:** The ILO Code of Practice on HIV/AIDS and the world of work comments in detail on this issue. Confidentiality at the workplace is essential to developing an effective HIV/AIDS workplace programme. Peer educators and managers of the project must receive training on how to ensure confidentiality.

- **Gender:** The issue of gender is very important for the design and implementation of BCC programmes because gender-based inequalities are one of the driving forces behind HIV/AIDS and because socially-sanctioned gender norms usually dictate sexual behaviour. These factors shape the extent to which men and women are vulnerable to HIV, determine how the epidemic affects them, and determine their potential. Finally, gender considerations determine the extent to which women are allowed into the workplace, and the expectations that exist for women in society. Therefore, addressing gender-based norms and expectations is critical to achieving behaviour change.

BCC interventions must always be mindful of gender-based concerns. For instance, programmes that focus on increasing condom use among women must address the issues that affect a woman’s ability to procure condoms, negotiate condom use, and seek treatment for sexually transmitted infections. Including gender concerns in programmes can help make health messages more effective, as well as encouraging communities to discuss and respond to issues of gender inequality.
Gender considerations can be addressed in the following ways:
- Include a gender perspective in your formative assessment. Assess the gender-related roles, responsibilities and needs of your target populations and what your programme might do to respond to them.
- Monitor gender information. Develop programme goals, objectives and indicators that capture gender information.
- Develop separate audience profiles for men and women. Assess (as applicable) differences in HIV/AIDS knowledge, attitudes and practices; health concerns; media habits; social support networks; etc. Plan interventions with these differences in mind.
- Develop positive messages. Promote positive gender roles and relationships in your messages and materials.
- Involve men and women. Involve men and women from the target audiences in your programme in every stage of strategy development and implementation.
- Consider primary and secondary audiences. If your BCC strategy targets primarily women, consider the role of men as a secondary audience. For example, a strategy for prevention of mother-to-child HIV transmission would understandably have a central focus on women. Nevertheless, men can play important roles—from providing emotional and financial support, to getting tested and becoming more faithful.

Stigma: For people living with, and affected by, HIV, the effects of stigma and discrimination are almost as deadly as the virus itself. Stigma and discrimination create an ‘us versus them’ mentality, whereby individuals refuse to look at their own behaviour and fail to assess their real risks of HIV infection. They also can keep people from undergoing HIV testing out of fear that their families, friends and communities will ostracize, reject and even harm them. This can accelerate the progression of opportunistic infections for HIV-positive individuals, and promote the spread of HIV to others. Stigma and shame can stifle community discussion and a desire for more information. This drives people living with HIV/AIDS into the shadows of society, where they fail to get care, support and treatment, and it allows governments, communities and individuals to deny the severity of the disease and downplay the need to scale up HIV/AIDS prevention, care and support efforts.

A comprehensive HIV/AIDS BCC approach to workplace programming should address stigma and discrimination through a variety of interventions, messages and channels. This can be done in the following ways:
- Conducting advocacy with key stakeholders to sensitize them to HIV/AIDS and the needs of those living with the virus, as well as those affected by, or vulnerable to, HIV. This is particularly important for senior management and any informal leaders at the workplace, whose example others are likely to follow.

- Thinking of people living with HIV/AIDS as stakeholders. Involve HIV-positive people and those affected by HIV/AIDS in every aspect of the development, implementation and management of HIV/AIDS programmes.

- Avoiding language that promotes stigma and discrimination. Include people living with HIV/AIDS in the development, pre-testing and delivery of BCC messages as much as possible.

- Striving to introduce ‘zero tolerance’ for stigma and discrimination at the workplace (including making a public stand) and ensuring that formal anti-discrimination policies are consistent with the ILO Code of Practice.

- Countering misconceptions by providing correct information about how HIV is and is not transmitted, means of prevention, HIV/AIDS symptoms, and care, support and treatment options.

- Promoting positive images, including family and community acceptance of people living with HIV/AIDS and the importance of caring for them.

- Promoting contact with people living with HIV/AIDS.

- Strengthening the capacity of providers to provide more compassionate and higher-quality care, support and treatment services.
4. Training in the implementation of the BCC toolkit

BCC practitioners will need to sensitize key tripartite leaders on behaviour change communication as an essential component of an HIV/AIDS workplace programme. These leaders will also need to be aware of the BCC toolkit and its uses. This can take the form of a half-day session aimed at business leaders, government officials, decision-makers, and facilitators in worker and employer organizations.

Training in using the toolkit

We recommend a five-day training course which consists of an orientation, an explanation of the kit and exercises to ensure mastery of every tool in the kit. The goal is to familiarize trainees with the substance and concepts of the toolkit. They will then be able to successfully facilitate training within their own sectors. Subsequent trainings within the sectors will enable the tripartite focal points to reach their goal of implementing HIV/AIDS behaviour change communication programmes at the workplace.

Training for peer educators

Training of peer educators is key to the success of a peer-education programme. Booklet 5 includes training topics and exercises.
Overview of HIV/AIDS
Behaviour Change Communication Programming for the Workplace

Using the toolkit: A case study

The case study outlined below illustrates how one workplace implemented an HIV/AIDS behaviour change communication (BCC) programme by using the BCC steps highlighted in the ILO toolkit.
Kenya is one of many African nations with a serious HIV epidemic. The HIV prevalence nationwide is estimated to be 6.7 per cent (9 per cent among women and 5 per cent among men, according to the Central Bureau of Statistics, 2003). Despite the lower-than-expected figure, the infection is still a generalized epidemic in Kenya, and efforts to bring it under control remain an urgent matter. One dramatic impact of AIDS-related deaths is the decline in life expectancy. The Kenyan Central Bureau of Statistics estimates that, without AIDS, life expectancy at birth would be about 65 years. However, because of the large number of AIDS-related deaths, it is actually only about 46 years and may decline to 45 years by 2010. Thus, almost 20 years of life expectancy have already been lost because of AIDS.

HIV infection is increasing rapidly in Kenya’s Western Province, where the agro-industrial plantations are a zone of high transmission. Absenteeism due to AIDS-related illnesses, loss of experienced personnel, replacement and training costs, reduced productivity, and increased medical expenditure threaten the viability of Western Province’s agro-industries.

Mumias Sugar Company (MSC) is the largest single sugar factory in Kenya, with 2,500 employees. Starting as a government-owned enterprise in the early 1970s, MSC has since been privatized and is listed on the Nairobi Stock Exchange. In 1999, the company began to work with Family Health International on the USAID-sponsored IMPACT project to implement a comprehensive HIV/AIDS workplace initiative targeting both workers and the surrounding residential community. These sites are particularly vulnerable to HIV infection, attracting large numbers of men who have disposable income, are away from their families, and are surrounded by low-income communities with disproportionate numbers of single women.

The programme includes behaviour change communication with a peer-education component, referrals for testing and treatment of sexually transmitted infections and voluntary HIV counselling and testing, as well as education, care and support in the community.
What follows is a description of BCC programme implementation at the Mumias Sugar Company, based on the eight-step process outlined in the ILO toolkit. The steps are:

**Step 1: Advocacy and stakeholder involvement**

**Step 2: Identification and segmentation of target populations**

**Step 3: Formative assessment for BCC**

**Step 4: Development of a BCC strategy**

**Step 5: Development of communication support materials**

**Step 6: Implementation of the BCC programme**

**Step 7: Monitoring and evaluation**

**Step 8: Feedback and revision**

**Step 1: Advocacy and stakeholder involvement**

When the programme began in Mumias in 1999, HIV/AIDS programming was limited within the company. However, since 1988, the company had been attempting to create general awareness about HIV/AIDS using traditional information, education and communication approaches (e.g., occasional lectures, brochures, etc.). The company medical officer spearheaded these efforts, directing them at the primary target population of unionized staff (approximately 1,500 front-line workers). The programme was implemented in collaboration with the Kenya Union of Sugar Plantation Workers (Mumias branch). Management and the families of all the workers comprised the secondary target population. But the company found it difficult to go beyond the stage of awareness creation.

When the IMPACT project team approached management at Mumias to talk about starting a more comprehensive HIV/AIDS programme at their workplace, they met with some resistance. As a result, the team sought the involvement of a number of top-level players and power brokers to persuade Mumias management to implement a workplace HIV/AIDS intervention. The stakeholders to whom HIV/AIDS BCC staff spoke were the following:

- Kenya Sugar Authority, the supreme sugar regulatory body in Kenya; and
- The Provincial Medical Officer of Health, who is in charge of all regional health matters. (The Medical Officer spoke to the Chief Executive Officer of Mumias and arranged an appointment for the team to meet him in person.)

The Chief Executive Officer and all eight departmental heads attended the meeting. The workplace HIV/AIDS BCC team gave a presentation to the top management of Mumias about why an HIV/AIDS intervention at their workplace would be beneficial. One of the most pivotal issues raised was the Kenyan HIV prevalence data. Another convincing aspect of the presentation that had an impact on management’s decision to start a programme was the experience from other worksites that showed the benefits of starting HIV/AIDS interventions in large companies. The Chief Executive Officer concluded the meeting by directing the company doctor to accord the project team all the support it required.
Once the project had begun at the Mumias Sugar Company, the team organized further briefing sessions for various section and departmental heads to inform them of the planned intervention, its design, and the benefits of the programme for workers and the company. After presenting these points, the project team asked for, and received, the support of the section and departmental heads.

The project team also advocated prevention education and referral to other services (such as HIV counselling and testing and treatment of sexually transmitted infections). In addition, they advocated for the company to provide free and unrestricted treatment to all employees who tested HIV-positive. The treatment included medication for opportunistic infections, as well as antiretroviral drugs.

Step 2: Identification and segmentation of target populations

When Mumias initiated its project in late 1999, the company had slightly more than 4,700 employees. Employees currently number about 2,500.

The primary target population for the behaviour change communication initiative at Mumias is its permanent workers. The secondary target population is made up of the dependants of the workers who also live within the Mumias community, but are not necessarily employees of the company.

Segmentation

The project has been refining the target population as activities unfold. This approach has, for instance, enabled the project to identify high-risk sections within the larger workforce, such as the mobile sales and transport staff.

When the project began, it worked with the lower cadres, since they comprised the largest percentage of the workforce. Most of the peer educators were drawn from this group. As the project has grown, there has been more and more involvement of middle and senior cadres in the company’s HIV/AIDS-related activities. For instance, the company medical doctor heads the company AIDS committee, of which the company legal officer is a member.

Step 3: Formative assessment for BCC

With the goal of designing an optimal intervention, the project team conducted a formative assessment. The assessment included the collection of baseline information prior to intervention, for comparison with a follow-up survey. This took the form of a baseline survey to establish employees’ knowledge, attitudes and practices with regard to HIV/AIDS. This assessment analysed the Mumias Sugar Company as a whole, in terms of its structure, geographical location, social settings, and the risk factors both within and outside the company.

A variety of data-gathering methods comprised the assessment, including qualitative methods, such as in-depth interviews, focus group discussions and key informant interviews, and quantitative methods, such as a structured questionnaire. The qualitative
methods were designed to yield a deeper understanding of the reasons why people engage or do not engage in certain behaviours. The questionnaire—a quantitative method—served to collect numerical information (e.g., the number of workers who reported consistent use of condoms) for comparison with evaluation results over time.

Findings

The main findings of the assessment included the following:

- The majority of the workers had inadequate knowledge about how HIV is transmitted and how to prevent it.

- About 90 per cent of the workforce is male. The few female employees work within the administration department. The nature of the company’s work probably explains the gender imbalance.

- Most of the employees had a negative attitude about HIV/AIDS, especially with regard to people living with AIDS. This led to stigma and, to some extent, discrimination. For example, employees did not want to mix with anyone they thought might have HIV/AIDS.

- Condoms were not readily available nor did the company distribute them. Knowledge of condom use was also limited. For example, some thought that the use of three condoms at one time would increase their effectiveness.

- Nearly all workers who had a sexually transmitted infection shied away from seeking treatment at the company clinic. The company policy outlawed treatment of sexually transmitted infections, labelling them “self-inflicted”. This led to poor health-seeking behaviour by the affected, since they resorted to cheap, and often ineffective, treatment options from traditional health practitioners in the village.

- The main sources of information that employees relied on were the national media, friends and written materials.

- The majority of employees (particularly males) had disposable incomes, which they used mainly for leisure purposes.

- Many employees (particularly males) lived away from their families, and they often engaged in risky (unprotected) sex with sex workers and with some women from low-income settings in the surrounding communities.

- In some cases, female workers were at risk due to the sexual advances of more senior male employees in positions of power.

- The workers trusted their colleagues and the union, but not management, when it came to matters related to HIV/AIDS. This was particularly true of the lower cadres – the union staff.

- There was no company policy on HIV/AIDS. Treatment for HIV-positive workers was informal and generally available only to top management and chief executives.
Step 4: Development of a BCC strategy

The project developed a behaviour change communication strategy based on the findings of the formative assessment. There are six steps to devising a BCC strategy, which include development of the following elements:

- Target population profiles
- BCC objectives
- Key benefit statements
- Messages
- Theme
- Channels.

An interactive workshop was organized to develop the workplace BCC strategy. The target population profiles were taken from the formative assessment results. The project’s behaviour change and behaviour change communication objectives follow.

**Behaviour change objectives:**

- Increase the proportion of workers who reported being faithful to one partner within a two-year period.

- Increase the proportion of workers who reported consistent use of condoms with female sexual partners within a two-year period.

- Increase the use of HIV counselling and testing services.

**Behaviour change communication objectives:**

- Increase the perceived distance between exposure and HIV infection, and HIV infection and AIDS.

- Increase in-depth knowledge about HIV/AIDS.

- Improve sexual and condom-use negotiation skills.

- Create a better understanding of, and confidence in, condoms.

- Create greater understanding of the risks of unprotected sex with multiple partners.

- Create greater interest and confidence in HIV counselling and testing.

One of the key benefit statements developed during the strategy design workshop was: “I will seek out sexually transmitted infection services because I don’t want my wife to be mad at me.” The message developed from this statement was: “Take care of your sexually transmitted infection and come home to a happy wife.”

The communication strategy had various themes, the most prominent of which was “question (our) relationships”. The theme was designed to be provocative, encouraging people to question their relationships. For example, whom are they relating to? Are they relating to the right person, in the right way, at the right place and time?

Mumias’s BCC approach corresponded to IMPACT’s larger strategy. Peer education was
the main activity. A mass media campaign dubbed ‘kati yetu’ – Kiswahili for ‘between us’ – supported peer-education efforts. This approach placed greater emphasis on interpersonal communication rather than production of communication materials, as had been the practice in the past. The idea was to stimulate community dialogue and discussion, create demand for information and services, and hopefully prompt people to adopt or maintain positive behaviour, thereby reducing the risk of infection and reducing stigma.

**Step 5: Development of communication support materials**

The project team adopted an interactive, learner-centred approach to the peer-education programme, weaving sessions around the needs and interests of participants. Facilitators (peer educators) start the discussion around pre-determined topics, but there is flexibility to bring in other issues, depending on the needs of the group and the ability of the peer educator to effectively handle them.

Support materials, such as small educational flipcharts and HIV/AIDS games, were developed for the peer-education project. A local artist was involved in the strategy-design workshop and drafted these materials with support from the HIV/AIDS project and workplace staff. The project team then pre-tested the draft materials with Mumias workers to see if they understood the illustrations, if they liked the games, and if they thought that the information in the materials was important and relevant. The team revised the materials based on workers’ inputs, then pre-tested them again with other workers. Several more pre-tests and revisions took place before the final versions were ready for production.

The communication strategy also included a comic strip and a radio programme (‘kati yetu’), aired on three channels, to support the interactive discussions at the workplace.

**Step 6: Implementation of the BCC programme**

To implement the BCC strategy, the Mumias Sugar Company took the following actions:

- Hired a full-time coordinator to manage the HIV/AIDS programme.

- Conducted sensitization sessions on HIV/AIDS for managers and union officials (some of whom were also trained as peer educators).

- Trained 100 peer educators. The ratio of peer educators to employees was about 1:50. Not all of the trained peer educators are currently active.

- Sponsored additional trainings for community peer educators (e.g., the wives and children of workers), who conducted group sessions and individual counselling for workers and their families in the community (e.g., in the factory-owned living quarters and beyond).

- Developed a life-skills curriculum, which included information on HIV/AIDS and was introduced in Mumias schools.
- Conducted trainings for health facility staff on HIV counselling and testing and sexually transmitted infections. A team of community health workers based in the health facility also received training on care and support for people living with HIV/AIDS.

**Step 7: Monitoring and evaluation**

**Monitoring**

The monitoring system is centralized. Peer educators hold weekly meetings with their peers, during which they facilitate interactive discussions about selected topics. Educators take note of difficult and unanswered questions and tackle them during subsequent sessions. Similar discussions are repeated during their meetings with their friends on a one-to-one basis. Peer educators fill in details about both meetings and submit them to a site-based BCC coordinator. These details are incorporated into the national system and form part of the project monitoring plan, as well as being a source of topics to cover in the national radio programme aired weekly on three popular radio channels. Mass media support the regional efforts by responding to issues that seem to be relevant in more than one region.

The project tracks progress based on data received from peer educators on the following indicators:

- Number of one-to-one counselling sessions held
- Number of group training sessions held
- Number of attendees at the group sessions
- Number of condoms distributed
- Number of referrals to sexually transmitted infection and HIV counselling and testing services (tracked on referral forms filled out by peer educators).

Outpatient records from the local health facility, St Mary’s Hospital, also serve to track referrals.

Monthly site meetings initiated by the project also serve to monitor the progress of implementation of BCC activities at a particular site. All partners involved in implementation take part in the meeting and raise important issues that are addressed either instantly or forwarded to the regional and or national office for further assistance. In this way, implementation difficulties receive almost immediate attention.

Examples of monitoring indicators include:

- Number of trainings conducted
- Number of active peer educators
- Number of peer educators trained
- Number of peer educators attending refresher courses
- Number of people trained as ‘trainers of trainers’ in peer education
- Number of IEC/BCC materials developed and disseminated
- Number of group/outreach meetings held
- Number of target population reached through community outreach/group meetings, as well as one-on-one sessions broken down by gender
Number of workplace managers and or supervisors trained
Number of condoms distributed by peer educators
Number of female condoms distributed by peer educators
Number of sexually transmitted infection referrals made
Number of HIV counselling and testing referrals made.

Evaluation

As mentioned previously, prior to launching the project, the project team conducted a survey among a sample of workers, in addition to carrying out a series of interviews and focus groups discussions. An evaluation of the Mumias project took place after its second year of operation to assess whether the knowledge, attitudes and behaviours of the workers had changed as a result. Using the same methodologies described in the baseline assessment, the project team conducted a survey questionnaire and interviews. One of the findings from the evaluation was that peer educators had better knowledge about HIV/AIDS than their colleagues who were not involved in the project.

Examples of evaluation indicators include:

- Percentage of targeted workers who correctly identify three or more modes of HIV transmission (sexual, mother-to-child, as a result of a blood transfusion)
- Percentage of targeted workers who correctly identify three means of protection against HIV infection (having no penetrative sex, using condoms, and having sex only with one faithful uninfected partner)
- Percentage of members of the target audience (men and women workers) who report having sex with a non-regular partner in the last 12 months
- Percentage of all workers who report having sex with a non-regular partner in the last 12 months
- Percentage of workers who report using a condom the last time they had sex with a non-regular partner
- Percentage of targeted workers accepting HIV counselling and testing services and receiving HIV test results in the last 12 months
- Percentage of targeted workers reporting personal knowledge of someone who has experienced stigma or discrimination due to known or suspected HIV-positive status in the last 12 months.
Step 8: Feedback and revision

Monitoring information is continually communicated to peer educators, workers, managers and administrators through interactive meetings, forums and discussions. In addition, monitoring data serves to improve the project. Based on the monitoring data, several changes have taken place within the Mumias Sugar Company. For example:

- The company now has a very active HIV/AIDS committee headed by the company doctor. The committee is charged with the overall coordination of HIV/AIDS-related activities within the company.

- The company policy has changed and now allows for the treatment of sexually transmitted infections.

- Any HIV-positive worker requiring treatment receives it (including antiretroviral therapy) without discrimination. No one is sent home. This applies to all cadres.

- Currently, the company is working closely with project staff on a transition plan for the assumption of full responsibility for all components of the project. While the medical department is the primary force in coordinating HIV/AIDS-related activities, the company is also exploring the development of a policy that includes a mandate for all departments to include HIV prevention in their programming (e.g., in staff meetings, safety talks, etc.).

- The peer educators have been able to meet their peers outside of work, if they are unable to get time off during normal working hours.
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

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Appendix: Formative assessment guides for HIV/AIDS behaviour change communication workplace programmes

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B: KAP survey for workers

C: Key informant interview

D: Focus group discussion

E: In-depth interviews

F: Observation
Introduction

This booklet offers users a framework for collecting data to form the basis of an HIV/AIDS behaviour change communication (BCC) programme for the workplace. Gathering data for BCC is generally called a ‘formative assessment’ and is defined as the gathering of in-depth information about the programme’s target groups to design effective behaviour change communication activities. ‘Formative’ means the formation or development of a body of information through which to assess or determine the nature of a population. Formative assessments will be conducted during the planning stage of the BCC programme’s development. A formative assessment provides a thorough understanding of current conditions, practices and attitudes among target populations. This understanding is essential for designing appropriate BCC interventions, as well as workplace HIV/AIDS programmes and policies.

This booklet describes the research methods available for gathering information, along with guidelines on how to select and use these methods. The appendix contains guides for designing a BCC formative assessment for the workplace.

Reading and using this booklet will enable a team or facilitator to:

- plan the formative assessment;
- select the appropriate data-collection methods;
- develop a formative assessment workplan;
- collect the data;
- analyse the data;
- develop a formative assessment report; and
- segment the target populations in preparation for BCC programming.
Step 1: Plan the formative assessment

A. Defining your goals

The goals of the BCC formative assessment in the workplace are:

- to identify opportunities, resources and potential barriers to BCC activities;
- to understand different target populations’ behaviours, attitudes, likes and dislikes, hopes and fears for the future;
- to specify the target populations’ current knowledge, attitudes and behaviours regarding HIV/AIDS;
- to identify the target populations’ specific interests and concerns regarding HIV/AIDS and the type of programming and support they need;
- to define their social networks and their high-risk settings (i.e., environments that can lead to high-risk behaviours—for example, bars, brothels and truck stops, where sex workers operate);
- to involve them in the behaviour change process; and
- to identify ways to increase HIV/AIDS-related health-seeking behaviour.

B. Gathering data

Achieving these main purposes means reviewing the information already available about a particular workplace, and identifying what additional information is necessary.

The following categories may help when collecting information for the formative assessment.

The broader environment

- Data on the epidemic in the country/region (including the main modes of HIV transmission)
- Role of national, regional or local government in addressing HIV/AIDS in the workplace (e.g., workplace strategy as part of national HIV/AIDS plan)
- Information and services available from community-based or AIDS service organizations.

The work environment

- Existing programmes, policies and practices at the workplace for HIV/AIDS prevention, care and support
- Condom distribution
- Basic health care
- Sexually transmitted infection diagnosis and treatment
- Access to voluntary HIV testing and counselling
- HIV/AIDS/tuberculosis treatment, care and support (including antiretroviral therapy)
- Workplace policy
- Workplace committees (e.g., health and safety)
- Basic and in-service training programmes
- Normally planned events
- Worker organization(s); what kind of support workers receive from their union
- Categories of workers by job function, education, gender, income and ethnicity.
Worker knowledge, attitudes, values and beliefs

- Current knowledge, attitudes and behaviour regarding HIV/AIDS
- Level of interest in developing HIV/AIDS programmes
- Specific interests and concerns related to HIV/AIDS (e.g., housekeeping staff in a hospital in Kenya were afraid to clean the rooms of AIDS patients)
- HIV-positive workers who are open about their status with employers and co-workers
- Treatment of workers living with HIV/AIDS
- Attitudes towards people living with HIV/AIDS at the workplace
- Behaviours, attitudes, hopes and fears for the future, likes and dislikes
- Social networks
- Potential high-risk settings
- Current health-seeking behaviour

Communication mechanisms

- How people get information at the workplace (e.g., newsletter, bulletin board, staff meetings, training sessions, new employee orientation)
- Trusted sources of information
- Media habits

Identifying information that is currently available

To identify relevant information that is already available, you will need to conduct a review of work already carried out by previous programmes. Potential sources of information may include:

- ILO country profile or status reports regarding HIV/AIDS and the world of work;
- UNAIDS country fact sheets;
- past studies and reports on HIV/AIDS;
- surveys of HIV/AIDS knowledge, attitudes, practices and beliefs among the target population;
- government epidemiological data and health surveys pertaining to HIV/AIDS;
- local university dissertation research;
- other organizations’ studies; and
- studies conducted in the selected workplace.

There may be no need to have focus group discussions and in-depth interviews with the target populations if the relevant data already exist. Instead, information gaps may be identified and a questionnaire developed on the basis of the missing information. In this way, valuable and scarce resources may be preserved for use in other areas of the programme.

Identifying necessary additional information

Once existing studies and data have been reviewed, there may still be gaps in information about the key target populations. It is important to systematically categorize these gaps in preparation for gathering additional data for the formative assessment.
Step 2: Select the appropriate data-collection methods

Once you have reviewed the existing data, you will need to collect the additional information needed for the BCC formative assessment. The following methods may be used to do this.

Site inventories help assess how target populations are structured in geographic and social space and how they network with other populations. Site inventories usually focus on informants who are knowledgeable about the geography and social structure of the area and experienced with BCC interventions. Inventories can also provide an overview of existing resources useful to the programme, such as HIV/AIDS-related services available both at the workplace and in the surrounding community, media opportunities and local partners. This exercise is easy to carry out at the workplace.

KAP surveys for workers consist of a list of questions with a range of pre-determined responses. Surveyors generally use these questionnaires to learn more about workers’ knowledge, attitudes and practices with regard to HIV/AIDS. HIV/AIDS knowledge can include misconceptions, prevention strategies and modes of transmission. Becoming more aware of workers’ attitudes, such as how they feel about condoms, will help you determine which topics your BCC programme should focus on. In addition, the practices that workers engage in will help you ascertain which activities would be most beneficial at your workplace. Knowledge, attitude and practice surveys are relatively simple to conduct and can provide baseline data for programme development.

Key informant interviews are conducted with people who are highly knowledgeable about the topic under investigation and who are linked to target populations. Key informants may include opinion leaders, local health providers and experts from the target population. Key informant interviews provide an insider’s view of the structural, organizational, social and cultural context of the workplace or community. They also give insights into the target population’s behaviour. This activity serves as the basis for the methods that follow.

Focus group discussions are conducted with eight to ten representatives of the target population, and require a skilled moderator. These discussions reveal major issues and patterns, including both shared and conflicting ideas about target population behaviour. They also allow interviewers to assess potential reasons for a target population adopting a particular behaviour.
In-depth interviews can take place with workers from different departments at the workplace and from different levels of management. They can also include representatives from human resources and medical departments, as well as union and health and safety representatives (if relevant). In the community, interviewees may include labour leaders, health-care providers and representatives from local non-governmental organizations that provide HIV/AIDS services. These individual assessments are necessary for an in-depth look at the intimate individual perspectives, beliefs, motivations and logic behind behaviour. They may also show how such behaviour fits into the broader social context.

Observation can help to confirm or refute results found through the methods outlined above. Observation involves choosing a setting of interest, such as a truck stop, to see how the workers engage in social and work activities. It helps in describing social networks, high-risk settings and the steps or influences that lead to high-risk behaviours.

BCC assessment monitoring involves the results of one method informing the content and structure of another. This feedback and revision will lead to more refined assessment protocols. For example, data obtained from the inventory exercise may reveal additional questions that will need to be put to management. Information from in-depth interviews with management may lead to questions for staff group discussions.

Each method can inform the development of other methods or help in determining if another method is needed. Developing a good BCC programme is an investigative process.

Factors to consider when choosing methods:
- Level of existing information
- Human and financial resources at your disposal
- Diversity of target populations
- Time available
Step 3: Develop a formative assessment workplan

Once the data-gathering activities have been selected, a review of the suggested methodology and of the kinds of questions to be included in each guide should be carried out. This will help define the scope of the assessment and determine which human and financial resources are necessary. Some activities may be curtailed if human and financial resources are limited. The Family Health International publication Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health is a valuable resource that covers topics such as planning research, methods, sampling and ethics.

To develop a workplan, you will need to:

A. set up the needs assessment team;

B. select the sample;

C. select key informants and information collection approaches;

D. create assessment tools based on the toolkit guides; and

E. train interviewers.
A. Set up the needs assessment team

What are the roles of the different assessment team members?

The assessment team can be as simple or as extensive as is necessary to complete your needs assessment. For example, if your needs assessment is small, then hiring one consultant could be enough. However, a larger assessment team will be necessary if you want to include multiple workplaces, review secondary resources, map each workplace, and use several of the qualitative formative assessment methods described below.

The assessment team may include programme staff, a consultant or a team of consultants, and representatives from the workplace. The roles outlined below are examples of how you might want to organize your assessment team if the needs assessment is on a larger scale. You can also combine tasks so that one person fills two roles.

**Assessment leader:** The person who provides technical leadership and oversight; the BCC programme coordinator might fill this role.

**Assessment coordinator:** The person in charge of logistics. He/she works in close collaboration with the partnership interviewers, setting up meetings, communicating with the rest of the team and carrying out other organizational duties.

**Partnership interviewers:** Members of the community who help recruit participants and identify respondents and interview sites. These people might help record responses and observations such as facial expressions and body language during focus group discussions, or they might keep a log of the discussion if a tape recorder is not available.

**Interviewers:** People who perform field tasks such as interviews, observations and moderating.

The programme coordinator may choose to maintain a formal role in the team or to act in an advisory capacity. The BCC assessment team should make decisions about how to set up a workable system to conduct the assessment. How the team is constituted will depend on the situation.
How to establish a timeline

It is advisable to develop a timeline for assessment activities prior to assigning specific tasks to team members. The assessment leader should work with team members to develop a timeline based on the overall BCC programme calendar. Together, this team can determine the pace of work.

The workplan will need to specify the roles and responsibilities of each team member and an appropriate timeline for assessment activities. For example, if the team decides to conduct four focus group discussions with long-distance truck drivers from 6 to 8 July, it will be necessary to organize logistics and conduct the interviews.

It is important to make several field visits to the selected sites to gain the support of the community and of those at the workplace for the formative assessment before implementing it. Site visits help you understand when, where and how to conduct the formative assessment, and encourage collaboration with stakeholders.

Table 1: Example of timelines for interviews

<table>
<thead>
<tr>
<th>Method</th>
<th>How long</th>
<th>How many</th>
<th>How often</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inventory</td>
<td>1 week</td>
<td>3 key informant interviews (plus review of documents)</td>
<td></td>
<td>1-5 July</td>
</tr>
<tr>
<td>In-depth interviews</td>
<td>90 minutes</td>
<td>15 interviews</td>
<td>2 per day</td>
<td>7-12 July</td>
</tr>
<tr>
<td>Focus group discussion</td>
<td>1 hour</td>
<td>3 groups</td>
<td>1 per day</td>
<td>6-8 July</td>
</tr>
</tbody>
</table>

Table 2: Assignment example

<table>
<thead>
<tr>
<th>Who</th>
<th>What</th>
<th>When</th>
</tr>
</thead>
</table>
| Assessment coordinator | Organize focus group discussions for truckers  
■ Meet with trucker union  
■ Meet with truckers  
■ Coordinate venue | 15-17 June |
|                    | Organize focus group discussions for secretaries  
■ Meet with secretaries  
■ Coordinate venue | 17-19 June |
B. Select the sample

The first task is to select the workplace to be assessed. In many cases, this will already be apparent. But you may also have to identify specific areas within the site.

Next, the respondents must be selected. Here are some suggestions for doing this:

- Always keep in mind the populations you are targeting.
- Go to sites or observe events that are easier to get to (or arrange).
- Go to the sites when people are most cooperative: for example, when members are on break or at the beginning or end of the day. Times for research may be different than times for setting up interviews: for example, you might contact secretaries during a coffee break but schedule the interview for the following day, when they are not busy.
- Always take advantage of opportunities that occur.
- Always follow up on leads about where you can find the people you are seeking.

C. Select key informants and information-collection approaches

(See Step 2, page 4.)

D. Create assessment tools based on toolkit guides

(See Step 2, page 4, and the appendix of Booklet 2)
E. Train interviewers

Once you have developed the assessment tool and are ready to implement it, you will need to schedule a training session for the interviewers on your team. The training will provide them with information and skills on how to conduct an interview and/or group discussion using the tool.

The activities listed below are examples of what to include in the training.

Day 1: Getting to know the tool

The main goal of the first day is to provide interviewers with background knowledge on the tool. Begin by walking interviewers through the tool, explaining the reason for including the questions or topics and what you hope to learn from the interviewees. The trainer should provide enough background information so that interviewees feel confident. The main concepts to cover include:

- modes of transmission and prevention strategies for HIV and other sexually transmitted infections;
- HIV/AIDS activities at the workplace;
- stigma and discrimination; and
- knowledge of HIV/AIDS workplace policies.

Interviewers should learn about general questionnaire/interview administration issues, such as obtaining consent, establishing rapport with a respondent, and the need for standardization of questions.

Day 2: Role play

The main activity of the second day is role plays. In role plays, one interviewer pretends to be an interviewee while another administers the questionnaire or interview. Others watch and, at designated times defined by the training facilitator, may offer suggestions for improvement and/or may point out good qualities. After all interviewers have assumed both roles, they should repeat the exercise with interviewers playing the part of a ‘difficult’ interviewee. After each session, the group should discuss the strengths and weaknesses of the interviewer, as well as possible ways of probing the interviewee. During the role plays, interviewers should gain good knowledge of questionnaire/interview administration. They should learn to handle clients who answer vaguely or not at all. They should also be able to filter out superfluous information and to note multiple answers.
Step 4: Conduct the formative assessment

The same behaviour may mean different things to different people. Talking with the target population can yield insights about the rationale behind their actions that help in designing effective communication products and activities aimed at altering behaviours.

The BCC assessment team will work with respondents to produce answers about topics of interest. The success of the assessment depends on the quality of the relationship between the respondent and researcher as well as on the level of interaction.

For formative assessment methods 2 to 7, described below, there are associated guides in the appendix, which provide examples of how to modify or adapt a programme, if needed.

Method 1: Review of existing information
Method 2: Site inventory
Method 3: Knowledge, attitude and practice (KAP) survey for workers
Method 4: Key informant interview
Method 5: Focus group discussion
Method 6: In-depth interview
Method 7: Observation
Method 1: Review of existing resources

Reviewing existing resources includes consulting existing studies and reports on HIV/AIDS, on the selected target population, and on the selected workplaces. Resources that cover HIV/AIDS-related issues can be useful in the design of successful BCC workplace interventions. Reviewing existing resources can yield much of the required information, saving time and money. Any gaps in the available information can be covered by a questionnaire or interview that focuses on the missing information.

Method 2: Site inventory

You can conduct the initial site visit and the site inventory at the same time. Both require meeting with managers, supervisors and line workers to outline the systems, structures and opportunities at the workplace. It is also a good opportunity to build partnerships between programme and workplace staff. Through the site inventory, you can:

- chart the organizational and physical structure of the workplace;
- identify the main target populations, worker organizations, and workplace activities and services; and
- identify opportunities for integration of HIV/AIDS-related activities into existing services or for easy creation of new services.

The site interview can be conducted by reviewing available documents that describe the organizational structure of the workplace, and by interviewing key staff to gain more up-to-date information about services, programmes, activities, associations and newsletters. The results of the site inventory will help in identifying opportunities and gaps for integration and/or addition of HIV/AIDS behaviour change communication activities. (See the appendix, page A-1, for a site inventory guide.)

Method 3: Knowledge, attitude and practice (KAP) survey for workers

The KAP method is a quantitative method used in HIV/AIDS studies and programmes. A statistician will need to be on your team so you can accurately analyse the results. KAP surveys are often used in a pre/post-test design to rapidly assess the population’s knowledge, attitudes and practices regarding a certain disease or area. In a pre/post-test design, the programmers and/or researchers can determine whether there have been any changes that could possibly be attributed to the interventions.

KAP surveys often give the programmers/researchers new insights about the target population. However, there are disadvantages to this approach. For example, in any survey, the respondents may give you answers that they think you want to hear. The respondents may also answer untruthfully in areas that are very personal, such as their sex lives or their feelings towards people with HIV. In addition, the many “yes/no” answers to many of the...
questions do not allow the researcher to explore the question in depth. Often, qualitative methods need to be conducted as well to get a fuller picture of the lives of the target population. The in-depth information from the target population is especially important when designing behavior change communication programmes.

**Method 4: Key informant interview**

Key informants are experienced people with direct, expert knowledge of the subject under study. Key informants may include:

- worker representatives;
- focal points from trade unions and employer organizations;
- representatives from the health facility that serves the target population; and
- staff from organizations that provide HIV/AIDS services to the target population.

It could also be relevant to interview:

- representatives of the ministries of labour and health;
- representatives of the national HIV/AIDS programme;
- private sector leaders who understand HIV/AIDS issues; and
- relevant non-governmental organizations.

It is important to include representatives from all levels of workplace personnel—from top management to line workers—and from different departments. Staff from medical services and human resource departments, as well as health, safety and union representatives (where they exist), should be high on the list of interviewees.

Talking to people from these groups will help in determining who the experts are. For example, when talking to garage owners, it is useful to ask who the lead mechanic is or who most people look up to in the garage. Similarly, when speaking with apprentices and other mechanics, you can ask which of their colleagues is most knowledgeable about the garage and possible HIV/AIDS-related activities. People identified repeatedly as experts may be promising key informants.

Try to probe potential key informants to make sure that they really are experts before accepting them as key informants and investing time in interviewing them. Look for a long record of involvement; direct, personal experience; and comments rich in situational and contextual detail and examples. Be wary of informants whose comments are limited to generalities. If your informant’s reply is satisfactory, you can proceed. If not, thank them politely and tactfully discontinue the conversation.
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

How to gain information from key informants

There are numerous ways of acquiring information from key informants. This can be done:

- informally;
- through formal introductions;
- via in-person interviews;
- through telephone interviews; and
- with formal techniques, such as written questionnaires.

Try to apply the following principles when conducting key informant interviews:

- Begin with truly exploratory, flexible, open-ended questions and pursue all unanticipated, but important, issues that arise.
- Never tell people they are wrong, give non-verbal clues, or offer value judgements.
- Share your own experiences (without disclosing strong views), if doing so relaxes informants.
- Never move to a new topic until you have completely explored the topic under discussion.
- Make detailed notes on each informant’s comments.
- Interpret and summarize the key informant interviews, perhaps using the following steps:
  - First, make a list of all areas, categories of places, addresses, days and times when/where risky activity occurs.
  - Second, produce a summary (in point form) of the key points made by each key informant.
  - Third, make a summary (in point form) of the separate key informant summaries.
  - Divide the summary into areas of major and limited agreement and consider possible explanations for inconsistencies.

The following strategies can help in determining whether the information received is reliable:

- Be attentive to internal inconsistencies in the comments of key informants and explore these inconsistencies in a reassuring way.
- If some conclusions seem questionable, try to determine whether an informant has drawn them from a single, memorable incident.
- Ask whether key informants’ experience qualifies them to make a statement whose reliability seems uncertain.
- Consider carefully whether the attitude the informant holds towards the workplace may have influenced particular answers.
- Compare answers of different key informants, looking for contradictions and points of consistency.
- Compare the information gathered from key informants with that yielded by other methods.

Key informant interviews will help yield the following information:

- An overview and in-depth information on the workplace and its social context
- Perceptions and insights into target population behaviour
- Information about human resources for the forthcoming BCC programme.
You can also ask key informants to suggest questions for possible use during in-depth interviews and focus group discussions, should you choose to use these methods. (See the appendix, page C-1, for a key informant interview guide.)

**Method 5: Focus group discussion**

Focus group discussions involve gathering a group of people from the workplace to thoroughly discuss important issues such as HIV/AIDS and related interventions. A group leader guides the discussion, using a series of carefully chosen questions. Individual in-depth interviews are often preferable to focus groups for examining personal, sensitive or complex issues, while focus groups are useful for producing ideas, examining group interaction and its effects, developing and testing educational materials, and refining health services.

Workplace focus groups can generate important information by:

- identifying worker perspectives on employers, unions, medical services and other benefits that help determine what type of BCC HIV/AIDS programme to develop;
- identifying high-risk behaviours and helping to determine the areas of prevention training that are most critical to the workplace;
- identifying which HIV/AIDS-related issues are of most concern to workers; and
- assessing the workplace environment regarding discrimination and stigma towards HIV-positive workers, or employee needs with regard to care and support, including testing and treatment issues.

A focus group discussion is not meant to be a problem-solving session, nor is it a decision-making group. At best, it is a discussion among participants rather than a series of two-way communications between the moderator and individual participants. Ideally, the moderator will ensure that participants feel free to express their thoughts and opinions openly, that all topics of the focus group discussion guide are presented, and that the discussion is broad and deep. One of the goals should be to foster an in-depth discussion among participants about their knowledge, attitudes and behaviours with regard to HIV/AIDS. The skill and experience of the moderator will determine the quality of the information gathered.

If possible, a skilled moderator should be hired. If not, informal group discussions are still a good way to learn about workers’ knowledge, attitudes and practices, as well as what they would like to see in a workplace HIV/AIDS programme. Be aware, however, that informal group discussions do not constitute a genuine qualitative research method.

In focus group discussions, the interaction of participants should stimulate richer responses and allow for new and valuable thoughts to emerge. It is not necessary for the group to reach a consensus, or for people to disagree, although this may occur. The objective is to get high-quality information in a setting where people can consider their own views in light of the views of others.
Focus group composition

The composition of the discussion group should include workers from different departments or a particular target audience (e.g., janitors). Focus group discussions are usually easier to conduct and generate better results if participants are of similar age, sex, education, socio-economic background, occupation and fluency in the language used. However, you may waive some of these criteria if the goal is to hold a discussion among a broad cross-section of the workplace. It is usually important to be careful when mixing people of different status. For example, in workplace settings, workers may have difficulty speaking freely among supervisors and managers.

Size

The ideal group size is eight to ten people. This gives everyone a chance to talk and permits a sufficient range of contributions. The number should seldom be below six or above 12.

Number of sessions needed

There are no firm guidelines about the ideal number of group discussions, although, as a rule, three sessions are held for each variable (males vs. females, in-school vs. out-of-school youth) and sessions are continued until no new information comes up. Participants usually begin to repeat information over the course of three group discussions. At least one focus group discussion should take place in each geographical region where a difference in information might appear.

Session length

Each session should last from one-and-a-half to two hours.

Setting and seating arrangement

Choose a site where it is easy to hear people speak. It should be accessible, private, quiet, comfortable, and in a non-threatening environment. Select a site where the presence of an observer will not disturb the group. It should also be large enough to seat eight to 12 people in a circle, as this makes it harder for anyone to dominate the discussion.

The seating arrangement should avoid showing status. Set up seating so that the moderator has good eye contact with everyone and every participant is equidistant from the moderator and in view of the other participants. The group leader should sit in the circle with everyone else and avoid standing in front of the group or doing anything else that suggests higher status. A circular seating plan usually fulfills these requirements.

Moderator technique

The moderator should not be (or seem) judgemental or try to dominate. He/she should convey warmth, enthusiasm and interest, encourage everyone to participate, and quietly try to control dominant participants.

When the group discussion is over, the leader should invite concluding comments, thank the group as a whole (noting how helpful they have been and citing specific insights they have provided), and thank them individually.
**Topic guide**

Before holding a focus group discussion, it is important to agree on the objective. For example, a focus group in the early stage of an intervention may be concerned primarily with the social and sexual context of HIV risk. A focus group held when an intervention is well established may examine participants’ responses to intervention services and programme adjustments needed. However, some themes are likely to be consistently important throughout a programme. These include how to remove barriers to condom use and how to improve the accessibility, acceptability and uptake of sexually transmitted infection management and other services.

Once the objective is clear, you will need to prepare a question guide. This guide must not be too long or the focus group will be rushed and superficial. In general, about ten to 12 questions are sufficient.

Topic guides will have this general structure:

1) **Warm-up and explanation**
   
   A) Introduction  
   B) Purpose  
   C) Procedure  
   D) Self-introductions

2) **Topics** (four to eight major ones with a total of ten to 12 questions)

3) **Closure**

Develop your own topic guide, using one or more of the following guides as a model. (See the appendix, page D-1, for a focus group discussion guide.)
Method 6: In-depth interview

What is an in-depth interview?

An in-depth interview is an extended and formalized conversation. This type of interview focuses on a good informant from the target population. In-depth interviews are open-ended and use many of the same principles discussed above for key informant interviews. As noted earlier, key informants have expert knowledge of other peoples’ lives, while in-depth informants are experts about their own lives. It is customary to interview key informants several times and in-depth informants once.

In-depth interviews focus on obtaining in-depth information about why the target population engages in certain behaviour. This includes aspects of high-risk behaviour, beliefs, motivations and the logic behind their behaviour.

While the main goal of the in-depth interview is to gather information, it also makes key target populations feel that they are being consulted and helps bring them on board as allies or partners.

Preparation

Define the purpose of the interview. Prior to interviewing, the person developing the assessment instrument must define the information required.

Script the interview. In-depth interviews require a format and process that entail the preparation of a script or protocol. You will need to prepare, pilot and review detailed questions with the interviewer and with representatives from the target population before conducting the interview.

Prepare the interviewee. Confirm the time and place of the interview before it takes place. Before beginning, summarize the main topic areas. Explain to the interviewee the contribution of the interview to the assessment and to the programme. Assure the interviewee that you will respect confidentiality and tell her/him how much time the interview will take.

Interview

Try to make the interview feel more like a conversation than a survey. Let the respondent do most of the talking.
Recording the interview

- You may want to tape the interview. This may help to convey your intention to ‘get it right’, and it encourages considered responses, while ensuring a back-up if the original notes are lost. Ask permission to tape and offer to stop taping on request. However, taping is optional, as no recorder may be available and it might inhibit the respondents from speaking freely.
- While conducting the interview, pause to allow the respondent to gather her/his thoughts, but not long enough to raise uncomfortable feelings.
- Take notes even if you are taping, so that you have a back-up copy of the interview in case your tape does not work. Return to key questions that have incomplete responses, using oblique questions to reveal additional facets.
- Tell the interviewee that you may follow up if you still have questions.
- Tell the interviewee that a summary of the interview will be available and that he/she will be welcome to look at it. This will raise the level of credibility of your programme.

After the interview

- Immediately after each interview, fill in the blanks in your notes while the interview is still fresh in your mind.
- Contact the interviewee for follow-up information, if necessary.
- Provide a summary of the interview notes to the respondent for approval, if requested.

(See the appendix, page E-1, for an in-depth interview guide.)
Method 7: Observation

Why observation?
The goal of observation is to obtain evidence about the social networks and the settings for risk and influences that lead a target population to engage in risky sexual behaviour. Observation allows you to see things that interviews do not reveal and to use this information to amplify data or to ask additional questions of the target population. Observation also reaffirms or contradicts information obtained as a result of other activities.

What to observe
In a workplace setting, you might observe who talks to whom, who the natural leaders are, where people spend their time (which may be good venues for future BCC activities), how they access information, and to what extent they use facilities or resources (e.g., do workers take advantage of the health services? Are educational events well-attended? Who attends?). You may also have an opportunity to observe situations that lead to high-risk behaviours (e.g., do workers typically go out drinking after work?).

When and how to use observation
Information about your target population should help you to determine when to observe, what to look for, and where to go to see who is in the social networks and what the high-risk settings are. (See Table 3 below for an example.)

Table 3: Observation locations

<table>
<thead>
<tr>
<th>Locations for:</th>
<th>Secretaries</th>
<th>Bank tellers</th>
<th>Truckers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Front desk</td>
<td>Bank lobby</td>
<td>Truck park</td>
<td></td>
</tr>
<tr>
<td>Outside boss’s office</td>
<td>Break room</td>
<td>Bars/clubs</td>
<td></td>
</tr>
<tr>
<td>Lunch room</td>
<td>Neighbouring bar</td>
<td>Garages</td>
<td></td>
</tr>
</tbody>
</table>

The observer can be a non-participant or participant (an observer who joins the activities as if he/she is a member of the population under observation). A non-participant observer can be more objective, but sometimes activities are too private or the people being observed are too defensive to allow an outsider to observe. It is important that the person making the observations be able to objectively record what he/she sees so that the data collected truly reflect what is occurring.

Once on location, the observer should let events unfold as freely as possible in order to observe the target population, networks and the culture, and to identify behaviour patterns.
How to make observations

- You may start by writing down everything that goes on in a blank notebook (field notes). Describe who you see, what they are doing and the setting they are in. There cannot be too many details when you are observing. These notes will help you form hypotheses about what is going on and to compare what you discover during observation with what you discover during interviews. You should take notes to help ensure validity of the data-collection and interpretation processes. You should also try to confirm your data with members of the target population.

- You may use audio- and/or videotape. Recording the essential elements of your observations requires knowing what you are looking for.

- In addition to your own observations, you can use the observations of others, journal notes, or anything else that reveals the culture of the target population.

- As you proceed with your observations, try to develop a synthesis of what you are seeing, and then compare new information with information already synthesized. If necessary, revise your synthesis and continue until you believe you have an accurate picture of what is occurring.

The framework shown below might help you to better organize your observations. Note that you can revise these categories to reflect the local situation. (See the appendix, page F-1, for an observation guide.)
Step 5: Analyse the data from focus groups and in-depth interviews

Purpose of data analysis

Data analysis of focus group discussions and in-depth interviews involves reviewing the statements made by participants on each topic to determine:

- what the audience members already know and what misinformation they have;
- why they behave the way they do;
- how comfortable they feel discussing a topic, what they want to know, and what they need to know; and
- how they want to receive information, what they believe, and why.

Analysis should bring to the surface some of the underlying factors or reasons for participants' behaviour or beliefs, as well as some ideas for arguments that you may use to motivate them to alter their behaviour or to allay their fears or doubts. Well-conducted in-depth interviews and group discussions will provide data that can serve to improve or modify counselling and service delivery, develop behaviour change communication materials, and design training programmes.

After each in-depth interview or group discussion (or as soon as possible on that same day), the facilitator and note-taker should review the notes together and, if possible, listen to the audiotape(s) of the interview or group discussion to fill in any gaps in the notes. They should jot down initial overall impressions and findings while the conversations are still fresh in their minds. These initial notes often capture key findings as well as the atmosphere of the interview or group. Certain emotional and interactive events are easily forgotten as the team prepares for the next interview or group discussion. The quality of the notes will directly influence the outcome of the data analysis.

Organizing notes

Organizing notes, after filling in any gaps, helps the project team understand the data collected. Here is one method for doing this:

- Photocopy notes. If photocopying is not possible, use coloured pencils for coding the margin of the note-taker's original notes, with a different colour assigned to each main topic.
- Place asterisks next to particularly 'quotable' passages (e.g., comments that might actually be used as messages or as text under a pictorial message).
- Write out key questions or topics from the discussion guide on the top of separate sheets of paper.
- Cut up the photocopy of the notes and glue all the information relevant to each discussion question on the appropriate sheet of paper. Create new sheets labelled with appropriate question headings for data that do not fit under any existing discussion questions. Try to group the new data by question or issue.
- Once you have cut and pasted all the notes onto sheets with headings, review the information for each question. (Note: If you have used the margin colour-coding method, take one topic at a time and read the coded items in the notes to see what informants said and felt about each topic.)
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

- Write a summary of the major findings for that question and, if possible, include some participant quotes supporting the finding(s).
- Review all the organized notes to see if programme staff can identify any emerging patterns that confirm or refute assumptions about the research question. Those organizing the discussion notes should be able to fill in these blanks:

  Most of the participants said ______________________________________

  Some of the participants said _____________________________________

  A few of the participants said _____________________________________

- Decide if it is necessary to add, change or delete any of the discussion questions or probing questions to get the information you are seeking. Remember not to automatically discount responses given by only a few people or that you had not expected to hear. If you suspect that there may be an important underlying reason for the comment, or that it may be an issue that is important to others, include questions in subsequent focus groups to check out the finding.

**Use of computer programmes**

Several computer programmes are now available to help in organizing the information gathered. Two popular programmes, NUD*IST and Ethnograph, are available from SCOLARI Sage Publications Software (www.scolari.co.uk). Other programmes such as Ez-Text are available free of charge from the US Centers for Disease Control website (www.cdc.gov/hiv/software/ez-text.htm).

When deciding whether to use manual tabulation or computer-assisted analysis, consider the following:

- The programme’s timeframe and resources. A computer programme will not code the data or do the analysis for you. However, once you have coded the data, you can use a programme to print out all coded text by topic area and do searches by several codes.
- The computer will count everything. If one person makes similar statements several times, the remarks may be inaccurately attributed to several group members, concluding more consensus than is warranted.
- Programme support staff may require the appropriate training to use the computer programs.
- Programme managers may decide that computer analysis is more suitable for analysing qualitative data gathered for a large research project (where use of tapes followed by transcription is part of the process) than for analysing a small series of focus group discussions to identify relevant messages for designing pictorial materials.
Comparing data across interviews or groups

After conducting all the in-depth interviews and group discussions, compare responses from the various interviews and groups. Gather the responses for a specific question from all of the interviews and groups, and, using either of the systems described above, write a summary of the major findings for each question, including participant quotes. Identify any patterns that may be useful.

If you do not have a software package to help you analyse the results, you will have to do it manually.

Do not quantify results

Remember that this is qualitative research, which has the objective of describing a situation or target population. Quantitative research, by contrast, is meant to report numbers and quantify findings. While you are looking for trends in qualitative research, it is not appropriate to quantify the results by counting or creating percentages for the number of participants in the interviews or groups who give similar responses. Participants represent only a small proportion of the population; thus, the findings from group discussions and in-depth interviews cannot be generalized to the entire population.
Step 6: Report on the formative assessment

The information collected will contribute to the development of an HIV/AIDS BCC strategy for the workplace and can also help justify broader programming at the workplace and in the surrounding community for HIV/AIDS prevention, care and support. You should also disseminate the results of the formative assessment to the target groups at the workplace. Interacting with target groups could provide the assessment team with more in-depth data for the final analysis, conclusions and intervention recommendations.

Purpose of a formative assessment report

Once data analysis is complete, a formative assessment report should be produced. The report should include opportunities, resources and potential barriers for BCC interventions and broader HIV prevention at the workplace. It should also summarize information on the target population’s knowledge, attitudes, behaviours, fears, goals, motivations and interests with regard to HIV/AIDS prevention, care and support. Your programme can disseminate information to target groups during BCC sessions, summarize the information in a newsletter, or post it on a bulletin board, depending on information channels at the workplace.
Suggestions for report-writing

While the information is fresh, the programme manager should designate someone to summarize the research findings in a report. This need not be a lengthy, official document; the objective of this qualitative research is to gain useful information about the workplace and the target groups at that workplace so that meaningful HIV/AIDS programmes can be developed and implemented.

Be sure to include the following elements in the report:

- Number of in-depth interviews and focus group discussions conducted for each category of participant
- Location of each in-depth interview and focus group discussion (city, clinic, home, etc.)
- Length of time spent in each interview and discussion
- Major findings, including:
  - Existing HIV/AIDS prevention, care and support activities at the workplace and/or community
  - Organization of the workplace and staff
  - What the target population knows about HIV/AIDS and the existing activities and services at the workplace
  - What members of the target population think they know about HIV/AIDS
  - What the target population would like to know about HIV/AIDS
  - How members of the target population feel about important issues such as HIV/AIDS stigma and discrimination at the workplace
  - What they do and why they do it
  - Ways they believe they can be motivated to change certain behaviours
  - Barriers to change
  - Patterns (trends) in the data
  - Suggestions for communication strategies, messages, and improved and relevant new materials.
Step 7: Segment target populations

It is important to differentiate between the various groups in particular target populations. The formative assessment will shed more light on these groups and will provide information on gatekeepers, and primary and secondary populations. Although target populations may be segmented during the formative assessment, additional groups may also be identified.

You can further segment the target population following analysis of the formative assessment data. The results will supply programme staff with a basis from which to further segment the primary target population. A number of factors will help determine subdivision of the population, including the following:

- High-risk behaviours
- Gender
- Age
- Location
- Position at the workplace
- Ethnicity
- Language

See Table 4 below for an example of how to organize the information collected about the different segments of the target population.

<table>
<thead>
<tr>
<th></th>
<th>Primary populations</th>
<th>Characteristics</th>
<th>Secondary populations</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmarried secretaries</td>
<td>♦ Low wages</td>
<td>♦ Feel vulnerable</td>
<td>Their bosses</td>
<td>♦ Most respect secretaries</td>
</tr>
<tr>
<td></td>
<td>♦ Feel vulnerable</td>
<td>♦ Lack of control</td>
<td></td>
<td>♦ Some take advantage of their position</td>
</tr>
<tr>
<td></td>
<td>♦ Do not want to loss their position</td>
<td>♦ Feel pride in job</td>
<td></td>
<td>♦ Some feel like secretaries “owe” them</td>
</tr>
<tr>
<td>Married secretaries</td>
<td>♦ Have more children than unmarried</td>
<td>♦ Do not feel as vulnerable as unmarried</td>
<td>Husbands/boyfriends</td>
<td>♦ Happy that wives and/or girlfriends can work</td>
</tr>
<tr>
<td></td>
<td>♦ Often feel lack of control over working environment</td>
<td></td>
<td></td>
<td>♦ Worry about men flirting with them</td>
</tr>
</tbody>
</table>

Workplace stakeholders may reach a consensus about whether or not further segmentation is necessary. Further assessments should be undertaken if there are gaps in the initial results and stakeholders express the need for a more conclusive analysis.
Contents

This appendix includes guides for the data-collection methods outlined in Booklet 2, namely:

A: Site inventory

B: KAP survey for workers

C: Key informant interview

D: Focus group discussion

E: In-depth interviews

F: Observation

Here are a few ideas to keep in mind when reading and adapting the guides:

- Many of the guides include sample questionnaires to apply to prospective respondents. Each questionnaire contains a wide array of potential questions. When developing a questionnaire that is appropriate for the workplaces or sectors involved, choose those questions that are most important and relevant for the target populations.

- As a rule, try to limit the number of interview questions to 12–15. Respondents probably have limited time and may suffer from ‘interview fatigue’ if asked too many questions.

- You will find many of the same questions in the guides to site inventories, key informant interviews, focus group discussions, and in-depth interviews. The same questions may yield different information in the context of each method.
Appendix A: Site inventory guide

Why conduct a site inventory?

Site inventories can help:

- identify existing workplace services into which BCC activities can be integrated;
- put information needs in perspective, allowing you to understand what information you really need;
- obtain useful background information; and
- avoid the duplication of research when adequate information already exists.

As a research method, conducting site inventories can also help determine:

- the approximate size and categories of staff within an organization;
- staff hierarchies;
- organizational structures;
- major target groups—for example, in a flower farm, these might include field workers, packers, drivers, support staff and health staff;
- major target areas, such as headquarters, departments, satellite offices;
- major stable and mobile target groups and the relative size of each;
- existing health and education services at the workplace;
- health, education, social and non-governmental organization services in an area;
- the social and sexual culture of the workplace;
- potential interventions;
- a general idea of resources required for interventions;
- the broader environment, including:
  - data on the HIV epidemic
  - roles of national, regional or local government in addressing HIV/AIDS programme development at the workplace (e.g., BCC programmes, materials and messages)
  - information and services available from community-based or AIDS-service organizations
- existing workplace initiatives that will support your BCC programme, including:
- existing programmes, policies and practices at the workplace for HIV/AIDS prevention and care
  - HIV/AIDS education programmes
  - condom distribution
  - diagnosis and treatment of sexually transmitted infections
  - access to voluntary HIV testing and counselling
  - available HIV/AIDS and tuberculosis treatment services, including antiretroviral therapy
  - access to other health-care services
  - monitoring of quality and assessment of impact and effectiveness
  - workplace policy
worker organizations: what kind of support do workers receive from their union?
employee knowledge, attitudes, values and beliefs, including:
  - current knowledge, attitudes and behaviour regarding HIV/AIDS
  - level of interest in developing HIV/AIDS programmes
  - specific interests and concerns related to HIV/AIDS (e.g., housekeeping staff in a hospital in Kenya were afraid to clean the rooms of AIDS patients)
  - whether there are people at the workplace or in the community who are HIV-positive and open about their status to their employers and co-workers
  - how employees living with HIV/AIDS feel about the treatment they receive at work
communication mechanisms, including:
  - how people get information at the workplace (e.g., newsletter, bulletin board, via staff meetings, training sessions, new employee orientations, through word-of-mouth)
  - who the trusted sources of information are
  - what people’s favourite media are and how often they access them

**Steps for conducting an inventory**

- Review documents carefully, noting major departments and offices.
- Consult with people who are familiar with each department, asking them to provide further detail.
- Visit the workplace and familiarize yourself with the site. During this visit, develop a plan to conduct a more detailed inventory of the site, by subdividing it into smaller, more manageable units and identifying focal points for further inventory.
- Develop a detailed key and organizational chart stating staff and structures for each of the features.
- During the inventory, also note the following:
  - The latest estimate of the workplace population
  - Geographical distribution of the target population (for example, if you are working with Bank X, note how many branches it has).
  - The general infrastructure, and which health and educational facilities are available at the worksite.
- On the basis of this information, assess whether it is feasible to initiate interventions in the entire site or whether to limit interventions to subsites. In making this assessment, consider these factors:
  - If the workplace population is too large, it may be advisable to limit activities to subgroups, at least initially.
  - In widely dispersed workplaces, it may be better to choose particular sites for initial activities.
Sample questionnaire for site inventory on the national perspective on HIV/AIDS at the workplace

To map out a broader picture of HIV/AIDS at the workplace, you may want to interview staff from key ministries operating HIV/AIDS-related activities at the workplace, such as the Ministry of Health and/or the Ministry of Labour. You might also want to interview representatives from business organizations and labour leaders. Remember to choose a maximum of 12–15 questions, based on your needs and objectives.

Epidemiology

- Are there existing studies that provide insights into workplace target populations?
- What are the incidence and prevalence of HIV?
- What are the incidence and prevalence of sexually transmitted infections?

Role of government

- What role has the national, regional and/or local government been playing in addressing HIV/AIDS programme and policy development at the workplace?
- Are there existing laws, guidelines or other regulations that address HIV/AIDS as it relates to workplaces? What are they? Are any under development? (Get copies of these documents, if possible.)
- Do any of these laws or guidelines address discrimination against HIV-positive employees?
- Which government ministries or other bodies have been most active in issues relating to HIV/AIDS and the workplace?
- What role is the Ministry of Labour playing in this regard?
- How could the Ministry’s capacity to promote and support the development of workplace programmes and policies be enhanced?

Role of community

- Do you know of other assistance programmes (whether run by government, labour unions, non-governmental organizations or private firms) that have been helping businesses with workplace-based HIV/AIDS programmes and policy development? If so, please name and describe them.
- Would you say they have been successful? Why or why not?
- What do you think could be done differently to help make these workplace HIV/AIDS policies and programmes (even) more successful?
- Are there particular areas of need in workplace HIV/AIDS programme planning that have not been addressed and that you think should be?
Role of business sector and labour unions

- What are businesses and/or labour unions doing to respond to HIV/AIDS?
- Are there enterprises that provide workplace-based HIV/AIDS education and prevention services? How typical is that?
- Are there employer organizations, or an existing business coalition on HIV/AIDS, that do or could focus on HIV/AIDS and the workplace?
- Are labour unions active in HIV/AIDS prevention, care and support?
Sample questionnaire for site inventory on HIV/AIDS at the workplace

People you might interview to map out a picture of HIV/AIDS at the workplace include human resource managers, health and safety representatives, medical officers, trade union leaders, and other enterprise spokespersons.

Remember to choose a maximum of 12–15 questions, based on your needs and objectives.

**Workplace profile, unions and socio-cultural influences**

**Workplace profile**

- How many people are currently employed within each category of employee? (Break down by gender, age and locale such as headquarters, province, district, factory, etc.)
- What are the levels of education of the different categories of personnel (technical, managerial, office support, etc.)?
- What level of training and experience is required for each category?
- What is the strategic importance of each category for the effective functioning of the workplace?
- Does the targeted workplace provide education/prevention programmes?
- What services are being provided at the workplace (e.g., education sessions, management of sexually transmitted infections, tuberculosis diagnosis and treatment, condom distribution)?
- What efforts exist to provide workers with access to voluntary HIV testing and counselling?
- What services exist for the care, treatment and support of HIV-positive employees and their partners (e.g., treating opportunistic infections, proving antiretroviral therapy)?
- Describe any health-related benefits offered to employees. For example:
  - Retirement benefits
  - Disability payments
  - Funeral expenses/burial fees
  - One-time payment of death benefits/life insurance
  - On-going family support
  - Other benefits
- If a worker is known to have HIV/AIDS, do the benefits continue, remain the same, or end?
Workplace unions

- Are one or more unions represented at the workplace?
- If so, which unions are represented and how many staff at the workplace belong to each union?

<table>
<thead>
<tr>
<th>Union name</th>
<th>Number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

- How interested are unions in HIV-related issues?

Socio-cultural influence

- What laws, government policies, agencies and pressure groups influence and limit various organizations and activities?
- What are the prevalent religious practices?
- What religious obstacles might there be to HIV programming?
- What is the situation concerning stigma and discrimination (e.g., fear of revealing status, reluctance to undergo HIV counselling and testing, lack of faith in confidentiality of services, fear of stigmatization by fellow workers and community, etc.)?
- What factors affect people’s purchasing power and spending patterns (e.g., alcohol consumption, sex work, affordability of condoms and health care)?
- Is there peer pressure to drink alcohol and have sex with sex workers?

Vulnerable groups at the workplace

a. Understanding vulnerability

- What features make it more or less likely that the workers at a specific workplace will contract HIV infection?
- Do certain male employees spend long periods away from home and family?
- Do young, unmarried female workers seek to supplement their incomes through sex for money?
- Is there sexual coercion within the workplace—for example, do older men in power pressure younger women working for them to exchange sex for better working conditions?

b. Identifying susceptible groups

- Which categories of employees (if any) are most likely to be susceptible to HIV infection?
- Are certain groups among employees particularly exposed to infection? (Examples include health workers exposed to blood products, and employees who are away from home for extended periods of time.)
- Why are they exposed?
- What are the gender and age characteristics of the most susceptible groups?
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

HIV/AIDS programming at the workplace

a. Management support for HIV interventions

- What is management’s perception of its role in HIV/AIDS prevention, care and support?
- Is HIV/AIDS programming perceived as a benefit to the workplace?
- What is management’s perception of the enterprise’s potential for loss of skilled workers and the cost of replacement?
- Given the known and predicted rates of HIV prevalence, how many people does management expect to become ill or die each year over the next ten to 15 years in each category of employment?

b. Workplace HIV/AIDS interventions

- Do employees have access to health services at the workplace related to prevention or care of HIV/AIDS? If so, please specify. Are any of the following offered?
  - HIV/AIDS focal point
  - Special HIV/AIDS budget
  - Full-time nurse
  - Information dissemination, including:
    - Open poster display
    - Peer education
    - HIV/AIDS discussion committees
    - Guest speakers
  - Condom distribution
  - Testing and diagnosis of sexually transmitted infections
  - Voluntary and confidential HIV testing
  - Counselling services
  - Tuberculosis treatment
  - Antiretroviral therapy
  - Antiretroviral treatment for women during pregnancy
  - Referral systems (to HIV/AIDS services in the community)
- Do HIV/AIDS services reach all employees?
- Do employees use the services?
- Do employees trust the confidentiality of the services?
- Which HIV/AIDS prevention, care and support services do employees most use and accept?
- Which of these services do they least use and accept?
- What are some of the reasons employees give for accepting or not accepting HIV/AIDS services and activities?
c. Prevention strategies
- What prevention strategies has your organization set up?
- Do these strategies target specific populations?
- What is the cost of these activities?
- Are the efforts punctual (e.g., an isolated education session) or regular (an on-going programme)?

d. Entry points for HIV/AIDS behaviour change communication at the workplace
- What health-related activities does the organization offer (e.g., health and safety training, first aid, counselling services, free medications, etc.)?
- What work-related training does the organization offer?
- How are announcements made (e.g., noticeboards, employee newsletters, pay package notes, flyers, posters, etc.)?
- Does the organization make use of washrooms to convey messages (hygiene messages, advertisements, etc.)?
- What social and recreation activities exist?

HIV/AIDS policy at the workplace

a. Workplace policies
- Does the organization have a written policy statement dealing with HIV/AIDS at the workplace? If so, what does it contain?
  - Statement on HIV/AIDS as a workplace and labour issue
  - How HIV/AIDS affects company growth
  - Prevention of discrimination on the basis of HIV status
  - Requirement to explain policy to employees
  - Assurance that the working environment is healthy
  - Protection of confidentiality
  - Prohibition of screening or testing for employment and other decisions such as training and promotions
  - Assurance that HIV/AIDS is not a cause for termination of employment
  - Entitlement of all employees to company benefits
  - Assurance of equal treatment of employees, including gender equality
  - Provision of care and support for people living with HIV/AIDS in the home
  - Company HIV/AIDS budget

Conclusion
The site inventory is a framework for all ensuing work. After completing the site inventory exercise, subsequent assessments and interventions can be planned around it. During interventions, mapping can be repeated at regular intervals (usually annually), to ensure that information is up to date.
Once the inventory has been carried out, the information can be summarized on the following chart, indicating those characteristics of the workplace that support the behaviour change communication objectives (assets) and those that may present barriers to the initiative (gaps) and should be modified or changed.

<table>
<thead>
<tr>
<th>Workplace assets</th>
<th>Workplace gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Appendix B: KAP survey guide

Sample questionnaire for workers

ILO WORKPLACE EDUCATION PROJECT

WORKER SURVEY

DATE: ___/___/___
DAY MTH YEAR

Questionnaire number: ___ ___ ____ Interviewer: ______________
Workplace: ______________________

Interviewer Instructions (READ OUT LOUD): “My name is … I am assisting the ILO HIV/AIDS Workplace Education Project in interviewing people at your workplace to see what they understand about HIV and AIDS. The information from this interview will help the ILO to develop and monitor a programme designed to assist you in protecting yourself against HIV, with help from your employer and the people who work here. You have been selected randomly from a list of all the workers at this [ministry, enterprise, informal sector association]. There are XX other workers who were also selected randomly from this [ministry, enterprise, informal sector association].

Confidentiality and consent: “I’m going to ask you some personal questions about what you think about HIV and AIDS and about your sexual behaviour. Your answers are completely confidential. We will not ask your name and will not record it anywhere. We will not tell anyone else your answers to the questions. You do not have to answer any questions that you do not want to answer. However, your honest answers to these questions will help us to better develop a programme for this workplace. We would greatly appreciate your taking part in this interview. The interview will take about 30 minutes. Would you be willing to participate?”

(Signature of interviewer certifying that informed consent has been given verbally by respondent)

---

1 This workers’ survey was developed by Management System International (MSI) as part of the project performance monitoring tools for the ILO/USDOL International HIV/AIDS Workplace Education Programme. For National Project Coordinators: The questions in yellow have been added to the generic workers’ survey developed in accordance with the project performance monitoring plan to specifically address BCC issues.
### Section 1: Socio-demographic Information
- NOT LINKED TO INDICATORS

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q101</td>
<td>Sex of respondent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Q102</td>
<td>How old were you on your last birthday?</td>
<td>Age in completed years</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Q103</td>
<td>Have you ever attended school?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Q104</td>
<td>What is the highest level of school you</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>completed?</td>
<td>Primary</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Higher</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Q105</td>
<td>What is your position at work?</td>
<td>Worker</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Management</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (specify:__________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Q106</td>
<td>How long have you been working here?</td>
<td>0 to 6 months</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6 to 12 months</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 to 2 years</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 2 years</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Q107</td>
<td>What is your current marital status?</td>
<td>Married</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
<tr>
<td>Q108</td>
<td>Who do you currently live with?</td>
<td>Spouse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relatives or friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alone</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (specify:__________)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No response</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>
### Section 2  HIV/AIDS-related knowledge and attitudes

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
</table>
| Q201   | Have you ever heard of HIV or the disease called AIDS? | Yes 1  
No 2 | 202 END |

**NOTE: QUESTIONS 201-207 ARE NOT LINKED TO INDICATORS; THEY ARE FOR GENERAL INFORMATION**

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
</table>
| Q202   | From what sources have you heard about HIV/AIDS? | Mass media  
Health provider outside workplace  
Workplace clinic  
Labour union representative  
NGO  
Family or friends  
Co-worker  
Other source | |
| Q203   | Which was the best source of information for you about HIV/AIDS? | Mass media  
Health provider outside workplace  
Workplace clinic  
Labour union representative  
NGO  
Family or friends  
Co-worker  
Other source | |
| Q204   | What sources of information on sexual health do you find most credible? | Mass media  
Health provider outside workplace  
Workplace clinic  
Labour union representative  
NGO  
Family or friends  
Co-worker  
Other source | |
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

<table>
<thead>
<tr>
<th>Q205</th>
<th>What sources of information on sexual health do you find most credible at the workplace?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interviewer: check appropriate boxes</td>
</tr>
<tr>
<td></td>
<td>Printed materials</td>
</tr>
<tr>
<td></td>
<td>Health provider at workplace</td>
</tr>
<tr>
<td></td>
<td>Workplace clinic</td>
</tr>
<tr>
<td></td>
<td>Labour union representative</td>
</tr>
<tr>
<td></td>
<td>Co-worker</td>
</tr>
<tr>
<td></td>
<td>Other source ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q206</th>
<th>How are announcements made at the workplace?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Interviewer: check appropriate boxes</td>
</tr>
<tr>
<td></td>
<td>Noticeboards</td>
</tr>
<tr>
<td></td>
<td>Emails</td>
</tr>
<tr>
<td></td>
<td>Employee newsletters</td>
</tr>
<tr>
<td></td>
<td>Pay package notes</td>
</tr>
<tr>
<td></td>
<td>Flyers</td>
</tr>
<tr>
<td></td>
<td>Posters</td>
</tr>
<tr>
<td></td>
<td>Word of mouth</td>
</tr>
<tr>
<td></td>
<td>Other __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q207</th>
<th>What occasion(s) bring(s) most of the employees together?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Meetings</td>
</tr>
<tr>
<td></td>
<td>Lunch</td>
</tr>
<tr>
<td></td>
<td>Breaks</td>
</tr>
<tr>
<td></td>
<td>After-work events</td>
</tr>
<tr>
<td></td>
<td>Encounters in hallways</td>
</tr>
<tr>
<td></td>
<td>Other ______</td>
</tr>
</tbody>
</table>

The next questions ask you about how you can become infected with HIV, the virus that causes AIDS. The first question uses the term “sex”. By this we mean vaginal, oral or anal sex. When we use the word “sex” in other questions, it will always mean vaginal, oral or anal sex.

<table>
<thead>
<tr>
<th>Q208</th>
<th>Can you become infected by having unprotected sex with a person who is infected with HIV?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td></td>
<td>Don’t know 88</td>
</tr>
<tr>
<td></td>
<td>No response 99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q209</th>
<th>Can you become infected from a transfusion of blood or blood products?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td></td>
<td>Don’t know 88</td>
</tr>
<tr>
<td></td>
<td>No response 99</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q210</th>
<th>Can you become infected by sharing needles with a person infected with HIV?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes 1</td>
</tr>
<tr>
<td></td>
<td>No 2</td>
</tr>
<tr>
<td></td>
<td>Don’t know 88</td>
</tr>
<tr>
<td></td>
<td>No response 99</td>
</tr>
</tbody>
</table>
### Q211 Can a HIV+ mother infect her unborn child?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q212 Can you keep yourself from becoming infected by having faithful sexual partners who are not infected with HIV?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q213 Can you reduce the chance of becoming infected by using condoms during sex?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q214 Can you keep yourself from becoming infected by having no sex?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q215 Can you become infected by having unprotected sex with a person who looks healthy?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q216 Is excessive use of alcohol or drugs a contributing risk factor to becoming infected with HIV?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q217 Is there a difference between HIV and AIDS?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q218 Can you always tell if someone has HIV by looking at them?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### The next questions ask you how you feel about using condoms if you have sex with a person other than your spouse(s)

### Q219 Do you believe a condom should be used if you have sex with a person other than your spouse(s)?

<table>
<thead>
<tr>
<th>Option</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>
Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q220</td>
<td>Do you believe you know how to use a condom correctly?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q221</td>
<td>Do you believe that it is acceptable for married men to use condoms at home?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q222</td>
<td>Do you believe that it is acceptable for single men to use condoms?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q223</td>
<td>Do you believe that it is acceptable for married women to use condoms at home?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q224</td>
<td>Do you believe that it is acceptable for single women to use condoms?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>

The next set of questions asks you how you feel about people who have HIV or AIDS.

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q225</td>
<td>Would you be willing to work alongside a co-worker who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q226</td>
<td>Would you be willing to use the same toilet as a co-worker who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q227</td>
<td>Would you be willing to eat food at a company canteen prepared by a co-worker who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Q228</td>
<td>Would you be willing to share utensils with a co-worker who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Question</td>
<td>Response Options</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
<td>No response</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------</td>
<td>-----</td>
<td>----</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Q229 Would you be willing to buy food prepared by a vendor who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q230 Would you be willing to hold hands with someone who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q231 Would you be willing to share a room with someone living with HIV/AIDS?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q232 Would you be willing to receive medical treatment from a health-care worker who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q233 Would you be willing to utilize the services of a barber or a hairdresser who is HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q234 Do you feel that a teacher who is HIV-positive should be allowed to continue teaching?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q235 Do you feel that HIV-positive children should be allowed to stay in school with uninfected children?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q236 In the last 3 months, have you known of someone at your workplace gossiping about a co-worker suspected of being HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
<tr>
<td>Q237 In the last 3 months, have you known of someone at your workplace refusing to work with a co-worker suspected of being HIV-positive?</td>
<td>Yes</td>
<td>1</td>
<td>No</td>
<td>2</td>
<td>Don't know</td>
</tr>
</tbody>
</table>
### Q238
In the last 3 months, have you known of someone at your workplace refusing to eat with a co-worker suspected of being HIV-positive?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q239
In the last 3 months, have you been aware of a situation in which employees received negative treatment because they were known or perceived to have HV or AIDS?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q240
If so, who treated the employee known or perceived to have HIV or AIDS negatively?

- Co-workers
- Supervisors
- Managers
- Labour representatives
- Other ______

### Q241
In the last 3 months, have you been aware of a situation in which employees received positive treatment because they were known or perceived to have HV or AIDS?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q242
If so, who treated the employee known or perceived to have HIV or AIDS positively?

- Co-workers
- Supervisors
- Managers
- Labour representatives
- Other ______

The next set of questions asks how your employer treats people who might have HIV/AIDS.

### Q243
Do you believe a physically fit worker at your workplace would be fired if he or she was known to be or was suspected of being HIV-positive?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
</tr>
</tbody>
</table>

### Q244
Do you believe a physically fit worker at your workplace would be denied promotion, salary increases, training or other career development opportunities if he or she was known to be or was suspected of being HIV-positive?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Don’t know</td>
<td>88</td>
</tr>
<tr>
<td>No response</td>
<td>99</td>
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</tbody>
</table>
### Section 3  HIV/AIDS-related services

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q301</td>
<td>Are you aware of any HIV/AIDS services available at your workplace?</td>
<td>Yes 1</td>
<td>→302-316</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
<td>→401</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q302</td>
<td>If so, which HIV/AIDS-related services at your workplace are you aware of? Interviewer: please check boxes</td>
<td>Education</td>
<td>→303-306</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Condom availability</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>STI treatment/information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>VCT/information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care and support/information</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Q303</td>
<td>What kinds of HIV-prevention materials exist at your workplace? Interviewer: check appropriate boxes</td>
<td>Brochures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Posters</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Books</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information sheets</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Q304</td>
<td>What kinds of HIV-prevention materials do you prefer? Interviewer: check appropriate boxes</td>
<td>Brochures</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Posters</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Books</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information sheets</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Q305</td>
<td>What kind of HIV-prevention education exists at your workplace? Interviewer: check appropriate boxes</td>
<td>Presentations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitated discussions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal discussions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support programmes for those living with HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Q306</td>
<td>What kind of HIV-prevention education do you prefer? Interviewer: check appropriate boxes</td>
<td>Presentations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitated discussions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informal discussions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer education</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support programmes for those living with HIV/AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Don’t know</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>----</td>
<td>------------</td>
</tr>
<tr>
<td>Q307 In the past 6 months, have you received any HIV/AIDS education, such as a training course, that was led by an expert or peer counsellor at your worksite?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q308 In the past 6 months, have you requested and received condoms at the workplace?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q309 If so, were the condoms consistently available WHEN REQUESTED?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q310 In the past 6 months, have you requested and received information at the workplace on resources in the community that provide treatment of sexually transmitted infections?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q311 In the past 6 months, have you requested and received information at the workplace on resources in the community that provide voluntary HIV counselling and testing?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q312 In the past 6 months, have you requested and received information at the workplace on resources in the community that provide care and support services and AIDS treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q313 Does your workplace’s HIV/AIDS education reach all of the employees?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q314 Do employees use the HIV/AIDS-related services available to them at the workplace?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q315 If so, which services do they use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q316 Do employees trust the confidentiality of the HIV/AIDS services at the workplace?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q315 Options: Education, Condoms, STI treatment, VCT, Antiretroviral therapy, Other ________________
### Section 4  **HIV/AIDS Policy**

The next set of questions asks you about your knowledge of HIV/AIDS policy or guidelines at your workplace.

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
</table>
| Q401    | Does your employer have an HIV/AIDS policy (or HIV/AIDS guidelines) that protects employees who have HIV/AIDS? | Yes 1 → Q402  
No 2 → Q501  
Don’t know 88 → Q501  
No response 99 → Q501 |
| Q402    | What are the components of that workplace HIV/AIDS policy (or guidelines)?  
Interviewer: please check boxes of components mentioned by respondent |  
Dialogue between management/workers  
Non-discrimination  
No mandatory HIV test  
No denial of employment  
Healthy work environment  
Medical confidentiality  
No job termination if fit to work  
Same opportunities as others  
Gender equality  
HIV-prevention education  
Other (__________________ ) |
| Q403    | According to workplace policy (or guidelines), do management and workers engage in regular dialogue to ensure the successful implementation of HIV/AIDS policy and programmes?  
Note: Questions 403-408 are not directly linked to an indicator – they evaluate level of knowledge for IO4. THESE QUESTIONS MAY BE DISREGARDED FOR INFORMAL SECTOR | Yes 1  
No 2  
Don’t know 88  
No response 99 |
| Q404    | According to workplace policy, do all employees have the right to the same treatment regardless of their HIV status? | Yes 1  
No 2  
Don’t know 88  
No response 99 |
| Q405    | According to workplace policy, are job applicants or workers protected from mandatory HIV testing for employment or promotion? | Yes 1  
No 2  
Don’t know 88  
No response 99 |
| Q406    | According to workplace policy, are employees' medical records confidential? | Yes 1  
No 2  
Don’t know 88  
No response 99 |
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q407</td>
<td>According to workplace policy, are employees informed of first aid procedures that would protect them against HIV infection?</td>
<td>1</td>
<td>2</td>
<td>88</td>
<td>99</td>
</tr>
<tr>
<td>Q408</td>
<td>According to workplace policy, is basic first aid equipment available to employees to protect them against HIV infection (gloves, for example)?</td>
<td>1</td>
<td>2</td>
<td>88</td>
<td>99</td>
</tr>
<tr>
<td>Q409</td>
<td>According to workplace policy, do workers have the right to education at the workplace on HIV prevention, transmission and treatment?</td>
<td>1</td>
<td>2</td>
<td>88</td>
<td>99</td>
</tr>
</tbody>
</table>
### Section 5  HIV/AIDS-related practices

The next set of questions asks about your sexual behaviour. We recognize that this part is sensitive and we appreciate your honest answers to the questions. This will help us better design an HIV/AIDS programme for your workplace.

<table>
<thead>
<tr>
<th>Number</th>
<th>Questions and filters</th>
<th>Coding categories</th>
<th>Skip to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q 501</td>
<td>Are you sexually active?</td>
<td>Yes 1</td>
<td>→Q501</td>
</tr>
<tr>
<td></td>
<td>Note: Question not related to an indicator</td>
<td>No 2</td>
<td>→end of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td>questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 502</td>
<td>If so, do you have a sexual partner other than your spouse(s)?</td>
<td>Yes 1</td>
<td>→Q503</td>
</tr>
<tr>
<td></td>
<td>Note: Question not related to an indicator</td>
<td>No 2</td>
<td>→end of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td>questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 503</td>
<td>In the past 3 months, have you had sex with a person other than your spouse(s)?</td>
<td>Yes 1</td>
<td>→Q504</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
<td>→Q505</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 504</td>
<td>If so, did you use a condom the last two times you had sex with person(s) other than</td>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>your spouse(s)?</td>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 505</td>
<td>If you have had multiple sexual partners in the past, have you intentionally reduced</td>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the number of those partners in the past 6 months in order to reduce the risk of HIV?</td>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 506</td>
<td>Do you feel you are at risk of becoming infected with HIV or another sexually</td>
<td>Yes 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>transmitted infection?</td>
<td>No 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 507</td>
<td>Are certain employees at the workplace more vulnerable to HIV infection than others?</td>
<td>Yes 1</td>
<td>→508-512</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No 2</td>
<td>→510</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Don’t know 88</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response 99</td>
<td></td>
</tr>
<tr>
<td>Q 508</td>
<td>If so, who?</td>
<td>Females</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Males</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Those who travel</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other ______</td>
<td></td>
</tr>
</tbody>
</table>
### Q509 If so, why?

<table>
<thead>
<tr>
<th>Multiple sexual partners</th>
<th>Not using condoms</th>
<th>Sharing needles</th>
<th>Not being faithful to spouse</th>
<th>Partner is not being faithful</th>
<th>Other ______</th>
</tr>
</thead>
</table>

### Q510 Do you think you can change your behaviours to reduce your risk of becoming infected with HIV?

| Yes     | 1    |
| No      | 2    |
| Don’t know | 88  |
| No response | 99  |

### Q511 Do you think men at your workplace can change their behaviours to reduce their risk of becoming infected with HIV?

| Yes     | 1    |
| No      | 2    |
| Don’t know | 88  |
| No response | 99  |

### Q512 Do you think women at your workplace can change their behaviours to reduce their risk of becoming infected with HIV?

| Yes     | 1    |
| No      | 2    |
| Don’t know | 88  |
| No response | 99  |

**THANK YOU VERY MUCH FOR TAKING PART IN THIS INTERVIEW.**
Appendix C: Key informant interview guide

Sample introduction to key informant

Good morning/afternoon/evening! Thank you for taking the time to speak with me today. My name is ____. I work for ______ and come from______________. (Note-taker/observer introduces her/himself.)

I would like to discuss some health issues that affect your workplace, including HIV/AIDS. I’m interested in all your ideas, insights, comments and suggestions. I’d like you to know that there are no right or wrong answers to any of the questions I will ask you. Your point of view is of the greatest importance during this interview. All comments—both positive and negative—are welcome.

To avoid missing any points that you make during our conversation, I would like to use a tape recorder. I want you to know that all your comments are confidential and will be used for research purposes only. To protect your confidentiality, your full name will not be recorded. I will be happy to answer any questions that you may have at the end of our conversation.

Sample questionnaire for key informants

People to interview in order to get a better picture of the target population and their specific vulnerabilities to HIV might include those who have been at the workplace for a long time, those who are perceptive about their workplace environment and colleagues, and those who are willing to share their insights with you.

The objective of key informant interviews focused on the target population differs from that of key informant interviews for site inventory. The goal of the site inventories is to gain a better understanding of the national and local HIV/AIDS environment related to the workplace. The goal of key informant interviews of the target population is to gain a better understanding of the population, which, in turn, will contribute to the design of effective behaviour change communication programmes. Therefore, these key informant interviews should focus on the ‘Behaviour change communication questions’, which begin on page C-7 of this guide. You should choose only a few of the questions listed under other headings below (if any), to complete key informant interviews.

Remember to choose a maximum of 12–15 questions, based on your needs and objectives.
**Socio-demographic information, workplace profile, unions, and socio-cultural influences**

**Key informant profile**

<table>
<thead>
<tr>
<th>Name of organization:</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job title/grade:</td>
<td>Salary:</td>
</tr>
<tr>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Education level:</td>
<td>Religious affiliation:</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Number of children:</td>
</tr>
<tr>
<td>Ethnic group:</td>
<td></td>
</tr>
</tbody>
</table>

**Workplace profile**

- Briefly describe the structure of the enterprise.
- What are the different categories of personnel (technical, managerial, office support, etc.)?
- What is the total number of personnel at your workplace?
- How many people are currently employed within each category of employee? (Break down by gender, age and locale such as headquarters, ministries, district, or other locations.)
- Are you familiar with any other programmes (whether run by government, labour unions, non-governmental organizations or private firms) that have been helping businesses with workplace-based HIV/AIDS programmes and policy development? If so, please describe.
  - Would you say they have been successful? Why or why not?
  - What, if anything, do you think could be done differently to make workplace HIV/AIDS policies and programmes (even) more successful?
  - Are there particular areas of need in workplace HIV/AIDS programme planning that you think should be addressed and have not been thus far?
Socio-cultural influence

- What laws, government policies, workplace policies, agencies, churches or pressure groups influence this organization’s ability to implement HIV/AIDS-related activities? (Ask each question individually—first about laws, then about government policies, then about workplace policies, etc.)
- What religious practices are prevalent at this workplace? Do they help or hinder HIV/AIDS-related activities?
- Are there any religious obstacles to HIV/AIDS programming (e.g., church’s view on HIV prevention)?
- What is the situation concerning stigma and discrimination in relation to HIV/AIDS (e.g., fear of revealing HIV-positive status, lack of faith in confidentiality of services, fear of stigmatization by fellow workers and community, etc.)?
- Do you think your workforce would be willing to undergo voluntary counselling and testing for HIV? What about you? What do you think the benefits of HIV counselling and testing might be?
- Is there peer pressure at the workplace to do things such as drink alcohol, dress a certain way and/or have sex with other workers? Please explain.

Knowledge, attitudes and beliefs about HIV/AIDS

Understanding vulnerability

- Are certain employees at the workplace more vulnerable to HIV infection than others? (Probe on females vs. males, those who travel vs. those who do not, etc.) Please explain.
- Is there sexual coercion within the workplace (e.g., do older men pressure younger women who work for them to exchange sex for better working conditions)?
- Do you think you are at risk of contracting HIV?
Knowledge, awareness and perceptions of HIV/AIDS

- What can you tell me about how [insert name of the target population here, e.g., the employees of X Company] think HIV and other sexually transmitted infections are transmitted and prevented?
- Do [name of target population] know the difference between HIV and AIDS?
- Do they know about the length of time an HIV-positive person can live with no symptoms before developing opportunistic infections (i.e., AIDS) and, finally, dying?
- Are they aware of the possibility of mother-to-child transmission of HIV? Please explain.
- Do they think it is possible to get HIV by having casual contact with HIV-positive people? Please explain.
- Where are they in the process of behaviour change (e.g., unaware, informed/aware, concerned, knowledgeable and skilled, motivated to change, ready to change, have tried or tested the new behaviour, or have adopted and maintained safer behaviour)?
- What is their estimation of their personal risk of becoming infected with HIV and other sexually transmitted infections?
- If they do not feel that they are at risk, what is their reason for this?
- Which peer groups and significant others are most important to them?

HIV/AIDS programming at the workplace

Management support for HIV/AIDS-related activities

- Is the HIV epidemic taken seriously at your workplace?
- What is management’s perception of its role in HIV prevention, care and support when an employee is living with HIV/AIDS, and in the elimination of HIV/AIDS-related stigma and discrimination?
- Is HIV programming perceived as a benefit to employees?
- What is management’s perception of the potential for loss of skilled workers and of the cost of replacement?
- Given the known and predicted rates of HIV prevalence, how many people does management expect to become ill or die each year over the next ten to 15 years in each category of employment?

Union support for HIV/AIDS

- If unions exist, how interested are they in HIV-related issues?
HIV/AIDS at the workplace

- What are businesses and/or labour unions in the country doing to respond to HIV/AIDS?
- What do you believe your employer and/or union should do to assist workers in preventing HIV?
- What do you think your employer and/or union would do if they knew an employee had AIDS?
- Do employees have access to health services at the workplace related to HIV prevention or care? If so, please list those services. Could include:
  - HIV/AIDS focal point
  - Special HIV/AIDS budget
  - Full-time nurse
  - Information dissemination, such as:
    - Open poster display
    - Peer education
    - HIV/AIDS discussion committees
    - Guest speakers
    - Condom distribution
    - Testing and diagnosis of sexually transmitted infections
    - Voluntary and confidential HIV testing
    - Counselling services
    - Tuberculosis treatment
    - Antiretroviral therapy
    - Antiretroviral treatment for women during pregnancy
    - Referral systems (to HIV/AIDS services in the community)
- If a preventive education programme on HIV/AIDS at the workplace exists, how would you describe it?
  - Basic facts in brochures, posters, etc.
  - A short presentation (30–60 minutes) of factual information about HIV/AIDS
  - A longer programme or discussion about HIV/AIDS such as attitudes towards AIDS, experiences with HIV, or support and care issues
  - A formal peer education programme for HIV/AIDS (if one exists, please describe the programme and how it began)
  - Education or support programmes for workers living with HIV/AIDS
  - Education or programmes for workers on sensitivity to HIV-positive co-workers
- Do HIV/AIDS services reach all employees?
- Do employees use the services?
- Do employees trust the confidentiality of the services?
- Which HIV prevention and care services do employees most use and accept?
- Which of these services do they least use and accept?
- What are some of the reasons employees give for accepting or not accepting HIV/AIDS services and activities?
What do you think this organization should do in terms of HIV/AIDS programming that it is not currently doing?

What was the cost of HIV/AIDS-related activities at the workplace last year? What is the cost of such activities this year? Who or what organization/agency is funding these activities?

Are these activities temporary (isolated events) or regular (ongoing programmes)?

Are any collaborative groups involved in these activities?

**Entry points for workplace behaviour change communication**

- What health-related activities does the organization offer (e.g., health and safety training, first aid, counselling services, free medications, etc.)?
- What work-related training does the organization offer?
- How are announcements made (e.g., noticeboards, employee newsletters, pay package notes, flyers, posters, etc.)?
- What occasion(s) bring most of the employees together? How often do these gatherings occur and how long do they last?
- Does the organization make use of washrooms to convey messages (hygiene messages, advertisements, etc.)?
- What social and recreational activities exist?

**HIV/AIDS policy at the workplace**

- Is there a workplace HIV/AIDS policy in this organization? If so, could you please explain it to me and could I have a copy of it?
- What is the policy of management regarding employees who are HIV-positive and those living with AIDS?

**HIV/AIDS-related practices**

- Based on your observation and personal contacts, what do you think are the behaviours that put employees most at risk of contracting HIV and other sexually transmitted infections?
- How do they currently understand and practise preventive behaviours?
- What do they see as the benefits of changing their high-risk behaviours?
- What do they see as the disadvantages of changing their high-risk behaviours?
- What pressures make it difficult for them to change their high-risk behaviours?
- What power do they believe they have to change their behaviours? If it is limited, please explain why and by whom or what.
- What would it take for them to change to a safer behaviour or to continue practising a safer behaviour?
Behaviour change communication questions

Media preferences and habits

- Which radio and television programmes do [insert name of target population here] prefer?
- What is the language of the broadcast?
- When do they listen to or watch these programmes?
- What print media do they prefer (e.g., newspapers, magazines, pamphlets, booklets, comic books, picture books, etc.)?
- What kind of music do they listen to?
- What kind of traditional theatre do they attend?

Sources of information

- When and where do [insert name of target population here] usually get information about topics related to sexual health?
- How do they communicate with their friends (email, telephone, in person, etc.)? Where do they meet? When? Who is in their immediate social network?
- When and where would it be best to talk to them about HIV prevention, to distribute condoms and to offer treatment services for sexually transmitted infections, and who could do this most effectively?
- Which teaching aids would help you learn the most in group information sessions (e.g., videos, slide shows, overhead projectors, flipcharts, picture codes, demonstrations, role plays, etc.)?

Fears and hopes

- How do [insert name of target population here] see themselves in ten years’ time?
- What are their hopes and dreams for the future?
- What would be the best thing that could happen to them in the future?
- What do they need to help them realize their hopes and dreams?
- What can they do specifically to realize their hopes and dreams?
- What is the biggest obstacle to them achieving their long-term goals?
- What fears do they have about the future?
- What is the biggest threat that they face today that could affect their future?
Stigma and discrimination

- What is being done to ensure that employees are not discriminated against and that they receive prevention and education services at the workplace regarding HIV/AIDS?
- Are you familiar with any support organization for people who are HIV-positive?
- Are there employees who are HIV-positive who are open about their status to their employers and co-workers?
- Are you aware of a situation in which employees/workers received different treatment because they were known or perceived to have HIV/AIDS? If so, please describe.
- Who treated the employee known or perceived to have HIV/AIDS differently?
  - Co-workers
  - Supervisors
  - Managers
  - Labour representatives
  - Others (specify)

Conclusion

- Do you have any other ideas or recommendations about what kind of HIV-prevention-and-education programmes should be implemented for the benefit of workers?
  - At the workplace?
  - In the community?
- Is there anything else you would like to tell me?
D: Focus group discussion guide

Sample introduction for focus group discussions

Good morning/afternoon/evening! Welcome to our group discussion. My name is ______. I work for ______ and come from______________. (Note-taker/observer introduces her/himself).

We’re here today to talk about certain health issues that affect your workplace, including HIV/AIDS. We are interested in all your ideas, insights, comments and suggestions. There are no right or wrong answers. All comments—both positive and negative—are welcome.

Please feel free to disagree with one another. We welcome all points of view. We want this to be a group discussion, so you need not wait for me to call on you to speak.

To avoid missing any points that you make during our discussion, I would like to use a tape recorder. I want you to know that all your comments are confidential and will be used for research purposes only. To protect your confidentiality, your names will not be recorded. We will be happy to answer any questions you may have at the end of the discussion.

You can leave at any time during the discussion and you do not have to talk about anything that makes you uncomfortable. Do I have your permission to start the group discussion?

Socio-demographic information and discussion

Introduction

- What are the main problems you face?
- How do you solve them?
- What do you do when on leave and at weekends?
Knowledge, attitudes and perceptions about HIV/AIDS

Levels of knowledge about HIV/AIDS

- What do HIV and AIDS stand for?
- What is a sexually transmitted infection?
- Name three common sexually transmitted infections.
- How are HIV and other sexually transmitted infections transmitted?
- Do you know colleagues/friends who have ever had a sexually transmitted infection?
- How did they treat it?
- How can HIV be prevented?
- What are the signs and symptoms of AIDS?
- What are opportunistic infections?
- What is the length of time between infection with HIV and the progression to AIDS?
- How can HIV infection pass from a mother to her child?
- What forms of social/sexual contact and activity do not involve a risk of HIV transmission?
- What is voluntary HIV counselling and testing?

Perception of HIV

- What are your thoughts about HIV?
- What are your thoughts about other sexually transmitted infections?
- What do your co-workers and friends think about HIV and other sexually transmitted infections?
- Do you think you are at risk of becoming infected with HIV or other sexually transmitted infections? Please explain.
- Which behaviours do you think put you at risk of contracting HIV and other sexually transmitted infections?
- Which behaviours do you think put your friends at risk of contracting HIV and other sexually transmitted infections?
- Do you think your partner is faithful to you?
- How do men react when their female partners ask them to use a condom?
- How would you react if your casual partner refused to use condom?
- Why do some colleagues and friends agree to sex without a condom?
- How do you feel about undergoing HIV counselling and testing?
- What do you think are the benefits of HIV counselling and testing?
- [For women] Would you consider undergoing HIV counselling and testing before getting married and before becoming pregnant in the future?
- What would you do if you found out that your co-worker was HIV-positive?
- What would you do if you found out that you were HIV-positive?
- Is there peer pressure to drink alcohol, dress fashionably and/or have sex with sex workers?
Understanding vulnerability

- What features of your workplace make it more or less likely for workers to contract HIV infection?
- Which categories of employees (if any) are likely to be exposed to HIV infection?
- Do some employees spend long periods away from home and family?
- Do you know of colleagues who have been approached on the job for sexual favours in exchange for better working conditions and other benefits?
- If they don't agree, what happens?
- If they agree, what happens?

HIV/AIDS programming at the workplace

- What HIV/AIDS prevention, care, support and treatment services are available to you at your workplace?
- What is your opinion about your employer's/union's response to HIV/AIDS?
- What kinds of HIV/AIDS programmes/services would you like to see at the workplace?

HIV/AIDS policy at the workplace

- Does your organization have a policy about HIV/AIDS at the workplace? If so, could you please explain it to me?
- What is the policy of management regarding employees who are HIV-positive and those living with AIDS?

HIV/AIDS-related practices

- What behaviours put you most at risk of becoming infected with HIV and other sexually transmitted infections?
- How do protect yourself from HIV infection?
- Do you want to change any of your behaviours that may put you at risk of contracting HIV? Please explain.
- What do you see as the benefits of changing your high-risk behaviour?
- What do you see as the disadvantages of changing your high-risk behaviour?
- What pressures make it difficult for you to change your behaviour?
- What power do you believe you have to change your behaviour? If it is limited, why is that, and by whom or what?
- What would it take for you to change to a safer behaviour or to continue practising a safer behaviour?
Behaviour change communication questions

Media habits
- Which are your favorite radio and TV programmes and when do you watch or listen to them?
- What is the language of the broadcast?
- What kind of music do you like?
- Which kind of traditional theatre do you attend (local drama, concert party, storytelling, etc.)?

Sources of information on HIV/AIDS
- When and where do you usually get information about topics related to sexual health?
- Who or what is your trusted source for health information at the workplace?
- How do you communicate with friends (in person, by email, on the telephone)? Where do you meet your friends? When? Who is in your immediate social network?
- What peer groups and significant others are most important to you?
- What are your preferred sources of information on health-related topics?
- What are the sources of information on sexual health that you find most credible?
- When and where would be the best times to talk to you about HIV prevention, to sell or distribute condoms and to provide treatment services for sexually transmitted infections? Who could do this most effectively?
- Which teaching aids would help you learn the most in group information sessions (e.g., videos, slide shows, overhead projectors, flipcharts, picture codes, demonstrations, role plays, etc.)?

Fears and hopes
- How do you see yourself in ten years’ time?
- What would be the best thing that could happen to you in the future?
- What do you need to help you realize your hopes and dreams?
- What could prevent your hopes and dreams from being realized?
- What are the biggest obstacles to you not achieving your long-term goals?
- What fears do you have about the future?
- What are the major barriers/hindrances you currently face that could affect your future?
Stigma and discrimination

- What is the organization doing to ensure that employees are not discriminated against and that they receive prevention and education services at the workplace regarding HIV/AIDS?
- Are you familiar with any support organization for people who are HIV-positive?
- Are there employees who are HIV-positive who are open about their status to their employers and co-workers?
- Are you aware of a situation in which employees/workers received different treatment because they were known or perceived to have HIV? If so, please describe.
- Who treated the employee known or perceived to have HIV/AIDS differently?
  - Co-workers
  - Supervisors
  - Managers
  - Labour representatives
  - Others (specify)
Appendix E: In-depth interview guide

Sample introduction to in-depth interviewee

Good morning/afternoon/evening! Thank you for taking the time to speak with me today. My name is ______. I work for ______ and come from ____________. (Note-taker/observer introduces her/himself.)

I would like to discuss some health issues that affect your workplace, including HIV/AIDS. I'm interested in all your ideas, insights, comments and suggestions. I'd like you to know that there are no right or wrong answers to any of the questions I will ask you. Your point of view is of the greatest importance during this interview. All comments—both positive and negative—are welcome.

To avoid missing any points that you make during our conversation, I would like to use a tape recorder. I want you to know that all your comments are confidential and will be used for research purposes only. To protect your confidentiality, your full name will not be recorded. I will be happy to answer any questions that you may have at the end of our conversation.

Socio-demographic information and introduction

Key informant profile

- Name of organization: Location:
- Job title/grade: Salary:
- Age: Sex:
- Education level: Religious affiliation:
- Marital status: Number of children:
- Ethnic group:
- Number of years at current position: Area in which you live:
- Hobbies:

Introductory questions

- What are the main problems you face?
- How do you solve them?
- What are your expenditures for the month?
- What are your sources of income?
- How much do you earn per month?
- What do you do when on leave and at weekends?
Knowledge, attitudes and perceptions about HIV/AIDS

Knowledge levels
- What do HIV and AIDS stand for?
- How are HIV and other sexually transmitted infections transmitted?
- Name three common sexually transmitted infections.
- Do you know a colleague or friend who has ever had a sexually transmitted infection?
- How can HIV be prevented?
- What are the signs and symptoms of AIDS?
- What are opportunistic infections?
- What is the length of time between infection with HIV and the development of AIDS?
- How can HIV infection pass from a mother to her child?
- What forms of social/sexual activity or contact do not involve a risk of HIV transmission?
- What is voluntary HIV counselling and testing?

Perception of HIV
- What are your thoughts about sexually transmitted infections? What are your thoughts about HIV and AIDS?
- Do you think you are at risk of getting a sexually transmitted infection? Do you think you are at risk of becoming infected with HIV? Please explain.
- What peer groups and significant others are most important to you? Do you think your partner is having sex only with you?
- How do men react if their female partners ask them to use condoms?
- How would your partner react if you asked him/her to use a condom?
- What would be your reaction if your partner refused to use a condom?
- Are your co-workers concerned about sexually transmitted infections? Are they concerned about HIV?
- What do you see as the benefits of adopting safer sexual behaviour (e.g., practising abstinence, being faithful to one partner, using condoms)?
- [If interviewing a female] Would you undergo HIV counselling and testing before becoming pregnant?
- [If interviewing a male] Have you ever undergone HIV counselling and testing? Would you like to? Why or why not?
- What would you do if you found out that one of your co-workers was HIV-positive?
- What would you do if you found out that you were HIV-positive?

HIV/AIDS programming at the workplace
- Which HIV/AIDS prevention, care, support and treatment services are available to you at your workplace?
- What is your opinion about your employer/union response to HIV/AIDS?
- What kinds of workplace programmes/services related to HIV/AIDS would you like to see?
**HIV/AIDS policy at the workplace**

- Does this organization have a policy on HIV/AIDS at the workplace? If so, could you please explain it to me?
- What is the management’s policy regarding HIV-positive employees and those living with AIDS?

**HIV/AIDS-related practices**

- What behaviours put you most at risk of becoming infected with HIV and other sexually transmitted infections?
- How do you protect yourself from HIV infection?
- Do you want to change any of your behaviours that may put you at risk of contracting HIV? Please explain.
- What do you see as the benefits of changing your high-risk behaviour?
- What do you see as the disadvantages of changing your high-risk behaviour?
- What pressures make it difficult for you to change your behaviour?
- What power do you believe you have to change your behaviour? If it is limited, please explain why, and by whom or what.
- What would it take for you to change to a safer behaviour or to continue practising a safer behaviour?
- Do you know of a colleague who has been approached on the job for sexual favours in exchange for certain benefits? Have you ever had an experience like this?

**Behaviour change communication questions**

**Media habits**

- What are your favorite TV and radio programmes? When do you watch or listen to them?
- What is the language of the broadcast?
- What print media do you prefer (e.g., newspapers, magazines, pamphlets, booklets, comic books, picture books, etc.)?
- What kind of music do you prefer?
- What kind of traditional theatre are you exposed to in your community (local drama, concert party, story-telling, etc.)?
Sources of information

- When and where do you usually get information about topics related to sexual health?
- Who or what is your trusted source for health information at the workplace?
- How do you communicate with your friends (telephone, email, in person)? Where do you meet your friends? When? Which friends do you see every few weeks?
- What are your preferred sources of information on health-related topics?
- What are the sources of information on sexual health that you find most credible?
- When and where would be the best times to talk to you about HIV prevention, distribution of condoms and treatment services for sexually transmitted infections, and who could do this most effectively?
- Which teaching aids would help you learn the most in group information sessions (e.g., videos, slide shows, overhead projectors, flipcharts, picture codes, demonstrations, role plays, etc.)?

Fears and hopes

- How do you see yourself in ten years’ time?
- What would be the best thing that could happen to you in the future?
- What do they need to help you realize your hopes and dreams?
- What could prevent your hopes and dreams from being realized?
- What are the biggest obstacles to you achieving your long-term goals?
- What fears do you have about the future?
- What are the major barriers/hindrances that you currently face that could affect whether or not you achieve your goals?

Stigma and discrimination

- What is being done to ensure that employees are not discriminated against and that they receive prevention and education services at the workplace regarding HIV/AIDS?
- Are you familiar with any support organization for people who are HIV-positive?
- Are there employees who are HIV-positive who are open about their status to their employers and co-workers?
- Are you aware of a situation in which employees/workers received different treatment because they were known or perceived to have with HIV/AIDS? If so, please describe.
- Who treated the employee known or perceived to have HIV/AIDS differently?
  - Co-workers
  - Supervisors
  - Managers
  - Labour representatives
  - Others (specify)
Appendix F: Observation guide*

Observer(s): ________________  Location: ____________
Date: _____________________ Approximate number of target population: __________

<table>
<thead>
<tr>
<th>Date/time observation began:</th>
<th>Date/time observation ended:</th>
<th>Date/time recording began:</th>
<th>Date/time recording ended:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe the situation/context.

Describe the activities of the target population.

Describe who is present.

Describe social networks/membership.

Which language(s) are used?

What are the high-risk behaviours?

Which other behaviours are associated with these high-risk behaviours?
Which factors trigger high-risk behaviours?

Which factors maintain high-risk behaviours?

Who are the potential members of the target population that are not engaging in high-risk behaviours)? Explain.

Which other people interact with the target population? What influence do they have?

What other observations should be made?

*Some of the questions listed above were obtained from the following source:

Designing a Behaviour Change Communication Strategy

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Day 3: How do we reach people? 43

Day 4: How do we know our programme is working? 55

Day 5: How do we network and link with the broader community? 69
Introduction

The development of an HIV/AIDS behaviour change communication (BCC) strategy for the workplace is best completed through an interactive participatory workshop that includes representatives from various sectors of the workforce. This booklet consists mainly of a facilitators’ guide that takes the participants through a process of deepening their understanding of BCC for HIV/AIDS and of developing ownership of the resulting programme.

The workshop agenda has been designed to be useful to those who would be either directly responsible for, or closely associated with, the planning and implementation of behaviour change programmes in the workplace. Participants may include HIV/AIDS focal points, members of workplace HIV/AIDS or health and safety committees, staff and members of the trade unions, representatives of management and employers’ organization as well as peer educators to be recruited from the workforce to participate in the forthcoming BCC programme. Because of the community-driven nature of behaviour change communication programmes, it is beneficial to include representatives of local non-profit organizations and clinical service providers as well as representatives from the local and national government (National AIDS Committee, Ministry of Labour, other ministries involved) because their assistance and engagement will be critical to the success of the programme. A facilitator trained in using the toolkit can work closely with all key stakeholders and ensure that everybody agrees on a common way forward.

The information presented in the workshop has been prepared to be accessible and useful to the participants who have had limited exposure to behaviour change communication programmes, as well as to those who want to improve their knowledge of a particular aspect of workplace programming. The workshop facilitators should also encourage participation of those stakeholders who may not be directly involved with BCC programming, but are interested in learning about behaviour change communication. These can include HIV/AIDS focal-points from the Ministry of Labour, employers’ and workers’ organizations, representatives of mass media and other community-based organizations.

The exercises in this guide can also be used to develop certain aspects of the strategy with smaller groups. A BCC practitioner or consultant can work with the data to develop messages and BCC objectives and then test them with the target population. However, the more participatory the design, the more accurate the messages and programmes will be.

The workshop will build on the data obtained from the formative assessment as well as from the experience and knowledge of the participants. The workshop will follow a step-by-step process to:

- generate understanding on the impact of HIV/AIDS at the workplace;
- generate understanding of behaviour change and behaviour change communication;
- develop key messages;
- develop BCC objectives;
- identify channels specific to the workplace;
- identify linkages with the broader community;
- identify support communication materials; and
- design activities.
Workshop objective

- To develop a BCC strategy and workplan for HIV prevention at the workplace.

Workshop methodology

- Use of structured learning activities: presentations, group discussions, group work, role-playing and simulation exercises.
- High level of participation through active involvement of participants. Participants work in small groups based on the targeted sectors or workplaces they represent (e.g., agriculture, mining, banking, etc.) and use the formative assessment data that have been generated on their sector to develop an appropriate behaviour communication strategy. If only one workplace or sector is represented, participants will work in small groups to generate ideas and come to a consensus in plenary.

Room arrangement: small group tables

Below is a suggested seating arrangement. It is very effective for both large group discussions and small group work.
Sample agenda

This sample agenda is for a five-day workshop with key stakeholders and members of the target populations. Careful selection of the exercises will enable you to adapt the agenda to meet the specific needs of the workplace.

Day 1: What do we know?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome, introduction and summary of</td>
<td>8:30 – 9:30</td>
<td>General presentation of the ILO Global Programme on HIV/AIDS and</td>
</tr>
<tr>
<td>expectations</td>
<td></td>
<td>the World of Work and the ILO Code of Practice.</td>
</tr>
<tr>
<td>The ILO's response to HIV/AIDS</td>
<td>9:30 – 10:15</td>
<td>An exercise to help participants understand the HIV/AIDS epidemic in the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>context in their own lives.</td>
</tr>
<tr>
<td>Break</td>
<td>10:15 – 10:30</td>
<td>An exercise to ensure a sound understanding of the behaviour change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>process.</td>
</tr>
<tr>
<td>Family silhouettes</td>
<td>10:30 – 11:30</td>
<td>Presentation and discussion of data collected in formative assessments.</td>
</tr>
<tr>
<td>Behavior change process</td>
<td>11:30 – 12:45</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
<td></td>
</tr>
<tr>
<td>Presentation of formative assessment data</td>
<td>1:45 – 2:45</td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>2:45 – 3:00</td>
<td></td>
</tr>
<tr>
<td>Target population profiles</td>
<td>3:00 – 5:55</td>
<td></td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>5:55 – 6:00</td>
<td></td>
</tr>
</tbody>
</table>
### Day 2: What do we need to say?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 1</td>
<td>8:30 – 9:00</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>BCC objectives</td>
<td>9:00 – 10:30</td>
<td>An exercise to define behaviour change communication objectives: What do participants hope to accomplish through the communication?</td>
</tr>
<tr>
<td>Break</td>
<td>10:30 – 10:45</td>
<td></td>
</tr>
<tr>
<td>Key benefits and barriers</td>
<td>10:45 – 12:30</td>
<td>Based on the formative assessment and the target population profiles, outline the perceived key benefits of, and major barriers to, changing behaviours.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:30 – 1:30</td>
<td></td>
</tr>
<tr>
<td>Messages</td>
<td>1:30 – 3:00</td>
<td>Develop messages based on BCC objectives and key benefit statements.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Themes</td>
<td>3:15 – 4:45</td>
<td>Develop themes to unite BCC programmes for various workplaces or a specific sector.</td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>4:45 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>

### Day 3: How do we reach people?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 2</td>
<td>8:30 – 8:45</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>Channels</td>
<td>8:45 – 10:15</td>
<td>Participants select channels based on the formative research and knowledge of the workplace structures and populations.</td>
</tr>
<tr>
<td>Break</td>
<td>10:15 – 10:30</td>
<td></td>
</tr>
<tr>
<td>Activity workplan</td>
<td>10:30 – 12:30</td>
<td>Participants develop a workplan for the kinds of activities they will create to engage the workplace in HIV/AIDS-related programmes.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:30 – 1:30</td>
<td></td>
</tr>
<tr>
<td>Activity workplan</td>
<td>1:30 – 3:00</td>
<td>Continuation of previous session.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Communication support materials</td>
<td>3:15 – 4:45</td>
<td>Based on channels and workplans for actual activities, participants identify the communication support materials to be developed.</td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>4:45 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>
Day 4: How do we know our programme is working?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 3</td>
<td>9:00 – 9:30</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>Analysing materials</td>
<td>9:30 – 11:00</td>
<td>Build skills in analysing materials in preparation for material development.</td>
</tr>
<tr>
<td>Break</td>
<td>11:00 – 11:15</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>11:15 – 12:45</td>
<td>Initial steps in setting up an on-going monitoring system.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td>1:45 – 3:00</td>
<td>Continuation of previous session.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>4:55 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>

Day 5: How do we network and link with the broader community?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 4</td>
<td>8:30 – 9:00</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>Networking, linkages, action plans</td>
<td>9:00 – 10:30</td>
<td>Participants identify services within the workplace or in the broader community (linked to the desired behaviours) and develop networking systems and action plans.</td>
</tr>
<tr>
<td>Break</td>
<td>10:30 – 10:45</td>
<td></td>
</tr>
<tr>
<td>Next steps</td>
<td>10:45 – 11:45</td>
<td>Participants identify next steps for developing the BCC workplace programme.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>11:45 – 12:30</td>
<td>Participants evaluate the workshop.</td>
</tr>
<tr>
<td>Closing</td>
<td>12:30 – 12:45</td>
<td>Closing comments.</td>
</tr>
</tbody>
</table>
# Day 1: What do we know?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome, introduction and summary of expectations</td>
<td>8:30 – 9:30</td>
<td></td>
</tr>
<tr>
<td>Break</td>
<td>10:15 – 10:30</td>
<td></td>
</tr>
<tr>
<td>Family silhouettes</td>
<td>10:30 – 11:30</td>
<td>An exercise to help participants understand the HIV/AIDS epidemic in the context in their own lives.</td>
</tr>
<tr>
<td>Behaviour change process</td>
<td>11:30 – 12:45</td>
<td>An exercise to ensure a sound understanding of the behaviour change process.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
<td></td>
</tr>
<tr>
<td>Presentation of formative assessment data</td>
<td>1:45 – 2:45</td>
<td>Presentation and discussion of data collected in formative assessments.</td>
</tr>
<tr>
<td>Break</td>
<td>2:45 – 3:00</td>
<td></td>
</tr>
<tr>
<td>Target population profiles</td>
<td>3:00 – 5:55</td>
<td>Participants sketch a drawing of the target populations to form the basis for the rest of the workshop.</td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>5:55 – 6:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>
Day 1, session 1: Welcome, introduction and expectations

Flipchart paper, markers, objectives on flipchart or PowerPoint, presentation on the ILO’s response to HIV/AIDS (PowerPoint optional)

Objectives

By the end of the session, participants will have:
- understood the objectives of the workshop;
- expressed their expectations of the workshop; and
- got to know one another.

Process

Step 1 [optional]: (10 minutes) If possible, a local government official should say a few words to open the workshop.

Step 2: (30 minutes) Participants divide into pairs and obtain the following information from each other:
- Name and hobby
- What is the one main expectation they have/thing they would like to see accomplished during the workshop

Participants then introduce their partner to the entire group.

Step 3: (20 minutes) In plenary, a facilitator will list the participants’ expectations for the workshop on a flipchart. The facilitator states the overall objective for the workshop, compares it to the group’s expectations, and reaches a consensus on what will be achieved in the five-day programme.
Day 1, session 2: The ILO’s response to HIV/AIDS

**Objective**

By the end of the session, participants will have an understanding of the ILO Global Programme on HIV/AIDS and the World of Work and of the ILO Code of Practice.

**Process**

- A representative from the ILO makes a presentation on the ILO Global Programme and the World of Work and the ILO Code of Practice.

- The presenter reviews the key components of a comprehensive HIV/AIDS workplace programme and explains how the BCC toolkit fits into the overall programme objectives.
Day 1, session 3: Creating family silhouettes and unfolding the scenarios

1 hour

Flipchart, index cards, markers, handouts on two different family scenarios (half of the participants will work on one scenario and half on the other)

Objectives

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

- explain the impact of HIV infection on individuals, families and the workplace, as well as the implications for workplace policies and programmes;
- explain that BCC functions in the context of commodities and services; and
- clarify the concept of the HIV/AIDS continuum of prevention, care and support.

Process

Step 1: (5 minutes) Tell participants that the point of this exercise is to better understand the impact of HIV/AIDS on the individual, the family and the community. To do this, they will be comparing what happens over time to a family not affected by HIV/AIDS to what happens to the same family when it is affected by HIV/AIDS.

Step 2: (15 minutes) Divide participants into small groups (e.g., five participants each). Provide each group with a description of a family. (You can develop these descriptions to meet country and sector issue. See the two sample descriptions below.) Assuming that HIV/AIDS is not an issue, have the group project where the family will be in five years’ time.

Step 3: (15 minutes) Continuing in groups, ask participants to establish one or two members of the family, including the worker, as HIV-infected. Ask the group to project what will happen to this family given the dynamics of illness and discrimination, in five years’ time. They should also project what impact this will have on the workplace.

Step 4: (15 minutes) Ask each group to present the family scenarios in plenary. Invite a response from one group. Instruct reporters from other groups to provide any other responses they may have or to expand on the response from the first group, but to avoid repeating information that has already been shared.

Step 5: (10 minutes) Summarize the discussion, taking note of the impact on the workplace and on the family of having an HIV-positive employee, in terms of stigma, care and support. Outline the services needed for a comprehensive HIV/AIDS programme – sexually transmitted infection (STI) services, voluntary HIV counselling and testing, links to services in the community, etc.
Handout 1: Family of a truck driver.

Kwame Lamptey works as a long-distance truck driver for the Ghana Trucking Company. He mostly works the route between Accra and Abidjan and is away from home 50 per cent of the time. He has been working as a truck driver for this firm for 12 years. He lives in Accra and is married to Nana who is ten years younger than he is and works in the local branch of a bank. They have three children: James, who is 15; Immaculate, who is 12; and Jennifer, who is turning 9. While on the road, Kwame has two other ‘wives’ who he visits regularly on his route. Kwame and Nana form a happy and prosperous family, belong to the local church, and have hopes and aspirations for the future. They especially want to see their children educated and married well.
Handout 2: Family of a miner.

Moses works in the mines in Botswana. He is away from home for three months at a time. He has been married for two years and his wife is now pregnant with their first child. While at the mines, he spends his leisure time drinking with his buddies in the local town. He hopes to save enough money to open a business in his hometown.
Day 1, session 4: Understanding the behaviour change process

1 hour 15 minutes

Flipchart, markers.

**Objective**

By the end of the session, participants will have an understanding of the process of behaviour change.

**Process**

**Step 1:** Plenary discussion and facilitator role-play (10 minutes). Initiate a discussion about how different people have different behaviours, which they often have to change or modify during the course of their lives. Ask the participants to think of various aspects of their own lives, such as the way they dress, their eating habits, and whether they smoke, drink or exercise, which may represent personal examples of behaviour change.

Optional: Provide ‘miniature vignettes’ or appropriate stories to illustrate members of target populations confronting and engaging in behaviour change.

**Step 2:** Small group work (25 minutes)

- Divide participants into groups. On a flipchart, write ‘unchanged behaviour’ on the left side and ‘changed behaviour’ on the right side. Ask them to imagine that they are on the side marked ‘unchanged behaviour’, that they have certain behaviours they want to change and that their goal is to cross over to the ‘changed behaviour’ side. Ask them to discuss the behaviours that they may have changed or tried to change and the steps they took to make that change. The objective is to illustrate the steps involved in behaviour change and to identify factors that may influence behaviour.

- Ask participants to pick one of the behaviours discussed within the group and write on a flipchart five steps that were taken to move from ‘unchanged behaviour’ to ‘changed behaviour’. They should highlight the factors that facilitated the change as well as those that represented barriers to making the change.

**Step 3:** Presentations (25 minutes). Ask each group to present their behaviour change story in plenary.

**Step 4:** Behaviour change model (15 minutes). Use examples provided by the group showing the steps involved in behaviour change to outline the behaviour change model. Use this model to explain HIV/AIDS-related behaviour changes.
Be sure to explain the difference between short-term and long-term behaviour change.

Point out that behaviour change steps do not occur in the same order for everyone, nor is there a fixed pattern for change to occur.

Emphasize that behaviour change is influenced by environmental factors and is therefore not only a matter of individual choice.

Point out that the more factors there are that promote or enable change, the more likely it is that behaviour change will occur.

**Need for behaviour change:**

- End the session by brainstorming about behaviours that need to be changed or maintained in order for HIV/AIDS programmes to be successful.
- Summarize by pointing out that there are several stages of behaviour change that a person can move between and also several factors that can enhance, or provide barriers to, healthier behaviour change. Remind participants that the goal of well-designed behaviour change communications programmes is to add to and support a community’s and an individual’s healthier behaviour changes as they relate to sexually transmitted infections and HIV/AIDS.
Day 1, session 5: Presentation of formative assessment data

Process

**Step 1:** Presentation of data (30 minutes).

- Divide the participants into groups based on the target populations they are working with. (These might include banking, manufacturing, mining, agriculture, etc., and/or specific workplaces in the country or region.) Make certain that all members of the group are taking on the role of someone who is either from the target population or working with the target population. Participants will continue to meet in these groups for many of the sessions that follow.
- Distribute summaries of findings from each target population to the groups. You can post key data on a flipchart—e.g., knowledge, attitudes, practices, social networks, media habits, etc.

**Step 2:** Discussion (30 minutes). Ask the group to identify:

- highlights of what they learned (high-risk practices, vulnerable populations, etc.); and
- aspects about which they will need additional information.

Objectives

By the end of the session, participants will have an understanding of the current conditions, practices and attitudes among target populations at the workplaces where formative assessments were conducted.
Day 1, session 6: Target population profiles

Objectives

By the end of this session participants will be able to clearly describe a target population: their hopes and fears, their relationships, their role models, their behaviours, and barriers to change.

Process

Step 1: Small group activity 1 (10 minutes)

Describe the target population, then do the following:

- Have participants re-form their small groups, based on the target populations they are working with.
- Inform participants of the objective of the exercise.
- Place a sign indicating the target population (see below for sample), three sheets of flipchart paper, and a few markers of various colours at each table.
Based on their personal knowledge of the target populations and the formative assessment findings, participants should describe a typical member of their target population by listing adjectives that describe that person. For example, men at the workplace may be stable, secure, family men, etc. They should write their description on their flipchart sheets.

**Step 2:** Small group activity 2: Develop a matrix on current and desired behaviours (20 minutes)

- Invite participants to remain in their groups and use the summary of their target population’s formative assessment to fill out the matrix below on current and desired behaviours.

<table>
<thead>
<tr>
<th>Behaviour change matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Current behaviour</strong></td>
</tr>
<tr>
<td>Prevention</td>
</tr>
<tr>
<td>Health-care-seeking behaviour</td>
</tr>
<tr>
<td>Stigma</td>
</tr>
</tbody>
</table>

**Step 3:** Small group activity 3 (90 minutes)

- Distribute a pre-drawn flipchart diagram to each group (depicting community/society/workplace/family/target population), as well as scissors, coloured paper and glue sticks.
- Instruct the groups to use formative assessment data on their target populations, their own personal perspectives, and the diagramme you have just distributed (as a guide) to depict the world of the target population they are representing. They should create a visual image of the world their target population inhabits, using flipchart paper, pens, coloured paper and any other materials they choose.
The visualization should include the target population’s:
  - hopes and fears
  - barriers to change
  - relationship to family
  - church, health system
  - employers, co-workers
  - media habits
  - wntertainment
  - role models
  - risky behaviours.

Advise the groups to also consider what their target populations are hearing about HIV/AIDS, what the sources are, and how that information is perceived.

Tell the groups that they should post their visual representations on the wall next to the area they are working in, and that they will have 90 minutes to complete this exercise.

**Step 4: Presentations and discussion (55 minutes)**

- When the time for step 4 is up, have participants move around the room to each group’s display, as if they were visiting paintings at an art gallery. Participants should gather around each display as the individual groups make their presentations and explain their visual representations.
- After each presentation, encourage participants to ask any questions they may have, and note commonalities between the target populations.

**Step 5: Summary statement (1 minute)**

- Tell participants the following: “Gathering information about your target population and forming a profile of that population are crucial to the success of your behaviour change communication programme. This information will help you learn how to work with the target population and design effective communication strategies to meet their needs. Giving each group an opportunity to present their profiles allows everyone to see how relationships and priorities are linked to each other.”
Day 1, session 7: Summary of day’s activities

Review highlights of the day's activities

End of the day
### Day 2: What do we need to say?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 1</td>
<td>8:30 – 9:00</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>BCC objectives</td>
<td>9:00 – 10:30</td>
<td>An exercise to define behaviour change communication objectives: What do participants hope to accomplish through the communication?</td>
</tr>
<tr>
<td>Break</td>
<td>10:30 – 10:45</td>
<td></td>
</tr>
<tr>
<td>Key benefits and barriers</td>
<td>10:45 – 12:30</td>
<td>Based on the formative assessment and the target population profiles, participants outline the perceived key benefits of, and major barriers to, changing behaviours.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:30 – 1:30</td>
<td></td>
</tr>
<tr>
<td>Messages</td>
<td>1:30 – 3:00</td>
<td>Develop messages based on BCC objectives and key benefit statements.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Themes</td>
<td>3:15 – 4:45</td>
<td>Develop themes to unite BCC programmes for various workplaces or a sector.</td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>4:45 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>
Day 2, session 1: Overview of day 1

30 minutes

Flipchart, and markers or blackboard and chalk (optional)

Process

Take participants through what they studied and learned on the previous day, fielding brief questions, as necessary.
Day 2, session 2: Behaviour change communication objectives

Objective
By the end of this session participants will be able to articulate the behaviour change communication objectives for a particular target population.

Process

Step 1: Full group discussion (45 minutes)

Begin the discussion by stating the following:

“The goal of this exercise is to help you define the behaviour change communication objectives for a particular target population. These objectives should answer the question, What do we want to accomplish with the communication?

“Let’s imagine that your programme objectives are to decrease the number of sexually transmitted infection cases and to increase life expectancy for people living with HIV/AIDS.

“These are your programme objectives. From them, you will develop your behaviour change objectives and, from your behaviour change objectives, you will develop your behaviour change communication objectives.

“Let us first define a behaviour change objective and a behaviour change communication objective.”

Then ask the following questions:

- Do you know someone who was a candidate in the last election?

- What did/does this person want you to do?
  (Elicit/listen for the response: “He (she) wanted us to vote for him (her)” (the action point of voting).
Explain that the behaviour change objective is the action: voting for this great candidate. Then circle the cluster of words under the word ‘Vote’.

Further explain that the behaviour change communication objective is the intention to act; wanting to vote for this great candidate; feeling that it’s the right thing to do, judging from the messages received.

Post the flipchart page on the wall (for easy reference when mentioning actions and intentions in the next example) and use a fresh page for the following exercise.

Introduce another example: truck drivers as the target population. Ask participants the following questions:

- What is our behaviour change objective (remember: the action)?
- What are the behaviours we want these truck drivers to adopt?”

Write the actions in the top section as you elicit answers from the participants. Answers may include (but are not limited to):

- Reduction in number of partners
- Immediate, appropriate use of sexually transmitted infection services
- Use of voluntary HIV counselling and testing services
- Consistent condom use.
Then write the word ‘Vote’ on a flipchart.

Next, ask: “How did/does that person try to get you to vote for him (her)?”

Then elicit/listen for answers that are, for example, persuasive, convincing or credible, that differ from the other candidates, that offer positive change, and that spur a person’s intention to vote. Write these on the flipchart with a different-coloured marker.

Explain the dynamic thus: “The candidate is trying to get you to have the intention, in your mind, to vote for him (her).” Then circle the word ‘Vote’ on the flipchart.
Then ask:

“Now that we agree on the actions—the behaviours we want them to adopt (our behaviour change objectives)—what are our behaviour change communication objectives? What can our messages do to support the intention to act?”

With a different-coloured marker, write in the bottom section the items supporting the intention to act as you elicit answers from the participants. Answers may include (but are not limited to):

- Increase self-risk assessment
- Increase confidence in condom use
- Increase demand for, and knowledge about, HIV/AIDS, sexually transmitted infections and HIV counselling and testing
- Increase discussion about HIV and other sexually transmitted infections
- Increase knowledge about universal precautions
- Increase knowledge and enhance attitude about services for sexually transmitted infections and HIV counselling and testing.

As in the previous example, circle the top portion. “We now have the action…”
“… and we have messages supporting the intention to act—our behaviour change communication objectives.”

Now ask participants if they are ready to come up with their own behaviour change and behaviour change communication objectives in small groups.

[Note: If the full group seems hesitant, you can take them through a third example. Have them provide an issue for behaviour change, such as the issue of smoking. Take them through this exercise with a flipchart page as you did with the above-mentioned examples.]

Behaviour change objective:
- Stop smoking

Behaviour change communication objective:
- Increase knowledge of health hazards associated with smoking
- Increase community discussion about smoking
- Increase knowledge of, and confidence in, programmes to assist in quitting smoking
- Increase knowledge that smoking is an addictive behaviour
- Increase willingness of the community to speak out against smoking.
Step 2: Small group work (40 minutes)

- Give each group a piece of flipchart paper and some markers.
- Tell participants they will have 40 minutes to work on this activity.
- Once participants receive their worksheets and make their diagramme, they should write their behaviour change communication objectives for the desired behaviour indicated on their activity sheet. They should ensure that your objectives are measurable because they will be working with these same objectives in a behaviour change communication monitoring session. Encourage them to think about the target workplace or sector they are working with when they develop their objectives.
- Hand out the activity worksheets to the groups. (Six behaviour change communication objectives worksheets are found on pages 31 to 33, following the description of this session. Each group should receive a different worksheet, but enough copies of that worksheet for every member of the group. You will need to make photocopies and assemble sets of worksheets ahead of time.)

[Note: To ensure that groups all complete their work at the same time, you can circulate among them to watch and listen. If they get stuck on one part, encourage them to just think of a few items and then move on to the next category. Five minutes before the end of the time allotted for this activity, visit each group and let them know they have five more minutes. About one minute before the end, visit each group to say, “Just one more minute”. Then reconvene the entire class.]

Step 3: Presentations and discussion (30 minutes)

- Encourage everyone to put down their materials and pay attention to each group presenting.
- Have each group post its diagram on the wall as they present their behaviour change communication objectives to the other participants.
- After each presentation, ask the audience to add comments and insights if they wish. Ask if certain objectives are measurable and how they would be measured. Thank each group after their report. When all the presentations have been made, encourage applause for all the groups’ great work.

[Note: It is important to label and save each group’s flipchart diagram, as it will be used later in an exercise on monitoring.]

- To sum up the session, tell the participants to bear in mind the following things:
  - Behaviour change communication alone does not lead to behaviour change.
  - Behaviour change communication works with other strategies, activities and approaches.
  - Understanding your programme objectives, behaviour change objectives and communication objectives is essential because it tells you where you are going and what you need to do.
- Announce that you are handing out examples of behaviour change and behaviour change communication objectives, as supplementary information for participants to keep. (See handout, page 31 to 33. Be sure that you have made enough photocopies for all participants.)
Handout 3: Behaviour change communication objectives

The following describes six separate exercises. For each exercise, draw an outline of a person in the centre of your paper (see overleaf), with plenty of space around it, but also with room for some writing inside.

Inside your drawing, write the behaviour you would like your target population to adopt (your behaviour change objective):

Exercise 1: reduce number of sexual partners
Exercise 2: increase condom use
Exercise 3: increase use of health services
Exercise 4: increase access to, and use of, voluntary HIV counselling and testing
Exercise 5: reduce the incidence of discrimination directed at people living with HIV/AIDS
Exercise 6: improve providers’ and clients’ compliance with drug-treatment regimens

Now, around the outside of the figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (i.e., supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (how will you know members of your target population have taken on this new behaviour?), because in a future exercise you will be working with these same objectives to learn how to monitor them.
Handout 4: Examples of behaviour change and behaviour change communication objectives

Programme goal: Reduce HIV prevalence among miners in X worksite

Behaviour change objectives:

- Increase condom use
- Increase appropriate sexually transmitted infection care-seeking behaviour
- Delay sexual debut
- Reduce number of partners
- Increased safer sexual practices (more frequent condom use, fewer partners)
- Increased incidence of health-care-seeking behavior for sexually transmitted infections, tuberculosis, and voluntary HIV counselling and testing
- Increased use of universal precautions to improve blood safety
- Reduction in number of partners
- Immediate appropriate utilization of sexually transmitted infection services
- Utilization of HIV counselling and testing services
- Consistent condom use
- Increased blood donations (where appropriate)
- Improved compliance with drug-treatment regimens
- Adherence by medical practitioners to treatment guidelines
- Increased use of new or sterilized syringes and needles by injection drug users
- Decline in stigma associated with HIV/AIDS
- Reduced incidence of discriminatory activity directed at people living with HIV/AIDS and groups with high-risk behaviour

Behaviour change communication objectives:

- Increase perception of risk or change attitudes towards use of condoms
- Increase demand for services
- Create demand for information on HIV/AIDS
- Create demand for appropriate sexually transmitted infection services
- Interest policy-makers in investing in youth-friendly voluntary HIV counselling and testing services (services must be in place)
- Promote acceptance among communities of youth sexuality and the value of reproductive health services for youth (services must be in place)
- Increase self-risk assessment
- Increase confidence in condom use
- Increase demand for services and knowledge about HIV/AIDS, sexually transmitted infections, and HIV counselling and testing
- Increase debate about HIV/AIDS and other sexually transmitted infections
- Increase knowledge about universal precautions
- Increase and deepen knowledge about services for sexually transmitted infections and HIV counselling and testing
- Improve attitudes and behaviour among health-care and other service-delivery workers who interact with people living with HIV/AIDS, sex workers, injection drug users, and other marginalized groups

Note: Indicators should be developed based on BCC objectives
Day 2, session 3: Key benefits and barriers

Objective
By the end of this session, participants will be able to develop clearly-articulated statements that show the perceived and real benefits of changing behaviours and the barriers to change.

Process

Step 1: (15 minutes)

- Begin by telling participants that the goal of this exercise is to help them identify and understand both the perceived and real benefits of behaviour change for a target population.

- Cover the following points:
  - Finding out what could help motivate a person or a community to change is an important step in developing an effective and convincing message. The data from the needs assessment and target population profiles – including information about their hopes and fears – can be used to develop key benefit statements.
  - It is important to have a clear understanding of, and agreement on, three things:
    - Your defined target population
    - Clear communication objectives
    - A desired action response
  - There are two components of a behaviour change message: [Here you should write ‘Desired behaviour’ on the left-hand side of a flipchart page.]
A ‘desired behaviour’ (for example, ‘I will seek treatment for my sexually transmitted infection’) [Write ‘Key benefit’ in another colour on right-hand side of the flipchart page.]

- The ‘key benefit’ (for example, ‘If I seek treatment, my wife won’t be angry with me’). If I do ‘x,’ then I will benefit by getting ‘y’.

- Then share some examples with the group.

[Note: As you cover the following information, indicate on the flipchart paper ‘desired behaviour’ or ‘key benefit’ as you explain those things in the examples that follow.]

- The example I used from research with truck drivers shows that they would be motivated to seek treatment for sexually transmitted infections (the desired behaviour) to avoid the anger of their wives when they returned home (key benefit). The key benefit was a happy wife.

- What would not be a good approach to use with these truck drivers (in other words, what might sound good as a public health message but would not relate to the truck drivers’ hopes and fears)?

  [Answers may include (but are not limited to):
  - Get treatment for sexually transmitted infections because it is the right thing to do
  - Take good care of yourself by getting treatment
  - Take care of your wife by getting treatment.]

- Researchers found that sex workers in Kamatipura, Mumbai, India, are primarily concerned about their children. So the key benefits to seeking treatment for sexually transmitted infections and using condoms need to be related to their fear of infertility and of not staying healthy for their children. What would not be a good approach to use with these sex workers (in other words, what might sound good as a public health message but would not relate to the sex workers’ hopes and fears?)
[Answers may include (but are not limited to):

- Get treatment for sexually transmitted infections to keep your community healthy
- Take good care of yourself by getting treatment
- Get treatment because it is bad to spread infection to your clients.

- Campaigning politicians generally tailor their speeches to the communities in which they are speaking. So, for example, if they are in a town with factories, they will say, “Vote for me [desired behaviour] and I will make sure the factory gets contracts” (therefore jobs). The key benefit for the voter is the promise of more jobs.

- Ask participants to come up with other examples from their workplace or local community.

**Step 2:** Small group activity no. 1 (30 minutes)

- Have participants re-form their target population groups.
- Now invite the participants to do the following as you demonstrate on your own sheet of flipchart paper:

  - Take a sheet of flipchart paper and write the words ‘Desired behaviour’ at the top and ‘Perceived benefits’ a few spaces below that.
  - Next, decide with your group the main behaviours that you would like your target population to adopt. Discuss and list what might be the target population's perceived benefits in changing their behaviour. Make a separate sheet for each behaviour.
  - Tell the groups they will have 25 minutes for this activity.
  [Note: Remember to circulate among the groups to make sure they are on schedule for the activity, and to warn them when time is almost up.]
  - Reconvene the entire group when time is up.
Step 3: Presentations and discussion (20 minutes)

- After reconvening the large group, ask for one volunteer from each small group to present the results of that group to the full class. Be sure that each group states the target population it is representing.

[Note: Have each group choose a different part of the room for their presentation where there is space to display their flip charts.]

Step 4: Small group activity no. 2 (25 minutes)

- While indicating the six sheets of flipchart paper you prepared ahead of time, ask the small groups to reconvene and list some ‘Barriers to adoption of a new behaviour’ for at least one or two of the desired behaviours they have identified for their target populations. Provide each group with tape or drawing pins to post their ‘barriers’ sheet, and instruct them to sit around the sheets they used to make their presentation. Tell them they will have 20 minutes for this activity.
- Reconvene the entire group when time is up.

Step 5: Presentations and discussion (10 minutes)

- Invite each group to present the barriers they identified for their target population. Have the entire class move to the appropriate area of the room to listen as each group makes a brief presentation.
- Thank the participants for their presentations.

Step 6: Summary (Five minutes)

- Tell the group that finding out what could help to motivate a person or a community to change is an important step in developing an effective and convincing message: “Data from your needs assessment can identify the hopes and fears of your target population as well as what they might see as the benefits of adopting a new behaviour – so you can create messages that are true motivators toward desired behaviours and actions.”

[Note: Be sure to label the materials used in these exercises. Group and retain them for use in future exercises and sections of this training.]
Day 2, session 4: Messages

**Objective**
- Develop messages based on the BCC objectives and key benefit statements developed in the previous sessions.

**Process**

**Step 1:** Review the characteristics of effective messages. (15 minutes)
- Remind participants of the examples from the exercise on key benefits and provide sample messages, as follows:
  - Truck drivers: “Take care of your sexually transmitted infections on the road and come home to a happy wife.”
  - Sex workers in India: “Use condoms to stay healthy so you can take care of your child.”
  - Voters (from political candidates): “Vote for me and I will make sure you get a job.”
- Emphasize that the message needs to state why someone should undertake a certain action. “Visit the HIV counselling and testing centre and find out your HIV status.” Why? “Because you want to plan your life for your family.”
- Then take participants through the characteristics of effective messages.
Handout 5: Characteristics of effective messages

<table>
<thead>
<tr>
<th>Characteristics of effective messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Command attention: Effective messages should stand out and get noticed above anything else.</td>
</tr>
<tr>
<td>Clarify the message: Most messages lack impact because the message is not clear. Remember ‘KISS’ – Keep It Short and Simple.</td>
</tr>
<tr>
<td>Communicate a benefit: Messages that communicate a benefit to the target population are more likely to appeal to the audience.</td>
</tr>
<tr>
<td>Create consistency: A message repeated consistently over time builds credibility.</td>
</tr>
<tr>
<td>Cater to the heart and the head: The most inspiring messages are those that appeal to the emotions (heart), thereby making us think more about the problem.</td>
</tr>
<tr>
<td>Create trust: People will trust what makes sense to them. A message must be believable and consistent with reality.</td>
</tr>
<tr>
<td>Call for action: The purpose of any message is to change people’s behaviour—that is, to enable people to change from behaviour A to behaviour B. Therefore, a message without a call for action is incomplete and its impact is usually not measurable.</td>
</tr>
</tbody>
</table>

- Distribute copies of the handout on ‘Characteristics of effective messages’ for participants to use in the following exercise as they develop messages in small groups.

**Step 2: Developing messages in small groups (45 minutes)**

- Explain to participants that they will be re-forming their small groups, based on the target populations they are working with. To create key messages for their target populations, they will use much of the information they developed in previous small group sessions, including:
  - formative assessment data;
  - target population profiles;
  - behaviour change and behaviour change communication objectives;
  - desired behaviours and key benefits; and
  - barriers to adopting a new behaviour.

- Inform participants that they should develop one or two messages for each of the desired behaviours they identified earlier, keeping in mind the other information, especially the related key benefits and barriers to adopting each new behaviour. [Note: Be sure that this information, in the form of flipchart pages, is still available and, if possible, organized for the groups in an orderly fashion. While the groups are working, circulate among them and make sure they are on the right track, assisting them, if necessary.]

**Step 3: Presentations and discussion (30 minutes)**

- Reconvene the large group.
- Move the large group to the part of the room where each small group has posted their messages, as each group makes its presentation.
- Keep track of common messages for use in the theme-development session.
Day 2, session 5: Themes

Objective
By the end of this session, participants will be able to develop possible themes for the BCC programmes that target a variety of groups.

Process

Step 1: Begin by telling the participants that the goal of this exercise is to help them develop themes for the BCC programmes that target a variety of groups at the workplace.

Step 2: Presentation and discussion (30 minutes)
- In plenary, lead a discussion about possible themes that could be relevant to the messages just developed.
- Tell participants that a theme is a global statement that encompasses the entire content of a behaviour change communication programme and stimulates interest. The purpose of a theme is to capture the attention of a target population or multiple populations and to unite campaigns and activities within a programme in the minds of that community of target populations.
- Some examples of themes are:
  - “Ready body: Is it really ready?” This theme was developed in Guyana to unite a variety of BCC programmes with segmented youth populations. It was successful in getting the attention of youth.
  - “Men can make a difference.” The International Planned Parenthood Federation developed this theme to mobilize men to be proactive with regard to reproductive health issues.
  - “Care for your health and family.” Family Health International developed this theme in Kano, Nigeria. It links work with a variety of high-risk and vulnerable populations and builds on the strong Islamic belief that the family is the centre of the cultural and social world. FHI has also elaborated target HIV/AIDS messages for dissemination and discussion through a variety of channels and social networks.
Take participants through a discussion of the elements involved in developing a theme:

- Image: Do the images used in messages convey the central theme? Do they help express the theme in a positive way that will inspire people to take action?
- Colour: Are common colours used in messages? Is there a central reason for using them? Do they help support a common theme?
- Language: Is the language used in different messages recognizable as supporting a common theme? Is it action-oriented language—i.e., language that makes people want to act (to find out more about the issues, to consider changing their high-risk behaviour, to obtain help in doing so)?

**Step 3: Small group work (30 minutes)**

- For this activity, divide participants into new groups representing a mix of target populations. (If you had participants form six groups for previous exercises, have them form six new groups made up of a cross-section of several target populations.) Each group should have a flipchart and markers to work with.
- Have the groups consult all of the messages developed for specific target populations and posted on the walls of the room. They should look for cross-cutting issues that might be relevant for all target populations. Ask them to brainstorm about themes that could get the attention of their target populations. This can draw on common cultural issues, common risk issues, or common geographical issues.

**Step 4: Presentations and discussion (25 minutes)**

- Reconvene the entire group.
- Ask each group to present their themes. Reach a consensus on the top three themes for pre-testing with the broader community.

**Step 5: Summary statement (5 minutes)**

- Thank the groups for their creativity. Conclude by saying: “So you see that you can link various target populations within a geographical community with a common theme to ensure that all channels and social networks are working together.”
Day 2, session 6: Summary of day’s activities

15 minutes  Review highlights of the day’s activities
            End of the day
Day 3: How do we reach people?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of day 2</td>
<td>8:30 – 8:45</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>Channels</td>
<td>8:45 – 10:15</td>
<td>Participants select channels based on the formative research and knowledge of the workplace structures and populations.</td>
</tr>
<tr>
<td>Break</td>
<td>10:15 – 10:30</td>
<td></td>
</tr>
<tr>
<td>Activity workplan</td>
<td>10:30 – 12:30</td>
<td>Participants develop a workplan for the kinds of activities they will create to engage the workplace in HIV/AIDS-related programmes.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:30 – 1:30</td>
<td></td>
</tr>
<tr>
<td>Activity workplan</td>
<td>1:30 – 3:00</td>
<td>Continuation of previous session.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Communication support materials</td>
<td>3:15 – 4:45</td>
<td>Based on channels and workplans for actual activities, identify the communication support materials to develop.</td>
</tr>
<tr>
<td>Summary of day’s activities</td>
<td>4:45 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
</tr>
</tbody>
</table>
Day 3, session 1: Overview of day 2

**Flipchart, and markers or blackboard and chalk (optional)**

**Process**

Take participants through what they studied and learned on the previous day, fielding brief questions, as necessary.
Day 3, session 2: Channels

Objective

By the end of this session, participants will be able to identify the most effective combination of channels for reaching the target population.

Process

Step 1: Full group discussion and presentation (15 minutes)

- Begin by telling participants: “The goal of this exercise is to help you identify which combination of communication channels can most effectively reach your target population.”
- Provide a definition of communication channels: vehicles that present and deliver messages. Then invite participants to examine the various kinds of communication channels that exist.

- Invite participants to brainstorm on each of the following areas. As you name each area, list the main vehicle type on a flipchart:

<table>
<thead>
<tr>
<th>Channels</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass media</td>
</tr>
<tr>
<td>Small media</td>
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<tr>
<td>etc.</td>
</tr>
</tbody>
</table>

- **Mass media** involves widespread diffusion to a large number of people. Answers may include (but are not limited to):
  - Radio, television, newspapers
  - Mass media advertisements
  - Billboards, posters, stickers, calendars.
Day 3

- Small media reaches fewer people. Answers may include (but are not limited to):
  - Print materials: booklets, pamphlets, comic books, photo novellas
  - Audio and video cassettes
  - Exhibits
  - Traditional media.

- Group media are materials used to enhance interpersonal communication. Answers may include (but are not limited to):
  - Flipcharts
  - Picture books
  - Flash cards
  - Slides and filmstrips
  - Models
  - Exhibits.

- Interpersonal communication is used with individuals or small groups, and is anything that brings people together, face to face. Answers may include (but are not limited to):
  - Peer education and peer leadership
  - Meetings
  - Counselling
  - Training sessions
  - Events
  - Role-playing and drama
  - Home and site visits.

Continue by communicating the following information: “So how would you select which communication channels to use when? A combination of channels appears to work best. Communicating the same message through different channels increases its overall effectiveness. [Point to each of the channels you have written on the flipchart as you mention them.]”
  - Mass media reach many people rapidly.
  - Small media reach small groups with specific messages.
  - Interpersonal communication with interactive group media is very persuasive and credible.

Ask participants to consider the cost-effectiveness of their approach, bearing in mind the importance of choosing the right channels and using resources that maximize changes in risk behaviours. For example:
  - Mass media is fast and has a low per-person cost.
  - Television is powerful, but is an expensive tool.
  - Pamphlets are detailed and reusable, but can be hard to distribute.

We can evaluate communication channels by observing how much of the target population they reach, how often the target population is exposed to this media, how much it costs to produce and disseminate this message, and what kind of human resources are necessary for using this channel.
If interpersonal communication (such as peer education, meetings, training sessions, events and drama) and mass media (such as radio, newspapers, posters and stickers) are effective, how do we determine which is better?

The answer is that it is not an either/or choice, since a combination of the two works best. Mass media sets the stage and creates demand for services, and interpersonal communication provides detail and interactivity. The two combined enhance each other.

Step 2: Small group work (30 minutes)
- Have participants re-form their target population groups.
- Ask the groups to use the formative assessment reports on their target population and the information generated on flipcharts in previous sessions to identify the appropriate communication channels to be used and to list the communication products or materials needed to support the identified channels. Remind the groups that these channels and products must pertain to their specific target population. They should consider which channels would be most effective, feasible and affordable for their target population.

Step 3: Presentations and discussion (45 minutes)
- Ask each group to begin by naming their target population, the communication channels they would prioritize and why, as well as the communication products they would like to develop. Also ask them to mention any areas (channels, products or materials) about which they would have liked to have further information.
- After each presentation, invite the other groups to ask questions or share their insights.

Step 4: Summary statement (1 minute)
- Conclude along the following lines: There are many different communication channels we can use to carry messages to target populations. The aim is to create an environment wherein people get similar messages from different sources. This multi-faceted approach enhances the effectiveness of each separate communication channel and results in a more effective behaviour change communication programme.
Day 3, session 3: Activity workplans

**Process**

**Step 1: Activity brainstorming (30 minutes)**
- Based on the channels selected, lead participants in brainstorming about activities that need to be developed to meet the BCC objectives and desired impact on behaviours. Activities may include the following:
  - Integration of HIV prevention into existing training programmes in the workplace
  - Peer education (including group sessions and individual counselling)
  - Development of a workplace newsletter
  - Planning of special events in the workplace, such as an activity to commemorate World AIDS Day
  - Integration of HIV prevention into employer-organization activities
  - Integration of HIV prevention into worker-association activities.

**Step 2: Small group work (90 minutes)**
- Divide participants into new groups for each activity area (not into the target population groups that met for previous small-group work). If there is a long list of activities, prioritize the top six for inclusion in a programme for HIV/AIDS in the workplace. For each activity area (e.g., peer education, special events such as World AIDS Day, integration into the workers’ organization), the group should develop a detailed implementation plan to include the following:
  - Preparation steps
  - Training
  - Supervision
  - Implementation.
- Distribute enough copies of the activity planning worksheet (see page 50) so that each member of each group has one. Instruct the members of each group to write in the appropriate activity on their worksheets (e.g., peer education for one group, development of a newsletter for another, etc.).

(Lunch break)
Step 3: Presentations and discussion (90 minutes)

- Invite reports from each group. Reports should include:
  - the activity they worked on;
  - the populations targeted by their activity;
  - obstacles and how they would overcome them;
  - who they plan to work with; and
  - next steps.
- Help participants chart areas for potential coordination of activities.
Handout 6: Activity planning worksheet for HIV/AIDS in the workplace

Instructions: Develop a detailed implementation plan for one activity area of a comprehensive HIV/AIDS behaviour change communication workplace programme.

Activity area: ____________________________________________________

1. Who is your designated target audience (e.g., a special event could target workers and the community)?

2. Develop an implementation plan for your activity. Include plans for the following, if relevant:
   - Training
   - Supervision
   - Materials development
   - Other

3. What human and financial resources are necessary and how do you propose to obtain them?

4. With whom do you plan to collaborate on implementation of this activity (in the workplace, in the community)?

5. What is your timeline? For example, what do you hope to accomplish in the next month, six months, year, five years?

6. What obstacles are you likely to encounter in trying to implement this activity and how do you propose to overcome them?

7. List the next steps. What can you realistically achieve in the next three-to-six months?
Day 3, session 4: Communication support materials

**Objective**
By the end of the session, participants will be able to identify critical communication materials to support activities.

**Process**

**Step 1:** Brainstorming (20 minutes)
- Ask groups to name the different types of communication materials that could be used to support HIV/AIDS BCC workplace programmes. Answers may include:
  - **Mass media:**
    - Print materials (brochures, flyers, pamphlets, posters, press kits, stickers, postcards, photo stories)
    - Broadcast media (TV/radio spots, programmes, talk shows, documentaries, entertainment programming)
    - Signage (clinic signs, billboards, murals, banners).
  - **Traditional media and community mobilization-related materials:**
    - Banners
    - Costumes for local events such as carnivals, ceremonies and rituals, marathons, marches, parades
    - Theatre/drama/dance support materials (scripts, sets, decorations).
  - **Support materials for interpersonal channels** (peer education, counselling, support groups), including:
    - Flipcharts
    - Cue cards
    - Video documentaries
    - Pamphlets
    - Manuals.
  - **Support materials** for training, workshops, games, discussion groups, etc.
  - **Programme guidelines,** including:
    - Lessons learned
    - Fact sheets
    - Press releases.
- Review the list of communication materials and ask participants to identify which they would be most likely to use in their workplace programming and how they would propose to use them.

**Step 2: Small group work (30 minutes)**
- Have participants re-form the small groups based on the target groups they are representing or will work with.
- Instruct groups to identify the materials they plan to develop, based on their target groups, BCC objectives, messages, channels and activities, and how they plan to use them.
- Distribute a copy of the worksheet to each participant (see page 56).

**Step 3: Presentations and discussion (40 minutes)**
- Invite presentations from the groups on the communication materials they plan to produce.
- Help participants reach a consensus on a key set of materials to be developed.
Day 3, session 5: Summary of day’s activities

15 minutes  Review highlights of the day’s activities
              End of the day
Handout 7:
Worksheet on developing communication support materials

Instructions: List the communication support materials that you would like to use in your behaviour change communication programme on HIV/AIDS in the workplace. Select the materials based on your target groups and the BCC objectives, themes, channels and activities that you developed earlier. Identify the target audience(s) for each material and how you plan to use or distribute the material.

<table>
<thead>
<tr>
<th>Communication material</th>
<th>Target audience</th>
<th>Plan for use/ distribution</th>
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## Day 4: How do we know our programme is working?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
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<tbody>
<tr>
<td>Overview of day 3</td>
<td>9:00 – 9:30</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
</tr>
<tr>
<td>Analysing materials</td>
<td>9:30 – 11:00</td>
<td>Build skills in analysing materials in preparation for material development.</td>
</tr>
<tr>
<td>Break</td>
<td>11:00 – 11:15</td>
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<tr>
<td>Monitoring</td>
<td>11:15 – 12:45</td>
<td>Initial steps in setting up an on-going monitoring system.</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
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<tr>
<td>Monitoring</td>
<td>1:45 – 3:00</td>
<td>Continuation of previous session.</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
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<tr>
<td>Summary of day’s activities</td>
<td>4:55 – 5:00</td>
<td>Highlights of the day’s activities are summarized.</td>
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</table>
Day 4, session 1: Overview of day 3

Process

Take participants through what they studied and learned on the previous day, fielding brief questions, as necessary.
Day 4, session 2: Analysing communication materials

**Objective**
By the end of this session participants will be able to identify elements of locally produced materials that are effective and/or in need of improvement.

**Process**

**Step 1:** Small group work (40 minutes)
- Divide participants into several small groups (not based on target populations), each of which will receive one or more sets of locally produced materials.
- Tell participants to look at the locally produced communication products to determine how and why they are effective/ineffective, discussing the questions posed on the worksheet.
  [Note: Arrange for participants or facilitators to bring in examples of local materials in advance of this exercise.]
- Distribute a set of handouts and sample materials and instructions to each group.

**Step 2:** Presentations and discussion (45 minutes)
- Invite each group to present their findings.
- Remember that their criteria for analysis included those listed on the worksheet. If any of these are not covered by the participants, be sure to incorporate them into the discussion.

**Step 3:** Summary and conclusion (5 minutes)
- Summarize key points that participants have raised for consideration when they develop materials for their programmes.
Handout 8: Worksheet on analysing communication materials

Examine these communication materials to determine whether they are effective and, if so, in what way.

Discuss them with your group and see what you think, using the criteria below.

For each item:

- How clearly can you tell who the intended audience is?
- How clearly is the message stated? How well is the message integrated into the material? Does the message seem to belong in the material or does it seem out of place?
- How attractive is the design of the material?
- How memorably is the message presented?
- Would the material be more appealing for men, women or both?
- What is the likely key benefit to the audience for adopting the promoted behaviour? Is the key benefit clearly presented? Is it presented visually (or aurally) as well as through the text?
- Does each item tell the audience to do something? If so, is the required action reinforced by visual or other elements in the material?
Day 4, session 3: Monitoring behaviour change programmes

Objective
By the end of the session, participants will understand how monitoring works.

Process

Step 1: Overview of monitoring (30 minutes) (see ‘Note to facilitator’ on page 60)

Step 2: Small group work (60 minutes)
- Instruct participants to re-form their target population groups.
- They will refer to the results of the ‘channels’ activity undertaken on day two (e.g., mass media, theatre, peer education) for their target group. For each of these channels, instruct participants to list quantitative and qualitative monitoring questions. In addition, looking at the BCC objectives they developed for their group, they should list questions they would like to see answered in order to gauge whether the programme is heading in the right direction.

(Lunch break)

Step 3: Presentations and discussion (45 minutes)
- Based on their target population channels, groups should report on the quantitative and qualitative monitoring questions to be asked, as well as on questions aimed at determining whether their programme is heading in the right direction (based on their target population BCC objectives).
- The facilitator then leads a discussion on how to collect qualitative and quantitative monitoring data, on monitoring forms, and on participatory monitoring. The handout on examples of what to monitor in a behaviour change communication programme should then be distributed (see page 66).

Step 4: Brainstorming (30 minutes)
- Lead participants in a brainstorming session on how to incorporate findings from monitoring and feedback into programme revisions.
Ask the group what kinds of feedback activities they could develop to help track their BCC programmes. For example, they could hold regular BCC meetings and seek input from those who attend. They could also interview members of the target population. Explain to participants that these feedback activities should always be linked with the BCC objectives and that the information they yield should contribute to an understanding of whether the objectives are being achieved.

Note to facilitator

Quantitative monitoring

Explain that process monitoring can be quantitative or qualitative. Quantitative monitoring tends to document numbers associated with the programme and involves record-keeping and numerical counts. Examples of quantitative data include how many posters were distributed, how many were posted, how many counselling sessions were held, and how many times a radio spot was on the air. In other words, quantitative monitoring focuses on which BCC programme elements are being carried out and how often. Explain to participants that they should closely examine the activities in the programme timeline to see what kinds of monitoring activities they might use to assess progress. Explain that the monitoring system and its associated activities should be integrated into the programme timeline.

Have the group as a whole brainstorm on what kinds of indicators can be used to gather the data on these quantitative aspects of the BCC programme process. List these indicators on a flipchart.

Qualitative monitoring

Qualitative monitoring will ask questions about how well the elements are being carried out. Qualitative information answers questions such as: How are people's attitudes changing towards abstinence, fidelity or condoms? What are the influences of BCC activities on real or incipient behaviour change? How does information permeate the risk community? Qualitative methods such as in-depth interviews and focus group discussions often help in obtaining this type of information, which will also be used as part of the feedback.

Examples of quantitative and qualitative questions to ask about peer education.

Peer education quantitative questions:
- How many sessions did the peer educator hold with the high-risk adolescent group?
- How many adolescents attended each session?
- Which and how many brochures were distributed during these sessions?

Peer education qualitative questions:
- What kinds of questions are people asking?
- Are the kinds of questions people are asking changing over time?
- How can we gather information based on the questions that people are asking their peer educators?
- From the point of view of the target audiences, what are the peer educators doing right/wrong?
- What could be done better
Feedback

Feedback is important to ensure that the programme is on track and achieving its objectives. Feedback enables programme designers to modify and adapt their programmes so that they are more likely to achieve their objectives.

The design of the BCC strategy should ensure that feedback is obtained about the effectiveness of the elements of the strategy—in particular, programme activities and messages. The design of the feedback system should take into account the need to continually ‘take the pulse’ of the community so that flexible responses can be made in accordance with evolving needs. Such a feedback system relies on both quantitative and qualitative monitoring information. Feedback activities can be integrated into an implementation plan.

Have the group as a whole brainstorm on what kinds of indicators can be used to assess BCC programme quality. List these indicators on a flipchart.
Handout 9:
Examples of what to monitor in a behaviour change communication programme

**Monitoring implementation of activities**

Sample monitoring questions:
- Are activities taking place on schedule, at the planned frequency?
- Are training sessions being conducted as planned?
- Are peer educators being identified and recruited as planned?
- Are the supplies that are needed for safe behaviour (condoms, HIV counselling and testing services) available to, and affordable for, members of the target audience?

**Monitoring the coverage of the programme**

Sample monitoring questions:
- Are planned numbers of the target audience being reached over time?
- Are the messages that are being communicated understood by the target audiences as intended?

**Monitoring quality of behaviour change communication and behaviour change communication products**

Sample monitoring questions:
- Is the right target audience being addressed?
- Are the messages appropriate, considering the stage of the epidemic in the country and the changing attitudes in the community (e.g., messages focus on prevention but ignore care and support or messages aim to increase awareness but ignore stigma)?
- Are the messages taking into consideration the changing national policies on HIV/AIDS treatment, care and support? For example, are messages raising knowledge about viral load as criteria for receiving antiretroviral treatment?
- Are the changing needs of the audience being captured?
- Do the messages appeal to the target audience's perceived needs, beliefs, concerns, attitudes, current practices and readiness to change?
- Do the messages model the skills required to change behaviours?

**Monitoring the process of behaviour change communication**

Sample monitoring questions:
- Are programme goals stated and well defined?
- Are relevant stakeholders involved in behaviour change communication development, implementation and monitoring?
- Does the intervention include follow-up mechanisms to reinforce and encourage the maintenance of newly acquired attitudes and behaviours?
Day 4, session 4: Evaluation

**Objective**
By the end of the session, participants will understand the link between BCC objectives and evaluation.

**Process**

**Step 1 (15 minutes)**
- In plenary, explain that behaviour change communication programme evaluation is part of the overall HIV/AIDS prevention, care and support programme.
- Tell participants that it is important to include the questions that were used to evaluate the BCC programme in the general programme evaluation plan. Explain that the questions asked should be based on, and refer to, BCC objectives.
- Ask participants to provide examples of BCC objectives and explain that the BCC objectives should be used in developing the BCC evaluation.
- Prompt or guide the participants to consider the following BCC objectives:
  - Increase demand for services
  - Position HIV/AIDS in a positive light to reduce stigma
  - Increase demand for condoms
  - Stimulate community dialogue about HIV/AIDS
  - Increase demand for information
  - Target and reach audiences effectively.
- Stress to participants that these BCC objectives are different from behaviour change objectives, although they support and are linked to them.
- Explain to participants that indicators are data that provide information about, or predict, what is happening with respect to the achievement of objectives. Then ask the participants which indicators could be developed to address each of the above objectives. Brainstorm with the participants to come up with a series of BCC evaluation indicators linked to the BCC objectives.
- Examples of quantitative indicators for the six BCC objectives listed above follow.
### BCC objective | Example of indicator
--- | ---
Increase demand for services | Number of persons presenting for a given service
Position HIV/AIDS in a positive light to reduce stigma | Number of persons who are able to state correctly how HIV is spread and how it is not
Increase demand for condoms | Number of condoms distributed
Stimulate community dialogue about HIV/AIDS | Number of times that HIV/AIDS is mentioned in certain types of gatherings
Increase demand for information | Number of incoming calls to a hotline
Target and reach audiences effectively | Number of persons who are aware of certain messages

**Step 2:** Small group work (45 minutes)
- Instruct participants to re-form their target groups.
- Ask them to use flipcharts to list indicators for the BCC objectives that they developed for their workplace programme to show that it is meeting its BCC objectives.

**Step 3:** Group presentations and discussion (40 minutes)
- Have a representative of each group read the group’s BCC objectives and corresponding indicators aloud, referring to flipcharts, as necessary.
- Close the session by giving an overview of a monitoring and evaluation plan that will include the BCC objectives and indicators they have developed in the last two exercises.
- Distribute monitoring and evaluation workplan handout (see page 65).
Handout 10: Monitoring and evaluation workplan

Introduction and overview of monitoring and evaluation workplan

Programmes at all levels, whether they are single interventions or integrated projects, should have an evaluation plan for assessing progress towards achieving their goals and objectives and for informing key stakeholders and programme designers about evaluation results. Such plans will guide the design of evaluations, highlight what information remains to be collected, and specify how best to gather that information.

Comprehensive evaluation plans should:
- describe the overall purpose of the evaluation;
- include specific indicators, evaluation questions, and methods to use;
- outline which data and surveys will be collected, and how;
- show the monitoring and evaluation plan timelines; and
- specify whether the evaluation is to measure ‘outcome (i.e., the immediate or short-term changes that were observed and what they mean) or ‘impact’ (i.e., the long-term effects.

Key elements of a monitoring and evaluation workplan

A. Scope of the evaluation—Specifying programme goals and developing a framework that integrates the inputs, activities, outputs, outcomes and impact and establishes realistic expectations for what the evaluation can produce.

B. Methodological approach—Developing a step-by-step approach, including outcome and impact indicators, the source of data, and plans for data analysis.

C. Implementation plan—Delineating activities, roles and responsibilities, and a timetable for identified activities with realistic expectations of when data will be analysed and results available.

D. Plan for disseminating results—Determining who will translate the results into terms understandable to programme designers, managers and decision-makers, how the findings will be shared (e.g., written papers, oral presentations, programme materials), and the implications for future evaluations.

Monitoring and evaluation workplan development steps

It is essential that programme planners, evaluators, donors and government staff be involved throughout the entire monitoring and evaluation process. Stakeholder involvement in the early phases helps ensure that the evaluation results will be used in the end. Involving members of the target audience also helps inform the process. In some cases, the evaluation planning group's task is to pull existing key elements together into an integrated whole. If these elements have not already been developed, the following steps may help to create an evaluation plan:
- Identify programme goals and objectives
- Determine evaluation questions, indicators, and their feasibility
- Prepare and design methodology for monitoring the process and evaluating the effects
- Resolve implementation issues: Who will carry out the work? How will existing data and earlier evaluation studies be used?
- Identify internal and external evaluation resources and capacity
- Develop the monitoring and evaluation workplan matrix and timeline
- Develop a plan to disseminate and use evaluation findings.
Monitoring and evaluation workplan rationale

The monitoring and evaluation workplan is a flexible guide to the steps used to document programme activities, answer evaluation questions, and show progress towards the achievement of programme goals and objectives. This guide will explain the goals and objectives of the monitoring and evaluation workplan, as well as the evaluation questions, methodologies, implementation plan, matrix of expected results, proposed timeline, and monitoring and evaluation instruments for gathering data.

Monitoring and evaluation workplan development steps

A. Identify programme goals and objectives

- Write a clear statement that identifies programme goals and objectives (and sometimes sub-objectives) and describes how the programme can be expected to achieve them. This makes it easy to develop an evaluation plan framework.
- State objectives and sub-objectives for each component of the programme and list the indicators that will be measured to determine progress.

B. Determine evaluation questions, indicators, and their feasibility

Identify the most important evaluation questions, which should link directly to the stated goals and objectives. Questions should come from all stakeholders, including programme managers, donors and members of the target audiences. The questions should address each group's concerns, focusing on the following areas:

- What do we want to know at the end of this programme?
- What do we expect to change by the end of this programme?

Be prepared to revise the evaluation questions as the workplan unfolds.

Determine which indicators you will use, keeping in mind that you will need two sets of indicators—one to measure outcome (immediate or short-term change) and another to measure impact (long-term change).

C. Data collection and analysis

Outline the data-collection methods and plan to analyse the data on an overall timeline. It is crucial to clearly spell out how you will collect data to answer the evaluation questions. The planning team must determine the appropriate evaluation designs, outcome measures or indicators, information needs, and the methods of data collection and analysis. A plan must be developed to collect and process data and to maintain an accessible data system.

Include the following data-collection questions in the plan:

- What information will you monitor?
- How will you collect the information?
- How will you record it?
- How will you report it to the central office?
- What forms will you need?

For issues that require more sophisticated data collection:

- What study design will you use?
- Will the data be qualitative, quantitative, or a combination of the two?
- Which outcomes will you measure?
- How will you analyse and disseminate the data?
D. Identify implementers and state how current and earlier evaluation data will be used

Identify individuals who will be responsible for each activity and for collecting and analysing the data. Identify evaluation experts from planning and evaluation units of the Ministry of Health, academic institutions, non-governmental organizations, and private consulting firms to assist with the plan and the final evaluation.

Identify existing data sources and other evaluation activities and determine if they have been done in the past, are ongoing, or have been sponsored by other donors. At this stage, evaluators should determine whether other groups are planning similar evaluations and, if so, invite them to collaborate.

E. Develop the monitoring and evaluation workplan matrix and timeline

Develop a matrix to present the inputs, outputs, outcomes and impacts (and their corresponding activities) for each programme objective. This matrix summarizes the overall evaluation plan by including a list of methods to be used for collecting the data.

Include a timeline that shows when each activity in the monitoring and evaluation workplan will occur.

F. Develop a plan for the dissemination and use of evaluation findings

Develop a plan for using the results of the evaluation and for the best approach to translating the results into viable programmes.

Develop a plan for sharing the results with stakeholders, decision-makers, programme planners, and others involved in programme implementation.

Ask how the evaluation plan has been implemented and how the results have been used to improve HIV-prevention programmes and policies.
Day 4, session 5: Summary of day’s activities

5 minutes

Review highlights of the day’s activities

End of the day
Day 5: How do we network and link with the broader community?

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<tr>
<th>Activity</th>
<th>Time</th>
<th>Overview</th>
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<tbody>
<tr>
<td>Overview of day 4</td>
<td>8:30 – 9:00</td>
<td>Facilitator presents an overview of what took place on the previous day.</td>
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<tr>
<td>Networking, linkages, action</td>
<td>9:00 – 10:30</td>
<td>Identify services within the workplace or in the broader community (linked to the desired behaviours) and develop networking systems and action plans.</td>
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<tr>
<td>plans</td>
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<tr>
<td>Break</td>
<td>10:30 – 10:45</td>
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<tr>
<td>Next steps</td>
<td>10:45 – 11:45</td>
<td>Participants identify next steps for developing the BCC workplace programme</td>
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<tr>
<td>Evaluation</td>
<td>11:45 – 12:30</td>
<td>Participants evaluate the workshop.</td>
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<tr>
<td>Closing</td>
<td>12:30 – 12:45</td>
<td>Closing comments.</td>
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Day 5 session 1: Overview of day 4

30 minutes

Flipchart, and markers or blackboard and chalk (optional)

Process

Take participants through what they studied and learned on the previous day, fielding brief questions, as necessary.
Day 5, session 2: Networking

**Objective**

By the end of the session, participants will be able to set up mechanisms for networking with HIV/AIDS-related services in the workplace and the community.

**Process**

**Step 1:** Small group work (45 minutes)

- Have participants re-form their target population groups and list the HIV/AIDS-related services needed for this group.
- They should refer back to the target population profiles and the desired behaviours, then discuss in the group where these services are available and how the workplace can make linkages to them at the workplace or in the broader community. Services may include the following:
  - Voluntary HIV counselling and testing
  - Sexually transmitted infection services
  - Services for the prevention of mother-to-child HIV transmission
  - Support groups for people living with HIV/AIDS
  - Legal services
  - Antiretroviral therapy
  - Clinical care for opportunistic infections.
- Ask the group for any additions to the list before they begin to work.

**Step 2:** Group presentations and discussion (45 minutes)

- Have a representative from each group present the group’s findings in plenary. Ask groups to specify how the services they have identified serve the needs of their target populations and to mention services gaps that need to be addressed.
Day 5, session 3: Next steps

Process

Step 1: Small group work (15 minutes)

- Have participants re-form their target groups, and distribute worksheets (see page 73) and paper.
- Instruct participants to brainstorm about the first three steps that they need to take right away to advance their programme on HIV/AIDS behaviour change communication in the workplace, using the worksheet. Remind them to return to their action plans. Ask them to write each step on one sheet of paper in large letters using a marker, then who is responsible for the step on a second sheet of paper and, finally, the date by which the step will be accomplished on a third sheet of paper. Therefore, each of the three steps will require three sheets of paper, making a total of nine.

[Note: Post prepared sheets of flipchart paper next to one another on the wall as an example to participants. The first sheet should say ‘Next steps’, the second sheet should say ‘Who’s responsible’, and the last sheet should say ‘By when’.]

Step 2: Group presentations and discussion (45 minutes)

- Have a representative from each group report back on the next steps they have identified for a programme based on their target population. As participants present each step, tape their sheets on the flipchart or wall. When all sheets are posted, you can reorder them, as necessary. Summarize common activities, themes and areas for potential collaboration.
- Encourage participants to form a BCC working group charged with specific responsibilities and composed of key stakeholders and representatives of the target population.
Handout 11: Worksheet: Next steps in planning for ‘HIV/AIDS BCC in the workplace’ programmes

Instructions: Based on the behaviour change communication activities you developed and the support materials you will need, list the immediate next steps that you will take to plan for the BCC programme in your workplace/sector. Then identify who is responsible for initiating that step and by when/what date that step should take place.

### NEXT STEPS IN PLANNING FOR HIV/AIDS BCC IN THE WORKPLACE PROGRAMMES

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<th>NEXT STEPS</th>
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**ILo/FHI: HIV/AIDS behaviour change communication - a toolkit for the workplace**
[Trial version]
Day 5, session 4: Evaluation

45 minutes

Evaluation forms, list of expectations for workshop from day 1

Objective
To allow participants to express their opinions about the structure and quality of the workshop and what they learned from it.

Process

Step 1: Brief summary of the day’s activities (10 minutes)

Step 2: Workshop evaluation (35 minutes)

- Post expectations from beginning of workshop and ask participants for their help in evaluating to what extent these expectations have been achieved.
- Distribute workshop evaluation forms for participants to fill out.
- Collect evaluation forms and thank participants for their comments.
Day 5, session 5: Closing

15 minutes

Thank participants and organizers for their hard work.

If possible, ask a local government representative to say a few words to close the workshop.

End of the workshop
Developing Materials for a Behaviour Change Communication Programme for the Workplace

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Form A: Participant-screening questionnaire

Form B: Pre-test background sheet

Form C: Pre-test data collection sheet

Form D: Pre-test summary of results

Form E: Sample questions for group pre-test

Form F: Group pre-test answers

Form G: Identification of changes and modifications

Form H: Monthly record for distribution of educational materials
Introduction

Communication materials and media are the vehicles or ‘channels’ for delivering messages to the target population. Since people respond in different ways to different communication approaches, choosing the right combination of channels will make the behaviour change communication (BCC) strategy more effective in promoting behaviour change. The results of the formative assessment should determine the choice of channels to be used.

The communication channels should complement and reinforce each other through shared themes and messages, as well as through a unified look, feel and tone. An effective behaviour change communication strategy should include some combination of the following communication materials and media:

- **Support materials for interpersonal channels** (peer education, counselling, support groups) including flipcharts, cue cards, video documentaries, pamphlets, manuals, etc.
- **Support materials** for training, workshops, games, discussion groups, etc.
- **Programme guidelines**, such as lessons learned, fact sheets, press releases, etc., for advocacy
- **Mass media**
  - Print materials, (brochures, flyers, pamphlets, posters, press kits, stickers, postcards, photo stories)
  - Broadcast media (TV/radio spots, programmes, talk shows, documentaries, entertainment programming)
  - Signage (clinic signs, billboards, murals, banners)
- **Traditional media and community mobilization-related materials**
  - Banners
  - Costumes for local events such as carnivals, ceremonies and rituals, marathons, marches, parades
  - Theatre/drama/dance support materials (scripts, sets, decorations)
- **Electronic/high-tech media** (Internet web pages, announcements, email, computer games)
  - Novelty items, such as t-shirts, coffee mugs, key-rings, pens, playing cards, calendars, umbrellas, matchboxes, make-up kits, condom boxes, etc.

While the workplace BCC strategy may include a variety of communication approaches, this booklet will focus on the production of high-quality print materials.
1. Putting together your team

Turning pre-tested messages into various materials is a creative process that requires different skills and talents, depending on the types of materials and channels selected. Developing sample draft materials usually requires an understanding of the purpose of the materials and the messages they contain. The process also calls for creativity in the development of the visual content and texture for the messages; this is often called the ‘concept.’ Some technical skills may be required for drawing illustrations, taking photos, directing dramas, or creating computerized graphics and page layout.

Outside help

You may need to identify outside resources to take charge of the development and pre-testing of material prototypes. You can establish contracts with communication consultants, commercial advertising firms, government agencies with experience in message development such as information, education, and the communication units of ministries of health, or others.

Identifying talent

Contracting more work to external service providers usually results in accomplishing more in less time. Contact other organizations for their feedback on contractors that they may have used when producing materials and look at the portfolios of graphic artists. Give several potential candidates a photograph and ask them to reproduce it in the form of a sketch in the office to judge the speed and quality of their work. If professional artists are too busy or too expensive, seek out art students or others with natural drawing talent.
2. Material design and development

Developing a storyboard with illustrations

To give the artist a clear idea of what you want illustrated, prepare a sequential layout of rough sketches. A storyboard can help present each aspect of the message visually and outline the message sequence, frame by frame. Programme staff can then work with local artists or photographers to determine how best to portray each message. Bringing some representatives of the intended audience together with the artist can be beneficial, since they often have good suggestions, based on their experiences, for relevant ways to portray the messages.

Programme staff can prepare more than one version of the illustration or photograph if they are not sure how best to portray the message. This allows for comparison of ideas for accuracy and effectiveness during pre-testing and, ideally, results in a new illustration that combines both elements.

Those developing the materials must also decide what kind of graphics to use: line drawings, shaded drawings, photographs, cartoons or other styles. Usually, it is prudent to seek the advice of the intended audience. This should begin during the qualitative research phase of the programme and can continue during actual pre-tests, using either individual pre-tests, focus group discussions, or some combination of the two. You should test identical messages, using the same symbols, in several graphic styles, to determine which is most acceptable to the target audience.

Some graphic artists seem to prefer more abstract images. However, low-literate target populations often do not understand or appreciate drawings of the virus in the form of monsters, or depictions of people as animated images, cartoon characters or animals. In addition, negative images of monsters can produce fear and lead to stigma. The more realistic the images are and the more they resemble real people in real situations, the easier it is for target populations to understand the images and to identify with them.

Managing the development of illustrations and drawings

- Get commitments on preparing art for specific deadlines before signing contracts to avoid delays. Build in financial penalties to the contract if deadlines are not met.
- Negotiate a price for each illustration used, including revisions.
- Tell artists exactly what you want and do not leave all the creative ideas up to them.
- Encourage artists to make illustrations as realistic as possible and to avoid abstract or cartoon characters.
- Encourage artists to use shading to give images dimension and to avoid the use of line drawings.
- Avoid showing hands not connected to bodies or other elements that require the imagination to fill in the blanks.
- Provide artists with photographs of the target population or settings, such as clinics and meeting places of people living with HIV/AIDS.
- Invite artists to clinics, meeting places of people living with HIV/AIDS, or other settings so that they can get a visual reference for their images.
- Invite artists to attend pre-tests to gain insights into what is/is not working with the material they have produced and to better understand the changes required.
• Provide frequent feedback to ensure that the artists do not spend too much time preparing images that are not usable.
• Have artists work with the BCC team so that they can get immediate feedback and stay focused.

**How to create draft text**

The draft text should correspond to the suggested drawings. The text should be concise, written in the language of the target population, and should reinforce the information in the corresponding illustration.

Sometimes focus group data reveal messages that are difficult to portray pictorially. In this case, the text may expand slightly on the illustration. Consider, for example, the message, “Using condoms or reducing the number of sexual partners is an effective way to prevent sexually transmitted infections, but not as effective as abstinence”. It is possible to illustrate each practice in a straightforward manner, but it is very difficult to illustrate the concept of one practice being more effective than another.

Keep in mind that the first draft is not the final BCC material. The initial product need not be perfect, since it will be tested to find out whether the target audience understands and accepts it and whether it effectively plays the intended role in the programme’s overall strategy.

**How to review drafts with a technical team**

Before field-testing draft materials with target audience members, conduct an in-house review of the material, especially with individuals who have technical expertise in the subject matter. The technical aspect of the message should have no errors; it is a waste of effort and resources to pre-test a material that is technically incorrect and doing so may result in members of the target population being misinformed.

Be aware that a delicate situation may arise during an internal review if members of the technical team disagree about the way the message is presented (e.g., colour, characters, type of letters, drawings, setting, etc.). Remind them that the target population will decide what is most acceptable and appealing during the pre-tests of these variables, and that their role is strictly to confirm and correct the technical accuracy of the message(s).
3. Guidelines for production of materials

The following tips may be useful in developing quality print materials for low-literate groups.

**Design and layout**

*Present one message per illustration.* Each illustration should communicate a single, distinct message.

*Limit the number of concepts/pages per material.* If there are too many messages, readers may become restless or bored or may find the information hard to remember. Try testing different formats with members of the target population to determine what is most appropriate for them. The number of pages in a document can also affect the cost of printing. (See section 5 on ‘Printing’, for more information.)

*Make the material interactive, whenever possible.* In cases where audiences have some level of literacy, include simple question-and-answer sections that allow readers to ‘use’ the information in the material. If you plan to give the material to these readers to keep, leave a space for the reader’s name, and include review or question-and-answer sections that encourage readers to write on the material.

*Leave plenty of white space.* This makes the material easier to read, follow and understand.

*Arrange messages in the sequence that is most logical to the audience.* People who learn to read from right to left, top to bottom, as well as those who are not used to reading at all, will have different ways of viewing pages.

*Use illustrations to supplement text.* Placing illustrations throughout the text makes the material more appealing and can help the reader to absorb the information presented. For illiterate and low-literate viewers, illustrations are critical for conveying the message.

**Illustrations**

*Use appropriate colours.* Use colours that have been pre-tested with the intended audience. Colours have different connotations in different cultures. For instance, in some Asian countries, such as India, the colour red is associated with happiness, whereas, in parts of Africa, it is associated with death.

*Use familiar images.* People understand and are attracted to pictures that seem familiar to them. Expressions, activities, clothing, buildings and other objects in illustrations should reflect the cultural context of the audience.

*Use realistic illustrations.* People and objects portrayed as they occur in day-to-day life are easier to recognize than anatomical drawings, enlargements, parts of things or people, schematic diagrams, maps or other drawings that do not resemble things that people normally see.

*Use simple illustrations.* Avoid extraneous detail that can distract the reader from the central message. For instance, it is easier to see a women’s health clinic set against a plain background than against a crowded city street.
Illustrate objects in scale and context, whenever possible. Although large pictures and text are easier to see, excessive enlargement of detail may diminish people’s understanding of the message.

Use appropriate symbols. You should carefully pre-test all symbols with the target audience (see section on ‘Pre-testing and revision’). Crosses, arrows, check marks, inserts and balloons denoting conversations and thoughts may be meaningless for people who do not know what they represent. Likewise, symbols to represent time are culture-specific: in some countries, calendar pages may represent months, whereas moons and stars may be more appropriate in other countries.

Use appropriate illustrative styles. There are different kinds of illustrative styles: line drawings, shaded drawings, photographs, cartoons, etc. Photos without background detail are more clearly understood by some audiences than are drawings. When drawings are more appropriate, some audiences prefer shaded line drawings to simple line drawings. Test shading carefully to make sure that it is acceptable and obvious enough not to be mistaken for poor-quality printing. Similarly, cartoon figures or highly stylized drawings may or may not be clear, depending on the audience’s familiarity with cartoon characterizations and abstract representation. You should test identical messages, using the same symbols, in several graphic styles to determine which style is most acceptable to, and best understood by, the target audience.

Use a positive approach. Negative messages may be alienating or discouraging rather than motivating.

Text

Choose a type style and a size that are easy to read. Choose type styles that are clear and easy to read, especially for audiences with low literacy skills. Choose a type size large enough for the audience to read (if possible, use a 14-point font for text, 18-point for subtitles and 24-point for titles). Italics and sans serif-type styles are more difficult to read. Use uppercase and lowercase letters and regular type. Text printed in all upper case (or capital) letters is more difficult to read. For emphasis, use underlining or a distinctively bold typeface.

Test the reading level. For low-literate audiences, use short words, whenever possible, and keep sentences short. For a literate audience, use more complex language since they may be offended by overly simplified language. If there is a significant amount of text, draft materials may be tested with standard readability tests such as SMOG (Simple Measure of Gobbledygook) or the Fry readability graph. Each of these tests is used to determine the reading level of your written materials. The simpler the language, the more readily the message will be understood. Generally, you need to aim for the reading level of 11–12-year-olds or less. In addition, to help ensure that the text is clear and readable, read your draft aloud. It is also necessary to pre-test your materials with the target audience as this will usually indicate whether the language level of the material is appropriate for that audience.

Review repeatedly. Re-state important information and include review sections, whenever possible. This will help the reader to understand and remember the messages presented.

1. See: http://www.healthsystem.virginia.edu/internet/health-education/read.cfm for details of these readability tests.
Adaptation

Materials developed for a specific programme, region and/or country can often be adapted for use elsewhere. It may be easier and more cost-effective to change something that already exists than to create entirely new material. Adaptation requires more rigorous pre-testing than developing new materials to ensure that they are acceptable to, and appropriate for, the needs of different target populations.

Reasons for adapting materials

Proven messages work well. If a pictorial message has been successful elsewhere, it may work well in another area with a similar programme. A major advantage of adapting materials is having the opportunity to test proven ideas in a different setting.

Technical information requires few changes. The technical information in adapted material is often the same. For example, the message “Hugging and showing affection for a person with HIV/AIDS will not give you the virus” will be the same for villagers in the Transkei and urbanites in Johannesburg. However, the approach to delivering the message (such as ways of depicting dress and hairstyles) may change.

Locally relevant materials are effective. Research has shown that materials are more acceptable and effective when they are written in the local language and when the pictorial messages include relevant objects that are easily recognizable in the local environment.

Adaptation saves time and money. Carefully adapting pictorial materials that are clear and relevant to local conditions can save both time and money.
4. Pre-testing and revision

What is pre-testing? Once the first drafts of the messages and a series of visuals are ready, you will need to conduct interviews with representatives of the target population to test the messages and visuals. This is called ‘pre-testing’ or ‘field-testing’. During pre-testing, an interviewer shows the materials to members of the target population and asks open-ended questions to determine whether the message is well understood and acceptable. The goal of pre-testing is to ensure that BCC materials convey the intended messages in a way that is acceptable to the target audience.

When is pre-testing done? Pre-testing takes place before the materials are finalized so that revisions can occur based on the audience's reactions and suggestions. You will probably have to pre-test and revise most materials several times. Each new or revised version will undergo testing again until the target population clearly understands and accepts the material.

Why pre-test? Pre-testing is crucial because target audiences can easily misinterpret illustrations and text, especially if they have had little exposure to printed materials. Pre-testing helps programme staff know whether the draft materials are understandable to the audience for whom they are being prepared. If people cannot understand the materials, or do not like them, the message is lost. It is also easier and cheaper to change materials before they are finalized rather than afterwards.

Variables to measure

Five variables are measured during pre-testing.

Comprehension

Comprehension refers not only to the clarity of the material content, but also to the way that content is presented. A complicated or unknown word may prevent the audience from understanding the message. Or the message may be clear and the language appropriate, but the use of a small typeface could make it difficult for the audience to read the message. Additionally, the transmission of too many ideas may confuse readers and cause them to overlook the action that the material asks them to take. Materials should also accomplish strategic objectives. If the strategy calls for the materials to evoke tenderness towards a family member with HIV/AIDS, pre-testing should make certain that the audience perceives this in the message.

Attractiveness

If a product is not attractive, it may not get much attention. A poster may go unnoticed if it has been printed in a dull colour or if the illustration is of poor quality or irrelevant. Print materials achieve attractiveness through appropriate visuals, such as colour or black-and-white illustrations and photographs.
Acceptance

The messages and the way they are communicated must be acceptable to those they seek to reach. If the communication materials contain something that offends, is not believable, or generates disagreement, the target audience will reject the message.

Involvement

The target populations should be able to identify with the materials and recognize the fact that the message pertains to them. To ensure that the target population becomes involved, appropriate use should be made of the symbols, graphics and language of that particular population. Illustrations and characters should faithfully reflect that specific population segment, together with its environment and characteristics, through clothing, hairstyles, furniture, building style, etc.

Inducement to action

The materials should indicate clearly what they are asking the target population to do. No matter how good the communication material is, from a technical standpoint, it will be worthless if it fails to transmit a message that people can act on. Even materials that create awareness should induce listeners or viewers to at least seek more information on a given subject, as this can prompt them to take the required action or change their behaviour.

Individual pre-tests

Whenever possible, you should conduct pre-tests of materials for low-literacy groups with only one target audience member at a time. This will ensure that other people do not influence a respondent’s answers. As with focus group discussion participants, pre-test respondents must be representative of the audience(s) that the programme wants to reach. The same respondents should not participate in more than one round of pre-testing and should not be the same individuals who participated in the earlier focus group discussions. This is to ensure that respondents have no prior knowledge of the messages being tested.

Like focus group discussions, pre-tests require a two-person team: an interviewer and a note-taker. Usually, a team can conduct individual pre-tests with six to ten respondents a day, depending on the length of the material they are pre-testing and whether respondents have had any schooling. Those who have been to school, even if only for a few years, are usually more adept at interpreting pictorial messages.

First rounds of pre-testing

The first drafts of materials for initial pre-tests should be the least complicated in terms of technical elements such as illustrations, graphics and colour. Initially, when pre-testing print materials for low-literate audiences, it is best to use line drawings of the illustrations with the accompanying simple text. You should test the text and picture for each message separately to obtain specific pre-testing results for each. One method is to print the text beneath the picture so that, while testing the picture alone, you can fold the text out of sight or cover it with a blank sheet of paper.
In materials showing people talking to one another, developers often use a ‘talk bubble’. You should test the illustrations separately from the text to ensure that respondents have understood both.

Programme staff can pre-test more than one illustration of the same message. When the World Health Organization published a monograph on preparing flyers to demonstrate proper condom use, they included alternative illustrations showing where to dispose of a used condom. They suggested that programme staff might alternate pictures (or substitute others, as needed) to pre-test the most appropriate condom-disposal illustration to use in flyers for a particular country.

**Tips on conducting individual interviews**

You should select pre-test sites and times with the audience in mind. It is often more convenient to pre-test materials where the participants work, reside or spend time. Sites might include the workplace canteen or cafeteria, clinic waiting rooms, or a place in the community that workers frequent, rather than the pre-tester’s office. Pre-tests can be either planned (scheduled) or unplanned (intercept interviews). The main difference between an intercept interview and a planned interview is how it begins.

Follow these guidelines when using the ‘intercept interview’ technique:

- It is important to seek the workplace management’s support in conducting these pre-test interviews. The workers should also be informed of their possible involvement in these interviews before they are asked to participate.
- Begin the intercept interview by stopping people who look as if they are representative of the group for whom the materials are intended. Explain that the programme is testing some materials and that you would like their opinion on them.
- Next, find out if the person is in the intended group by asking him or her predetermined questions. (See Form A in the appendix for a sample participant-screening questionnaire.)
- Conduct the interview in a private place. You can create a private atmosphere by providing a room with a curtain or by interviewing the person away from crowded areas.

Apart from these few points, the intercept interview and the planned interview proceed in the same way. Once the pre-tester has selected a site and identified a respondent, he/she should introduce him/herself and the note-taker. He/she should explain that the purpose of the pre-testing is to solicit comments from respondents to help improve print materials to benefit people such as the interviewee. The pre-tester should emphasize that it is the material that is being tested, not the respondent.

Tell the participant that her/his name will not be used and that the conversation is confidential. Tell her/him how much time the interview will take. Discourage onlookers, since they may be distracting to the respondent. During pre-testing, the interviewer must:

- Ask questions that are open-ended rather than closed, and probing rather than leading.
- Be supportive of the respondent’s answers: use phrases such as “very good” and “you are doing a fine job,” even if the respondent misinterprets the message the picture is meant to convey. If the respondent gets the idea that he/she is doing something wrong, he/she may stop talking and the pre-test will be invalid.
Allow the respondent to talk freely without interruption, disagreement or ridicule. After receiving—and recording—the respondent’s interpretation and comments on all the messages you are pre-testing, thank her/him for participating. Provide refreshments for participants, if possible, as a way to thank them for their participation in the process.

**Number of respondents**

During early rounds of pre-testing, improvements needed in the drawings should quickly become evident. Therefore, it is usually not necessary to interview more than ten respondents before analysing the results. In subsequent pre-tests, you should interview at least 20 respondents per round before making revisions.

**Number of copies**

When conducting individual interviews to pre-test leaflets, brochures or other print material intended for individual consumption, you can use the same copy for each person. For group interviews, make a photocopy for each participant. When pre-testing posters, flipcharts, counselling cards or any print material that is usually viewed in a group setting, one copy is enough.

As the material content improves during subsequent rounds of pre-testing, drafts should begin to closely resemble the final product in terms of colour, size, layout, etc. When testing any materials to use in a group setting, make sure respondents can clearly see the illustrations.

**Group pre-testing**

In later rounds of pre-tests, it is often appropriate and less time-consuming to work with groups—again composed of representatives of the target population(s). This is especially true when programme staff members are having trouble finding visuals that an audience can fully understand. A cost-effective way to generate many ideas in a short period of time may consist of assembling a group of eight to 12 people, explaining to them the messages you want to convey, and then asking for their suggestions. When doing this, consider having the artist present to sketch out suggestions and get immediate feedback. Of course, it is still important to pre-test these new illustrations with other members of the intended audience, but this exercise may generate immediate ideas that are both comprehensible and acceptable.

**Final pre-testing**

During the final pre-test, use a mock representation of the material (final size, layout, type size and colours) exactly as programme staff envision it. Following this final round, minor changes may be necessary, but comprehension and acceptability should be high enough to proceed with printing.
Use of pre-testing forms

The Program for Appropriate Technology in Health (PATH) and Family Health International (FHI) use several forms and outlines to help organize and gather data during pre-testing:

- Participant-screening questionnaire
- The pre-test background sheet
- The pre-test data-collection sheet
- The pre-test summary of results sheet
- Sample questions for group pre-tests
- The group pre-test answer sheet
- Identification of changes and modifications sheet
- Monthly record for distribution of educational materials.

The appendix to this booklet provides a sample of each form. These forms can be adapted to suit each programme. Each form documents one round of pre-testing; the same general procedures are used for all rounds of individual pre-tests until an acceptable version of the message is created. It is important to use forms because of the following:

- Pre-testing generates many details about how to improve the materials and, if they are not carefully organized and documented, such details are easily lost.
- Keeping track of pre-test participant characteristics ensures that only individuals who meet the screening criteria are included in pre-testing.
- Forms help systematize the pre-testing process, making it easy to summarize what programme staff learned and how they applied it.

Participant-screening questionnaire is to be used to determine whether you will ask the participant to pre-test your material(s) or not. You can begin by asking the participant several questions to see if they are in the appropriate target group. If they meet your criteria, you can ask to speak to them further to pre-test your materials. If they do not meet your criteria, you can end the brief questioning and thank them for their time.

The pre-test background sheet is for the recording of information about pre-test respondents. You should prepare one pre-test background sheet for each round of pre-testing. Programme staff must decide in advance which criteria to use in selecting pre-testing respondents and which information is important to record. You will find these selection criteria listed at the top of each column and should fill them in prior to pre-testing. (See sample filled-in form overleaf.)
## Sample completed pre-test background sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Resp. #</th>
<th>Years of schooling</th>
<th>Sex</th>
<th>Age</th>
<th>Profession</th>
<th>Condom use**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug 8</td>
<td></td>
<td>0</td>
<td>M</td>
<td>&lt;25</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>1***</td>
<td>1-2</td>
<td>M</td>
<td>25+</td>
<td>Taxi driver</td>
<td>No</td>
</tr>
<tr>
<td>Aug 8</td>
<td>2</td>
<td>3+</td>
<td>F</td>
<td></td>
<td>Farmer's wife</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>Student</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>Cassette tape salesperson</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>Hotel maid</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td>Typist</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td>Accountant</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>Guard</td>
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</tr>
<tr>
<td>Aug 8</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td>Truck driver</td>
<td>Yes</td>
</tr>
<tr>
<td>Aug 8</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>Produce seller</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Total 10

- # 30%
- % 40
- % 50
- # 30
- % 50
- # 30
- % 70

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* Conduct the pre-test in the language in which the material is written.
** Use these columns for additional information, if necessary.
*** The respondent number should correspond to the one used on the pre-test data-collection sheet.
Personal information that some individuals may feel sensitive about revealing (age, level of schooling, vocation, ability to read) should be solicited tactfully. For example, after approaching a potential respondent in an intercept interview and explaining the need to pre-test a particular element among people with limited reading skills, the interviewer may then enquire about the potential respondent’s educational level. If the person does not qualify, the interviewer should politely thank the person and continue to search for respondents who represent the target population.

You should assign each individual the same respondent number for the pre-test background sheet and the pre-test data-collection sheet. (See Form B in the appendix for a sample pre-test background sheet.)

The pre-test data-collection sheet is used to record feedback from respondents about the material that you are pre-testing. You should complete one pre-test data collection sheet for each message (page) during each round of pre-testing. Programme staff should fill in the requested information above the bold line prior to pre-testing. The letters ‘A,’ ‘B,’ ‘C,’ etc., in the ‘Describe picture’ box correspond to major elements of the illustration. This shorthand system allows the interviewer to record responses quickly by listing the appropriate letters.

The interviewer then completes everything below the bold line on the pre-test data-collection sheet during and after pre-testing. (See the sample filled-in pre-test data-collection sheet below.)

Here are the steps for using the pre-test data-collection sheet:

- First, assign each respondent the same number assigned to her or him for the pre-test background sheet. Record this number in the left-hand column of the sheet.
- Before showing the picture to the respondent, the interviewer should fold any text out of sight or cover it. He or she then asks questions about the picture.
- Next, the interviewer unfolds the page and asks about the text.
- In the box labeled “What do the words mean to you?” the interviewer should circle the ‘R’ if the respondent read the accompanying text, and the ‘H’ if the respondent cannot read and heard the text read aloud by the interviewer.
- The interviewer should record the respondent’s feeling about the message and suggestions for improvements in the next two boxes.
### Sample completed pre-test data-collection sheet

<table>
<thead>
<tr>
<th>Topic of material</th>
<th>AIDS education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Local dialect</td>
</tr>
<tr>
<td>Pre-test round</td>
<td>1</td>
</tr>
<tr>
<td>Region</td>
<td>Compound X</td>
</tr>
<tr>
<td>Date</td>
<td>8-9 August 1998</td>
</tr>
<tr>
<td>Interviewers</td>
<td>SM and DD</td>
</tr>
<tr>
<td>Message no.</td>
<td>4</td>
</tr>
</tbody>
</table>

#### Describe picture:

<table>
<thead>
<tr>
<th>Message no.</th>
<th>Topic of material</th>
<th>Language</th>
<th>Region</th>
<th>Interviewers</th>
<th>Message no.</th>
<th>Describe picture:</th>
<th>Write text:</th>
<th>How do you feel about the picture and/or words?</th>
<th>What would you change?</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AIDS education</td>
<td>Local dialect</td>
<td>Compound X</td>
<td>SM and DD</td>
<td>4</td>
<td>A) Two men</td>
<td>Used clothing is HIV-free</td>
<td>People look dirty, wearing funny shoes. HIV-free is confusing</td>
<td>Put clothes on table like at a market</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B) Used clothing</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>C) Buying at market</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A) One man washing clothes, the other drying them</td>
<td>You can get HIV from gifts</td>
<td>Men are villagers especially those in pata pata shoes</td>
<td>Show a nurse buying used clothes. Remove pata pata shoes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B) no</td>
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<td>C) no</td>
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<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A)</td>
<td>Used clothing is HIV-free</td>
<td>Men look angry</td>
<td>Have men smiling</td>
<td>Change text to: “You cannot get HIV from used clothing”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Notes:
- The number 1 indicates that this is the first time that this picture has been pre-tested.
- In this case, this is the fourth of ten messages that the material is attempting to convey.
- Background information on whether the test was read or heard will help project staff to determine whether changes are needed.
- One leading rule is that if respondents make any appropriate suggestions for changes to the illustration, this means that the picture is ‘Not OK’ and it should be changed.
- If the text is not understood, it should be changed.
- If the respondent does not understand a part of the picture, his/her interpretation should be noted.
- This means that the respondent did not recognize this part of the picture.
- If the respondent recognized part of the picture, a check mark can be used, to save the recorder time.
- The numbers in this column correspond to the respondent numbers on the pre-test background sheet.
After the team completes a round of pre-testing, the coder should carefully read all the responses, determine whether the picture and text are ‘OK’ or ‘Not OK,’ and mark the appropriate box. This assessment should be based on the following:

- **Comprehension** (indicated by the boxes marked “What do you see?” and “What do the words mean to you?”)
- **Acceptability** (indicated by the boxes marked “How do you feel about the picture and/or words?” and “What would you change?”)

You should mark a response to a picture as ‘OK’ if the respondent correctly describes all major elements in the illustration, is comfortable with the picture, and suggests no changes. Similarly, a response to the text is ‘OK’ if the respondent correctly states the meaning of the text and is satisfied with the way the message is stated and that it reinforces the illustration. Otherwise, you should mark the response as ‘Not OK.’

Programme staff must determine when a message is ‘OK’ or ‘Not OK’ in terms of the overall level of comprehension and acceptability. Staff should consider and decide in advance how many ‘OKs’ signify a successful message. As a rule, at least 70 per cent of respondents should be able to correctly interpret the visuals alone, and at least 90 per cent should be able to interpret the visuals with the text, find them acceptable, and understand any action the messages recommend. (See Form 3 in the appendix for a sample pre-test data-collection sheet.)

An **alternative to collecting pre-test data** is a simple pre-test question guide. Some find it easier not having to prepare a special chart with small boxes to be filled in. However, a pre-test question guide is somewhat bulkier, as the interviewer and the note-taker must use a separate sheet of paper for each message that each respondent pre-tests. A pre-test question guide would include the following questions:

- What do you see in this picture? What is it telling you? Are you supposed to do anything? If so, what? (Then leave room to write down the respondent’s answers, or use the group pre-test answer sheet—see Form F in the appendix. Note: Show only illustration.)
- What does the text mean, in your own words? (Again, always leave empty space to enter reply. Note: Uncover text and read it or have participant read it.)
- What information—or message—is this page trying to convey?
- Does it ask/tell you to do something? If so, what?
- Does the picture on the page match the words? Why, or why not?
- Are there any words in the text that you do not understand? Which ones?
- Is there anything on the page that you do not like? What? Why? How might we improve it?

The **pre-test summary of results sheet** indicates any changes that need to be made to the text and/or visuals to increase the messages’ comprehension and acceptability. As soon as a round of pre-tests ends and the coding is completed, the coder must transfer the results to the pre-test ‘summary of results’ sheet. Usually, only one or two sheets are needed to record data from all the messages pre-tested during one round.

You should use two separate lines to record reactions to the pictures (‘P’) and text (‘T’) for each message. For example, if you are pre-testing several pages of a material, label the first line ‘1P’ and record the comments for improving the picture of message number 1 on that line. Label the next available line ‘1T’ and record the results for the text of message number 1. Record subsequent messages as ‘2P,’ ‘2T,’ ‘3P,’ ‘3T,’ and so forth.
The coder should calculate the percentages of ‘OK’ and ‘Not OK’ pictures and text based on the total number of pre-tests. He or she should also summarize the suggested changes recorded on the pre-test data-collection sheet in the right-hand column of this summary form. (See the sample filled-out ‘pre-test summary of results’ sheet below and see Form D in the appendix for a blank version of this form for you to use.)

### Sample completed pre-test summary of results sheet

**Coder(s):** Rani Kundah  
**Pre-test round:** 1  
**Region:** Compound X  
**Topic of material:** AIDS education

<table>
<thead>
<tr>
<th>Message number</th>
<th>Total interviewed</th>
<th>OK</th>
<th>Not OK</th>
<th>Suggested changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>#</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>1P</td>
<td>10</td>
<td>1</td>
<td>10%</td>
<td>Put clothes on table; show</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>90%</td>
<td>money; show nurse buying</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>clothes; show men smiling;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>show city shoes, delete patches</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>on shirt, as they were mistaken</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>for stains;</td>
</tr>
<tr>
<td>1T</td>
<td>10</td>
<td>4</td>
<td>40%</td>
<td>Change text to “you cannot get HIV from used clothing”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Continue summarizing pertinent suggestions from</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>the forms used when pre-testing. This summary is</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>very useful when explaining proposed changes to the layout artist.</td>
</tr>
</tbody>
</table>

---

*Fill in the coder’s name here.*

*P = picture  
T = text  
This will help you to judge which message needs the most work. If a message is unclear to many in the pre-test sample population, it needs to be changed.*

Incorporate these suggested changes into Pre-test Round 2.
Group pre-tests

Group pre-tests are sometimes used as an alternative to individual interviews, but are recommended primarily for literate audiences. Literate persons are often more self-assured and not as likely to be influenced by other members of the group when reviewing materials, and can provide valuable information when testing materials intended for audiences with more schooling. Group pre-testing is particularly effective for materials containing primarily textual messages and materials such as film scripts, audiocassettes or videos.

Group pre-tests can also help programme staff determine if existing materials developed by other groups meet programme objectives. It may be possible to borrow and pre-test ideas from materials developed for other regions and adapt them, but staff must be sure to include messages that meet the needs of the new audience, as indicated by local audience research.

As with focus group discussions, a pre-test group should include eight to 12 people who represent the target population. The pre-tester should explain that the group’s suggestions will serve to improve the materials. The pre-tester then asks each group member to take a turn reading a section of the material aloud. The pre-test team listens for words that the readers have difficulty reading or understanding. After one respondent reads a section (one paragraph, for example), the pre-tester asks the whole group to discuss the section and make suggestions for improving it. The pre-tester may ask some general review questions to make sure that all main points and concepts presented in the material are understood. Likewise, pre-testers can test pictorial messages by asking members of the group what they see, having them read the accompanying text, and discussing whether the message and illustration address the same topic and reinforce one another.

Forms E and F of the appendix contain some sample questions for pre-testing existing textual materials with groups. These questions are similar to those used in individual pre-tests when selecting the alternative method that uses the pre-test question guide.

If the programme requires preparing materials for other audiences, such as peer educators, counsellors, health workers and/or policy-makers, it may be necessary to test longer, primarily textual materials. Make copies of the new material for all participants and, if possible, deliver it to them prior to the pre-testing time. If you do not allow audiences advance time to read and absorb the content, pre-tests will be superficial and will not provide meaningful feedback for programme staff.
**Alternative pre-test summary form:** When using the pre-test question guide, it is necessary to collate responses collected from the individual pre-tests. Create a master compilation form, with one question per page, and leaving large spaces to record what was said. Again, there are shortcuts that programme staff can initiate. For example, if respondent no. 4 gives the same reply to question 1 as respondent no. 2, then staff compiling the summary can just put a tick (or + or some other symbol) next to the comments of respondent no. 2. Similarly, if respondent no. 6 saw everything she was supposed to see in an illustration, the interviewer or note-taker could just write “visuals OK” (or some similar abbreviation that the two-person team has agreed upon before beginning to summarize the results).

In subsequent rounds of pre-tests, an efficient way to note recommended changes is to use an identification of changes and modifications sheet. (See Form G in the appendix.)

After the materials are finalized, the monthly record form for distribution of educational materials (see Form H in the appendix) can be used to track the dissemination of your BCC materials.

**Review by gatekeepers**

Once the individual messages have achieved the desired level of understanding through pre-testing and revision, all of the material should be reviewed by the organization(s) collaborating on the programme, other institutions interested in using the material, and anyone else with authority to approve it. These gatekeepers often control the distribution channels for reaching the target population. If they do not like the material or do not believe it to be credible or scientifically accurate, it may never reach the target population. It is therefore important to have gatekeepers review the materials before they are finalized. It is good policy also to show them the pre-test summary forms, to help them better understand the perceptions of those for whom the materials are intended, and to perhaps prevent them from blocking distribution of the materials later on. Keep in mind that these gatekeeper reviews are not a substitute for pre-testing the materials with target population representatives, or for obtaining technical clearances from medical experts.
5. Printing

Creating print materials requires considerable effort by those responsible for developing and testing them and those who actually print them. A crucial phase in the development of materials begins when the items to be printed go to the printer. Mishaps during this phase can jeopardize the results of developmental activities. Spend time working closely with all those involved in printing the materials to ensure that they understand exactly what the final product should look like, what resources are available to pay for it, and when the job needs to be completed.

Printing considerations

Printing costs vary tremendously by country, subject, type of material (booklet, poster, flipchart, etc.) and format (size, colours, style). When preparing material for printing, always consider the following:

- Request cost estimates, references and samples of work from at least three printers. The printers will need to know:
  - the size of the material;
  - the number of pages;
  - the type of paper to use for the pages and for the cover;
  - the number of colours to use in printing the material;
  - whether the material includes any photographs;
  - the number of copies to print; and
  - the printing and distribution deadline.

- Consider the quality of each printer’s previous work, the printer’s responsiveness to deadlines, and the recommendations of other clients.

- In some countries, the more copies you print, the lower the unit price (price for each copy). For example, if 5,000 copies of a booklet cost $3,750 to print, the unit price is $0.75 each ($3,750 ÷ 5,000 = $0.75). If 10,000 copies cost only $5,000 to print, the unit price is $0.50.

- When printing a booklet, find out from printers whether certain numbers of pages are more cost-effective to print. Sometimes booklets with a total number of pages that is a multiple of four avoid wasted paper and higher costs. Pages printed on both sides are usually cheaper.

- Ask for advice about page sizes, and choose the most cost-effective size based on the paper sheet the printer uses regularly.

- Type of paper (e.g., bond, cover, coloured, book) is another consideration when budgeting for printing. Paper is also measured by weight; the heavier it is, the thicker it is. Coloured paper is more expensive. For the cover of a booklet or pamphlet, consider using heavy book paper instead of cover paper; it is usually less expensive and saves on binding costs.

- One of the biggest factors in printing cost is the type of binding and whether the cover is ‘scored’. Scoring is the process used in folding the heavier-weight cover paper so that it will lay flat when the document is closed. Binding choices include saddle stitch, spiral, velo, tape, among others. Ask the printer what bindings their equipment can produce, and request samples. There can be big differences in cost between bindings, so get comparative quotes.
• In pamphlets, paper folds should always be along the grain of the sheet to ensure ease of opening and to ensure that the pamphlet lies flat when opened. Check this with the printer when ordering the print job and the paper.

• If the printer is producing negatives for a print job, request a ‘blue line’ before printing. This is an exact duplicate of what the document will look like once it is printed, but it is produced on yellow paper with blue ink. It will show the text, graphics, screens, colour separations, etc. The blue line allows you to check for errors prior to the printing process. Typically, there is no charge for a blue line, but there are charges for corrections, unless the errors were the printer’s mistakes.

• Carefully consider how many colours you can afford to use. Multiple colours will increase printing costs. Always count black as one colour.

• If possible, use black letters on white paper for text, rather than white letters on dark paper, as this is easier to read.

• If other organizations will be copying or photocopying the materials, choose a format that is easy to copy (e.g., leaflets rather than stapled booklets). Keep in mind that dark colours do not photocopy well.

• It is most cost-effective to make drawings the same size as they will appear in the pamphlet; otherwise the printer will have to make reductions requiring either separate camera shots or photostats (‘stats’). Stats are cheaper than separate camera shots, and are made by a commercial graphic artist.

• Try not to print a photo across a fold. It is not visually effective and it is difficult to do successfully. More work is required to make sure that the two sides match, which adds to the expense.

• Expect additional cost if the material includes a coloured illustration that will extend to the sides of the page or into the fold of a pamphlet, which is called a ‘bleed’. White type against coloured or half-toned background also costs more and photocopies poorly.

• Consider printing small quantities of the material initially, so that changes can be made, if necessary. However, in some countries, this decision must be weighed against the lower unit cost of printing a larger quantity, as mentioned earlier.

• Programme managers should retrieve negatives from the printer as soon as print jobs are completed. Store them in a cool, dark, safe place so they can be re-used if the materials are reprinted at a later date.

• Camera-ready artwork should be accessible to staff artists so that necessary changes can easily be made before the materials are reprinted.

• Computers make it possible to produce professional-looking materials in-house. If the document is to be created on programme computers and provided to the printer on a disk for printing, arrange a meeting to discuss software options before preparing the document. The printer’s and the programme office’s computers must use compatible software that will allow the printer’s staff not only to see the document on the computer screen, but also to output the document for printing.

• If the document is to be prepared on a computer disk for the printer, the programme manager should speak with the typesetter before preparing the document, taking into account the press specifications. The size of the press determines the parameters (such as margins) for each page.
Alternatives to printing

Not all pictorial BCC materials require large-scale printing. Depending on the nature, objectives and budget of a particular programme, a lower-cost alternative may be equally effective. For example, a programme that decides to post pictorial messages in community gathering-places may decide that staff and community members can purchase sturdy, heavy paper and draw (or trace) and colour/paint the final pre-tested draft version of the posters they wish to distribute. Or, in some countries, there is a tradition of painting cotton on silk cloth. Both fabrics are useful for the preparation of attractive and durable posters or banners.

Similarly, if the programme plans to provide flipcharts, flash cards, or trigger cards (pictures used to trigger a discussion) for peer educators and/or health providers, but only plans to work initially with a small number of such educators and/or providers, staff and volunteers could make these items by hand. Programme staff may begin with hand-drawn visuals; as the programme expands, they can update the posters, flipcharts, etc. (based on evaluation feedback), and then contact printers later in the programme’s evolution. If the programme has good photographic capabilities, staff may decide to take photos to use in flash and/or trigger cards, and duplicate sets for each counsellor and peer or community educator. This decision should not be made before staff members have carefully pre-tested such photographs and are certain that the meanings of any behaviour change messages are clearly understood, and that the visual presentation (photos, in lieu of hand-drawn illustrations) is acceptable.

A six-panel leaflet with pictorial messages augmented with simple text can be photocopied on standard-size white or coloured paper, folded by hand and used by counsellors, peer educators and others to explain key messages to their programme audiences. Keep in mind that such materials are often less eye-catching and therefore less likely to be retained and shared with others. Also, if something is copied on coloured paper, the viewer will see different-coloured people and other objects used to convey the messages. This can be distracting, especially for the low-literate viewer. But photocopying is another option to consider, especially in locales where access to photocopying equipment is widespread, thereby reducing per-copy costs, or where the need for large quantities of handouts is not yet evident.

Some cultures have centuries-old traditions of using indigenous media such as puppetry, marionettes and story-telling. Again, depending upon the setting, programme scope and available resources, these media can serve to successfully transmit public health messages. In such cases, even though the messages will be transmitted orally, you will need to design and pre-test both the messages and the scripts.

Managing production

Once you have developed the messages and the concept and chosen the type of materials to produce, you may encounter delays in producing, pre-testing and printing the materials. The delays may be due contractors’ having too many clients demanding work and not enough time to get it done. Or it could be as a result of bad management on the part of the BCC workplace coordinator who did not provide timely feedback. Some suggestions on speeding up the production process include the following:
- Give contractors clear instructions and feedback on their work and changes required.
- Build financial penalties into contracts if long delays in delivering work occur.
- Verify with other clients how rapidly work was produced before signing contracts.
- Provide feedback on drafts rapidly.
- Get specific written commitments on when the work will be completed.
- Use colour photocopying instead of printing to produce small quantities of materials.
- Identify one BCC focal point to liaise with contractors to ensure that the work is well coordinated and priorities are clear.

This booklet was adapted from the following:


Appendix:
Forms for pre-testing and developing materials

Contents

This appendix includes forms for pre-testing and developing material as outlined in booklet 4, namely:

Form A: Participant-screening questionnaire

Form B: Pre-test background sheet

Form C: Pre-test data collection sheet

Form D: Pre-test summary of results

Form E: Sample questions for group pre-test

Form F: Group pre-test answers

Form G: Identification of changes and modifications

Form H: Monthly record for distribution of educational materials
Form A: Participant-screening questionnaire

Date ______________ 
Place __________________________________________________________

Introduction:

Questions: Invite ______ Do not invite ______
1. 
2. 
3. 
4. 
5. 
6. 

Thank you.

Notes:

Subgroup discussion invited to _________________________(date, time, place)

Name of screener/recruiter ________________________________

Participant’s name and how to contact ________________________(if invited)
Form B: Pre-test background sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Resp. No.</th>
<th>Schooling</th>
<th>Sex</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
### Form C: Pre-test data-collection sheet

| Res. No. | What do you See? | What do the words mean to you? | 1) How do you feel about the picture and/or words?  
2) Is the message asking you to do anything? What?  
3) What would you change?  
4) Why?—or suggestions on how to improve | Coding |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Picture</td>
<td>Text</td>
<td>OK</td>
<td>Not OK</td>
<td>OK</td>
</tr>
<tr>
<td>1.</td>
<td></td>
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</tr>
<tr>
<td>2.</td>
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<td>3.</td>
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</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
**Form D: Pre-test summary of results**

Coder(s) ____________________________________________

Pre-test round ____________________________________________

Region ____________________________________________

**Topic of material** ________________________________

<table>
<thead>
<tr>
<th>Message number</th>
<th>Total interviewed</th>
<th>OK</th>
<th>Not OK</th>
<th>Suggested changes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>Per cent</td>
<td>No.</td>
</tr>
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</tbody>
</table>
Form E: Sample questions for group pre-tests

Ask these questions about each page:

1. What information is this page trying to convey?

2. What does the test mean, in your own words?

3. What does the illustration show?

4. Do the words match the picture on the page? Why or why not?

5. Are there any words in the test that you do not understand? Which ones? [If so, explain the meaning and ask respondents to suggest other words that can be used to convey that meaning.]

6. Are there any words that you think others might have trouble reading or understanding? [Again, ask for alternatives.]

7. Are there sentences or ideas that are not clear? [If so, have respondents show you what they are. After explaining the intended message, ask the group to discuss better ways to convey the idea.]

8. Is there anything on this page that you like? If so, what?

9. Is there anything on this page that you do not like? If not, what?

10. Is there anything on this page that is confusing? If so, what?

11. Is there anything about the pictures or the writing that might offend or embarrass some people? If so, what? [Ask for alternatives.]

Ask these questions about the entire material:

12. Do you think the material is asking you to do anything in particular? If so, what?

13. What do you think this material is saying, overall?

14. Do you think the material is meant for people like yourself? Why?

15. What can be done to make this material better?

Ask the above-mentioned questions for each version of the material. Then ask:

16. Which version of the material do you prefer? Why?
Form F: Group pre-test answers

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<tr>
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<td></td>
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<td>Question 3:</td>
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Form G: Identification of changes and modifications

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Form H: Monthly record for distribution of educational materials

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Guide to Conducting Peer Education at the Workplace

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Introduction

What is peer education?

Peer education is one of the most effective ways of inspiring behaviour change and conducting HIV/AIDS-related education at the workplace. Peer education is based on the idea that individuals are most likely to change their behaviour if people they know and trust persuade them to do so. It helps to break down barriers by allowing people to discuss sensitive matters without fear.

In the context of HIV/AIDS workplace programmes, it involves the training of male and female workers to facilitate discussions with their co-workers, with the goal of encouraging them to examine and change their high-risk behaviour.

Peer educators also provide a link between workers and services, such as sexually transmitted infection treatment, voluntary HIV counselling and testing, and condom distribution. Workers' confidence is inspired when the workers receive accurate and helpful information from people to whom they can relate.

Why peer education at the workplace?

Peer education is a cost-effective option for employers. Compared to the cost of lost productivity, absenteeism, retraining and payment of health benefits due to HIV/AIDS, establishing a peer-education programme as part of the HIV/AIDS workplace programme can save money by helping to reduce new infections. It capitalizes on volunteer workers who will encourage their fellow colleagues to consider changing their current high-risk behaviour. A peer-education programme can be initiated rapidly and can reach a large number of workers.

At the workplace, HIV/AIDS programmes, including peer education, have proven to be very effective. Workplaces have organizational structures, hierarchies and policies. It is relatively easy to establish peer-education programmes in an environment where people with common socio-cultural, economic and educational characteristics can be easily identified and organized. Employees are generally easy to reach and participation can be high, especially if sessions occur during working hours.

The development of a peer-education programme improves the morale of workers, who see their employers and workers’ representatives contributing to the protection of their rights, health and well-being.

What do peer educators do?

Peer educators are generally trained to:

- facilitate discussions on high-risk behaviours;
- disseminate basic facts about HIV and other sexually transmitted infections;
- motivate workers to seek prompt and complete treatment from competent health-care workers;
- disseminate information about HIV/AIDS services at the workplace and/or in the surrounding community, make referrals to services such as those providing HIV counselling and testing, antiretroviral therapy, prevention of mother-to-child HIV transmission, orphan care, and treatment for tuberculosis and other opportunistic infections;

- assist workers affected by HIV/AIDS and put them in touch with support groups;

- promote HIV prevention through abstinence, mutual fidelity or condom use;

- train workers on using, and negotiating the use of, condoms with a sexual partner, and promote condom use among groups with high-risk behaviour;

- distribute condoms;

- help peers to assess their own personal risks;

- lead large group meetings;

- provide peer counselling on a one-to-one basis;

- disseminate information about the HIV/AIDS workplace policy;

- conduct advocacy and influence people to support HIV/AIDS programming; and

- answer any questions that co-workers may have.

**What is the purpose of the peer-education guide?**

This guide aims to provide workplace coordinators with the necessary information to establish a peer-education programme, including training and supervision. It also provides resources for peer educators, including background information on HIV/AIDS and training exercises.

**How is the guide organized?**

The guide is comprised of the following parts.

**Part 1: Establishing peer education at the workplace**

Part 1 is designed to help workplace coordinators and other planners understand what peer education is and why it is important. It also provides them with the information they need to develop and manage peer education at their workplace. Included are the basic concepts of peer education and a step-by-step process for setting up a programme.

**Part 2: Training and supervising peer educators**

Part 2 focuses on preparation and supervision of peer educators. Several appendices contain reference materials related to the content of Part 2 of this guide. These are Appendix B,
which consists of sample exercises for use in training peer educators; Appendix C, which contains an outline of a sample training workshop; Appendix D, which consists of a sample pre- and post-training test; and Appendix E, which looks at record-keeping to support supervision, as well as sample monitoring and evaluation forms. A training workshop for peer educators should include both exercises on the process of peer education (e.g., how to lead a peer-education session), such as those found in Appendix B, and exercises on HIV/AIDS prevention, care and support, such as those found in Part 4 of this guide.

Part 3: Guidelines for peer educators

Part 3 provides information on how to organize and conduct peer education. It can serve as a reference for both peer-education coordinators and peer educators during training and as a reference for peer educators once they begin conducting sessions. It covers the basics of interactive communication and includes suggestions on how to attract participants.

Part 4: Resources for peer educators: background information and exercises

Part 4 is the largest part of the guide. It consists of two sections—one dealing with HIV prevention and the other devoted to care and support. Each topic includes background information and training exercises that will serve to train peer educators and may be used by peer educators in sessions with workplace participants. Topics related to prevention include basic information about HIV and other sexually transmitted infections, condoms, HIV counselling and testing, stigma and discrimination, alcohol and drug use, gender issues, and codes of practice. Topics linked to care and support include living positively with HIV/AIDS, opportunistic infections and antiretroviral therapy, preventing mother-to-child HIV transmission, and wills and inheritance.

How can the guide be used?

Some behaviours and lifestyles are common to almost all workplaces in all countries. At the same time, each country and workplace has varying cultural backgrounds, levels of acceptability of sensitive issues, and patterns of sexual behaviour. This peer-education guide is designed to be comprehensive and to allow individual workplaces to pick and choose elements and exercises that are useful to them and that correspond to their particular needs and environment. Peer-education coordinators and peer educators at each workplace should use the guide and the tools it contains to design a programme that meets their needs.
Part 1: Establishing peer education at the workplace

Part 1 of this guide is designed to help workplace coordinators and other planners and policy-makers understand what peer education is and why it is important. It also provides them with the information they need to develop and manage peer education at their workplace.

Peer education at the workplace

How is peer education established in the context of a workplace HIV/AIDS programme?

Considering its proven track record at workplaces, peer education should be an integral part of HIV/AIDS workplace programmes. Workplaces often prioritize the establishment of an HIV/AIDS policy before starting any other aspect of a programme. In order to save time, the development of the peer-education programme could be done in tandem with policy development.

In some cases, services such as HIV counselling, testing and treatment, sexually transmitted infection control, and condom distribution are provided through workplace medical services. In other cases, agreements may exist for the referral of people to services offered in the community. Either way, peer educators have an important role to play in linking workers and services.

Peer-education success story at the workplace: Mining company in Botswana

In Botswana, NAMDEB Diamond Corporation employs nearly 4,000 people, who have about 6,000 dependents. The company collaborated with unions to develop a programme providing peer education as well as free condom distribution, syndromic management of sexually transmitted infections, voluntary and confidential HIV counselling and testing services, and prophylaxis for tuberculosis and opportunistic infections for all HIV-positive employees. Peer educators come from various educational and ethnic backgrounds and various professional levels. Senior officers on both the management and worker sides have opportunities to work with their peers to promote HIV prevention. Peer educators also promote the discussion of HIV/AIDS issues during meetings of worker and employer organizations. The comprehensive programme has had a positive impact on controlling HIV and other sexually transmitted infections. Approximately 200,000 condoms are distributed annually, annual reported cases of sexually transmitted infections among workers dropped from 533 to 186 in three years, and diagnosis of new cases of HIV decreased by 25 per cent.

Selecting peer educators

Who is a peer educator?

Peer educators should share common characteristics with the peer group on which their programme focuses. For example, if the peer group is made up of female seamstresses in a textile plant, it is essential that peer educators be women of about the same age, economic status and position. Peer educators who do not share the same characteristics as their peers are not likely to have the necessary credibility and confidence to be effective. If a peer
educator is from the middle management of a company and has the power to hire and fire workers, it is unlikely that workers will risk talking openly to them about high-risk sexual behaviour.

**How are peer educators selected?**

Recruiting and training peer educators should be a major component of any workplace peer-education programme. Management and workers’ representatives should work together to identify and train a pool of peer educators for each workplace or group of smaller workplaces. Groups of workers can also be asked to nominate individuals as peer educators or even vote for those that they prefer.

**What are the characteristics of a good peer educator?**

The success or failure of a peer-education programme often depends largely on the characteristics of peer educators. Desirable characteristics in peer educators include:

- being part of the workforce;
- being motivated by concern for the health of their colleagues;
- being available and accessible to workers at all times;
- having effective interpersonal communication skills;
- having natural leadership skills;
- possessing good organizational skills;
- being respected by colleagues;
- the ability to listen to other peers without bias or assumptions;
- the ability to speak the languages spoken at the workplace; and
- the ability to keep sensitive information confidential.

**How should people living with HIV/AIDS be involved in peer education?**

If people living with HIV/AIDS are already part of the workforce, ensure that they are involved in the planning and implementation of the peer-education programme. They often enrich the programme with fresh and practical perspectives. Their involvement will lend credibility to the programme and help to reduce stigma.

**What common problems are encountered in selecting peer educators?**

One common problem to avoid is the selection of peer educators who are not really peers of the intended target population. Communication will be more difficult if educators have a higher level of education, income or employee status than those whom they are educating. Another common problem is that people are so busy in their work or outside of work that they have little time available to be involved in peer-education activities.

**Implementing peer education at the workplace**

**What steps are needed to establish peer education?**

The following actions can help in the preparation of a peer-education programme:

- Establish the objectives of the peer-education programme.
- Gain support from all levels of management for the programme.
- Identify barriers to peer education at the workplace.
- Advocate the benefits of peer education to mid-level gatekeepers, such as shop stewards, branch managers and supervisors.
Guide to Conducting Peer Education at the Workplace

- Conduct a training-needs assessment to establish knowledge levels and attitudes (or use the findings from the BCC formative assessment).

- Establish the objectives of the peer-education programme.

- Establish clear roles and responsibilities for trainers, supervisors and peer educators.

- Ensure that different categories of peer educators are selected to correspond to different worker groups and groups with high-risk behaviours.

- Create opportunities for peer educators to meet on a one-to-one basis with those who need special attention or have discreet questions.

- Ensure that a system is in place to either offer services or make referrals to services such as condom distribution, HIV counselling and testing, prevention of mother-to-child HIV transmission, and treatment of sexually transmitted infections, opportunistic infections and HIV/AIDS, through antiretroviral therapy.

- Create opportunities for peer educators to provide outreach to the extended workplace community (spouses, children, communities located around workplace sites, etc.).

- Create incentives to motivate peer educators, such as time off work for education activities, profits from condom sales, awards and novelty items such as caps, t-shirts, scarves or hats designating them as peer educators.

Lessons learned in Viet Nam

In Viet Nam, a variety of factories and industries trained and formed peer-educator teams. Activities included group discussions, one-on-one discussions, workshops, question-and-answer sessions, contests, dramas and performances for special days, meetings, camping and sports events. Company management became involved and invested in the project. Peer educators helped design and disseminate BCC materials appropriate to the needs of the workers. Condoms were made more accessible with outlets established in and around some of the enterprises. Positive images of male responsibility were created and reinforced, and interventions reached stable populations as well as many migrant workers.

The following are some key lessons learned from workplace peer-education programmes in Viet Nam:

- Workplace activities succeed best when company boards of directors and labour unions are involved and supportive.

- Peer education at workplaces requires good-quality training for educators, including sufficient follow-up training.

- The project had to develop a wider range of BCC materials for peer educators, because many workers soon became bored with the brief leaflets on HIV/AIDS and condom demonstrations. Workers wanted more information, pictures and videos on HIV/AIDS and other sexually transmitted infections, and more diversified, colourful and entertaining BCC materials.

- Interventions that focus on men as key decision-makers in sexual negotiation are critical to promoting safer sexual practices.
Role of the peer-education coordinator

Peer-education coordination can take place through either one person or a team of people who are responsible for implementation. The person or people liaise with workplace management and those who conduct the actual peer-educator trainings. The peer-education coordinator is responsible for supervising the peer educators and monitoring their performance. If there is a coordination team, each peer educator should have a designated supervisor.

What is the role of the peer-education coordinator?

a. Negotiate the peer-education programme with employers

It is critical that management have a sense of ownership of the HIV/AIDS programming and understand the value of peer education. Helpful strategies include sharing with employers examples of successful peer-education programmes and emphasizing their positive impact on the workforce and production.

Initial steps for the coordinator:

- Inform company management of the time and resource commitment required for the peer-education programme.
- Get approval for training and meeting time for peer educators and time for peer interaction each month.
- Identify places for displaying materials and distributing condoms.
- Select the optimum number of peer educators at the workplace setting (one for every 30 workers).
- Get management to provide a space for training and regular meetings with peer educators.
- Notify workers of the programme and get workplace management to express support for it.

b. Organize training schedule and activities

Peer-education coordinators need to work closely with those who control the schedules of workers to determine the number of days and hours during which employees will be available for peer-education activities, either as educators or participants.

c. Facilitate workplace policy development

The coordinator should also be active in the development of HIV/AIDS workplace policy and ensure that new policy is communicated to workers through the peer-education network. The network can be used to actively engage workers in the development of the HIV/AIDS workplace policy through participatory processes.

d. Ensure comprehensive peer education

Coordinators need to ensure that the peer-education programme is comprehensive and not piecemeal. The programme should reach large numbers of workers with a balanced approach, including risk assessments, condom promotion and links to services.
e. Ensure links to condom distribution

Peer education at the workplace works best when it is directly linked to condom distribution and promotion. It is the responsibility of the coordinator to ensure that condoms are available for peer educators. At many workplaces, employers buy condoms for distribution by peer educators or at condom-distribution points that peer educators can monitor and re-stock. In other cases, a programme can establish links with condom social marketing organizations that set up condom sales points at or near the workplace. Peer educators can sell socially marketed condoms for a small profit, which serves as an incentive for them. Although condom distribution is more sustainable if condoms are sold, it is difficult to charge even nominal amounts for condoms if they have first been offered free.

f. Ensure links to prevention and care services and sources of information

The coordinator has the responsibility to ensure that there are links to services within or outside of the workplace. Peer educators play an important role in making referrals to services such as:

- HIV counselling and testing;
- sexually transmitted infection diagnosis and treatment;
- treatment of opportunistic infections such as tuberculosis;
- access to all appropriate drugs, including antiretrovirals for HIV infection;
- care and support;
- legal advice, care and support for dependants of infected employees;
- annually-updated information on employee benefits;
- assistance with will-writing;
- support for widows; and
- education funds for children.

g. Assess training and monitor peer-education activities

The coordinator is responsible for ensuring that peer education is of good quality, by monitoring and supervising educators. Appendix F includes a peer-educator quality checklist.

h. Meet regularly with peer educators to discuss progress

Ideally, the coordinator should hold monthly meetings with supervisors and peer educators (depending on how large the workplace is and the number of workers involved). Such meetings allow educators to raise concerns and questions and to identify problems. These meetings should serve to provide positive feedback and to thank supervisors and educators for the role they are playing.

i. Coordinate special events

Special events, in the context of this guide, are activities designed to attract attention to HIV/AIDS-related issues within the workplace. Events could be as simple as setting up information booths on World AIDS Day or inviting a medical specialist or person living with HIV/AIDS to speak to workers at lunchtime. Other events might consist of peer educators answering questions at a football (soccer) game or athletics competition sponsored by the HIV/AIDS programme. Special events are usually organized around a
specific theme such as promotion of condoms, HIV counselling and testing, or reduction of stigma and discrimination. The coordinator is responsible for the overall coordination of special events and ensuring that educators understand their role and have the materials and resources they need.

j. Demonstrate leadership commitment at the workplace and beyond
The coordinator is responsible for ensuring that all those involved in peer-education efforts demonstrate the leadership needed to inspire confidence in the programme. Part of this leadership role involves offering a good example of personal behaviour at the workplace and the greater community. This also includes reducing stigma by involving people living with HIV/AIDS in peer-education programme and supporting and empathizing with workers and their families who have been touched by the virus.

k. Provide clear, consistent and up-to-date information
The coordinator should ensure that the latest information and strategies are integrated into the programme. This should include the latest information on the disease, workplace issues relating to the disease, and new and innovative responses to the epidemic.

Making peer education work
What are the common challenges in peer education?
There are a number of common challenges faced by peer-education programmes. Anticipating these challenges can be helpful when planning the programme.

The most common challenges in peer-education programmes include the following:

- Resistance to discussing prevention of HIV and other sexually transmitted infections, especially at the workplace
- Lack of time to interact with peers
- Lack of space to hold group meetings or peer-education sessions
- Non-availability of a group of peers to conduct sessions
- Inadequate time to train all of the peer educators on how to conduct effective interpersonal communication sessions
- Inadequate privacy for discussing sensitive topics and giving condom demonstrations
- Unwillingness to demonstrate how to use a condom with a penile model
- Providing information to peers without motivating them to change their behaviours
- Unwillingness of senior officers to support the peer-education activities
- Inability of peer educators to sustain their motivation
- High drop-out rate of peer educators if they are volunteers
- Inadequate resources to cover the cost of training and supervision
- Large variations in skills and motivation level of peer educators
- Difficulty evaluating the programme and linking peer-education efforts to behaviour change
- Insufficient supply of support materials and training for the peer educator
- Peer educators’ desire to have a distinct identity from other members of their peer group.

**How can sustainability be achieved?**

One of the biggest problems for peer-education programmes is to sufficiently maintain the interest and motivation of peer educators. When gauging the sustainability of such programmes, the following questions may be asked:

- Have the peer educators received sufficient training, retraining and supervision?
- Are there sufficient incentives for peer educators?
- Is there sufficient interest on the part of the participants?
- Have sufficient resources been provided to the programme?
- Have peer educators and workers been involved in the initial planning and operation of the programme?
- Are support services (e.g., HIV counselling and testing, sexually transmitted infection services and condoms) readily available?
- Has an HIV/AIDS committee been established?
- Are the programme-management structures efficient?
Part 2: Training and supervising peer educators

Training peer educators

Part 2 has been developed for peer-education coordinators. It focuses on the preparation of peer educators and their supervision. The peer-education coordinator is responsible for ensuring that peer educators are trained and have the equipment, resources and support to do their job. Coordinators are also responsible for supervising peer educators, as well as monitoring and evaluating their performance. If there is a coordination team, each peer educator should have a designated supervisor.

What steps are needed to establish training?

Step 1: Determine which topics the training will cover by either conducting research or reviewing existing research (such as findings of the BCC formative assessment) to know more about the workers’ knowledge, attitudes and behaviours. For example, findings might reveal low condom use and misinformation about condoms among the workers of that specific workplace. The peer-educators’ training would need to cover this topic.

Step 2: Set training priorities that correspond to the specific needs of each workplace. The training should include basic knowledge about HIV/AIDS as well as activities to develop peer-educators’ skills.

Step 3: Conduct a pre-training test and a post-training test to measure progress. Get feedback on training sessions for future reference. Prepare certificates for the peer educators who take the training.

How are peer educators trained?

a. Training of trainers

- A team of trainers should be established for the training of future peer educators. The larger the team, the more quickly the programme can be established. However, it is important to keep in mind that the quality of the training is often related to the size of the group. In other words, training 20 at a time will be more effective than training 100 at a time.

b. Continuous training

Training peer educators is an ongoing process. The main activities linked to continuous training include:

- assessing learning needs of the beneficiaries of peer education through rapid-assessment surveys, focus group discussions, etc.;
- assessing existing knowledge and attitudes within each category of peer educators; and
- development of a training design based on the findings of training-needs assessments and beneficiary-needs assessments.
Why conduct a training-needs assessment?

A training-needs assessment:

- ensures that the training design is based on the learning needs of participants;
- increases the commitment of participants to learning, if they are involved in preparation of the training design;
- makes learning a joint responsibility of the participants and the facilitator;
- helps to develop rapport between facilitators and participants before the actual training begins;
- helps identify the strengths and limitations of the group;
- helps define learning objectives; and
- helps assess the impact of training on the performance level of participants.

How is a training-needs assessment conducted?

- Administer a written questionnaire before and after the peer-education training. (See the exercise on assessing knowledge levels, Exercise 1 Appendix B, and the sample pre- and post-training test, Appendix D.)
- Assess peer educators’ interests and what they would like to learn.
- Talk to peer educators individually or collectively to inform them about possible topics and objectives of the training programme.
- Ask a number of probing questions to assess the existing knowledge of peer educators on possible topics to cover.
- Ask peer educators to rank or rate the relative importance of each topic.
- Assign priorities for the topics based on peer educators’ rankings, assessment of their existing knowledge, and the knowledge and skills that they require.

Which key elements should be included in the training?

a. Basic knowledge about HIV/AIDS

- HIV transmission and prevention, and how the virus affects the body
- Steps involved in, and benefits of, HIV testing
- Confidentiality of a person’s HIV status, especially at the workplace
- Availability of HIV treatment and support
- Relationship between HIV and tuberculosis.

b. Peer-education skills

- Understanding the role of peer educators and the benefits of a peer-education programme
- How to make a presentation to a group
- How to stimulate a discussion
- Knowledge of where to refer people for legal, medical and counselling services
- How to communicate effectively with peers
- How to promote positive behaviours with regard to HIV/AIDS.

(See also Part 4 for sample training exercises on basic knowledge about HIV/AIDS and Appendix B Exercises 2 and 3 for details of skills required for answering questions.)
How to assess the effectiveness of training

a. Conduct a pre- and post-training test

One way to measure a peer educator’s progress during training is to give participants a test before they take the training and then give them the same test after the training, and compare the differences in the results. If there is a significant improvement in the results, the training can be deemed successful. (See the sample pre- and post-training test in Appendix D.)

b. One-on-one practice as peer educators

Another method for evaluating the effectiveness of the training and the competence of peer educators is to have the educators conduct a group presentation and a one-on-one session, with supervisors playing the role of participants, before they work with employees. This will provide an opportunity to assess whether educators have understood the training and what is required. The following steps may be taken:

- Ask the peer educator to prepare a presentation.
- Have the educator present a group discussion on a particular subject.
- Use the review form to note your observations regarding the educator’s performance.
- Provide constructive feedback to the educator.
- Repeat these steps during an individual session with the peer educator.
- Observe and evaluate actual peer-education sessions. (See the quality-assurance checklist in Appendix E.)

Why organize refresher training?

Revitalizes and renews. Peer educators are often trained at the beginning of a programme but given little support afterwards. Refresher training helps revitalize peer educators and reorient their work. The content of the refresher training should be based on feedback obtained during supervision and monitoring. The following elements should be considered when planning refresher training:

- Focusing training on the acquisition of new knowledge and skills
- Obstacles to effective peer education, based on feedback from educators and beneficiaries
- Need for reinforcement of previous learning

What kinds of support do peer educators need after training?

Peer educators are required to absorb information and skills in a short period of time. They need ongoing access to information and skills to perform their job successfully. Follow-up or supervision can take different forms.

Hold monthly meetings. Peer educators need a place to discuss issues, problems, share ideas and simply talk about their work. Coordinators and supervisors can also use this time to discuss specific topics or conduct skill-building exercises. Coordinators can:

- establish a monthly time and place for meetings;
- ask peer educators for specific issues or topics they want to discuss;
• review resources that peer educators are using for referrals and ensure that they are appropriate;
• address any issues that involve management and workers; and
• share new materials and information with the group.

Provide fact sheets and regular programme updates. Another way to communicate with peer educators is to develop a monthly or quarterly fact sheet on a particular subject or issue. These fact sheets can provide useful information for educators to use in group sessions or in one-on-one sessions. Topics can be specific to the HIV/AIDS workplace policy or can cover new HIV/AIDS-related information.

Additional training. Use one meeting per quarter as a training session. This session can serve to introduce new skills and allow peer educators to practise interacting with peers. A half or full day should be dedicated to this follow-up training.

Individual meetings with peer educators. Supervisors and coordinators should make themselves available to answer educators’ questions or provide advice. Some peer educators may need to talk about their feelings or fears related to the job. Others may need some technical help. It is particularly important to be available to them immediately after they have finished training.

Identify and deal with problem peer educators. Many workers volunteer to be peer educators and are truly interested in helping other colleagues. Others may be selected by management and are not interested in peer education. The coordinator and supervisors are responsible for ensuring that educators are doing their jobs correctly. If educators are giving out incorrect information, passing moral judgement on the behaviour of others, or otherwise alienating them, the coordinator or supervisor should take immediate action. In some cases, simply talking to the individual and illuminating the problem may remedy things. Some peer educators may need to refresh their communication skills through training or individual help. In some cases, it may be appropriate to ask the person to give up his or her role as an educator. However, careful monitoring can often prevent things from getting out of hand.

Record-keeping, supervision and monitoring

Record-keeping involves having peer educators and their supervisors systematically track education activities by collecting data, such as the number and type of sessions held (individual or group), number of participants, topics covered and types of questions raised.

Supervision should take the form of support to peer educators from supervisors who observe the educators’ sessions, answer difficult questions, offer suggestions on improving techniques, and offer advice on how to overcome obstacles.

Monitoring involves systematic tracking of what is being accomplished, through analysis of reports by supervisors and review of records.

Why are record-keeping, supervision and monitoring so important?

Management and coordinators sometimes assume erroneously that, once peer educators
are trained, they will automatically conduct education sessions exactly as they were taught. Monitoring and supervision are needed to support peer educators in their work and to provide quality control. In reality, a number of common pitfalls can reduce the effectiveness of a programme. For example:

- Peer educators receive training in participatory methods but resort to less effective didactic methods.
- Peer educators repeat misinformation or are unable to answer questions asked by peers.
- Peer educators are trained, but fail to conduct education sessions because they are too busy, are transferred, or have difficulty grouping their peers for sessions.

**What essential records should be kept?**

Maintaining the following records will help monitor the successful flow of peer-education programmes:

- **Register of participants:** Keep track of the number of people attending peer-education sessions and their profile (age, sex, position). (See sample peer-educator diary in Appendix E page E-2.)
- **Reporting forms:** Provide an account of the topics covered, the duration of the sessions and where they took place.
- **Time management:** Have peer educators prepare workplans that outline their schedule, including time spent organizing, preparing and holding sessions. Compile a monthly report of workplan implementation.
- **Information flow:** Track the distribution of support materials (pamphlets, posters, flipcharts, notices) and list the types of information sought by peer educators from their supervisors.
- **Distribution of commodities (e.g., condoms).** (See sample condom stock card and monthly data-collection form in Appendix E page E-3 and E-4.)
- **Referrals for HIV/AIDS-related services at the workplace or in the community.** (See sample peer educator referral sheet in Appendix E page E-5).

**Supervising peer educators**

- Determine the number of supervisors needed.
- Identify the supervisors.
- Determine the method of supervision (one on one or as a group).
- Determine the frequency of supervision.
- Prepare a checklist or tools for supervisors.
- Train supervisors.
- Clearly define the supervision structure. Ensure that a clear pyramid structure is in place, with clearly defined responsibilities and communication channels from top to bottom and from bottom to top.

**What are the characteristics of effective supervision?**

- Supervisors should be knowledgeable about HIV/AIDS and the peer-education programme, and be in close contact with peer educators.
- Supervision should be organized to ensure that peer educators are working effectively with peers.
Two-way communication between peer educators and the supervisors is essential. Peer educators should understand that the purpose of supervision is not to judge them individually. Supervisors are there to support them, and their experience is contributing to an understanding of how well the whole programme is working.

Ideally, the same supervisor should contact peer educators on a weekly basis. The supervisor should meet with participants about once a month to assess the effectiveness of the programme.

Supervisors should be able to identify and recruit additional or alternative peer educators, if required, especially if existing ones are found to be ineffective.

Supervisors need to motivate peer educators by making them understand the value of their contribution and to what degree the programme appreciates it.

The supervisors’ reports should be analysed and reviewed at least quarterly to determine what changes should be made to the programme.

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How to monitor peer-education programmes

One of the biggest challenges of peer-education programmes is determining whether they are working or not. There is a wide array of methods and approaches for collecting information to determine whether the peer-education programme is working and if high-risk behaviours are being reduced in the target population. The basic steps to monitoring a peer-education programme include the following:

- Defining the types of information to be collected
- Designing a reporting system
- Defining the appropriate indicators to monitor the progress of the programme to assess its actual impact on the target population. Examples of peer-education indicators include:
  - Number of individuals that peer educators referred to a health facility for the treatment of sexually transmitted infections, opportunistic infections and/or for additional counselling
  - Number of condoms that peer educators sold or supplied to peers
  - Number of condoms reportedly used by peers
  - Quantity of behaviour change communication materials that educators distributed to their peers
  - Number of peer-education sessions that educators conducted
  - Participants’ level of satisfaction with peer-education sessions

- Developing approaches to supervision and monitoring, such as:
  - observation (simply watching peer educators in action);
  - interaction with participants;
  - obtaining feedback from peer educators;
  - focus group discussions;
  - providing feedback to peer educators;
  - feedback from site visits and key informant interviews;
  - weekly peer-educator meetings;
  - routine refresher training for peer educators; and
  - structured interviews with high-risk groups in their place of work or residence.

- Developing impact indicators for the peer-education programme, including:
  - number of peers who reduced their high-risk sexual practices;
- number of sexually transmitted infection cases referred by peer educators and treated by qualified medical practitioners;
- number of socially marketed condoms that peer educators sold/gave to peers;
- number of peers who attended clinical facilities offering services in prevention and treatment of sexually transmitted infections; and
- percentage of individuals within the target population who reported using a condom the last time they engaged in casual sex.

- Developing a means of verification, using the following tools:
  - Referral slips
  - Information (obtained from private and government medical practitioners) on sexually transmitted infection cases treated
  - Reports from organizations involved in condom distribution and from peer educators.
Part 3: Guidelines for peer educators

Part 3 provides information to peer educators on how to organize and conduct peer education. It can be used as a reference for both peer-education coordinators and peer educators during training, and as a reference for educators once they begin conducting sessions. It covers the basics of interactive communication and includes suggestions on how to attract participants, and how to plan and conduct sessions.

Introduction

How do people change their behaviour?

People have to make their own decision to change behaviours that put them at risk of contracting HIV infection. A peer educator persuades participants to examine those behaviours and consider their consequences. However, simply telling people to change or providing them with information about the risk of HIV infection is usually not enough to get them to make changes. Behaviour change is a process that involves several levels of awareness.

a. Unaware/aware

Initially, people are usually unaware that a particular behaviour may be dangerous or could put them at risk of contracting HIV. The first step in a behaviour-change process is for peer educators to make people aware of the risks. For example, to decrease the risk of mother-to-child HIV transmission, people planning to have children first need to know about the risks of transmission. Peer educators could provide this information through interpersonal communication with couples or through sessions that make men aware of the link between their unprotected sex with casual partners and the risk to their regular partners and future children.

b. Concern

People who are aware of an issue may not necessarily be concerned about it. Peer educators should supply information in such a way that their peers feel that it applies to them. For example, women may become concerned about giving birth to a baby infected with HIV, which may motivate them to evaluate their behavioural options. Peer education at the workplace has proven effective in reaching workers and getting them to make the transition from awareness to concern.

c. Knowledgeable and skilled

Once individuals are concerned, they may acquire more knowledge by talking to friends, peer educators, social workers, or health-care providers about actions they can take. The dangers of HIV, other sexually transmitted infections, and methods of protection can be conveyed through interpersonal communication with peer educators. At this stage, peer educators can help build skills by discussing sex and sexuality and educating people about responsible sexual behaviour.
d. Motivated and ready to change
At this stage, individuals might begin to think seriously about the need to protect themselves and their loved ones from HIV or other sexually transmitted infections. They may become motivated and ready to change. They may think about this for a long time and decide not to have multiple sexual partners, to abstain completely from sex, to remain faithful to an uninfected partner, or perhaps to begin to use condoms regularly. Peer educators therefore have a role to play in ensuring that condoms and services are available. Educators can make sure that individuals are capable of using condoms and negotiating for safer sex with their partner. Various forms of media, such as posters and printed materials, can help provide a supportive environment by showing role models promoting a positive view of safer sexual behaviour. Positive messages from peer educators are particularly effective.


e. Trial change of behaviour
If individuals find themselves in a situation where a sexual encounter could take place and they have access to a condom, they may decide to try practising safer sexual behaviour by using the condom. However, if the experience proves too difficult or embarrassing, due to lack of experience or skills, they may not wish to repeat the behaviour. It is therefore essential that peer educators teach them the necessary skills, such as how to negotiate condom use and how to use condoms correctly.

f. Maintenance/adoptions of new behaviour
Ensuring that individuals do not revert to their former high-risk behaviours is a challenge. Peer educators have a role to play in reinforcing the positive behaviours and encouraging their continuation. New risks may present themselves and, as a result, people will need to be kept informed and motivated if they are to adopt new behaviours.

Mobilizing support for education sessions

Coordinate with other peer educators. Discussing approaches to peer education and reviewing what was learned during the training with other peer educators is a good way to begin. If obstacles exist and educators need further assistance, the peer education trainer or supervisor should be available to help them get started. Peer educators can approach supervisors and members of management together to schedule sessions during work time, if permitted. If managers are uncomfortable with sessions being held during work time, educators should negotiate other times, such as extended break periods.

Why write a workplan?
A workplan sets the stage. A workplan simply states what each peer educator intends to do, when they intend to do it, with whom, and where. Regularly-scheduled peer-education sessions, even if they are informal, work best. Once a workplan is prepared and approved by the supervisor, it is more likely that the sessions will take place as planned and that participants will participate. This is especially the case if supervisors encourage participation and sessions are allowed to be held during work time.
How can peer educators attract participants?

**Make peer education fun and interesting.** The duller and more formal the peer-education sessions are, the harder it is to arouse and maintain the interest of co-workers. Likewise, the more dynamic and amusing the sessions, the greater the likelihood that people will want to participate. If they are going to receive a long, moralistic lecture, there is a good chance that potential participants will head the other way when they see the peer educator walking in their direction.

**Use exercises learned in training.** Most peer educators greatly enjoy the games, role-playing and participatory discussions they engage in during training. Participants are likely to enjoy those activities as well. Encouraging animated discussion by asking provocative questions can make sessions more attractive.

How to prepare sessions

**Being well prepared is important.** The better prepared the peer educator is, the smoother the session will be. Educators should make sure that they know exactly what topics they would like to cover, which exercises they would like to conduct, and what they expect to accomplish.

**Peer educators should read background information before sessions.** Nothing is more boring than a peer educator who is ill-prepared and who reads the reference material during a session. Material should ideally be read a short time before the session to increase the chances of it being remembered.

**Practise sessions with friends first.** Peer educators can practise conducting sessions with some friends beforehand. This increases the educators’ confidence and effectiveness when conducting sessions with the participants.

**Arrive on time.** When sessions are scheduled, it is best to arrive a little early to greet the participants. Arriving late is disrespectful and participants may be prompted to leave if the educator has not arrived by the appointed time. Arriving early allows the educator to get some feedback on previous sessions by talking informally to any participants who may arrive early.

How to choose a location for sessions

**Choose a quiet, discreet location.** When discussing intimate topics such as high-risk sexual behaviour, it is important to hold sessions in as discreet a location as possible. Privacy is recommended so that others cannot overhear the conversations and passers-by cannot disturb the proceedings.

**Go to where the workers are.** It is always more effective if a peer educator goes to where their peers are, rather than having their peers come to them. The more convenient the location is for co-workers, the more likely they will be to participate. Meeting them where they already congregate, such as drinking spots and clubs, can work well. The workplace during working hours (or right after) is the best location if employers and supervisors agree for sessions to take place at those times.
Making peer education participatory

Why make peer education participatory?

Information alone is usually not enough to change behaviour. When it comes to conducting training at the workplace or in schools, methods tend to be formal. The trend is for one informed person to lecture others who are less informed. Providing information is important. However, experience shows that interactive and participatory methods are more effective than simply providing facts to motivate people to think through their behaviour choices and to inspire change.

Formal lectures tend to be dry and dull. People seldom appreciate it when educators read directly from documents or recite facts about HIV/AIDS. They prefer for peer educators to introduce topics for discussion, such as sexually transmitted infections, prevention of mother-to-child HIV transmission, or stigma and discrimination, and for educators to introduce information or answer their questions in the course of the discussion.

Participation improves the quality of contact between peer educators and participants. Encouraging participation actually makes sessions easier for peer educators because they do not have to do all the talking or spend time preparing lectures. Also, when participants find sessions enjoyable, they are more likely to attend and benefit from them.

How to conduct a session

Introduce yourself and the goals of the session. If the participants do not already know the peer educators, they should identify themselves and explain what their role is. (For example, “I am here to ask questions to stimulate discussion, to introduce games and exercises, and to listen to what you have to say.”) Then educators should explain the purpose of the session. The emphasis should be placed on encouraging participation and the fact that everyone’s opinion and experience are equally important.

Create an environment of trust. Let participants know that there will be free and open discussion so that everyone can better understand what puts people at risk and how those risks can be reduced. Reassure them that anything said in the session will be kept confidential. Encourage participants to be discreet about what they hear in sessions and urge them to respect one another.

Be relaxed and informal. Participants generally prefer informal sessions with educators who facilitate a discussion rather than acting like teachers.

Allow participants to have fun. Role-playing, game-playing and discussing sex can be fun and cause laughter. It is up to educators to create an informal atmosphere that allows this to happen. (See Appendix F for a series of role-playing exercises.)

Avoid being judgemental or moralistic. Making participants feel guilty when they are talking about high-risk behaviour can cause them to withdraw and usually does not result in positive behaviour change. Peer educators should respect everyone’s opinion even if they do not agree with it. A peer educator who is faithful to his or her partner may find it hard to understand why others visit sex workers, prefer anal sex, or sell sex. However, it is essential for educators to focus on protecting people from infection, rather than on trying to change their moral and social values. Doing so often ends up alienating those at risk rather than helping them to reduce the risks they face.

Try not to tell people what to do. Remember that participants have to conduct their own risk assessments and then decide for themselves whether it is to their advantage to change their behaviour. Simply being told to change usually does not work.
Ask probing questions or follow-up questions. To get participants to provide feedback about their experience and what they were thinking and feeling, ask additional questions based on what they say. For example, ask people how they feel and not just what they think or know. Find out if they were happy, guilty, sad, worried, afraid or indifferent about specific situations.

Get participants to move and stretch. If the attention level is waning and participants are getting a bit restless, suggest that they stand up and stretch, touch their toes or jog on the spot. Some group activities, such as singing, can also help to break the monotony and refresh the participants.

Ensure that everyone participates. There are always a few people who will want to dominate and a few quiet ones who prefer not to say too much. It is up to the educators to try to get everyone to participate. Pose questions directly to individuals rather than to the whole group and pose the same question to several different people, especially the quieter participants. Some suggestions on how to engage them:

- Ask participants what kinds of activities and topics they would like to discuss and lead the discussion accordingly.
- Involve participants in deciding on the times and locations for sessions.
- Use the more dynamic participants as helpers and sub-group leaders.
- Break into small group or pairs for more intimate discussions and get the groups to report back.
- Suggest using the buddy system to help participants support each other outside of the sessions.

How do you get participants to talk?

Ask questions. The more participants talk and the less peer educators dominate, the more successful the session will be. Educators can ask a question to start a discussion, such as, “Can you describe what happens when somebody visits his girlfriend/her boyfriend?” When the group runs out of things to say, the educator should ask another question, perhaps sending them in a specific direction, such as, “What happens if neither one has condoms?”

Encourage two-way communication. The best approach for peer educators is to ask a question, listen to the answer, and then ask another question based on what was said. Ask questions that probe why things happened or how people feel about certain situations. The idea is not to provide facts but to find out what each person thinks and feels about high-risk behaviours and their choice of behaviour.

People naturally want to talk about themselves. Participants generally like to contribute to a discussion by talking about their own experiences. The challenge for peer educators at the workplace is to create a positive environment in which participants feel comfortable enough to start talking. It may seem difficult at first, but once educators discover how easy it is to initiate a discussion, they usually enjoy their work much more.

Work with small groups. Between six and ten is the best number of participants for a peer-education session. If there are more, the group becomes unwieldy and harder to control, and it is less likely that all participants will get the chance to participate actively. If the group is smaller, too much attention is focused on a few individuals that may make them feel more uncomfortable, especially when talking about their sex lives.
What are probing questions?

Go beyond surface comments. Probing questions are used to obtain more detailed and meaningful information about a particular subject. Participants often provide short answers or even try to give you the answers you want to hear. Peer educators who are skilled at asking probing questions are more likely to get to the reality of a situation and encourage open and frank discussion. Developing skills for asking probing questions is important. Some examples of probing questions are listed below.

- Could you tell me more about that?
- What made you do that?
- How did you feel when that happened?
- Why do you think that is important?

What are open-ended questions?

Look for more than “yes” or “no” answers. An open-ended question is one that does not require a “yes” or “no” answer. Open-ended questions are useful to educators to get discussions started. Open-ended questions can not be answered in a few words and usually begin with “how”, “why” or “could...”. A closed question asks for only a simple answer that usually does not require any reflection on the listener’s part. Answers to such questions are usually brief (“yes” or “no”) and usually begin with “is”, “are,” or “do.” Open-ended questions are more valuable than closed ones because they increase participants’ involvement in peer education sessions.

Examples of closed questions:
- Do you like rice?
- Do you drink beer?
- Do you like this training?
- Do men and women think differently?

Examples of open-ended questions:
- What are your favourite foods?
- What do you think of beer drinking?
- How could this training be improved?
- In what ways do men and women think differently?

Examining behaviour choices is beneficial to peer education

Help participants to understand the consequences of their behaviours. Create a relaxed and informal atmosphere that encourages participants to describe their high-risk behaviour and reflect on its possible consequences. These might include feelings of guilt, fear of infecting their wives or husbands, fear of a premature death, or fear of suffering from sigma and discrimination.

Get participants to identify their decision-making process. Peer educators can encourage participants to pinpoint exactly when they made the decisions that put them at risk. Educators can ask questions such as, “When did you decide to go to the brothel?” “When did you decide to obtain or not obtain a condom?” “When did you make the decision to use or not to use a condom?” “Did you imagine that your sexual partner wasn’t infected because he or she looked healthy?”

The idea is that if those engaging in high-risk behaviours understand why they made
certain decisions and when, they may decide to choose differently the next time they find themselves in the same situation, thereby avoiding the risk.

Encourage participants to consider what influences their behaviour. Peer educators can help participants figure out which external influences have an impact on the behaviour choices they make. Peer pressure to go to brothels with other men, alcohol consumption that clouds decision-making, or women who resist using condoms because they fear that their partner may think they are sex workers, are all factors that can influence behaviour choices.

Help participants to confront their defences. Some people have a tendency to deny that their high-risk behaviour is a problem. Sometimes they blame others for their behaviour. They often give a long list of reasons for not using condoms. Peer educators should try to get participants to think through the realities of HIV/AIDS, examine the behaviour choices they make, and not hide behind misinformation or wishful thinking. Educators can do this by getting other participants to comment on excuses offered or talk about which risks they consider to be genuine.

How to use support materials

Support materials enhance peer education. Support materials are usually printed documents with illustrations or photos that peer educators can use to convey ideas and stimulate discussion. Below are some suggestions on how to use these materials. (See also Appendix G for an example of illustrated materials that could be adapted for use in HIV/AIDS workplace programmes.)

▪ Do not tell participants what is happening in the photos or illustrations; ask them to talk about what they see and understand.
▪ Let participants comment extensively before offering information.
▪ Make sure everyone has a good view of the materials by moving participants in closer or passing the materials around so that each participant can have a good look.
▪ Create a relaxed atmosphere by placing participants in a circle without desks in front of them.
▪ Re- pose questions that participants ask for other participants to answer.
▪ Avoid letting the same participants answer all questions. Pose each question to specific individuals.
▪ Ask simple questions, such as, “What do you think?” “What do you see?” “How do you think the person feels?” “What do you think they will do?”

Overcoming barriers

What are common barriers to peer education and what are the solutions?

**Barrier**: Peer educators talk too much.

**Solutions:**

**Ask more questions.** Peer educators who talk too much are not doing their job properly. Most participants find lectures boring. Peer educators can initiate discussions by asking questions. Most people are more interested in talking about their lives than in listening to educators speak in incomprehensible technical language about HIV/AIDS.
Find out what is happening in the lives of participants. The more peer educators understand the lifestyles of participants, the better they will be able to help them think through their behaviour choices. For example, rather than providing facts about HIV counselling and testing, educators can ask participants if they ever thought about being tested or ask those who were tested to describe how they felt about the experience.

Barrier: Peer educators are ill-prepared.

Solutions:

Read reference materials. An informed peer educator is a confident educator. Reading reference materials several times increases the chances of remembering the content. Re-reading the materials every six months helps to keep the memory fresh.

Offer to answer tough questions later. Pretending to know the answer to a question to save face can backfire. Good peer educators write down questions they cannot answer and either look up the answer in a reference book or ask another educator if he/she knows the answer. Educators can then offer the correct answer at the next session. As a rule, peer educators should tell participants if they do not have the answer to a question. A good response would be, “I don’t have an answer to that question right now. I will look it up and tell you next time.” With this approach, educators will not damage their credibility with the group. Sometimes a participant may know the answer. Always endeavour to give the group an opportunity to answer difficult questions.

Seek advice and counsel. Part of the job of peer-education supervisors is to provide educators with the information they need. They should also be available to offer advice on problems in organizing or conducting peer education. They should express willingness to meet with participants who have particular problems that peer educators cannot handle.

Barrier: Peer educators are reluctant to bring up sexual issues.

Solutions:

Keep peer education focused on sex. Almost all HIV infection is transmitted through sex. Even in the case of the second-most important mode of transmission—mother-to-child transmission—a woman is almost always infected by her partner before she transmits the virus to her baby. Despite this reality, there is often reluctance on the part of peer educators and participants to deal frankly and openly with human sexual relations. Effective HIV prevention requires an understanding of risky sexual behaviour and the willingness to talk openly about it.

Be bold when discussing sex. Talking about sex is an unwritten taboo in many parts of the world, especially when it involves details of sexual behaviours that may be socially unacceptable, such as relations outside marriage or sex for money. It requires special skills for peer educators to become comfortable with dealing with sexual questions and then getting their peers to feel comfortable as well. The following are some suggestions for facilitating discussions about sex:

- Try to appear at ease when talking about sex. If educators are embarrassed, participants will be, too.
- Provide a comfortable and quiet place where people will not be interrupted so that participants feel safe in revealing sexual information honestly.
- Ask direct questions about sex, which encourages participants to offer concrete detailed information about their sexual choices.
- Get people to talk about “someone just like them” or “someone they know very well,” if they are too shy to talk about their own sexual habits. This sometimes allows them to speak more freely than if they have to reveal things about themselves.
Think about your own sexual values. Peer educators should start by looking at their own sexual behaviour, and examining their personal opinions, moral values and feelings about sexuality. They should learn what kinds of questions elicit sexual information without unduly embarrassing participants.

Admit that talking about sex is not always easy. Tell participants that you realize that people do not usually discuss sex and that it can be embarrassing to do so. However, most people have sex and the questions and problems facing people demand that they be able to talk openly about it. Other suggestions:

- Use humour. Nothing reduces embarrassment as effectively as a good laugh.
- Begin questions with a general statement about different sexual behaviours. Do so in an accepting manner and then proceed to ask participants to describe their own sexual behaviours or those of people they know very well. For example, “Someone told me that some men want to use condoms but get so drunk they forget. Do you know of anyone to whom this has happened?”
- Start with general questioning and become more specific as participants relax and begin talking. For example, get men to describe where they go to drink alcohol, who they go with, who they meet there, and then ask them to describe their sexual encounters.
- Use words that are understandable and acceptable to participants. Develop a vocabulary of terms that are commonly used. These words may include different terms for sexual intercourse, penis, vagina, sperm, oral sex, anal sex, sex worker, words pertaining to various sexually transmitted infections, etc.
- Be aware of cultural attitudes and values concerning sexual behaviours that affect a person’s risk of contracting HIV.

Barrier: Peer educators are morally opposed to condom use.

Solution:

The issue of condom use must be addressed. Some peer educators may be personally against condoms or feel uncomfortable talking about them. However, educators will not be doing their job effectively if they do not encourage participants to consider consistent condom use.

Barrier: Peer educators have moral judgements about those engaging in high-risk behaviours.

Solution:

Bear in mind that moral judgements are counter-productive. Peer educators can set a good example by avoiding brothel visits and excessive alcohol consumption. But criticizing others who do not practise the same healthy behaviour can end up alienating those they are trying to help. More often than not, passing moral judgement on the behaviour of participants discourages them from talking about or addressing their high-risk behaviours. Instead, the educators should focus on creating strong lines of communication and getting participants to better understand their behaviour choices.

Barrier: Peer educators do not know where to refer participants for services that they may require.

Solution:
All peer educators should have the names of individuals and organizations that provide services, including counselling, home-based care and support, treatment for sexually transmitted infections, HIV counselling and testing, treatment of opportunistic infections such as tuberculosis, and other health-care services, including support groups in the community. This information is critical for peer educators and it is important that these sources be reliable and open to referrals. If participants are looking for specific services not on the list, educators should ask the supervisor or peer-education coordinator for recommendations.
Part 4: Generic peer education guide
Background information and exercises

Introduction

Part 4 is the largest part of this guide. It contains most of the exercises that peer educators will use, including step-by-step instructions and relevant background information. Peer-education trainers will also find Part 4 useful for introducing educators to the document and the different exercises.

Section topics

Part 4 consists of two major sections: one focusing on prevention and the other on care and support. Countries with relatively low rates of HIV infection will find the first section especially useful, whereas those with relatively high rates of infection will also find the care and support section relevant and useful. The section topics and their corresponding numbers are listed below.

Section A: HIV prevention

- Basic information about HIV/AIDS
- Basic information about sexually transmitted infections
- Condom use, demonstration and negotiation
- Voluntary HIV counselling and testing
- Human rights, stigma and discrimination
- Alcohol and drug use
- Gender issues
- Code of practice or conduct

Section B: HIV/AIDS-related care and support

- Living positively with HIV/AIDS
- Opportunistic infections and antiretroviral therapy
- Preventing mother-to-child HIV transmission
- Wills and inheritance

How to use Part 4 of the guide

Step 1: Read as much of Part 4 as possible, to increase your background knowledge. This will be helpful when answering questions during informal contacts.
Step 2: Ask participants which topics they are interested in exploring, referring to some of the topics covered in the guide. Remember that the peer-educator programme should be an integral part of the BCC workplace programme. The programme has been developed on the basis of the findings of a formative assessment, and behaviour change communication objectives have been developed in order to reduce high-risk behaviour among the target population. Ask the peer-education coordinator for a copy of the BCC workplace programme including the BC and BCC objectives. These will guide you in the choice of topics to be covered by the peer-education session.

Step 3: Make a plan that includes the exercises that are most appropriate for participants. For example, unmarried men with many sexual partners will need information and exercises on condom use, while married women may be interested in preventing mother-to-child transmission. Numerous exercises are provided to ensure that they meet most people’s needs. It is very unlikely that educators will use all of them.

Step 4: Choose a short and easy exercise as an “ice-breaker” for the first session, such as the exercise on “Getting comfortable with sexual terms.” Practise your introduction beforehand.

Step 5: Note the estimated time that each exercise is likely to take and make sure that it is feasible in the time available for the session.

Step 6: Keep track of the participants attending the sessions and get regular feedback from them.
Section A: HIV prevention

Basic information about HIV/AIDS

What is the definition of AIDS?

A stands for acquired. It means that HIV is passed from one person who is infected to another person.

I is for immune and refers to the body’s immune system. The immune system is made up of cells that protect the body from disease. HIV causes problems by entering a person’s body, then attacking and killing cells of the immune system.

D is for deficiency, which means not having enough of something. In this case, the body does not have enough of certain kinds of cells, called immune cells, which it needs to protect against infection. HIV enters the body and acts like a patient sniper, staying hidden for as long as it takes to weaken the immune system. Over time, HIV kills more and more immune cells, the body’s immune system becomes too weak to do its job, and the person living with HIV becomes sick.

S refers to syndrome, which is a group of signs and symptoms associated with a particular disease or condition. People with AIDS have symptoms and diseases that occur together only when HIV infection has progressed to AIDS.

How is HIV transmitted?

There are four possible methods of HIV transmission:

- sexual intercourse (anal and vaginal);
- contaminated blood and blood products;
- contaminated needles, syringes and other piercing instruments; and
- mother-to-child transmission (MTCT).

How does HIV spread during sex?

The following definitions may help in understanding exactly how the virus is passed from one person to another during sex.

Sexual intercourse means vaginal, anal or oral sex. Unprotected penetrative sex is the most frequent means of spreading and acquiring HIV infection.

Vaginal sex involves a man inserting his penis into a woman’s vagina. During vaginal sex, HIV can enter the body through cuts or tears inside the vagina or on the penis. HIV is contained in both semen and vaginal fluid, so a man can give HIV to a woman and a woman can pass HIV to a man. When a man is aroused, his penis stretches. Likewise, when a woman is aroused, her vagina stretches. This stretching makes the membranes in the penis and in the vagina more porous and causes very tiny cuts and breaks that you cannot see.

Anal sex refers to a man putting his penis into the rectum, or anus, of a woman or a man. During anal sex, HIV can enter the body through cuts or tears in the rectum, or anus. The
rectum does not stretch readily (like the vagina) and, because of this, can tear and bleed more easily. Both men and women can contract HIV from semen if an HIV-positive man ejaculates in his/her rectum. A penis can irritate and cut the anal lining, increasing the likelihood of the virus entering the body.

**Oral sex** involves sucking or licking of the genitals – a man can suck or lick a woman’s genitals or a man’s penis; a woman can suck or lick a man’s penis or a woman’s genitals. During oral sex, HIV may enter the body through the mouth if there are any cuts or tears inside the mouth due to injury or gum disease. People taking sperm into their mouths are more vulnerable than those ejaculating. Oral sex poses much less of a risk of infection than vaginal or anal sex, especially if sperm is not taken into the mouth.

**Other forms of HIV transmission**

**By receiving a transfusion of HIV-contaminated blood.** Not all blood is routinely tested for HIV. This may be the case in some developing countries if the necessary facilities or resources are unavailable.

**Sharing needles with a person living with HIV.** HIV-infected blood can be passed from one person to another as a result of sharing needles. This is particularly the case with those who inject drugs, such as heroin.

**During pregnancy, birth or breastfeeding, from a mother living with HIV to her baby.** During pregnancy, HIV can be passed from mother to baby through the placenta. At birth, HIV can be transmitted through blood during delivery. HIV is present in breast milk and can be transmitted to a baby during breastfeeding. A mother’s decision about whether to breast feed, if she is HIV-positive, is a difficult one that only she can make. Current statistics suggest that there is a 30 per cent chance that a mother can transmit HIV to her baby by breastfeeding.

**What are the stages of HIV infection?**

**Window period:** Once a person becomes infected with HIV, there is a period of three to six weeks (sometimes as long as three months) before the body reacts to the presence of the virus and produces antibodies (chemicals) that can be detected in the blood by laboratory tests. If these substances (antibodies) are found, the test result is “positive” and the person is said to be “HIV-positive”. The period of time during which an HIV test remains negative is called the “window period”. It is important to understand this, since an infected person can pass on the virus during this time, even though they may still test negative for HIV.

**Asymptomatic period:** After a person is infected with HIV, there is usually no change in that person’s health for quite a few years. The person feels well, is able to work as before and shows no signs of being sick (this is what is meant by “asymptomatic”). Although HIV is present in the body, the person is fit for work. This asymptomatic period varies in duration from a few years to as many as 12 years, with the average range being between eight and 12 years. However, some individuals begin to get sick just a few years after infection.

**Symptomatic period:** This is the period during which people become sick with AIDS-related illnesses. Remember, AIDS is a syndrome—a collection of conditions, which, taken together, leads to a diagnosis of AIDS. Most of the conditions that start to appear
are called "opportunistic infections". These infections are caused by bacteria or viruses that normally do not cause illness in a person with a strong immune system, but do cause illness in someone whose immune system has been weakened by HIV. These infections include diarrhoea, tuberculosis and pneumonia, and they repeatedly make the person sick. When a person is diagnosed with AIDS, the length of time until death can vary depending on the number and type of opportunistic infections and the availability of treatment and drugs. People with AIDS can live for a couple of years or much longer, if they receive drug treatment for opportunistic infections.

Window period and HIV testing: If a couple wants to stop using condoms or have a family, both individuals can undergo HIV testing at the same time and then use condoms with every sexual act (vaginal, oral or anal intercourse) during the six-month window period (assuming that they both test negative). When the six-month period is over, the couple can get tested again for HIV at the same time. If both still test HIV-negative, then they can start having sex without using a condom. To ensure their mutual safety, both individuals must agree to have sex only with each other.

How is HIV not spread?

- Through casual (non-sexual) social contact such as shaking hands, touching or hugging, sharing toilets, or eating food prepared by someone living with HIV.

- Sharing eating and cooking utensils such as cups, plates, pots, forks, spoons, etc.

- By kissing, including tongue kissing (French or deep kissing). HIV has been found in saliva, but the amount of the virus present in saliva is extremely small. No one has ever contracted HIV by kissing.

- By mosquitoes. Mosquitoes cause other diseases, such as malaria, but they do not transmit HIV.

Can a person become infected through a single exposure?

Anyone can become infected with HIV from a single unprotected sexual act or by injecting drugs just once. The vast majority of all HIV infections (80 per cent) are due to unprotected intercourse with a woman or a man who is already infected with HIV. Having sex with an infected person does not mean, however, that every time an infected person has unprotected sex they infect their sexual partners. An infected man might have sex with his wife for two years before infecting his wife or it could happen the first time they have sex. People are more infectious just after acquiring HIV.

What is the origin of HIV?

There is no definitive information about the origin of HIV. One theory suggests that it was first transferred to humans from monkey bites in Africa. Another theory is that it first came to Asia through injecting drug users who came from the west as tourists. However, knowing the origin of the virus makes no difference when it comes to protecting yourself from getting it.
Is there a cure for AIDS?

There is no cure for AIDS at present. A great deal of research and vaccine trials is currently taking place, but nothing has proven successful up to now. A combination of drugs called antiretrovirals can help control the virus so that it does not weaken the immune system and make it vulnerable to AIDS-related illnesses and opportunistic infections. Antiretroviral drugs can indefinitely control the virus but they are not able to eliminate it.

Do traditional healer ‘cures’ for AIDS work?

Traditional healers around the world are selling ‘cures’ for AIDS. Scientists have examined many of these so-called cures, but none so far has proven to eliminate HIV. There would be great joy in the world if traditional healers came up with something that really did cure AIDS. Some traditional healers have identified substances that can ease some of the symptoms of AIDS-related illnesses and opportunistic infections. Unfortunately, however, many people with HIV/AIDS turn to traditional healers with false hope and waste their money.

Is it easier for women to get infected than men?

Women are more vulnerable to infection than heterosexual men, due to the fact that their sexual organs are more internal. Women are also vulnerable to infection because they can be victimized by rape or coercion. They can also be driven to selling sex for financial reasons. Female sex workers who do not use condoms are vulnerable to contracting sexually transmitted infections, which increase their likelihood of infecting their many partners.

What is the impact of sexually transmitted infections on HIV infection?

The presence of an untreated sexually transmitted infection such as syphilis or gonorrhoea facilitates the transmission of HIV from one person to another. This is because open sores and blisters caused by the infection provide more direct access to the bloodstream, making it easier for other infections, such as HIV, to enter the body. Having a sexually transmitted infection is already a sign of risky behaviour or vulnerability to HIV. Prevention and treatment of sexually transmitted infections are therefore important aspects of protecting oneself against HIV infection.

How does alcohol and drug use increase the chance of infection?

Drinking alcohol or using illegal drugs can impair a person’s judgement and ability to act within the bounds of safe behaviour. When people are under the influence of alcohol and/or drugs, they are more likely to indulge in risky sexual contacts. Consumption of alcohol also tends to increase the libido and make people feel like having sex. Due to isolation or boredom with repetitive work, some workers are inclined to use alcohol or drugs as a means of escape.

What is safer sex?

Practising safer sex means taking precautions to reduce the risk of contracting HIV or other sexually transmitted infections during sexual intercourse. The easiest way for sexually active individuals to do this is to use condoms every time they engage in vaginal,
anal or oral sex. (In rare cases, usually as a result of improper use, a condom may break during sexual intercourse. There is then a risk of HIV being transmitted, if one partner is already infected.) Other approaches to safer sex include being faithful to one’s partner (assuming that both partners are HIV-negative) and practising non-penetrative sex such as masturbation, mutual masturbation and intercrural sex (that is, simulating sex between a partner’s thighs).

What is the ABC...DE approach?

**Abstain:** Choose not to have sex.

**Be faithful:** Only have sex with one partner whom you know (from an HIV test) to be HIV-negative.

**Condoms:** Use condoms correctly every time you have sex. Condoms provide a barrier that prevents fluids from entering the body.

**Delay:** Wait another year before having your first sexual experience.

**Early treatment of sexually transmitted infections:** Sexually transmitted infections increase the risk of HIV infection. All sexually transmitted infections should be treated as early as possible.
### Exercise 1: True or false

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>To clarify misunderstandings about how HIV is, and is not, transmitted</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is often an unwarranted fear of HIV infection being contracted through casual contact, such as sharing cups or shaving razors. The point of this exercise is to get participants to better understand what puts them at risk of infection.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Time</th>
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<td>1 hour</td>
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#### Instructions

Ask participants the following questions and ask them to explain why they think their answer is true or false. Provide them with explanations about potential risks (if any) in each situation and how to protect themselves against infection.

1. **You can get HIV from kissing (false).**

   HIV has been found in saliva, but the amount of the virus present in saliva is extremely small. No one has ever contracted HIV by kissing.

2. **Breastfeeding can transmit HIV (true).**

   The breast milk of infected women contains a small amount of HIV, but it is often not enough to infect breastfeeding babies. The risk of transmission increases if the baby's gut has been irritated by dirty water or other contaminated liquids. This is why mothers are advised to exclusively breastfeed their child for the first six months.

3. **People can protect themselves from HIV by always using condoms during sex (true).**

4. **You can get HIV by having oral sex without a condom (true).**

   During oral sex, HIV may enter the body through the mouth if there are any cuts or tears inside the mouth due to injury or gum disease. People taking sperm into their mouth are more vulnerable than those ejaculating. However, oral sex poses much less of a risk of infection than vaginal or anal sex, especially if sperm is not taken into the mouth.

5. **People can protect themselves from HIV by only having sex with one faithful partner who is HIV-negative (true).**

6. **You can get HIV by receiving a transfusion of HIV-contaminated blood (true).**

   Not all blood is routinely tested for HIV. This may be the case in some developing countries if the necessary facilities or resources are unavailable.
7. A person can get HIV from mosquito bites (false).
Mosquitoes cause other diseases, such as malaria, but they do not transmit HIV.

8. Faithful married women can get HIV (true).
A faithful spouse may have no way of knowing if her husband is also faithful or if he uses a condom if he has sex with other women. If the husband gets HIV, his wife will also get it if they do not use condoms when they have sex.

9. You do not get HIV by having sexual intercourse only with healthy-looking people (false).
Most people living with HIV just look like everybody else and you cannot tell by looking at them if they have the virus.

10. Some condoms have invisible holes through which the virus can pass (false).
Studies prove that HIV, other sexually transmitted infections and sperm are unable to pass through a latex (rubber) condom.

11. All children born to HIV-positive women will get HIV (false).
During pregnancy, the placenta is usually a good barrier between the mother and the baby and keeps infected white blood cells away from the baby. But if there is damage to the placenta, it is possible for the mother's blood to come in contact with the baby during pregnancy.
During childbirth, the baby's eyes, mouth or nose can come in contact with the mother's blood and the virus can enter the baby. There are ways to reduce this risk, including elective caesarian sections and the use of antiretroviral drugs. HIV-positive women should consult a health-care professional once they know they are pregnant.
During breastfeeding, HIV can be transmitted through infected breast milk. This is especially true if the baby has an irritated stomach from a gastrointestinal infection caused by ingestion of contaminated water. The breast milk of infected women contains a small amount of HIV. If possible, an HIV-positive mother should not breastfeed, but should give her baby milk formula made with clean water. If replacement feeding is not possible, then a mother should exclusively breastfeed her child for six months (no water, juice or other foods). When the mother stops breastfeeding, she must stop entirely otherwise the baby's stomach may become irritated, thereby increasing the risk of HIV infection.

12. You can get HIV by hugging a person with AIDS (false).
HIV is not spread through casual (non-sexual) social contact such as shaking hands, touching or hugging, sharing toilets, or eating food prepared by someone living with HIV.

13. You can get HIV by sharing needles with a person living with HIV (true).
HIV-infected blood can be passed from one person to another as a result of sharing needles. This is particularly the case with those who inject drugs such as heroin.
**Exercise 2: The glove game**

**Objective**
There is often an unwarranted fear of HIV infection being contracted through casual contact, such as sharing cups or shaving razors. The point of this exercise is to get participants to better understand what puts them at risk of infection.

**Background**
This game is more complex than some of the others in this guide. It is important to explain the rules slowly and clearly.

**Materials**
Small pieces of paper (sheets of paper torn into four parts), two pairs of gloves.

**Time**
45 minutes

**Instructions**

**Step 1:**
Prepare small slips of paper so that you have a number equal to three less than the total number of participants. (For example, if you have 20 participants, prepare 17 slips of paper.) Write an ‘X’ on one of the slips and leave all of the others blank. Put the slips into a hat or bowl. Prepare three additional slips of paper with the following instructions:

- **G** – Wear a glove on your right hand during rounds 1 and 2 of the activity.
- **G** – Wear a glove on your right hand during rounds 3 and 4 of the activity.
- **A** – During the game, if somebody tries to shake your hand, apologize and explain to them that you do not shake hands.

**Step 2:**
Put the two pairs of gloves where participants can easily find them. Instruct participants to take a sheet of paper and to write the numbers 1 to 4 down one side. Then ask each participant to choose a slip of paper from the bowl or hat and read it if something is written on it (without saying anything to anybody).

**Step 3:**
Ask the participants to find a partner (if there is an odd number of participants, the facilitator can join the game). They should greet their partner, shake hands, and write the partner’s name opposite the number 1 on their sheet of paper.

**Step 4:**
Instruct them to now move around and find another partner. Again, they should greet their partner, shake hands and write the partner’s name opposite the number 2 on their sheet of paper.
paper. Repeat until everybody has shaken hands with four different people, and has written four names on their sheet of paper.

**Step 5:**

Ask the person with the ‘X’ on his/her slip of paper to come forward. Explain that, in this game, this person is infected with HIV. Ask everybody to look at line 1 of his or her sheet of paper. If the infected person’s name is on line 1 of their sheet, they should come forward. Ask each person who comes forward if they were wearing a glove when they shook hands with the infected person. If they were not wearing a glove, they should join the ‘infected’ person and stand in the middle. If they were wearing a glove, they should return to their seats.

**Step 6:**

Now ask everybody to look at line 2 of their paper. Anyone who has the name on line 2 of any of the people standing in the middle should come forward. Unless they were wearing a glove, they should join the people (standing or sitting) in the middle.

**Step 7:**

Now ask everybody to look at line 3 of their paper. Anyone who has the name of any of the people standing in the middle should come forward and join them, unless they were wearing a glove when they shook hands.

**Step 8:**

Now ask everybody to look at line 4 of their paper. Anyone who has the name of any of the people standing in the middle should come forward and join them, unless they were wearing a glove when they shook hands.

**Step 9:**

Ask participants what the handshake represented (answer: sexual intercourse). Ask participants to take note of the number of participants who became infected from only one person with HIV. This demonstrates how rapidly the disease can spread, and the multiplier effect. How did they feel when they saw the number of people who ended up in the middle?

**Step 10:**

Ask the person who had the ‘A’ on their sheet to come forward. Explain that the ‘A’ represented abstinence. Ask this participant how they felt when they could not join in the handshaking. Was it difficult? How did others feel when this person refused to shake hands?

**Step 11:**

Ask what the glove represented (answer: condom). Find out if either of the people wearing gloves became infected. If so, use this to make the point that one must use condoms.
every time one has sex in order to be protected from HIV and other sexually transmitted infections. Ask the two participants who wore the gloves how they felt when they shook hands. How did their partners feel?

**Step 12:**

Ask the people who were not infected:

- How was your behaviour different from those who became infected?
- How did you end up not becoming infected?
- How did you feel about those who became infected?

**Step 13:**

Ask the people who were infected:

- What are you thinking, now that you realize you may be infected?
- What could you have done differently to protect yourself?
- How would you know in real life if you had been infected?
- Would you tell anybody that you might be infected? Who?
- Would you tell your sexual partner(s)?
- What support would you need at this stage and to whom would you turn?

**Step 14:**

Be sure to remind participants that this was only a game and that the person with the ‘X’ is, of course, not necessarily infected with HIV. Also be sure to emphasize that HIV cannot be transmitted by a handshake or prevented by wearing a glove. The selection of slips from the bowl or hat was random. Each handshake represented a round of unprotected sex. Even one instance of unprotected sex presents a risk of HIV infection.

**Step 15:**

Stress the importance of going for an HIV test and provide information on where this can be done.
Exercise 3: *Wildfire*

**Objective**
To decrease the perceived distance between workplace personnel and the HIV epidemic. This exercise also tends to instill a sense of empathy and understanding for people living with HIV/AIDS.

**Background**
This exercise can be very emotional. The facilitator should allow time for individuals to share their feelings and experiences. The exercise should close with reinforcement of the fact that you cannot get HIV from shaking hands, together with a presentation on the basic facts of HIV/AIDS.

**Time**
45 minutes

**Instructions**

**Step 1:**
Have the participants sit in a circle. Ask them to close their eyes. Explain that you will be going around the circle and will tap two or three people on the shoulder. The person that is tapped will be considered HIV-positive for the purpose of the exercise. (If you have participants who you know are HIV-positive, you should consult with them and ask them to help to facilitate the exercise, if they are willing.)

**Step 2:**
Ask participants to stand up and walk around. They should shake the hands of no more than three people.

**Step 3:**
Once participants are seated again, ask those individuals whose shoulders you tapped to raise their hands. Ask those individuals who shook hands with the tapped individuals to raise their hands. Ask the next level to raise their hands (those who shook hands with an individual who shook hands with the first people tapped).

**Step 4:**
Explain to the group that you cannot get HIV from shaking hands, but that, for the purpose of this exercise, we will assume that high-risk behaviour took place and that each of the individuals who raised their hands was exposed to the virus. Ask those who were tapped how they felt.

**Step 5:**
Ask those who have been exposed whether or not they would like to go for an HIV test. Those who do not want to go should explain why.
Step 6:

Explain that the majority of people who are HIV-positive do not know their status and might be transmitting the virus to others by having unprotected sexual intercourse. Stress the importance of going for an HIV test and provide information on where this can be done.
Exercise 4: HIV scratch chain

**Objective**
To generate a better understanding of how quickly HIV can spread

**Background**
This game is more complex than some of the others in this guide. It is important to explain the rules slowly and clearly.

**Time**
20 minutes

*Instructions*

**Step 1:**
Have participants stand in a circle with their eyes closed. Tell them that you will designate one person to be infected with HIV. That person will be given a tap on the shoulder.

**Step 2:**
Get the participants to shake hands with three different people and tell the infected person to gently scratch the palm of three people he or she shakes hands with.

**Step 3:**
After all the handshaking is complete, ask the person who was tapped on the shoulder to step into the middle of the circle and to say how he/she felt after realizing that he/she was infected with HIV. Ask how the person felt about infecting others. Ask those who had their hands scratched by that person to step into the middle of the circle. Ask them how it felt when they realized that they had been infected.

**Step 4:**
Stress the importance of going for an HIV test and provide information on where this can be done.
Exercise 5: **Personal risk assessment**

**Objective**
To increase awareness of an individual’s personal risk from HIV infection

**Background**
The purpose of this exercise is to get participants to reflect on how the behaviour choices they make may render them vulnerable to HIV infection.

**Materials**
Sheets of paper.

**Time**
45 minutes

**Instructions**

**Step 1:**
Get participants to mark one point on a piece of paper for each of the following questions to which they answer “yes”.

a) Have you ever had sex without a condom?

b) Have you had sex without a condom with a woman (or a man) who was not a faithful partner?

c) If you are or were married, have you ever had sex without a condom with a woman (or a man) who is not your wife (husband)?

d) Have you ever engaged in unprotected sex with a woman who broke a law, in exchange for not reporting her to the police or letting her go free?

e) Have you ever had a sexually transmitted infection (such as Chlamydia, gonorrhoea or syphilis)?

f) Have you ever been so drunk that you did not remember having sex?

g) Have you ever treated a sexually transmitted infection without consulting a health professional?

h) Have you had sex without a condom with more than 15 women (or men) during your lifetime?

i) Have you ever had a blood transfusion?

j) Have you ever had sex without a condom with a woman (or a man) you just met?

k) Have you ever had one or more new sexual partners in the period of a month and not used a condom in each case?

l) Have you ever paid money for sex?

m) Have you ever had anal sex without a condom?

n) Did your wife (or husband) ever have sex with another man (or woman) before you were married?

o) Do you desire sex more after drinking alcohol?

p) For men: Have you ever had sex with a schoolgirl and not used a condom?

q) For men: Have you ever forced a woman to have sex against her will?
Step 2:
Have the participants add up their scores and explain to them the consequences of the categories in which their point totals place them.

12-18 points: Extremely high risk. You should consider having an HIV test.

6-12 points: High risk. You should seriously consider increased condom use, reflect on your behaviour choices and get tested for HIV.

0-6 points: Low risk. Your risk is moderate but still exists.

Step 3:
Ask participants to each make a list of the things they do that put them at risk of contracting HIV and the actions that they personally can take to change those behaviours. (For example, one risk is having unprotected sex. The behaviour change might be to use a condom when having sex.)

Step 4:
Stress the importance of going for an HIV test and provide information on where this can be done.

Basic information about sexually transmitted infections

Why are sexually transmitted infections important?

- They are an indication that a person has engaged in unprotected sex and may therefore be vulnerable to HIV infection.

- They greatly increase the chances of HIV being transmitted by providing an opening (in the form of tears in the skin due to irritation or inflammation) for the virus to enter the body.

- Sexually transmitted infections are the leading cause of infertility among women. These infections can damage a woman’s reproductive system, making it difficult or impossible for her to get pregnant. For example, Chlamydia is a very common infection that can cause infertility. Some women can have an infection without any symptoms, but it may still prevent them from having children.

What are the key issues for workplace personnel?

Sexually transmitted infections need to be treated rapidly and professionally. Employees are often reluctant to use workplace medical services for the treatment of sexually transmitted infections. They may also think it is less expensive to go directly to a pharmacy than to see
a doctor or nurse. There is a tendency to let sexually transmitted infections go untreated or to treat oneself by getting an over-the-counter remedy at a pharmacy. It is important to get reliable treatment. Letting sexually transmitted infections go untreated or treating oneself may lead to serious complications, including sterility and even death.

Ensure that all sexual partners are tested and treated. If you have a sexually transmitted infection, it is important to notify your partner(s) so that everyone can receive treatment. If you receive proper treatment and your partner does not, you may be re-infected in the event of further sexual relations between the two of you. A person can be infected and have no symptoms, and may even re-infect a partner after he or she has been treated.

**What are the most common sexually transmitted infections?**

The sexually transmitted infections most commonly found around the world are listed below, along with those who suffer from them, the symptoms and what happens if they are left untreated.

**a. Chlamydia**

Males: 25 per cent have no symptoms. Men may experience a painful or burning sensation when they urinate and/or a watery or milky discharge from the penis.

Females: 75 per cent have no symptoms. Women may experience abnormal vaginal discharge, irregular vaginal bleeding and abdominal or pelvic pain, accompanied by nausea and fever. May cause painful urination, blood in the urine or a frequent urge to urinate.

Both sexes: Eyes may become infected, producing redness, itching and irritation. Infection of the eyes can result from an infected person touching his or her genitals and then the eyes.

Babies: Some types of sexually transmitted infections can be transmitted from the mother to the baby’s eyes during childbirth.

If sexually transmitted infections are left untreated: May cause severe complications such as non-gonococcal urethritis in men and pelvic inflammatory disease in women. If untreated, pelvic inflammatory disease often leads to infertility. If a baby’s eyes become infected, they can be treated with antibiotic cream. If left untreated, the baby can become blind.

**b. Gonorrhoea**

Males: A cloudy (thick, grayish-yellow) pus-like discharge from the penis and a burning sensation during urination. Some males show no signs of infection.

Females: Usually show no signs of infection. Some women have a pus-like vaginal discharge, irregular bleeding, painful urination and lower abdominal pain.

Both sexes: Symptoms may occur two to ten days after contact with an infected person.

Babies: Can cause blindness.

If left untreated: Sterility can occur. Can cause pelvic inflammatory disease in women.
c. **Genital herpes**

Both sexes: Caused by the herpes simplex virus and transmitted through direct skin-to-skin contact during vaginal, anal or oral sex. Although some people have no symptoms, most experience an itching, tingling or burning sensation, which often develops into painful, blistering lesions on or around the genitals or in the anus. Symptoms may appear two to ten days after exposure and last two to three weeks. Some people have no symptoms.

If left untreated: Recurring outbreaks of the painful blister occur in 33 per cent of those who contract herpes. May increase the risk of cervical cancer. Can be transmitted to a baby during childbirth.

d. **Syphilis**

Both sexes: For both males and females, symptoms appear ten days to three months after contracting syphilis. A painless chancre sore appears on or in the genitals, anus, mouth or throat. If initially left untreated, a skin rash will develop, often on the hands and soles of the feet, three to six weeks after the chancre appears. It then usually disappears. Other symptoms may include hair loss, sore throat, fatigue or mild fever.

If left untreated: It can eventually, after many years, cause heart failure, blindness and damage to the brain and spinal cord.

e. **Chancroid**

Both sexes: Symptoms includes soft, painful sores that bleed easily on or around the entrance to the vagina, penis or anus. May also cause enlarged, painful lymph nodes in the groin and slight fever.

Females: Many have no symptoms. May have pain upon urination or defecation, rectal bleeding, pain during intercourse or vaginal discharge.

If left untreated: People with chancroid are highly susceptible to HIV because the sores bleed easily and allow the virus to enter the body via the bloodstream.

f. **Genital warts**

Both sexes: Genital warts are the result of a virus spread during sexual contact. They often grow together in little clusters on and inside the genitals, anus and throat. Depending on the location, they can be pink, brown or gray, and soft; or small, hard and yellowish-gray. They are not common.

If left untreated: Genital warts disfigure the genitals. It is possible to treat them without creating permanent damage.
g. *Trichomoniasis*

Females: This is a vaginal infection that is most often contracted through intercourse, but can also be transmitted through moist objects such as wet clothing, towels, washcloths, etc. Symptoms include a burning sensation during urination and an odorous, foamy discharge, along with a reddening and swelling of the vaginal opening.

Males: Men usually have no symptoms but might have a slight discharge and/or lesions, and experience itching.

If left untreated: Can cause urinary infections.

h. *Pelvic inflammatory disease*

Pelvic inflammatory disease affects the fallopian tubes, uterine lining and/or ovaries. It is usually caused by untreated sexually transmitted infections that enter the reproductive system through the cervix, such as Chlamydia or gonorrhea. While symptoms vary from person to person, the most common symptom is pain in the pelvic regions. Other symptoms may include frequent urination and/or burning during urination, sudden fevers, nausea or vomiting, abnormal vaginal discharge and/or pain or bleeding after intercourse.

If left untreated: Infertility or ectopic pregnancy may result.
Exercise 6: Musical partners

Objective To create a better understanding of the risk of contracting a sexually transmitted infection from unprotected sexual relations with different partners.

Background This game is designed to demonstrate graphically how quickly a sexually transmitted infection can spread.

Instructions

Step 1:
Write ‘STI’ (meaning sexually transmitted infection) and ‘clinic’ on two index cards or pieces of paper. Have five condoms and a drum (or an object that can be banged like a drum) on hand. Designate a small area as the location of the ‘clinic’ and place the sign there. Using chairs or other objects placed at the four corners of the room, mark off another area measuring 9 feet by 9 feet (3 metres x 3 metres).

Step 2:
Ask for about ten volunteers and give the ‘STI’ card to one of them, telling that person that he or she has a sexually transmitted infection. Give the condoms randomly to half of the participants. The game can be played with more or less people but condoms should always be given to half of them.

Step 3:
Explain that people must circulate in the square while the drum is played. As soon as the drum stops, the person with the STI card grabs the nearest person. (Recorded music can be used instead of a drum.) If they have a condom on them, they do not contract the sexually transmitted infection and are released to continue the game. If they do not have a condom, they contract the infection and must retire to the ‘clinic’ for treatment. The game continues until only those with condoms are left in the square and transmission of the sexually transmitted infection has been stopped.

Step 4:
Following the exercise, ask those without condoms what they were thinking when the drum was beating. Did they feel vulnerable and nervous that they might be caught? Then ask those with the condoms how they felt.

Step 5:
Provide information on where workers can obtain access to STI-treatment services.
Exercise 7: **Contact tracing**

<table>
<thead>
<tr>
<th>Objective</th>
<th>To increase understanding of the importance of prompt treatment of sexually transmitted infections by participants and their partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>If people with sexually transmitted infections do not ensure that their partners get treatment as well, they risk getting the infection again if they continue to have unprotected sex with the same person.</td>
</tr>
<tr>
<td>Time</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

**Instructions**

Step 1:
Ask for volunteers to act out the parts of the sexually transmitted infection clinic client and the clinic worker.

Step 2:
Ask the volunteer participants to perform a one-minute role-play following this story line:

*Robert, a car mechanic, finally gets the courage to go to the clinic and check out a red sore on his penis. The clinic worker examines him and tells him he is suffering from a sexually transmitted infection. The clinic worker tells him to bring in his wife and any other sexual partners for treatment. Robert is very embarrassed and worried. He tells the clinic worker that he thinks this will be impossible. She explains that it is very important to keep the sexually transmitted infection from spreading to others.*

Step 3:
Ask participants the following questions. (Make sure that each question is thoroughly answered before moving on to the next one.)

- What is happening here?
- Why does this happen?
- What problems does this cause?
- Does this happen to people you know?
- When it happens, what can be done?
- Why is it important to treat people with sexually transmitted infections and their partners?
Step 4:
Summarize some of the issues raised by the participants (such as examples from their relationships, poor communication between couples, personal denial and overwhelming embarrassment).

Step 5:
Provide information on where workers can obtain access to STI-treatment services.
Exercise 8: Sexually transmitted infections, true or false

<table>
<thead>
<tr>
<th>Objective</th>
<th>To learn the basic facts about sexually transmitted infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>The idea of this game is to learn basic facts about sexually transmitted infections by designating listed statements as true or false.</td>
</tr>
<tr>
<td>Time</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Instructions

Step 1:
Either read the statements one by one or write them out beforehand on folded sheets of paper (one statement per sheet). If they are written out, have the participants choose a statement.

Step 2:
Introduce the activity by explaining that the group is now going to discuss facts about sexually transmitted infections and write out the letters “STI” on a piece of paper or flipchart. Explain what the letters stand for:

S – sexually          T – transmitted          I – infections

Explain that some people use the term STD (sexually transmitted disease).

Step 3:
Explain that HIV is considered a sexually transmitted infection, but that, in this section, you will mostly be talking about “classic” infections – that is, all sexually transmitted infections except HIV. HIV will be discussed in detail later. Tell them that you will always clearly indicate when you are talking about sexually transmitted infections including HIV, or when you are talking about sexually transmitted infections excluding HIV.

Step 4:
Divide the participants into two teams and ask them to stand opposite each other. Explain that you are going to play a game and that the team with the most points wins. Choose a scorekeeper.

Step 5:
Give the following instructions to the participants: Each team will draw a statement from the basket or have a question read out. The team must decide if the statement is true or
false by discussing it together. Then, one team member should read the statement and state the team’s answer, together with their reason for giving that answer. If the team is correct, they score two points. If they can explain why the answer is correct, they get one extra point. If the team is incorrect, they gain no points. Offer the explanation for the right answer after each incorrect response.

a) **A person can always tell if she or he has a sexually transmitted infection.**
   (False. People can and do have sexually transmitted infections without having any symptoms. This happens most often to women because their sexual body parts are internal. However, men who have sexually transmitted infections such as Chlamydia may not have symptoms either. People who are infected with HIV generally have no symptoms for a long time—sometimes years—after infection.)

b) **With proper medical treatment, all sexually transmitted infections except HIV can be cured.**
   (False. Herpes, a sexually transmitted infection caused by a virus, cannot be cured at the present time.)

c) **The organisms that cause sexually transmitted infections can only enter the body through either the woman’s vagina or the man’s penis.**
   (False. Sexually transmitted bacteria and viruses can enter the body through any mucus membranes, including those along the vagina, penis, anus, mouth and, in some cases, the eyes. HIV can also enter the body as a result of using unsterilized drug-injecting equipment.)

d) **You cannot contract sexually transmitted infections by holding hands, talking, walking or dancing with a partner.**
   (True. Most sexually transmitted infections are contracted as a result of close sexual contact with an infected person.)

e) **Many curable sexually transmitted infections, if left untreated, can cause severe complications.**
   (True. Some complications can lead to infertility in women. If a baby’s eyes are infected with Chlamydia and not treated, the baby can become blind. Other complications can lead to heart failure or damage to the brain.)

f) **People who have a sexually transmitted infection should not have unprotected sexual intercourse, because they are more likely to contract or transmit HIV.**
   (True. Someone with a sexually transmitted infection is more likely to contract or transmit HIV, especially if the sexually transmitted infection causes open sores. The inflamed areas act as an open window, allowing HIV to enter.)

g) **It is impossible for sexually transmitted infections to penetrate through a condom if it is properly used and does not break.**
   (True. Sexually transmitted infections cannot penetrate latex (male condoms) or polyurethane (female condoms).)

h) **It is impossible for men to get sexually transmitted infections when they have sex with other men because men get sexually transmitted infections from women’s vaginas only.**
(False. Men can acquire sexually transmitted infections by having anal or oral sex with other men. They risk contracting the same infections that can be contracted by men who have sex with women).

**Step 6:**
Play the game until all statements have been drawn from the basket. Have the scorekeeper announce who the winning team is. You can distribute condoms or other materials as a prize to the winning team members.

**Step 7:**
Provide information on where workers can obtain access to STI-treatment services.
Exercise 9: *Names and symptoms of sexually transmitted infections*

**Objective**
To familiarize participants with the different sexually transmitted infections, symptoms and problems that result if they are left untreated.

**Background**
The presence of sexually transmitted infections during sexual relations greatly increases the chances of HIV being passed from one person to another.

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**Instructions**

**Step 1:**
Peer educator should read the section on sexually transmitted infections for background information.

**Step 2:**
Write the following list of sexually transmitted infections on a flipchart, chalkboard or sheet of paper before starting the exercise. Beside the medical name for the infection, leave space for the commonly used name for the same sexually transmitted infection in slang or local languages.

<table>
<thead>
<tr>
<th>Sexually transmitted infection name</th>
<th>Common/local language</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
</tr>
<tr>
<td>Herpes</td>
<td></td>
</tr>
<tr>
<td>Genital warts</td>
<td></td>
</tr>
<tr>
<td>Candidiasis (thrush)</td>
<td></td>
</tr>
<tr>
<td>Chancroid</td>
<td></td>
</tr>
<tr>
<td>Granuloma inguinale</td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td></td>
</tr>
<tr>
<td>Genital warts</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td></td>
</tr>
</tbody>
</table>
Step 3:
Show participants the list of sexually transmitted infections. Read each name, one at a time, and ask participants to give the common or local names for this infection. Point out that HIV is also a sexually transmitted infection, but it is not included in this exercise.

Step 4:
Clarify that these signs and symptoms DO NOT include the signs and symptoms of AIDS. Remind participants that many people with sexually transmitted infections do not have any signs or symptoms and that people can have more than one infection at a time.

Signs in males:
- Discharge from penis (green, yellow, pus-like)
- Painful urination, difficulty urinating, urinating more often
- Swollen and painful glands/lymph nodes in the groin
- Blisters and open sores (ulcers) on the genitals; painful or non-painful
- Nodules under the skin
- Warts in the genital area
- Non-itchy rash on limbs
- Itching or tingling sensation in the genital area
- Flu-like symptoms (headache, malaise, nausea, vomiting)
- Fever or chills
- Sores in the mouth

Signs in females:
- Irregular bleeding
- Lower abdominal/pelvic pain
- Abnormal vaginal discharge (white, yellow, green, frothy, bubbly, curd-like, pus-like and odorous).
- Swelling and/or itching of the vagina; swelling of the cervix.
- Painful or difficult intercourse

Step 5:
Ask participants to list the sexually transmitted infections that they consider to be the most common.

Step 6:
Ask participants to describe any sexually transmitted infections that they (or close friends or relatives) have had and what the symptoms were.

Step 7:
Tell participants that untreated sexually transmitted infections can eventually cause serious, sometimes life-threatening, complications. Read through the list of complications of untreated sexually transmitted infections (which should be written, if possible, on a
flipchart, chalkboard, or piece of paper):

- Infertility
- Blindness
- Pelvic inflammatory disease
- Cervical cancer
- Transmission of infection to newborn
- Increased risk of HIV infection

**Step 8:**
Mark a star next to “Increased risk of HIV infection” and tell participants the following:

*Some sexually transmitted infections can increase the risk of HIV transmission as much as tenfold. This is because of the open sores associated with genital ulcers and other infections. HIV infection may also increase transmission of some sexually transmitted infections, due to the body’s weakened immune system.*

**Step 9:**
Ask participants whether they have any questions about sexually transmitted infection signs, symptoms or complications. Look for the answers in Part 4: Basic facts about sexually transmitted infections.

**Step 10:**
Provide information on where workers can obtain access to STI-treatment services.

Exercise 10: Treating sexually transmitted infections

**OBJECTIVE**
To increase understanding of the importance of seeking professional treatment of sexually transmitted infections

**BACKGROUND**
A sexually transmitted infection, if not properly treated, cannot get better and can even get worse. This exercise helps participants think about the implications of treatment.
Exercise 10: Treating sexually transmitted infections

Objective
To increase understanding of the importance of seeking professional treatment of sexually transmitted infections

Background
A sexually transmitted infection, if not properly treated, cannot get better and can even get worse. This exercise helps participants think about the implications of treatment.

Materials
Sheets of paper

Time
1 hour

Instructions

Step 1:
Write each of the following statements on five different sheets of paper:

a) “I thought I had a sexually transmitted infection. But now, thank God, my symptoms are gone. I don’t have to worry any more.”

b) “I’m sure I had a sexually transmitted infection. But I got some antibiotics from the chemist’s, so I’m feeling better. I didn’t even have to finish all the medicine.”

c) “My male partner has a discharge and probably has a sexually transmitted infection. Since I have no symptoms, I’m sure I didn’t get it.”

d) “I think I might have a sexually transmitted infection, but I’m too nervous about going to the clinic.”

e) “I had a red sore on my penis/vagina and bought four blue pills from a young man at the market. It was cheaper than going to the chemist’s. After a long time, the sore went away.”

Step 2:
Tell the participants that it is possible to have a sexually transmitted infection, show no symptoms, and yet still transmit it to other people. Give one piece of paper to each group and ask them to read through their problem situation carefully. Ask them to imagine that one of their friends was in this situation and to consider what advice they would give them.

Step 3:
Have each group tell the other groups what advice they would give their friend. The following points may be added if they were not raised by the groups.
a) “I thought I had a sexually transmitted infection. But now, thank God, my symptoms are gone. I don’t have to worry anymore.”
   - It is possible to contract a sexually transmitted infection and have symptoms that later disappear.
   - You are probably still carrying the sexually transmitted infection and able to infect others with it.
   - Go to the clinic and get checked.
   - You should use condoms so that you do not get another sexually transmitted infection.

b) “I’m sure I had a sexually transmitted infection. But I got some antibiotics from the chemist’s, so I’m feeling better. I didn’t even have to finish all the medicine.”
   - Not taking all the prescribed antibiotics is bad, because although the symptoms may have disappeared, you may still have the sexually transmitted infection in your system.
   - Stopping the antibiotic halfway through its course enables the sexually transmitted infection to develop a resistance to the antibiotic, which means that subsequent use of this antibiotic will be less effective.
   - You paid for the antibiotic. You should get your money’s worth and use it all.

c) “My male partner has a discharge and probably has a sexually transmitted infection. Since I have no symptoms, I’m sure I didn’t get it.”
   - You can have a sexually transmitted infection without having any symptoms.
   - You may have passed on the sexually transmitted infection to your partner.

d) “I think I might have a sexually transmitted infection, but I’m too nervous about going to the clinic.”
   - You should pluck up the courage to go to the clinic for a check-up.
   - You should be concerned if you or your partner is having unprotected sex with someone else. You should be using condoms.

e) “I had a red sore on my penis/vagina and bought four blue pills from a young man at the market. It was cheaper than going to the chemist’s. After a long time, the sore went away.”
   - The symptom may have gone but the sexually transmitted infection might still be there.
   - You may think you are saving money but you may not be, if the medicines are not the right ones and do not do the job.
   - You should use condoms. Getting a sexually transmitted infection is a warning sign that you are vulnerable to getting HIV.
   - You should go to the clinic and get checked.

Step 4:
Ask the participants what they think the lessons of this exercise might be. Mention the following:
   - You can have a sexually transmitted infection without having any symptoms and can pass it on to others.
You should take the full treatment prescribed for the treatment of sexually transmitted infections.

You should use condoms in the future to avoid getting sexually transmitted infections again.

You should go to a clinic for proper treatment when you suspect that you might have contracted a sexually transmitted infection.

Step 5:
Provide information on where workers can obtain access to STI-treatment services.

**Condom use, demonstration and negotiation**

Peer educators often experience resistance from those who:

- oppose condoms for religious or moral reasons;
- deny the reliability of condoms in preventing HIV;
- are embarrassed by condoms and sexual matters;
- deny the risk presented by sexual activity and the need for condoms; or
- think condom promotion will encourage sexual activity.

**Why overcome obstacles to condom use?**

If obstacles to condom use are not overcome, its effectiveness as a tool for prevention will be compromised. To prevent the transmission of HIV and other sexually transmitted infections, it is necessary to deal openly and honestly with human sexuality and condom use. If peer-education planners and peer educators do not make the promotion of condoms a priority, little progress can be made. Failure to overcome obstacles to condom promotion and condom use means that more people will die from AIDS.

**How can obstacles be overcome?**

There are no set ways of overcoming obstacles and no guarantees that efforts will always meet with success. Nevertheless, the following suggestions may be helpful:

**Identify obstacles as soon as possible.** The earlier obstacles are identified, the easier it is to overcome them. No matter how well-intentioned peer educators are in promoting condom use, unforeseen obstacles can sabotage their efforts. Rather than guessing what the obstacles might be, peer educators should find out what they actually are by asking their peers.

**Find out what is acceptable.** One way to find out to what degree condom promotion is acceptable is to speak with a few individuals about condoms before speaking to a larger group. Perceptions of what may be offensive are not always accurate. At times, people are more open to challenging convention than peer educators give them credit for.

**Get those involved to understand the obstacles that exist.** Sometimes, just pointing out that an obstacle exists and talking about it is enough to eliminate it. It may also require a special effort and take time to get people to appreciate the fact that they harbour prejudices or that their attitudes are closed, or to accept a reality that they deny exists or makes them feel uncomfortable.
Deal openly and honestly with the obstacle. It is important to discuss the reasons behind obstacles and look at possible compromises for overcoming them. Role-playing, group exercises, games and other techniques can help people come to grips with obstacles. (See Appendix G for a series of role-playing exercises.)

Be bold, firm and convincing. Peer educators have to be strong in their conviction that the approach they are taking is correct; they should not be afraid of breaking with convention and pushing currently accepted limits. It might be easier to avoid all discussion of sexual questions and ignore the fact that obstacles exist, but that will not slow the spread of HIV. Those conducting condom promotion have to be both subtle in their approach, so as not to offend people unnecessarily, and determined to ensure that obstacles are confronted and dealt with. Many people feel ambivalent about condoms and condom use. They may experience conflict between the pull of strong religious values that oppose condom use and the fact that they need protection from HIV. The challenge presented by the HIV/AIDS epidemic has led to more open discussions about sexual health, and condom use is increasingly seen as the most reliable means of protection.

Make condom promotion fun. One of the best ways of overcoming shyness and discomfort when it comes to condoms is to make fun out of them. Just the mention of the word “condom” can get a giggle out of people. Passing condoms around or showing how to put them on over bananas or wooden models can also help individuals to overcome their discomfort around condoms.

How can peer educators respond to obstacles to condom use?

**Obstacle: Condoms are not seen as reliable, the quality of condoms available locally is poor, or condoms are believed to be porous and therefore not resistant to HIV.**

- Point out that condoms are electronically tested and that the chances of HIV being sexually transmitted when condoms are used is almost zero.

- Emphasize the importance of ensuring one’s personal safety by using a condom during sex, rather than running the risk of contracting a fatal disease as a result of not using one.

- Refer to studies that prove that HIV, other sexually transmitted infections and sperm are unable to pass through a latex (rubber) condom.

**Obstacle: Condoms reduce the pleasure of sex.**

- Point out that condoms may be felt when the penis is first inserted into a vagina, but once a condom warms up to body temperature, it is rarely felt and quickly forgotten.

- Users usually cannot detect whether condoms have broken or slipped off during sex—proof that condoms are rarely felt when in use.

- People get accustomed to using condoms and the disadvantage of any reduced sensation is slight when compared to the satisfaction of not having to worry about contracting HIV or other sexually transmitted infections.
Obstacle: Fear that condoms get lost in a woman’s womb.

- Provide instructions on condom use, including the suggestion that men should hold on to the condom when withdrawing from women after ejaculation and the penis is no longer erect.

- Explain that condoms cannot get into the womb or other parts of a woman’s body. If a man leaves the condom inside the vagina, the woman can simply pull it out with her fingers.

How can condom use be made more enjoyable?

Many people do not use condoms because they feel it will reduce their sexual pleasure. Following is a list of suggestions on how to get more pleasure out of using condoms.

- Experiment with condoms. Play with them with your partner. Condoms will never feel like naked skin. Simply accepting this and exploring the sensations of latex can increase the pleasure of condoms. If condoms are seen as part of the pleasurable process of lovemaking instead of a hygiene device, much of the resistance to using them is eliminated.

- Have your partner put the condom on. Condoms can be put on one’s sexual partner and can become an exciting part of sex, instead of an interruption. They can be put on with the mouth or along with affectionate caressing and kissing.

- Use one condom after another. Men often make the mistake of thinking that once they have put a condom on they have to ejaculate, which may make them nervous about their sexual performance. Condoms can be taken off and a new one put on during sex before ejaculation.

- Lubricants increase sensation. Additional water-soluble lubricant can enhance sensations when using condoms. The lubrication on the surface of condoms helps but is usually not enough. Putting a small amount of lubricant in the reservoir tip before putting a condom on can heighten the pleasure. This helps keep air out of the tip and greatly increases the sensation when the lubricant seeps around the top of the penis. It takes a little practice to determine the right amount. Even the best water-soluble lubricants can dry out during use. Either add more lubrication or add saliva or water to the exterior of the condom. Lubricants are especially necessary for men engaging in anal sex with women or men, since a condom without lubrication is more likely to break in the anus than in the vagina.

- Condoms make sex last longer. Condoms reduce friction and, as a result, can delay ejaculation. This is an advantage for many men and women, but a problem for others. For those for whom it is a problem, other non-penetrative lovemaking techniques can be used until the man is close to ejaculation and then a condom can be put on.

- Try different condoms. If possible, keep several types and colours of condoms around so that you can experiment to find the ones you and your partner like best. Choosing a condom can be like choosing a type of soap. Some people like to try different brands and some people always like to use the same one because they are used to it and it makes them feel secure.
- Fantasize about sex with condoms. Include images of condoms in your sexual fantasies. If the fantasy involves a movie star, imagine the star making love with a condom. Some men experience difficulties when putting on condoms. For these men, it may help to maintain an erection if they fantasize or masturbate while wearing the condom.

- Talk with partners about condoms. Talk with your partners and friends about how to make condom use more pleasurable.

- Try female condoms. Using the female condom is one way of increasing the pleasure of sex. Both men and women prefer the sensation of the female, as opposed to the male, condom and find it less of a distraction.
Exercise 11: **Demonstrating correct condom use**

**Objective**
To provide participants with the opportunity to practise manipulating condoms

**Background**
If a condom breaks during sex, it is more likely to be because the user has not properly handled or put it on than because of a problem with storage or manufacture. Therefore, it is vitally important that peer educators help participants to learn how to use a condom.

**Materials**
Condoms, wooden models of a penis, broom handles or bananas

**Time**
30 minutes

**Instructions**

**Step 1:**
Find a suitable model—ideally a wooden model of a penis—with which to demonstrate how a condom is put on. Other similarly shaped objects, such as a banana or the end of a broom handle, can also be used. If none of these is available, two fingers may be used.

**Step 2:**
Explain that participants need to protect themselves and that condoms, if used correctly, provide excellent protection.

**Step 3:**
Using your model, demonstrate how to put on a condom, while highlighting the following points:

- Check the expiry date and look for signs of wear such as discoloured, torn or brittle wrappers. Do not use condoms that have passed the expiry date or seem old.
- Tear the package carefully along one side. It is better not to do this using teeth or fingernails, to avoid damaging the condom.
- Place the rolled-up condom on the top of the penis.
- Pinch the tip of the condom (to leave space for the semen to collect).
- Place the condom on the end of the penis and unroll the condom down the length of the penis by pushing down on the round rim of the condom. If this is difficult, the condom is probably inside-out. You should not turn the condom the other way around as some semen could already be on it. You should open another condom and unroll it correctly over the penis.
- When the rim of the condom is at the base of the penis (near the pubic hair) penetration can begin.
- After intercourse and ejaculation, hold the rim of the condom and pull the penis out before it gets soft. Tie the condom in a knot, sealing in the semen. Dispose of the condom in a safe place. Use a new condom each time you have penetrative sex.
Step 4:
Hand out condoms to each of the participants. Have each participant practise putting the condom on the model and recite aloud each of the steps as they go. Ask the participants who are observing to point out any difficulties or omitted steps. If the group of participants is very large, they can be divided up into groups of five to practise, and then report what has happened.

Step 5:
List the most common difficulties encountered. Ask the participants to suggest how these problems might be resolved. Some common problems include the following:
- Trying to roll the condom down when it is inside-out
- The condom is not rolled down all the way
- The condom is placed crookedly on the model
- The user is too rough when opening the package or uses teeth to open it
- The air in the tip is not squeezed out.

Step 6:
Provide information on where workers can obtain condoms.
Exercise 12: Correct and consistent use

Objective
To practise manipulating condoms

Background
This exercise is similar to the previous one on demonstrating correct condom use. However, it is a little more interactive and forces participants to think through the steps more thoroughly.

Materials
Sheets of paper or index cards

Time
45 minutes

Instructions

Step 1:
Prepare sheets of paper or index cards in advance. Write one of the following phrases on each sheet or card:

- Check expiry date of manufacture
- Discuss condom use with partner
- Have condoms with you
- Have an erection
- Open the condom wrapper carefully
- Squeeze out air from tip of condom
- Roll condom on erect penis all the way down to the base
- Intercourse
- Ejaculation
- Withdraw penis from partner, holding onto condom at base
- Be careful not to spill semen
- Remove condom from penis
- Penis gets soft
- Tie up the condom and throw it away in places where children will not find it
- Use another condom (if you have sex again).

Step 2:
Mix the cards up and have each participant, in turn, choose one at random, read it, then show it to the group. Ask participants to work together and tape their cards on a wall or lay them out on the floor in the correct order, so that the cards describe the step-by-step use of a condom.

Step 3:
When all the cards are placed, ask participants to comment on the order. Make any necessary changes. Be sure that the final line-up is correct.

Step 4:
Ask participants the following questions:
- What might happen if condoms are not used correctly?
- What are the consequences of this?
- What was it like using condoms for the first time?
- What is it like now?

**Step 5:**

Provide information on where workers can obtain condoms.
Exercise 13: Demonstrating the reliability of condoms

Objective: To instill confidence in the reliability of condoms

Background: Almost all workers know about condoms and why they should be used, but not everyone uses them. Some have never even tried them. One often-cited reason for not using condoms is the myth that they are unreliable. This exercise allows participants to experience the durability of condoms.

Materials: Condoms, water, two buckets and a cup

Time: 30 minutes

Instructions

Step 1:
Fill one of the buckets with water.

Step 2:
Open a condom and slowly pour water into it, using a cup. Hold the condom over the bucket as you pour, to avoid spillage. After filling the condom with at least a litre of water, tie the top, making a kind of water balloon. (Practise this exercise before doing it in front of participants to determine how much water must be poured to expand the condom to a large size without breaking it. If the condom breaks, take out another one and try again.)

Step 3:
Ask participants what they have learned from this. Point out that condoms are very strong and can fit any size of penis. They can contain a large volume of water without breaking.

Step 4:
Take another condom out of the package, blow it up like a balloon and tie the top. Hand out a condom to each participant and have them blow up the condoms. Add some humour to the exercise by asking the participants if any of them has a penis so large that it will not fit into a condom.

Step 5:
Have the participants take turns filling condoms with water.
**Exercise 14: Condom facts, opinions and rumours**

**Objective**
To allow each participant to separate facts from opinions and rumours about condoms

**Background**
People are often looking for easy excuses not to use condoms. As a result, they may accept, without questioning, misinformation circulating about condoms.

**Instructions**

**Step 1:**
Choose five or six statements from the list below that you feel are the most important ones for the participants to consider. Feel free to add any other false rumours that you might have heard.

**Step 2:**
Tell participants that they are going to play the “Fact, opinion and rumour” game, and that they will be asked to categorize statements about condoms. When a statement is read, they have to indicate their opinion with the following signals:
- **Fact:** Raise one arm.
- **Opinion:** Put both your hands on your head.
- **Rumour:** Cross your arms in front of your body.

**Step 3:**
Read the following statements one at a time. Allow the participants to make their signals. (They might need to practise them a few times first.) Ask several participants why they chose a particular response for each sentence. (Let the participants correct each other if there are differences in their answers.)

- Sex with a condom is not “real sex” (Opinion)
- Condoms prevent HIV and other sexually transmitted infections (Fact)
- Condoms always break (Rumour)
- Condoms can get lost inside a woman (Rumour)
- Condoms prevent pregnancy (Fact)
- Condoms are laced with HIV (Rumour)
- Using condoms means you are unfaithful (Opinion)
- Putting condoms on can be sensual (Opinion)
Condoms are only for casual partners (Opinion)
Using condoms is easy (Fact)
Sex is not pleasurable with a condom (Opinion)
Lubricated condoms feel good (Opinion)
Condoms are embarrassing (Opinion)
Condoms are for sex workers (Opinion)
Condoms cost too much (Opinion)
Condoms cause irritation and pain (Rumour)
Using condoms prevents you from feeling close to your partner (Opinion)
Condom use shows that you care for your partner (Opinion)
Condoms increase promiscuity (Opinion)
Condoms are unnecessary for HIV prevention in a steady, mutually faithful relationship between two uninfected partners (Fact)
Condoms are made of latex rubber (Fact)
One size of condom fits all (Fact)
Poor-quality condoms are sent to Africa (Rumour)
Condoms are tested electronically (Fact)
Condoms can be blown up into balloons as big as a football (Fact)
Condoms cut off blood circulation and can strangle a penis (Rumour)

Step 4:
Take one example of a clearly false rumour (such as “condoms are laced with HIV”) and ask the large group the following questions:
- Why do you think rumours like this exist?
- What are some of the consequences of rumours?
(Depending on their answers, you may want to provide examples that mention fear, ignorance, strong beliefs and denial.)

Step 5:
Select examples of a clear opinion, both negative and positive (such as “using condoms prevents you from feeling close to your partner” and “condom use shows that you care for your partner”). Ask participants the following questions:
- How are these opinions different from facts?
- Are opinions true or false? Why or why not?

Step 6:
Provide information on where workers can obtain condoms.
Exercise 15: Condom excuses

Objective: To get participants to examine the reasons why they do not use condoms

Background: What follows is a list of common excuses that people use to explain why they do not want to use a condom, and possible responses to those excuses.

Materials: Sheets of paper, flipchart paper or chalkboard (optional)

Time: 30 minutes

Instructions

Step 1:
Have participants consider the list of excuses and identify the ones they consider to be the most common. List them on a piece of paper, a flipchart or chalkboard, if possible.

Step 2:
For the first excuse, provide them with the three responses given below. For the excuses that follow, ask participants if they can think of any replies before offering the responses listed below.

Step 3:
Ask them if they think the responses are realistic and could be apply to people like them.

Excuse 1: You think I have a disease.
- a) I don’t want either of us to run the risk of getting HIV.
- b) Many people infected with HIV have no symptoms at all.
- c) Probably neither of us has a disease, but isn’t it better to be sure?

Excuse 2: But condoms don’t work.
- a) They’re OK if we use them the right way.
- b) Condoms may even be fun.
- c) I have never had a condom break.

Excuse 3: They spoil the mood.
- a) It will be OK once we’re used to them.
- b) Why don’t we try condoms a few times and see?
- c) But it would make me feel more relaxed if I felt safe.
Excuse 4: They don’t feel good.
   a) But we know condoms can protect us.
   b) I know you don’t like the idea, but condoms are so important now.
   c) Think about the fun we are going to have and not the condom.

Excuse 5: They make me feel cheap and dirty.
   a) These days, condoms have become a way of life for everyone. You would be surprised how many people use them.
   b) You know I care for you and respect you. That’s what’s important.
   c) I want to use condoms because I don’t want you to get pregnant before you want to. There is nothing cheap and dirty about that.

Excuse 6: I’m already using pills for birth control.
   a) We have to use condoms as well because the pill doesn’t stop infections.
   b) That doesn’t help against HIV and other sexually transmitted infections.
   c) Too bad – no condoms, no sex.

Excuse 7: I’d be embarrassed.
   a) It won’t be so awkward after the first time.
   b) I’ll buy them, so we’ll have them next time.
   c) Embarrassment never killed anyone.

Excuse 8: They cost too much.
   a) When it comes to our health, we shouldn’t think about the cost.
   b) I can pay for them.
   c) Compared to the cost of beer, it isn’t that much.

Step 4:
   Provide information on where workers can obtain condoms.
Voluntary HIV counselling and testing

What is voluntary HIV counselling and testing?
Voluntary HIV counselling and testing involves a person choosing to go for a blood test to find out if any HIV antibodies are present in their blood. The presence of antibodies is an indication that the person being tested is infected with HIV, the virus that causes AIDS. At the same time, a trained adviser listens, asks questions and offers advice about the process of being tested, and he/she offers help when the result is given, whether the person is infected or not. HIV counselling and testing provide an important link between those being tested and HIV/AIDS care and support.

Should HIV testing be mandatory?
Mandatory testing is testing that is forced on someone, with or without their consent (and sometimes even without their knowledge). It arouses very strong feelings and provokes opposition because it disregards fundamental rights and almost inevitably leads to discrimination.

The ILO Code of Practice on HIV/AIDS and the world of work has a detailed section on testing. HIV screening should not be required of job applicants or persons in employment. However, workers who, of their own initiative, wish to be tested should be encouraged to do so. Voluntary testing should normally be carried out by the community health services and not at the workplace. In a workplace where adequate medical services exist, voluntary testing may be undertaken at the request, and with the written consent, of the worker, with advice from the workers' representative, if so requested. It should be performed by qualified personnel with adherence to strict confidentiality and disclosure requirements. Gender-sensitive pre- and post- test counseling, which facilitates an understanding of the nature and purpose of the HIV test, the advantages and disadvantages of the tests, and the effect of the result upon worker, should form an essential part of any testing procedure.

In an environment where rights are respected, workers are more likely to undergo voluntary testing and change their behaviour so that they take fewer risks, and indeed become active agents for prevention.

What concerns do workers have about accessing HIV counselling and testing services?
Fear of the result. People are understandably afraid of learning that they may be HIV-positive, since they often are not aware of the benefits of learning their status early in the course of the infection.

Confidentiality. At the workplace, no employee should be asked to reveal HIV-related information. All medical information must be kept strictly confidential and be handled only by personnel bound by the rules of medical confidentiality. Where an employee chooses to reveal his or her HIV status to management, the company will keep the identity of the person strictly confidential unless the employee is ready to disclose his or her status.

What happens during HIV counselling and testing?
Deciding to go. The most difficult part of HIV counselling and testing is plucking up the courage to go for the test and to return for the results, if they are not given right away. Many people prefer to deny that they might be engaging in high-risk sexual behaviour and others may have an exaggerated fear of being infected.
Getting support. HIV counselling and testing can be a lonely process if some one goes through it alone. It is best to discuss the idea of going for a test with spouses or trusted friends. Many people find it easier to go for the test if they are accompanied by their spouse or friend. Some even arrange to be tested together.

Role of counsellor. A counsellor is a person who has had special training in helping people with any nervousness they might have about getting tested. They offer helpful information about the test and listen to any concerns raised by the person being tested. They also help clients prepare themselves for the results and plan the next steps.

Blood test. Blood is drawn from the arm of the person being tested by a laboratory technician. The blood placed in a vial for testing does not have a name on it, only a number. That way, it is only the counsellor who associates the test result with the person who was tested.

Confidentiality. Due to fears of discrimination or stigma, most people do not want others to know whether or not they have contracted HIV. For this reason, those providing HIV counselling and testing services should ensure that the process remains confidential.

Getting the results. In walk-in clinics around the world, most people who undergo an HIV test are found to be uninfected rather than infected. Prior to being tested, individuals may have engaged in high-risk behaviour at some point and they may subsequently use their negative test result as a starting point for being more careful in the future. Those who find out that they are HIV-positive are encouraged by counsellors to protect others from infection, and themselves from re-infection, by adopting healthy behaviours, seeking support from groups of people living with HIV/AIDS, and accessing services for treatment.

What is the window period?
Antibodies to HIV are the chemicals that the body produces to inform other white blood cells to mount an attack on HIV. An HIV test looks for antibodies to HIV and not the virus itself. It takes the body three weeks to three months to develop antibodies to HIV. This is called the window period. During the window period, an infected person has HIV in the body but has not yet have developed antibodies to it, so the test is negative. The person can still infect others with the virus. It is important to wait at least three months after possible HIV exposure before undergoing the test.

What are the advantages of getting tested?

Ends worry about status. Testing helps people know their HIV status and stops them worrying about whether or not they are infected. Those who are worried about their past behaviour can get a new lease on life by finding out their status.

Fresh start for prevention. Finding out if you are HIV-negative provides you with a clean slate on which to build safer sexual practices.

Helps couples plan for the future. Couples may want to get tested for HIV before getting married. If both partners are HIV-negative, then they know they will not have an HIV-positive baby. If one or both are HIV-positive, they can seek the necessary treatment and the woman can obtain antiretrovirals to help protect her baby.

Plan the rest of your life. Those who find out they are positive can then plan for the future. It could be many years before they become ill. In the meantime, men can protect their wives from getting infected and prevent future mother-to-child transmissions. People
can also plan for the future security of their families by preparing a will and making financial plans.

**Live longer.** It is also possible to extend the period of time an infected person will live, through lifestyle changes and the treatment of opportunistic infections. For example, avoiding getting re-infected, reducing alcohol consumption, and eating healthily will help extend life.

**Prevent infecting babies.** Those who know that they are infected can take steps to avoid having babies or can take measures to reduce the likelihood that they will get infected.

**What discourages people from undergoing HIV counselling and testing?**

- **People equate AIDS with death.** People often think of HIV counselling and testing as a death sentence. They do not realize that not all those who have engaged in high-risk sexual behaviour are necessarily infected.

- **Fear of rapid deterioration.** Some people imagine that being HIV-positive is more horrible than it is in reality. They think they will deteriorate rapidly and die soon after testing, when, in fact, most people live for many years after infection with no illnesses or symptoms.

- **Fear of being stigmatized.** The stigma associated with HIV makes people afraid to go for testing for fear that others will suspect that they are infected.

- **A lack of knowledge about the benefits of testing.** People mistakenly think that there is nothing they can do to improve their situation except wait for imminent death. They do not know that their lives can be extended if they know they are infected, take care of themselves and access the appropriate services.

- **Location/timing of testing/counselling services are often inconvenient.** Services are often far from where people live and unaffordable. The cost of testing is increased if people have to travel long distances from other communities to get tested because they are afraid to get tested close to home.

- **Lack of confidence in testing and counselling services.** Some are afraid of testing HIV-positive and their results being leaked out by indiscreet health-care providers.

- **Fear of the impact on one's job.** Some workers are afraid that testing will not be discreet and anonymous and that, if they test positive, their status will become known to those they work with and they will suffer from stigma or discrimination.

- **Guilt.** Some people feel guilty about past behaviours that have put them at risk. They do not want to have to tell their wives or husbands that they are HIV-positive.
Exercise 16: Exploring obstacles to voluntary HIV counselling and testing

<table>
<thead>
<tr>
<th>Objective</th>
<th>To get participants to reflect through group discussion on why they might be reluctant to undergo voluntary counselling and testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>In many countries, and for a variety of reasons, HIV counselling and testing services are underused. The idea of this exercise is to get participants to think about why they would or would not like to go for a test, and to consider what influences their decision.</td>
</tr>
<tr>
<td>Materials</td>
<td>Paper</td>
</tr>
<tr>
<td>Time</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Instructions

Step 1:
Write down the following questions on pieces of paper.

Group 1: Why should people undergo HIV counselling and testing? What are the advantages or benefits of undergoing HIV counselling and testing?

Group 2: Why are people reluctant to undergo HIV counselling and testing? Why would a wife choose to undergo testing but her husband would refuse? How can those who are reluctant be convinced to undergo HIV counselling and testing?

Group 3: How does stigma or fear of HIV affect people's attitude to undergoing testing, bringing in sexual partners for testing, or accepting a positive result and benefiting from the appropriate health-care services?

Step 2:
Divide the participants into small groups and assign questions for discussion to each group. Have each group designate a note-taker and someone to report the conclusions of the discussion.

Step 3:
Give participants 30 minutes to discuss the questions.

Step 4:
Have the groups come together and report their conclusions.

Step 5:
Summarize the points made by the groups. Some examples of possible points to develop:
Why people may want testing

• They are pregnant (in the case of women)
• Their doctor says they should get tested
• They feel sick (and voluntarily choose to get tested)
• They suspect that their partner has been unfaithful

Why people may refuse testing

• Fear of rejection by partner if found to be HIV-positive
• Stigma associated with the disease
• Lack of awareness of the benefits of HIV counselling and testing
• Fear of being HIV-positive
• They know there is no cure
• AIDS is associated with death
• Cost of testing is prohibitive
• Guilt and fear of rejection
• Test centres are too far away or difficult to access
• Fear of lack of confidentiality

Stigma in relationships

• It's easier for a man to tell his wife that he's HIV-positive (because men have economic power)
• The man is in a dominant position
• Women fear beatings, divorce and poverty
• The tendency to blame the first partner to be tested for being the first one to be infected
• Both men and women are reluctant to tell partners of HIV-positive status

Stigma associated with HIV counselling and testing

• The stigma associated with AIDS prevents them from accessing the appropriate health-care services
• Fear of being seen at service points and being branded as HIV-positive
• They do not know that health-care services exist
• Stigma can be worse in small communities where health-care providers are integrated
• HIV counselling and testing and other services may be too far away for them to access

Step 6:

Provide information on where workers can access VCT services.
Exercise 17: Making the decision to undergo HIV counselling and testing

**Objective**
To increase the likelihood that participants will undergo HIV counselling and testing by increasing their knowledge of what the process means, why testing is important, what is discussed in pre- and post-test counselling, and where to go for services.

**Background**
People may be reluctant to undergo HIV counselling and testing because they are not sure what it is, what the benefits are for them, or where to go for the service.

**Time**
1 hour

**Instructions**

**Step 1:**
Ask participants if they know what ‘VCT’ stands for. Read to them the following definition:

**V**-Voluntary
Voluntary counselling and testing means that you access these services of your own free will. A person can never be forced to go for an HIV test.

**C**-Counselling
Trained counsellors help a person to help him/herself. Counselling takes place before the test (pre-test counselling) and after the test, when you go for the results (post-test counselling).

**T**-Testing
Testing involves a sample of blood being taken from the body to see whether a person is HIV-positive. The test looks for antibodies to HIV, not the virus itself.

**Step 2:**
Ask participants to make a list of reasons why people should undergo HIV counselling and testing. If they have difficulty creating a list, ask them if they agree with the list below:

- Many people do not know their status and could infect their partners.
- HIV-positive people are at risk of re-infection if they are re-exposed to the virus by having unprotected sex with an infected partner.
- Knowing your status is also essential for planning your life: If you are HIV-positive, you should immediately adopt a healthier lifestyle to extend your life and ensure that you seek medical help for early detection and treatment of other opportunistic diseases.
- Testing is also a very important step for partners who want to get married or have children.
Guide to Conducting Peer Education at the Workplace

Step 3:
Ask participants to make another list of reasons why they do not like to go for HIV counselling and testing. If they have difficulty creating a list, ask them if they agree with the list below:

- Many people do not know about HIV counselling and testing or where to go for it.
- If they test positive, people are afraid that their HIV status will not be kept confidential.
- Since many people think that nothing can be done for them if they are HIV-infected, they do not see the point in taking any action.
- Denial, caused by fear, results in individuals not wanting to know the truth.
- Many people are afraid of having to tell their spouse if results are positive.
- Fear of dying soon.

Step 4:
Point out that we are all afraid of what the result might be. We fear that, if we are HIV-positive, it will change our life and that of our family and friends. Point out that professional counsellors are there to help us cope with the testing procedures and the result. They will give us information about living with HIV, how to avoid infecting others, and how to stay safe and healthy. Describe what is discussed during pre- and post-test counselling (see information below).

Pre-test counselling: This is the counselling that occurs before you go for an HIV test. The counsellor prepares you for the test and makes sure that you understand what HIV and AIDS are and what a positive or negative test result will mean. If you then choose to be tested, blood is drawn from the body and tested for antibodies to HIV. You will be asked to come back (usually after two to four days) for the test result.

Post-test counselling: The second stage of counselling is called post-test counselling, which takes place when you go to get your test result. The counsellor will give you the result. Again, this will be in total privacy and confidentiality. The counsellor will talk about what the test result means for your future.

If your test result is negative (non-reactive), you will receive counselling about the importance of getting a second test because of the window period. The window period is the stage between the moment you are infected with the virus and the time when your body starts producing antibodies (which is what the test detects). That means that the test could still produce a negative result even though you are already HIV-positive. The window period lasts an average of three weeks to three months. Also, people who test negative will receive counselling about how to remain HIV-negative.

If your test result is positive (reactive), the counsellor will try to help you come to terms with your status and to deal with the social, emotional and medical consequences of being HIV-positive or refer you to another health-care professional for further assistance.

Step 5:
Tell participants the following story about Sylvia and Anna, and then ask them what they think of the reactions of the two women and what they think Sylvia should do.
Sylvia and Anna are talking during their tea break. They are discussing a relationship that Anna had with a handsome man who was in the city for only a few days. Sylvia says that she thinks Anna should go for an HIV test. Anna is very surprised by this and the two start talking about why a person would ever want to go for an HIV test. Sylvia explains to Anna that, “Life is about knowing”. She gives the example to Anna about taking a job. If you don’t know anything about the type of work you will do, how much you will get paid, etc., how do you feel? Anna says that she would not feel good, not secure, not sure of herself. It’s similar with HIV testing, explains Sylvia. If you know, then you can be more secure and can do things to protect your health. She’s not saying that Anna is HIV-positive, but that if she is and she knows her status, she can adjust her lifestyle and diet in order to live longer. Anna is still a little unsure and asks if Sylvia has been tested for HIV and Sylvia says that, yes, she has. Sylvia tells Anna a little about the HIV counselling and testing centres and says that the counselling was helpful and that she is very happy that she knows her HIV status.

Step 6:
Ask participants if they know where the nearest HIV counselling and testing centre is to their home or workplace. Ask them what they think of the cost (if any) of the test. Before you close the session, remind your peers of the importance of going for an HIV test.

Step 7:
Provide information on where workers can access VCT services.
Exercise 18: ‘True or false’ exercise on HIV counselling and testing

Objective
To examine myths and truths about HIV counselling and testing

Background
Since HIV counselling and testing are relatively new services, there are a lot of unknowns in the minds of potential users. This exercise attempts to clear up misunderstandings about HIV counselling and testing.

Materials
Flipchart, chalkboard or sheet of paper

Time
45 minutes

Instructions

Step 1:
Read each of the following statements one by one. After each statement, ask one participant to say whether he/she thinks the statement is true or false and to give reasons for their response.

a) Anonymous testing means that you are given a number and no one knows your name when you are tested.
   True: To ease the fears of people who do not want those conducting the test to know if they are infected or not, some testing services do not require that clients give their names. Their blood sample is identified by a number only.

b) If found positive through mandatory HIV testing, a person is automatically eliminated as a candidate for a job.
   False: Testing for pre-employment screening is discriminatory and against the key principles of the ILO Code of Practice on HIV/AIDS and the world of work.

c) The ‘window period’ is the time during which a person may have been exposed to HIV but may still test HIV-negative.
   True: It takes up to three months for HIV antibodies to show up in the blood. To be certain that the test result is accurate, it is important wait for three months after possible exposure to HIV before taking the test.

d) Those found to be HIV-negative after testing do not need to avoid high-risk behaviour in the future.
   False: A person may engage in risky sexual relations and be lucky enough not to get infected. But that does not mean that the person will not become infected the next time he/she has unprotected sex.

e) Everyone should be tested for HIV.
   False: Not everyone is equally at risk. Those who are not sexually active or are in mutually faithful sexual relations have little to worry about and do not need HIV testing.
f) If a person is found to be HIV-positive, it is important to inform sexual partners of his/her status.
   True: Although it might be difficult, it is important to tell those who might have been exposed to the virus about the infection so that they can get tested and protect themselves and others during future sexual relations.

g) The first person in a couple to find out that he or she is HIV-positive is the one who brought the virus into the family.
   False: The time when a person learns they are infected is no indication of when they actually became infected.

Step 2:
Correct wrong responses and offer the reasons listed above if participants do not mention them.

Step 3:
Provide information on where workers can access VCT services.

**Workers’ rights and HIV/AIDS workplace policies**

**What are human rights?**

Human rights are entitlements that are due to all individuals. Persons living with HIV/AIDS have the same human rights as any other person. These internationally recognized rights include the following:

- the right to life
- the right to protection against discrimination
- the right to private life
- the right to employment
- the right to education
- the right to health care
- the right to dignity
- the right to shelter
- the right to freedom of movement
- the right to freedom of expression
- the right to freedom of thought and religion

Human rights violations based on HIV status often occur at the workplace. These violations can take numerous forms, such as: mandatory testing of job applicants or persons in employment; breaches of confidentiality regarding HIV-related personal information; and discrimination in access to, or conditions of, employment (including training and promotion opportunities, and social benefits). Protection of human rights in the context of HIV/AIDS is essential not only to protect the dignity of infected persons, but also because the protection of those rights is a necessary part of the fight against the epidemic: if people are frightened of losing their job or being stigmatized, they are more likely to conceal their HIV-positive status and pass on the virus to others. Moreover, they
will probably not seek treatment or counselling. All successful prevention initiatives have been part of a wider approach that included establishing an atmosphere of openness, trust and a firm stand against discrimination. At the workplace, people living with HIV/AIDS need and deserve the respect and support of their co-workers in dealing with the challenges of being HIV-positive.

**What do we mean by stigma?**

Stigma can be defined as negative thoughts about a person or group based on a prejudice. In the context of HIV/AIDS at the workplace, stigma may lead to workers living with HIV being ostracized by their co-workers because of the latter’s misconceptions about HIV and how it is transmitted.

**What do we mean by discrimination?**

Discrimination occurs when a person is treated unfairly or unjustly, on the basis of her/his actual or presumed HIV-positive status. For instance, a HIV-positive worker is discriminated against if he or she does not get promoted because of his/her HIV-positive status.

**How can stigma and discrimination be overcome?**

**Emphasize that casual contacts do not pose a risk of HIV infection.** In the overwhelming majority of professions, the presence of HIV-positive persons at work does not place other people at risk of infection. Employers and fellow workers need have no fear of infection from routine contacts with those who are HIV-positive. Shaking someone’s hand, coughing, sneezing, using a public phone, opening a door, sharing food or cutlery, drinking from water fountains, using toilets or showers – none of these can lead to the transmission of the virus.

**Stress the fact that HIV-positive persons can live a productive life.** HIV-positive people can remain in good health and work for years, despite their infection. Work keeps them going and enables them to bring home food and medicine. Not discriminating against persons living with HIV/AIDS does not mean that employers are bound to keep them at work, however sick they may be. If a worker is no longer able to work, even with an adapted work environment and lighter duties, then there are reasonable grounds for dismissal. What should be prohibited is discrimination based on a person’s HIV-positive status when he or she can still carry out his/her work.

**Involve people living with HIV/AIDS in peer-education sessions.** Whenever possible, ask people living with HIV/AIDS to talk about their situation with participants. If it is impossible to enlist the help of co-workers, see if there are groups of people living with HIV/AIDS in your community who will come to meet with participants. If you are seen shaking hands with, or hugging, people living with HIV/AIDS, it will reassure participants that casual contact does not pose a risk of HIV transmission.

**Bring HIV out of the shadows.** Most adults have sex. Many have sexual relations that put them at risk. Youths are particularly vulnerable because most do not have regular partners. Sexual realities that put people at risk need to be talked about openly and honestly. If people are more open about HIV in general, they will be also more open about those who are being infected. Treating others who are infected just as you would like to be treated is the first step to understanding what it means to be HIV-positive.
HIV/AIDS workplace policies

Employers should not engage in, or permit, any personnel policy or practice that discriminates against workers infected or affected by HIV/AIDS. In particular, employers should:

- not require HIV screening;
- ensure that work is performed free of discrimination or stigmatization based on perceived or real HIV-positive status;
- encourage persons with HIV-related illnesses to work as long as medically fit for appropriate work;
- in the case of a worker with an AIDS-related condition being too ill to continue to work, and where alternative working arrangements including sick leave have been exhausted, provide for termination of the employment relationship, in accordance with anti-discrimination and labour laws and respect for general procedures and full benefits.

The International Labour Organization (ILO) is a specialized agency of the United Nations system that has developed, through its secretariat (the International Labour Office, ILO), a Code of Practice that provides internationally recognized guidelines for the development and implementation of HIV/AIDS workplace policies and programmes. The ILO Code of Practice on HIV/AIDS and the world of work has been developed in collaboration with governments and employers’ and workers’ organizations. The ILO Code of Practice states ten key principles (explained below) to be adopted in the development of effective policies and programmes at the workplace:

1. Recognition of HIV/AIDS as a workplace issue
HIV/AIDS is a workplace issue and should be treated like any other serious illness/condition at the workplace.

2. Non-discrimination
In the spirit of providing decent work and respecting the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status. Discrimination and stigmatization of people living with HIV/AIDS inhibit efforts aimed at promoting HIV prevention.

3. Gender equality
The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men, due to biological, socio-cultural and economic factors. The greater the gender discrimination in societies and the lower the socio-economic position of women, the more negatively the latter are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.
4. Healthy work environment
The work environment should be healthy and safe, so far as is practicable, for all concerned parties. Universal precautions and measures should be applied and appropriate equipment should be provided so that HIV transmission via contaminated blood and/or body fluids can be avoided.

5. Social dialogue
The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government, where appropriate, with the active involvement of workers infected and affected by HIV/AIDS.

6. Screening for purposes of exclusion from employment or work processes
HIV screening should not be required of job applicants or persons in employment.

7. Confidentiality
There is no justification for asking job applicants or workers to disclose HIV-related personal information. Nor should co-workers be obliged to reveal such personal information about their colleagues. Access to personal data relating to a worker’s HIV status should be handled only by personnel bound by the rules of medical confidentiality.

8. Continuation of employment relationship
HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit, in available, appropriate work.

9. Prevention
HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies that are appropriately targeted to national conditions and that are culturally sensitive. Prevention can be furthered through changes in behaviour, knowledge, treatment and the creation of a non-discriminatory environment.

10. Care and support
Solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them or their dependants in access to, and receipt of, benefits from statutory social security programmes and occupational schemes.
Exercise 19: Causes of stigma and discrimination

Objective
To get participants to better understand what causes stigma and discrimination for people living with HIV/AIDS, and how participants may be contributing to the problem.

Background
Fear of stigma and discrimination causes people to deny the existence of HIV/AIDS and makes the lives of those who are infected very difficult.

Materials
Flipchart, chalkboard or sheet of paper

Time
45 minutes

Instructions

Step 1:
Read the basic facts on stigma and discrimination for background information (Part 4, Section on Human rights, stigma and discrimination).

Step 2:
Explain to participants that there are a lot of misperceptions about HIV/AIDS, which creates an environment that fuels stigma and discrimination. Ask the participants to give examples of stigma and discrimination and explain why they might contribute to the problem. A list of possible answers follows.

Unfounded fear of casual contact with people living with HIV/AIDS. Though almost all HIV infection is transmitted sexually, many people still think that they can be infected by casual contact with those infected. They avoid sharing common household objects (such as cups, kitchen utensils or hairbrushes) or touching people living with HIV/AIDS for fear of infection, even though it is perfectly safe to do so.

HIV is seen to affect ‘immoral people’. HIV/AIDS has regrettably been associated with what many people consider to be immoral behaviour, including sexual relations outside of marriage. People living with HIV/AIDS are associated with sex work (prostitution) and are often seen as deserving their fate because of their sexual activities. These prejudices are compounded by the moralizing tone often used in the media and in some religious organizations that condemn HIV-infected people.

Denial that behaviour is a risk. Some people who engage in sexual behaviour that makes them vulnerable to HIV infection deny that they are at risk. They either convince themselves that their partners do not look as if they have HIV (although it is impossible to tell by looking at someone) or deny that HIV is a reality in their country. Some people believe that HIV/AIDS has nothing to do with them and is someone else’s problem.

Fear of talking about sex. There is a general reluctance to talk about sexual issues openly and honestly among couples, families and religious groups, and in communities and schools. This keeps the realities hidden and perpetuates the shame of being associated with HIV.
Denial that HIV is a problem. Some people have no hesitation about having sex outside of marriage with different partners but also consider themselves to be good family men and believe strongly in religious values. They also think HIV is someone else’s problem.

Belief that money spent on someone who is dying is a waste. When resources are scarce, some people prefer to spend money on medicines and treatment of children rather than caring for people living with HIV/AIDS. HIV-positive people can remain in good health and work for years, despite their infection. In about 50 per cent of cases, there is a period of ten years between infection and the appearance of the first opportunistic infections that characterize AIDS. Most opportunistic infections and AIDS-related illnesses are treatable, and most people who have them are able to work between bouts of illness.

Step 3:
Summarize the points made by participants.
Exercise 20: **Examining workplace policies**

<table>
<thead>
<tr>
<th>Objective</th>
<th>To get participants to better understand what their workplace policies are or what they ought to be. Participants will think through what form policies take and why they are important.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Some workplaces have established workplace policies that clearly establish the employer’s and workers’ responsibility to prevent HIV infection and protect and support those who are infected. Some workplaces may be in the process of developing a policy and others see no need for a policy or have not considered developing one. Employees have a role to play in the development of policies and advocating for their creation.</td>
</tr>
<tr>
<td>Materials</td>
<td>Flipchart, chalkboard or sheet of paper</td>
</tr>
<tr>
<td>Time</td>
<td>45 minutes</td>
</tr>
</tbody>
</table>

**Instructions**

**Step 1:**
Locate a copy of your workplace HIV/AIDS policy, if one exists. Take notes of what the policy covers and how it is being implemented.

**Step 2:**
If there is a workplace policy, ask participants to talk about the important points it contains and ask them if they know what to do in the event that the policy is not respected.

If there is no workplace policy, tell participants that an HIV/AIDS workplace policy is a list of rules and guidelines that establish the responsibilities of workplace management and employees regarding HIV/AIDS.

**Step 3:**
Ask the participants what they think a workplace policy should cover. Answers should include the following:

**Non-discrimination statement:** A statement that there will be no differential treatment of job applicants or employees on the basis of real or perceived HIV-positive status.

**No mandatory HIV testing:** HIV testing or screening should not be required of job applicants or persons in employment.

**No denial of employment:** There will be no denial of employment for qualified job applicants or employees on the basis of real or perceived HIV-positive status.

**Reasonable accommodation:** The employer will make reasonable accommodations in terms of the work responsibilities and schedules of employees with HIV/AIDS, using the same procedures applied to workers with other serious illnesses.
Safe work environment/universal precautions: The work environment should be healthy and safe, and utilize universal infection-control procedures, to prevent the transmission of HIV and facilitate optimal physical and mental health among the workforce.

Confidentiality: All employees shall have the right to privacy. No employee will be asked to reveal HIV-related information. All medical information will be kept strictly confidential and be handled only by personnel bound by the rules of medical confidentiality. Where an employee chooses to reveal his or her HIV status to management, the company will keep the identity of such person strictly confidential.

No job termination if fit to work: Persons with HIV-related illnesses should be allowed to work for as long as medically fit, in available, appropriate work.

Same opportunities/benefits as other employees: Persons with HIV/AIDS and their dependents shall have access to, and receipt of, the same opportunities for training, advancement and other benefits as other employees.

Gender equality: Gender dimensions of HIV/AIDS are recognized and appropriate measures are effectively adopted and introduced into the HIV/AIDS programme.

Access to education: Employers shall provide the opportunity for worker education on the modes of transmission, prevention and treatment of HIV/AIDS.

Social dialogue: The successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives, with the active involvement of workers infected and affected by HIV/AIDS.

Implementation provisions: Such provisions should include details of how the policy will be implemented, disseminated and monitored, and which procedures can be used by workers in the event of a breach of their rights with regard to HIV/AIDS.

Step 4:
Ask participants if they think some modifications should be made to their HIV/AIDS workplace policy.

Step 5:
Summarize the points made by participants.

Alcohol and drug use

What role does alcohol play in HIV infection?
Alcohol can reduce an individual’s inhibitions and thus lead to high-risk behaviour. In places where alcohol is served, such as bars, discos and restaurants, sex workers may also be present. Alcohol can reduce a person’s resolve to avoid sex workers or use condoms. A person may intend to use a condom but forget, if too drunk. Also, alcohol consumption can impair motor skills and reduce the likelihood of condoms being correctly used—if used at all.
What are the effects of alcohol and other drugs?

The use of alcohol and other drugs can impair thinking and judgement. When people are under the influence of drugs or alcohol, they sometimes take risks they would not otherwise take. These can include having sex without using a condom or sharing needles and syringes. Even a single incident of sex without using a condom, or sharing needles with a partner infected with HIV, can lead to infection.

How do alcohol and other drugs change a person’s behaviour?

Drugs and alcohol can cause people to become aggressive and engage in impulsive decision-making. Sexual aggression, such as coercion or rape, may also occur. When men go out in groups and get drunk, they may encourage each other to have sex with sex workers. Even those who are less interested may feel pressure from their peers to have sex.

Why are some employees more vulnerable to alcohol and drug use?

Male employees who live away from home, are unmarried or live in communities with few diversions are often more vulnerable. Those who are employed regularly also have disposable income with which to socialize and buy alcohol and drugs. Some employees may be dealing with stressful workplace situations, including isolation, boredom, harsh working conditions, insensitive supervisors or long hours, and they may seek relief from this stress by resorting to alcohol or drugs.

How can people keep alcohol and other drugs from putting them at risk of HIV and other sexually transmitted infections?

The simplest solution is to avoid alcohol and drugs altogether. Another way is to moderate consumption and to not let others order alcohol for you or refill your glass. Limiting your consumption of alcohol at any one time or switching to soft drinks or water after consuming a certain amount of alcohol is another approach. Use of the buddy system or having an arrangement with a friend to look out for each other can increase one's chances of not abusing alcohol, not taking drugs and therefore making wiser decisions about one's behaviour.

Other than alcohol, which drugs affect judgement?

Marijuana, cocaine, crack cocaine, amyl nitrites (‘poppers’) or ecstasy are, like alcohol, associated with social gatherings and tend to reduce the fear of sexual infections and, consequently, reduce one's resolve to use condoms for protection.

Why are bars and social gatherings sometimes risky environments?

Having sex with someone you meet at a party or bar presents a risk because those who regularly frequent bars or go to lots of parties often tend to have multiple sexual partners at the same time, or one after another. Sex workers can also be found in some bars, discos or restaurants. The risk is high because it is impossible to tell by looking at a person if he/she is infected with HIV.
Why do people use drugs and alcohol?
- To socialize
- Availability and accessibility
- Peer pressure
- Boredom
- Poor self-esteem
- Seduced by mass media advertising
- Poor role models
- Temporary relief of pain, anxiety, depression and worries
- Isolation and a need to belong
- Habit

Why does injecting drugs present such a high risk?
Injecting drugs is one of the most direct ways of transmitting HIV and other infections, such as hepatitis. This is largely because needles and syringes are often shared between users and blood from one user often gets mixed up with the drugs and is then injected directly into the veins of another user.

How is drug injection linked to sexual transmission?
Heavy drug-use reduces one’s ability to work, leading to less disposable income for purchase of drugs. Consequently, some injecting drugs users may turn to sex work as a mean of supporting their habit. This increases the probability of the virus spreading to the general population.

Why do some workers potentially face problems with injecting drug use?
Approximately the same percentage of injecting drug users found in the general public exists within many workplaces. It is erroneous to assume that drug users, including injecting drug users, are unable to hold down a job. For example, some countries estimate that 5 per cent of male youths are injecting drug users. Since the activity is illegal, it remains largely hidden.

Why is injecting drug equipment shared?
Sharing of equipment is widespread. It does not seem to be only a result of restricted availability, although there are great concerns that, where possession of equipment is illegal and police enforce the law, users are more likely to share needles and syringes with others, rather than carrying them on their person. In some places, a strong group culture has emerged among many injecting drug users, which stimulates needle-sharing and the joint purchasing and preparation of drugs.

What can be done to help injecting drug users?
Making sure that injecting drug users understand the link between sharing needles and syringes and HIV infection is the first step to reducing infection. The rules of safe injection for injecting drug users are as follows:
1. Use new equipment and wash hands after use.
2. When the above is not possible, clean the equipment with water, then clean it with bleach, then rinse with water again.
3. If bleach is not available, rinse the equipment with liquid detergent or medical alcohol.
4. Practise safer sex by using condoms.
5. If you need support or treatment, find a support group that is led by a skilled practitioner.
Exercise 21: Impact of alcohol in the context of HIV infection

Objective: To better understand why people use alcohol and its influence on HIV infection and health

Background: Drug and alcohol use and abuse contribute to the impact of HIV/AIDS at many levels. In particular, they affect:
- the rate of transmission of HIV; and
- the health of people living with HIV/AIDS (who use and/or abuse drugs and alcohol).

Time: 30 minutes

Instructions

Step 1:
Many people have heard about the negative health effects of using drugs and alcohol, yet usage continues in many communities. Ask participants to think of some of the reasons why people use alcohol and drugs, despite knowing about the health risks involved, and make a list of their responses.

Step 2:
Now ask participants to think of how drinking alcohol and using drugs increase the risk of being infected with HIV and discuss some of these points. Suggest the following points to the group if they do not bring them up:

- When people use alcohol and drugs they have fewer inhibitions: people are more likely to engage in behaviours that they would not do if sober (without drugs or alcohol in their system).
- People are often forgetful under the influence of drugs and alcohol: a person might intend to practise safe sex (for example, using condoms) but could forget to do so after drinking alcohol or taking drugs.
- Men have difficulty maintaining an erection under the influence of too much alcohol and certain drugs. This means that a condom may not stay on a man’s penis properly, therefore increasing the risk of transmission of HIV and other sexually transmitted infections.

Step 3:
Explain some of the effects of alcohol and drug use on a person’s health (especially on the health of people living with HIV/AIDS):

Drugs and alcohol have many negative effects on a person’s physical and mental health, regardless of their HIV status. For a person living with HIV, the physical effects of drugs and alcohol are even greater. A person with HIV needs to keep the immune system strong. This is not possible with the use of drugs and alcohol. Tobacco, alcohol and even caffeine all adversely affect the immune system and the...
body's ability to fight off infections. It is important that people living with HIV/AIDS limit the amount of drugs and alcohol to help keep their immune system strong for as long as possible.
**Exercise 22: Alcohol and the workplace**

**Objective**
To reflect on external influences on alcohol consumption

**Background**
Alcohol use and abuse are common throughout the world. The nature of some kinds of work may contribute to alcohol consumption. In this exercise, participants are asked to consider the environment in which they live and work, and to critically reflect on their personal choices and responsibilities.

**Time**
30 minutes

**Instructions**

**Step 1:**
Ask participants to list all the positive things associated with alcohol and write them on a sheet of paper, blackboard or flipchart paper. The list may include as the following:
- Makes a person feel good
- Helps them to escape their worries
- Makes them more sociable and less timid
- Reduces their stress
- It can be a way of celebrating a special event.

**Step 2:**
Ask participants to list all the negative things associated with alcohol and write them on a sheet of paper, blackboard or flipchart paper. The list may include the following:
- Makes people feel sick
- Gives them a headache the next day
- Can lead to physical abuse of others
- Costs money
- Makes them forget to use condoms.

**Step 3:**
Ask participants to list the circumstances that may lead to alcohol consumption and write them on a sheet of paper, blackboard or flipchart paper. The list may include the following circumstances (which may occur alone or in combination):
- Work-related stress
- Isolated locations
- Boredom
- Separation from families
- Camaraderie
- High tension and danger
- Regular salary
- Easy access
- Peer pressure
Step 4:
Ask each of the participants to consider their own circumstances and ask the following questions:

- What do you like about drinking alcohol?
- How does alcohol make you feel?
- How does drinking too much alcohol make you feel?
- How does drinking too much alcohol affect your judgement?
- Have you noticed that it is hard to stop once you have started drinking alcohol?
### Exercise 23: Alcohol and drug abuse

<table>
<thead>
<tr>
<th>Objective</th>
<th>To create an understanding of the negative impact of excessive alcohol consumption</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Alcohol consumption is considered a risk factor for HIV and other sexually transmitted infections. This is especially true if consumption is excessive. Alcohol consumption tends to impair judgement. Those who intend to use condoms may lose their resolve after drinking alcohol. Negotiating condom use with a drunken partner is very difficult. Alcohol is also related to violence against women. Many sex workers fear violence from drunken clients. Spending money on alcohol can also affect household income, resulting in less money being available for food and other necessary items or services.</td>
</tr>
<tr>
<td>Time</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

### Instructions

**Step 1:**
Read aloud or have one of the participants read aloud the following stories once or twice and then ask the related questions listed below each story.

**a) Physical abuse**

A young construction worker was working at a site near the entrance to a large secondary school. He often watched the teenage schoolgirls walking by on their way to and from school. Sometimes they would stop and talk to him. There was one in particular whom he found very beautiful and sexy. Her name was Brenda. Though he had several girlfriends in the market town, it was Brenda whom he dreamed of having, but she always politely rejected his advances. It seemed to him that Brenda got more beautiful and sexy as each day went by. But no matter how hard he tried to convince her, Brenda said she wasn’t ready and was not going to go with him. On his day off, the construction worker had the habit of going to a bar where a locally brewed alcohol was available. This drink was very strong and he usually got very drunk. Late one afternoon, he was staggering back to his residence after drinking and he saw Brenda off in the distance carrying fresh bread that she had just bought for her family. She looked very appealing to him. She looked more like a woman and less like a schoolgirl when she wasn’t wearing her school uniform. He was surprised that she was not glad to see him when he put his arm around her. She told him he was drunk and should leave her alone. This made him angry and he decided he should teach her a lesson. He twisted her arm behind her back and forced her to walk off the road into nearby bushes and slapped her several times hard across the face to quieten her.
her. He then proceeded to force himself on her. After it was over, she lay on the ground whimpering, her clothes ripped and soiled. The bread lay on the ground. He told her that if she ever told anyone about this, he would beat her severely.

- Do you think it is possible for your judgement to be impaired by drinking a lot of alcohol?
- Do you know of anyone who gets violent when they drink?
- Do you think people can drink to the point of losing control?
- Is there anything Brenda could have done to avoid this situation?
- What is the worst thing you can imagine happening after the rape? (Introduce the possibility that he rapes her several times and she eventually contracts HIV from him but neither knows they have the virus. Brenda then gets pregnant and he denies that he is the father. The baby is born with HIV and Brenda discovers that she is infected. He gets transferred to another post, refuses to believe he is infected and continues to have unprotected sex with other women.)

#### b) Drinking away pay

John was an accountant who had been assigned to a remote mining town and, because housing was not available, he was forced to leave his family back in the city. Four months went by, and he thought of his family every day. In fact, he missed them so much that the only way to get any relief was to drink alcohol. It started with just a few beers after work with the other men. Then he found that he needed a beer first thing in the morning to get up the courage to go into work. Part of the problem was the boredom of working in a remote border town with very little going on. Missing his family and being in such a desolate place made him drink more and more. He even started to carry a small bottle with hard alcohol in it, which he drank even while on duty. His friends noticed that he was not himself. He would get into arguments over nothing. He even got into a fight with his best friend at work and the two stopped speaking to each other. His supervisor sent him home one day when he showed up for work so drunk that he could hardly walk. Buying the alcohol was taking so much of his pay package that there was little or nothing left to send home. His wife made some money selling a few things at the market. But on days that she sold nothing, she found that the only way she could feed their four young children was to sell sex. Though she knew she should be using condoms, she found that the men would not have sex with her if she insisted on using them.

- Do you think it is possible to start drinking a little and end up drinking a lot?
- Do you know of anyone who gets angry and argumentative when they drink?
- Do you think some people drink alcohol because they are bored or lonely?
- What do you think of the situation the wife found herself in?
- What is the worst thing you can imagine happening to this family? (Introduce the possibility that she contracts HIV from the men and then passes it to her husband. She then gets pregnant and the baby is born with HIV. The couple eventually dies from AIDS, leaving their five orphaned children, one of whom is infected with HIV.)
c) Injecting slow death

Ivan and Petr came from the same town and faced the same bleak future. There were few jobs and little money. They were not unlike many other young people in their town who had nothing in their lives to look forward to. They both got low-paying jobs as cleaners in the local factory. They first started drinking homemade alcohol and then began looking for more effective means to obliterate their despair. They got involved with a small group of people who processed their own heroin and shot it into their veins as often as they could. The boys found that there were a lot of other young people like them working in the factory who were discouraged and frustrated with their dead-end jobs and their lives, and who were interested in sharing the drugs. The drug injecting equipment they had stolen was put to good use as a group of ten friends shared the heroin they bought when they pulled together the little money they had. They were so afraid of being seen with the needle and syringe that they rarely took the time to properly clean it. There was no question of getting other injecting equipment. They considered themselves lucky to have the equipment they had. Most weren't even aware that sharing injecting equipment put them at risk of contracting HIV and the others didn't care. Their only concern was getting their next fix and forgetting about their lives and their bleak future. They didn't go out of their way to recruit others to join their group, but they didn't mind sharing their drugs with others who were willing to share the cost.

- Describe what is going on in this story.
- What advice would you give to those thinking about joining Ivan and Petr's group?
- Why do you think this goes on at some workplaces?
- What is the difference between those who inject drugs and those who do not?
- Why do you think they shared the same injecting equipment without cleaning it?
- How did the boys feel about their future?
- How do you think the two of them would feel if they found out they were infected with HIV?
- Who do you think the boys could turn to for help with their drug addiction?

Step 3:
Summarize the points made in the discussions and the lesson overall.

Step 4:
Provide information on where drug and alcohol abusers can get support.
Exercise 24: Controlling alcohol consumption

Objective
To get participants to consider options for controlling excessive alcohol consumption

Background
In some countries, there are restrictions on the consumption of alcohol. The idea is that, if opportunities for consuming alcohol are reduced, opportunities for abuse are also reduced.

Time
30 minutes

Instructions

Step 1:
Share the following points with the participants about rules designed to control alcohol and drug consumption, and ask the related questions:

a) In many places where alcohol sales have been banned (such as in some Muslim countries today and in the United States many decades ago), people have continued to make and sell it illegally, often producing dangerous mixtures. People have continued to drink alcohol in spite of the ban.
   ▪ Do you think banning alcohol altogether is a realistic solution?

b) In some parts of Africa, the drinking of alcohol has been reduced by limiting, for example, the timing of weddings and bar opening hours to daylight or early evening hours. But others say that drinking then just gets more concentrated in a shorter time. There are no simple solutions.
   ▪ Do you know of any restrictions on the times that alcohol is served in public places?

c) Many of those who make alcohol are women, who are selling it to earn an income for themselves, for school fees or to pay taxes.
   ▪ If people drink too much alcohol, whom or what should be blamed: the person who makes it, the alcohol or the drinker?

d) In every country, most fatal car crashes are caused by drivers who have consumed too much alcohol.
   ▪ Do you think it is right to take a driver’s licence away from someone who has drunk heavily and then driven a car or truck?

e) In most countries, it is illegal for workers to consume illegal drugs, including injecting drugs such as heroin.
   ▪ Do you think that a friend or colleague of an injecting drug user should turn the user in to a superior or law-enforcement officer and have the person punished?

Step 2:
Resume the points made in the discussion and summarize differences in opinion.
Step 3:
Share with participants the following points about individual choices and alcohol consumption and ask the related questions:

a) Some people believe that rules restricting alcohol consumption make it harder to get alcohol but do little to stop alcohol abuse.
- What do you think might be done to get those who abuse alcohol to change their behaviour?
- What do you do to ensure that you do not drink more than you want to or than is wise for you to drink?

b) When people have consumed too much alcohol, it is very difficult for them to act responsibly or to control their actions. The morning after a night of heavy drinking, people often regret having had unprotected sexual relations the night before.
- How do people know that they have drunk too much?
- What can people do to avoid getting to that point?
- What do you do to maintain control of your actions?

c) Drinking alcohol is usually a pleasant social activity. But drinking too much alcohol can make a person overly aggressive and abusive.
- What can be done to reduce the abuse of women by men who have drunk too much?

d) Some organizations have used the buddy system to help prevent their employees from drinking too much. Each person is assigned a partner when going out. Both partners are responsible for monitoring each other’s alcohol consumption and for reminding each other to use condoms, if engaging in sex.
- Do you think this idea would work at your workplace?
- Would the buddy system work for you?

f) A growing number of people think that putting injecting drug users in jail is not the best solution. It is better to ensure that users are protecting themselves and others from HIV infection by not sharing needles and syringes. Referring a friend or colleague to confidential, professional treatment centres, where available, would increase the likelihood of users overcoming their addiction.
- What advice would you give to someone you know who takes illegal drugs?
- Do you think injecting drug use is more of a legal, social or economic problem?

Step 4:
Summarize the points made in the discussion.
Gender issues

What is meant by ‘gender issues’?

We need to face up to the sensitive issues of power relations between men and women, and of their sexual relations. The gender dimensions of HIV/AIDS should be recognized. Women are more likely to become infected and are more often adversely affected by the HIV/AIDS epidemic than men, due to biological, socio-cultural and economic factors. The greater the gender discrimination in societies and the lower the socio-economic position of women, the more negatively the latter are affected by HIV. Therefore, more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.

What factors make women and men vulnerable to HIV/AIDS?

Inequality in gender operates in many ways, most of which reinforce each other and also promote the spread of the epidemic:

**Inequality in personal relations.** Women in many different cultures are systematically assigned inferior social and economic roles. This makes them less powerful in their relationships with men. As a result, they are often unable to resist men’s sexual demands. They cannot negotiate safer sex or refuse unsafe sex – even if their partner engages in high-risk behaviour. Some men may not want to use a condom, or they may want numerous sexual partners. According to UNAIDS, up to 80 per cent of HIV-positive women in long-term relationships acquired the virus from their partners.

In its most extreme form, this inequality results in violence against women - rape, sexual assault and beatings. It is most often perpetrated by the woman’s partner. Studies of women in all regions show that about half of them have been physically abused by an intimate partner.

**Inequality before the law.** Unequal property, custody and support laws in some countries mean that women’s rights are often determined by their father and/or husband. Widows are in a particularly weak position: after losing her husband to AIDS, a woman may also lose her home and land, and even be blamed for her husband’s illness. This can force widows to resort to ‘survival sex’.

**Education and health.** Women are also disadvantaged because of lower levels of literacy – due to a lack of investment by governments and families in the education of girls. They are therefore less able to access information and education about HIV/AIDS.

Health services often fail to provide facilities for women, particularly reproductive health care. Maternal mortality is increasing in a number of countries where structural adjustment has led to cuts in the provision of health care. Women are also more likely to be malnourished and anaemic, which makes them more susceptible to infection.

**Women as carers.** The burden of caring for sick family members and neighbours falls more often on women and girls than men, thus increasing the females’ workload and diminishing their income-generating and schooling possibilities. Where orphans are taken in by the extended family, it is the women who provide most of the care.

**The special vulnerability of girls.** The average age of infection for women is much lower than for men. The UNAIDS Report on the global HIV/AIDS epidemic, 2002 shows that,
in Africa, HIV prevalence in the 15–24-year-old age group is twice as high among females has among males. Young girls are especially vulnerable in a number of ways. Until her body is fully physically developed, a girl’s reproductive system is more likely to be torn during sex, making her more vulnerable to sexually transmitted infections (including HIV). There is also the persistent myth that sex with a virgin will cure a man of the virus, and the belief that younger females are less likely to be infected. Young women are also the least able to assert themselves or protect themselves from the sexual advances or coercion by older men. This can result in commercial sexual exploitation, with increasing numbers of girls being trafficked, but it can occur in any situation where a male is in a position of authority and power over younger people.

The challenge men are facing. If we want to reduce the vulnerability of women to HIV infection, and the spread of the disease, we must look at ways of making men and women more able to negotiate their relationships on a basis of equality. The ILO Code of Practice on HIV/AIDS and the world of work stresses the fact that, “men have an important role to play in adopting and encouraging responsible attitudes to HIV/AIDS prevention and coping mechanisms”. This does not mean blaming men, or ignoring the pressures on them to behave in certain ways. On the contrary, it means improving our understanding of masculinity – the characteristics of male behaviour and the many factors that shape it, and rejecting the many stereotypes that surround it. Men also have expectations and burdens placed upon them, which contribute to their vulnerability. Just as women are often expected to remain within the home, and assume the main responsibility for child care and domestic labour, men are expected to be the chief provider of income through work - however dangerous, dirty or unpleasant. This can be a source of pride, but also of stress. Men are unable to spend much time with their children. They may travel within their country, or even abroad, to find work. Or they may have to take jobs that mean they are away from their families for long periods – as is the case with seamen or truck drivers, for example. In many societies, men are also expected to be powerful and strong, and not to show or talk about feelings. They may also believe that they should know about sex and what to do, though they may not. When men do not admit to NOT knowing, it makes it harder for them to receive information about AIDS.

How do gender issues affect the world of work, and what action can be taken at the workplace to promote equality and empower women in the fight against HIV/AIDS?

Women’s lower status in society and their poorer income-generating possibilities make them more vulnerable to the economic impact of HIV/AIDS. Women are more likely to be in the urban informal sector, in subsistence farming, or in the most poorly paid jobs in the formal sector. This means a low income for most and little social or economic security, in terms of savings, insurance or social security.

The world of work is unequal in many ways. Unlike men, women still face:

- unequal hiring standards
- unequal opportunities for training and retraining
- unequal pay for equal work
- segregation and concentration in a relatively small number of ‘women’s jobs’
- unequal access to productive resources, including credit
- unequal participation in economic decision-making
- unequal promotion prospects
- greater likelihood of being unemployed.
Women often find themselves in positions of weakness and dependence at the workplace, which can easily lead to sexual harassment and abuse. It can be very difficult to say “no” to the boss or the landlord, the official who can deny you a licence, to the lorry driver who can refuse to transport your goods, or to the policeman who can keep moving you on in the street. A survey of 200 women in the United Republic of Tanzania discovered that 90 per cent of them felt that sexual harassment threatened their jobs and economic survival. Research in Kenya’s export-oriented sectors such as the coffee, tea and light manufacturing industries found that women experienced violence and harassment as a normal part of their working lives:

- over 90 per cent of the women interviewed had experienced or observed sexual abuse within their workplace
- 95 per cent of all women who had suffered workplace sexual abuse were afraid to report the problem, for fear of losing their jobs
- 70 per cent of the men interviewed viewed sexual harassment of female workers as normal and natural behaviour.

Violence also happens to women on their journey to and from work. In some societies, there is a view that attacking women who work outside the home is justified. A study in Bangladesh found that more than 50 women were raped while travelling to and from work in a six-month period; five of them were murdered.

This level of violence at work occurs in a context of high levels of violence against women in the home. It was only in 1993 that it was internationally recognized that violence against women is a denial of their human rights (at the Vienna Human rights conference).

What causes friction in relationships between sexual partners?

**Lack of communication between men and women.** When men and women feel uncomfortable talking about sexual relations, they are less likely to use condoms with each other or in other relationships outside of the marriage. Men and women must deal frankly and openly with important issues such as fidelity, HIV counselling and testing, and sexually transmitted infections to ensure their protection from HIV infection.

**Physical violence towards women.** Nothing destroys trust and confidence in a relationship quicker than physical violence. It is hard for a woman to respect her husband or boyfriend if he beats her. Beating a woman not only results in possible injury to her, but can also lead to divorce or conviction by a court of law.

**Unsatisfied sexual needs.** Both men and women are more inclined to seek extra-marital sexual relations if their partner does not satisfy their sexual needs.

**Insufficient money given to support family.** If men do not provide enough money to keep their families well fed, clothed and housed, their female partners may seek financial support from other sources, including other men, in exchange for sex.

**Money spent on girlfriends (or boyfriends), alcohol, drugs and gambling.** When a person spends large portions of his or her income on social activities, there is very often little left to support partners and families.

**Transmitting a sexually transmitted infection that causes infertility.** The ability to have children is greatly valued by women and men. Men who have sex without condoms outside their regular relationships can pick up sexually transmitted infections that they then pass on to their regular partners. Even if the man never has any symptoms, the infection may be
transmitted to his partner, and may make it impossible for her to have children.

**Infecting a woman with HIV, who then gives birth to an infected baby.** Many couples learn that the man has been infected with HIV and passed the infection to his partner when she gives birth to a baby infected with the virus. Some families stick together, but many partners split up after discovering that their husband or regular male partner was unfaithful and transmitted the virus to them.

**What are men’s and women’s responsibilities to each other?**

**Protect each other from HIV infection.** The most effective way of protecting regular partners from HIV is to not have sex with other people. If that is impossible, then it is necessary to use condoms for every sexual act.

**Respect each other.** Men and women can learn to trust each other. However, trust is not automatic; it is something that must be earned. Men and women can also:

- be faithful (not having sex with others is the best way for couples to protect themselves and their future children from HIV infection);
- learn to appreciate each other’s needs;
- discuss and solve problems together;
- appreciate and encourage mutual affection and support;
- strive to understand each other, in order to create harmony for the family; and
- create a sex life based on affection, rather than on coercion or violence.

**Prepare for the future.** Planning financially for the future and preparing a will are essential to protect the interests of partners and uninfected children.

**What can be done to address gender inequality in the context of HIV/AIDS?**

**Education about the need for mutual respect and communication.** Men need to learn to respect all women and understand that women have the right to refuse sex. Men need to understand the harm they can do to women and to themselves when they abuse their power and take advantage of women’s vulnerability. Men should be encouraged to listen to the needs of women, take responsibility for their acts, and protect their loved ones.

**Workplace programmes for prevention and care should be gender-sensitive.** Education and training are essential to changing attitudes, behaviour and rules governing workplace and personal relationships between men and women.

**Work patterns that separate workers from their families for prolonged periods should be avoided.** Problems are experienced where, for example, mine workers are living in single-sex hostels and are unable to live with their families. We have already discussed the situation of truck drivers. Even if these working patterns are difficult to change, conditions can at least be improved - facilities for rest and recreation could be provided, as could family accommodation.

**Enterprises need to be careful that their business practices do not encourage or condone risky behaviour.** It is relatively common practice for businesses to entertain their clients by paying for various services from the sex sector as part of their business entertainment expenses.

**Zero tolerance for violence and harassment against women at work.** Procedures for complaints by women should be simple and support should be made available to them in
this context. Trade unions should make it clear to union members that this is regarded as a trade union issue. Employers should make it very clear that violence or harassment is a disciplinary offence.

**What does ‘men who have sex with men’ mean?**

This term refers to men who engage in sexual relations with other men. These men may be homosexual and only have sex with men, or they may be bisexual, which means that they have sex with both women and men. Despite the fact that they have sex with other men, they might not want to identify themselves as being either homosexual or bisexual. In addition, some men married to women also have occasional sex with men. Finally, there are men, such as those restricted to remote construction sites or prisons, who sometimes have sex with men because they do not have access to women.

Men who have sex with men come from all social, cultural and economic groups, in all countries worldwide. Most men who have sex with men have no apparent physical characteristics that distinguish them from other men. In some countries, it is common to see men who cross-dress—that is, they dress like women. Some may also take hormones and have surgery performed in order to look like women. In many countries, there are ‘gay’ subcultures, with special bars, discos and restaurants for men who are homosexual. Men who have sex with men often prefer to be secretive about their sexual preferences because they fear negative repercussions if they are found out.

**Are there men who have sex with men at the workplace?**

*Workers reflect society.* It is generally estimated that 10 per cent of all men have sex with other men. It can thus be expected that the percentage of male personnel at most workplaces having sex with other men is about the same. In some cultures, men who have sex with men may have a higher profile and even be allowed to marry legally. In others, their sexual activity may be illegal and men who have sex with men may suffer discrimination and even violence. In some countries, there are strong cultural taboos against men who have sex with men. By and large, there is much more sex between men occurring than is acknowledged because of the secretive, clandestine nature of it and the repression and sanctions against it. Physical and sexual violence against men by other men as punishment for having sex with men is not uncommon.

*No discrimination.* There are some workplaces that go out of their way not to discriminate against men who have sex with men if the sexual activities of the men are discreet and low-profile. The elimination of employment-related discrimination against men who have sex with men is an essential first step in developing strategies to reduce their high-risk behaviour.

**Why are men who have sex with men important?**

*Men who have sex with men are vulnerable to HIV infection.* In developing countries, most HIV-prevention campaigns have targeted heterosexuals (men and women who have sex together). As a result, there are men who mistakenly think they are not at risk of being infected with HIV when they have sex with other men. The truth is that they are extremely vulnerable, especially if they engage in anal intercourse without using condoms. Men who have sex with both men and women can become infected from their male or their female partners or they can pass on the virus to them.
Why is sex between men clandestine?

In many countries, sex between men is illegal. Two men caught having sex could be arrested and sent to jail. Heterosexual men can also be cruel to men who have sex with men, ridiculing and even beating them. In many countries, there are reports of police arresting men who cross-dress and raping them. Rape may occur even when the men in question do not cross-dress. Sex between men occurs in all societies, but because it is stigmatized and often illegal, many believe that same-sex sexual behaviour does not exist, when it is, in fact, simply hidden.

Are there male sex workers?

There are young men who have sex with men who are willing to pay for it. Many of these men also have sex with women and risk infecting them, and vice versa. Like female sex workers, male sex workers have higher levels of HIV infection because they have many different sexual partners and often are offered extra money to have sex without a condom. In many countries, the clients of those men may include male workers.

What are the challenges to preventing HIV among men who have sex with men?

- In many countries, because of the clandestine nature of sex between men, it can be hard to reach these men and organize peer-education sessions with them.
- Many men who have sex with men resent being associated with homosexuality and may deny that they have sex with men. This is also true among men who have sex with both men and women. As we do not know the sexual orientation of the participants in peer education sessions, the programme should cover prevention in all types of sexual relations to ensure that all issues are addressed.
- It is sometimes difficult to address the issue of men who have sex with men if institutions and employers are not supportive.

What can be done to lower the risk of HIV transmission among men who have sex with men?

- Among men who have sex with men, increase awareness of the fact that all unprotected sex, whether with a man or a woman, can result in HIV infection.
- Promote condom use among men who have sex with men.
- Recommend culturally accepted alternatives to penetrative sex, such as mutual masturbation and engage in oral, rather than anal, sex and avoid having partners ejaculate inside the mouth.
- Promote use of non-oil-based lubricants among men who have sex with men. For example, the white of an egg used as a lubricant during anal sex with a condom will reduce the chance of the condom breaking.
- Encourage men who have sex with men to carry condoms at all times.
Instructions

Step 1:
Explain to the men that you will provide them with various scenarios and that they are to indicate verbally or on a sheet of paper whether the action taken in a particular scenario was 'appropriate' or 'inappropriate'.

Step 2:
Read, or have the men read, the list of situations one at a time. After the men have considered their responses, have them explain why they think the action taken was appropriate or inappropriate. Note that the correct answer and reasons why it is correct are found in brackets under each scenario description.

Scenario 1: Visit to the doctor

A doctor informs a market woman that she has tuberculosis—a common opportunistic infection caused by HIV infection. He suggests that both the woman and her husband undergo HIV counselling and testing. The woman tells her husband that his chronic coughing is caused by a bad cold and it will go away eventually. She is afraid that she will be beaten for bringing HIV into the family, although it is likely that her husband was infected first.

(Inappropriate: The woman has a responsibility to tell her husband the truth about her encounter with the doctor and give him the chance to obtain care and treatment, if HIV-infected, and to deal with the consequences of being infected.)

Scenario 2: Embarrassment about sexually transmitted infections

An inter-city van driver travelling away from home meets a local girl and has sex with her every time he passes through her village. One day while bathing, he notices a red sore on the tip of his penis. He is too embarrassed to talk to his girlfriend but he takes her to the clinic to get a check-up by a doctor and tells the doctor about his sore.

Objective
To help men understand the choices they face in their relationships with others

Background
This exercise increases men’s awareness of the importance of thinking before acting and understanding the consequences of inappropriate actions.

Time
30 minutes
(Appropriate: Even though it would have been better to talk directly about the sexually transmitted infection with his girlfriend and ensure that both take action to protect themselves, he did the right thing in taking her to the doctor and telling him the truth.)

Scenario 3: Women beware

Two plantation security guards on patrol come across women carrying bundles on their heads on plantation property. They tease the women by raising their clubs and pretending to beat them. They then hit them lightly, making the women tremble. Finally, they make the women go down on their knees and beg for the men to let them go. They try to get the women to agree to come back at night to have sex with them.

(Inappropriate: The women did not deserve to be humiliated and frightened, even if they had broken the law. The men showed no respect for the women. It is unlikely that they would want their daughters, wives, sisters or mothers to be treated in such a way.)

Scenario 4: Back-room passion

A male customer in a bar finds his way to a back room with one of the young barmaids. They excitedly take off their clothes and, just before he is about to penetrate her, she pulls out a condom and asks him to put it on. He accuses her of thinking that he is dirty and has AIDS. She explains that it is to protect them both and he finally agrees to put it on.

(Appropriate: It would have been better if the man had had a condom and wanted to use it. But he did the right thing by respecting the barmaid’s desire to protect herself with the condom.)

Scenario 5: No free lunch

A car mechanic has been charming a girl who sells oranges and eggs at the market. He buys her a snack every time he sees her and has bought her several small gifts. He very much wants to have sex with her. One evening, they kiss and he fondles her breasts. He is burning for more but she says she isn’t ready. He can’t stand waiting a moment longer and pushes her to the ground, pins back her arms and forces himself inside her.

(Inappropriate: The mechanic might have felt the girl ‘owed’ him sex because he had given her food and gifts, but he did not have the right to force her to have sex against her will.)

Scenario 6: Caught in the act

A man was walking in a park when he heard a rustling sound. He was shocked to see two male having oral sex, with a box of condoms beside them. One of them was somebody he used to work with. He was so disgusted by what he saw that he wanted to beat the men. He then thought it was his duty to turn them in to the workplace supervisor. The men pleaded with him to let them be; they
were afraid of being fired. Sex with men was not for him, but he decided that it wasn’t up to him to judge the preferences of others.

(Appropriate: The right not to be discriminated against on the basis of the sexual orientation is a human right. Though heterosexual men may be revolted by the idea of men having sex with men, it is not up to them to judge the behaviour of others.

Step 3:
Summarize the points the participants have made and the lessons learned. Some suggestions:

▪ Open and frank discussions about sexual issues can be difficult but it is important that these things be discussed.

▪ Men in authority should not take advantage of the women they supervise.

▪ Men should respect women’s rights to refuse to have sex, if they so choose, and to ask men to use condoms, if they do choose to have sex.

▪ Men who have sex with men can make other men uncomfortable, but they should not be punished for their sexual preference.
Exercise 26: Negotiating condom use

Objective: To improve skills for discussing condom use

Background: This exercise increases men’s and women’s awareness of the importance of discussing condom use before having sex.

Time: 30 minutes

Instructions

Step 1:

Have two participants read the following scenario with a view to developing a role-play dialogue, with one person playing Joseph and the other taking the role of Caroline (If there are only men in the group, ask a man to play the role of Caroline. If necessary, the peer educator can play one of the characters.) In other words, the participants will invent a conversation about the topic.

Joseph has just been transferred to a new posting outside the capital. He meets Caroline and they want to have sex. Caroline suggests using condoms, but Joseph is against it, saying that he is clean. He says that he hasn’t had sex with anyone in six months. Caroline answers that, as far as she knows, she is also disease-free. But she explains that she still wants to use a condom since one of them might have an infection and not know it. Joseph says that condoms are unnatural and they ruin his enjoyment of sex. Caroline says that she will help him to put it on and that they can make it enjoyable. Joseph reluctantly agrees to try it.

Step 2:

Explain to participants that when one person wants to use a condom and the other does not, negotiation is needed to determine whether or not a condom will be used before they have sex. Then have participants act out the role-play.

Step 3:

Stimulate a discussion about the role-play by asking the participants the following questions:

- What did you see happening here?
- Why do you think it is not a good idea to assume that someone is not infected with HIV, based on how they look?
- Do you think the girl was right in suggesting that a condom be used? Why?
- How were the two able to resolve the problem about the condom use?

(Answer: They talked openly about the problem. They understood each other’s point of view. They showed that they cared and were willing to compromise.)
Step 4:
Give participants the following definition of negotiation:
- Negotiation involves making a mutual decision.
- Different options are proposed and discussed.
- The consequences of different options are also discussed. (For example, in the role-play, Caroline and Joseph decided that the consequences of sex without condoms were much worse than feeling that sex with condoms might not be comfortable.)
- A mutually beneficial solution is found.

Step 5:
Tell participants that negotiation requires the following steps:
- Each person is able to express him or herself.
- Each person listens to the other.
- There is time to discuss opinions and options.
- Each person is respectful.
- Each person recognizes the feelings that the other person may be having.
- There is a willingness to compromise.

Step 6:
Ask participants to give some examples about how these negotiation steps were illustrated in the role-play. (Examples might include the fact that the couple took time to consider their respective opinions before having sex. Caroline recognized Joseph's discomfort and tried to suggest ways of making condom use more appealing for both of them.)

Step 7:
Ask participants to think of a situation in their own lives where negotiation was necessary. Ask them the following questions:
- How easy or difficult would it be to negotiate using the above-mentioned steps and principles in this situation?
- What would be easy or difficult?
- How might things have changed if you had used the suggested steps or principles?

Step 8:
Ask participants to think about risky sexual situations where negotiation might help and ask them to do the following:
- Describe a situation involving risky sexual behaviours where negotiation could help.
- Describe a situation involving risky sexual behaviour where negotiation would be difficult.
Codes of conduct

What is a code of conduct?
A code of conduct is a series of rules relating to certain types of behaviour; it is usually developed for adoption by certain groups or in certain environments. Being part of a workplace or a workers’ organization can bring with it personal responsibilities. Workplace codes usually involve a list of behaviours that employees are expected to follow and that are related to their work. For example, the code may require employees to show up on time, refrain from drinking alcohol during working hours, and be courteous and respectful to other workers. Members of professional associations, such as nurses, may have a special code of conduct for all members, including such things as helping sick and injured people with pride and courtesy. In general, workplace codes are an agreement between employers and employees to act in a responsible, dignified and civilized manner. Bank employees, for example, may sign a code agreeing to:

- uphold the law
- respect human rights;
- be fair and non-discriminatory;
- set an example to society; and
- be courteous and honest with clients.

What is the link with HIV/AIDS?
There are specific forms of behaviour that degrade the image of those working for a particular workplace or organization and that put people at risk of being infected with HIV or infecting others. These forms of behaviour include abuse of alcohol and drugs, which may result in unprotected sex and/or violence. Excessive alcohol consumption by men also increases the likelihood of them having sex with a sex worker. Coercing women into sex, or threatening them with negative consequences at the workplace if they do not agree to have sex, is an abuse of power as well as involving a risk of HIV infection if condoms are not used.

What difference will a code of conduct make?
When an employee or employer signs a code of conduct, it makes them more aware of what is expected of them in terms of acceptable behaviour. It can also act as a restraint by making them aware of when they are breaking the code and possibly putting their job at risk, as a result.

What is acceptable sexual behaviour?
Discussion is needed at the workplace about what constitutes acceptable sexual behaviour among employees and employers. Discussions of sexual behaviour are delicate for everyone concerned, but issues relating to respect, human rights, gender equality and the legal implications of unacceptable sexual behaviour should be addressed.
What can be done to create codes of conduct?

It is essential that managers and employee representatives together establish standards for employees to follow. This is not to suggest that the company define appropriate social or sexual partners. The code should include statements that reinforce HIV prevention, while discouraging sexual coercion or harassment. Specifically, such statements should discourage:

- sexual harassment or coercion of female employees, both on and off the job;
- the use of monetary or material inducements to gain sexual favours with women;
- sexual relations with adolescents; and
- sex with sex workers and/or casual sexual partners, unless condoms are used.

Why are codes of conduct important?

Power at the workplace can be abused. Those who are superior in a workplace hierarchy, whether they are employers, supervisors, employee representatives or others in a position to control those below them, have power. Such people sometimes abuse this power in order to gain personal benefit. In the context of HIV, the risk is often for men in positions of influence to coerce younger women to have sex in exchange for work-related benefits. Men in positions of power also usually have more resources than those working for them and can offer money for sex to those wishing to supplement their income. Because of the power and influence associated with being an employer, supervisor or employee representative (in terms of hiring, firing, granting promotions, raises and time off), the potential for abuse exists. Such abuse can generate disrespect and disgust among the workforce towards the abusive person. It also sets a poor example for other employees and brings disrespect to the workplace as a whole.

What conduct is expected at the workplace?

Discretion and respect. It is not expected that people abstain totally from alcohol consumption and sexual relations. What is expected is that they do not put themselves or others at risk of HIV infection. People have a responsibility to uphold the high standards expected of them as members of their community, as defined by their workplace, profession, neighbourhood or other association. Employers, supervisors, employee representatives and others who have power and influence over other personnel have an important role to play as positive models to those under their charge and they should be seen to respect and observe the code of conduct.

What does this mean, on a personal level?

Follow the code of conduct. All personnel have a responsibility to follow a professional code of conduct, once it is established. Many businesses, workers’ organizations, civil services and other associations have a code of conduct that clearly spells out the roles and responsibilities of their personnel and members. Others may not have a written code, but all employees are still expected to uphold the law and behave appropriately. This is especially true of employees who deal with the public.

End abusive behaviour. This means ending behaviour that is harmful to others and that brings disrespect to the employer or worker associations. Ideally, it should also involve examining the choices that lead to such behaviour.

Protect others. Those who follow the code of conduct have a responsibility to ensure that others follow it as well, for everyone’s protection.
Exercise 27: Code of conduct

Objective
To have participants consider the possible content of a professional code of conduct and better understand the implications for each individual.

Background
A professional code of conduct is a list of roles and responsibilities that all personnel are obliged to follow. The obligation to protect the workplace community, their families and the community at large is often included. Workers are more likely to follow a code of conduct if they understand its implications and agree to abide by it.

Materials
Sheets of paper, flipchart paper or chalkboard (optional)

Time
30 minutes

Instructions

Step 1:
Read the following list of elements that are often included in a code of conduct.

We will:
- at all times conduct ourselves in a professional manner;
- support and encourage proper conduct throughout the workforce;
- treat our co-workers and the community with respect, courtesy and consideration; and
- always be aware of the human rights of women and children and never violate them.

We will never:
- bring discredit upon our organization through improper personal conduct, failure to perform our duties, or abuse of our positions;
- take any action that might jeopardize our work or our organization’s mission;
- abuse alcohol, use drugs or engage in drug trafficking; or
- commit any act that could result in physical, sexual or psychological harm or suffering to others.

Step 2:
Read each of the items included on the list above again, one at a time, and ask participants to answer the following questions for each one:

- What do they think this item means?
- How does this relate to HIV/AIDS (if at all)?
- How can this sample code of conduct be applied to other workplace settings like ours?
- Which of these items should be included in the code?
Step 3:
Summarize the points made during the discussion and emphasize that adherence to professional codes of conduct will greatly reduce an individual’s risk for contracting HIV or other sexually transmitted infections or transmitting these infections to other persons.
Section B: HIV/AIDS-related care and support

Living positively with HIV/AIDS

What is meant by living positively?
Living positively means doing everything possible—mentally, emotionally and physically—to stay healthy, active and well for as long as possible. In the case of HIV, it also means helping the immune system to stay strong so that it can cope with the virus.

Why live positively?

Living positively works. Research in Uganda and other countries has shown that poor people with HIV who take care of themselves and have a positive outlook on life can live much longer than other people who have the virus—even without expensive medicines or other treatments. Manuals and pamphlets about living positively by adopting healthy eating and hygiene habits are often available from health departments, HIV/AIDS organizations, public libraries and on the Internet.

What kinds of things can people living with HIV/AIDS do to live positively?

Make plans for life. People living with HIV/AIDS should not stop doing the things they enjoy doing or give up on their dreams and aspirations. They should keep working for as long as possible. It is still possible for HIV-positive individuals to be active, to keep old friends and make new ones, and to continue leading a fruitful, enjoyable life.

Find people to talk to for emotional support. People living with the virus can tell those who matter to them that they have HIV. This may be difficult, but people living with HIV/AIDS need the love and support of those around them. Keeping their infection a secret can weaken the immune system and diminish their quality of life.

Avoid tobacco, drugs, alcohol and other harmful substances. These can weaken the immune system and hamper the absorption of essential nutrients. Stimulants such as alcohol, tea and coffee can also cause a lack of sleep.

Devise a healthy eating plan. This means eating a variety of foods from the four main food groups every day, so as to get enough of the vitamins, minerals and other nutrients that the body needs to stay healthy. Eating at least three meals a day and having wholesome snacks in between can bolster health. The traditional foods of many countries are often the healthiest. It is also important to drink plenty of clean water and other liquids—at least eight cups or glasses every day.

Keep up daily hygiene. Maintaining good daily hygiene helps prevent infections and makes people feel good about themselves.

Exercise regularly. It is important for people to remain active as long as they can, rather than sitting around all day. Exercise tones the muscles and keeps them strong. It is also good for the heart, ensuring that the blood circulation maintains a good supply of oxygen to the brain and the body.
Get enough rest. Getting a good night’s sleep is beneficial. Naps or rest periods during the day can help if someone is feeling tired or weak.

Avoid other infections. People with HIV are vulnerable to other infections as the immune system is weakened and cannot defend the body well. They should therefore avoid close contact with anyone who has a cold, upset stomach, cough or flu. People with HIV/AIDS should also stay away from animal and chicken enclosures, rubbish heaps and other places where lots of harmful bacteria may be present. They should consume clean food and water. They should abstain from sex or, if that is not possible, use a condom to avoid sexually transmitted infections or re-infection with HIV. Women with HIV should also avoid getting pregnant, unless this is something that they have planned and have discussed with their doctor in advance. Re-infection with HIV, other sexually transmitted infections, and pregnancy can weaken the immune system and hasten the progress of AIDS.

Monitor general health. People living with HIV/AIDS should visit a health-care facility regularly for check-ups, early treatment of possible co-infections, and any other health problems. Pregnant women should visit clinics regularly to make sure that they and their unborn baby have the best possible care. Children with HIV/AIDS also need regular medical attention, as they have special needs.

Seek spiritual and other counselling. This does not necessarily have to take place with a religious official or trained counsellor. Sometimes, just having a good friend to talk to or laugh with can be uplifting. People with HIV should avoid those who make them feel bad about themselves.

What is home-based care?

Home-based care, in the context of HIV/AIDS, involves families taking care of family members with AIDS who are bedridden as a result of related illnesses. Many people who are in the terminal phase prefer to be at home rather than in a hospital, if they can get the help they need there. Family members can provide basic physical care as well as emotional and psychological support. They can learn how to provide basic treatment as well as protect themselves from potential infection though good hygiene practices when handling menstrual blood, for example. In some cases, the home-based care provided by families can be complemented by regular visits by health-care providers.

What can be done for people living with HIV/AIDS when they have a fever?

Medical doctors can prescribe drugs to control chronic fever. Giving people with fever a sponge bath as often as possible will make them feel more comfortable and can lower the fever. Removing all or most of the individual's clothing or any other covering also helps. Keeping the person in a cool place with good air circulation or in front of a fan is also recommended. Giving the person clean, cold water to drink as often as possible helps keep the temperature down and replenish liquids lost through sweating. Changing soaked bed covers also makes a person with fever feel more comfortable.

What can be done to alleviate pain for people living with HIV/AIDS?

Painkillers can be prescribed by medical doctors but many are available without a prescription. It helps to take them to control pain rather than waiting until the pain becomes intolerable. If obtaining drugs is impossible, try distracting people suffering from pain by talking with them, singing or playing their favourite music softly. Placing people in
a dark and quiet environment or by a window where they can watch passers-by or children playing can also help.

**What can be done for HIV-positive individuals who have diarrhoea?**

Drinking large amounts of clean water is essential to prevent dehydration. Adding some salt, sugar and lemon juice to the water also helps. In most places, oral rehydration solution (ORS) packages can be purchased at a pharmacy and mixed with clean water. Flavoured oral rehydration solutions are preferable as they are easier to drink in large amounts. Food-based fluids that normally contain some salt, such as rice water, vegetable or chicken soup, or green coconut water, are also recommended. The key is to drink as much as possible. However, the fluid taken does not replace the need for food. It is important for people to remain strong and prevent weight loss by eating solid food as well.

**What are the signs of dehydration?**

It is important to remember that a severe lack of liquid in the body or dehydration can cause death. The sooner dehydration is recognized and treated, the better the chances of saving people. When people are dehydrated, they feel very thirsty. Their skin is usually dry and more wrinkled than usual and they may be unusually irritable or lazy.

**What can be done to prevent infections?**

The immune systems of people living with HIV/AIDS are weaker than those of other people. This means that they are more prone to infections. Therefore, good hygiene practices are important to prevent infections. Some suggestions for reducing infections follow.

- Those around people living with HIV/AIDS should wash their hands regularly.
- Those living with HIV/AIDS should ensure that they live in a clean, well-ventilated and fresh environment.
- They should drink and eat only freshly cooked and nutritious food.
- Their bed linen and clothes should be changed often.
**Exercise 28: Doing the right thing**

**Objective**
To get participants to examine the moral choices they may make, related to care and support, and to examine the consequences of those choices.

**Background**
To get participants to examine the moral choices they may make, related to care and support, and to examine the consequences of those choices.

**Materials**
Sheets of paper, flipchart paper or chalkboard (optional)

**Time**
30 minutes

**Instructions**

**Step 1:**
Read the basic facts on care and support before starting the session (Part 4, Section B).

**Step 2:**
Summarize the basic facts on care and support for participants. Ask if they have any questions on the points made.

**Step 3:**
Explain that you will read a list of statements and ask participants to decide if the action recommended in the statement would be a good or bad thing to do, and why.

**Step 4:**
Read the statements listed below, one at a time. Note that the correct answer and reasons why it is correct are listed below each statement. Read the correct answer after the participants have finished discussing each statement.

a) **Lock a person with an AIDS-related illness in a back room so that they do not infect others in the family.**
   (Bad. It is almost impossible for people living with HIV/AIDS to infect other people through casual contact. As with all sick people, having contact with others caring for them improves their morale and their health.)

b) **Find out where people living with HIV/AIDS can get treatment for opportunistic infections and AIDS-related illnesses.**
   (Good. People living with HIV/AIDS who are sick are often too weak to look after themselves and really appreciate someone giving them a helping hand. Knowing that someone is trying to help them makes them feel much better.)
c) **When people living with HIV/AIDS are feeling better after suffering from an AIDS-related illness, ask them to help out by, for example, watching small children for an afternoon, to make them feel useful.**

(Good. People living with HIV/AIDS are not always sick. They often feel strong and well for long periods of time. Giving them simple tasks, such as supervising children, is a way for them to offer thanks to those who have helped them as well as making them feel useful.)

d) **If someone is suffering from a fever and sweating, avoid giving the person water since he/she may infect the drinking cup.**

(Bad: When people have a fever, they need to drink a lot of fluids and clean, cold water is one of the best things to give them. There is no risk that sharing a cup with a person living with HIV/AIDS will transfer the virus from one person to another.)

e) **Sponge baths make people living with HIV/AIDS who have a fever feel much better and cost nothing.**

(Good. It is impossible to get infected with HIV by giving a person with HIV/AIDS a sponge bath, and it can help the fever to break.)

f) **Take the time to chat with a person with HIV/AIDS who has become ill to distract him or her from the discomfort or pain that he or she may be feeling.**

(Good. People living with HIV/AIDS often feel lonely and isolated, if not downright abandoned. Even simple contact with others makes them feel better and encourages them.)


g) **Money is better spent on food for children rather than on the transportation of a person living with HIV/AIDS to a clinic for health-care services.**

(Bad. It is important to help those who are living as well as those who might be dying. Every living person deserves basic comforts and attention from others.)

h) **Do not allow a person with HIV/AIDS who is sick to sit near a window because neighbours will see the person and the whole family will suffer.**

(Bad. Looking out a window at passers-by and children playing is a healthy distraction for people living with HIV/AIDS who are ill. The fresh air and cool breeze from an open window can also be refreshing.)

i) **Do not bring children to see people living with HIV/AIDS, because it is better for them to remember the people as they were before they got sick.**

(Bad. Seeing children tends to cheer up people living with HIV/AIDS who are ill. There is no risk of children getting infected through casual contact such as hugging or touching. Children have no fear of people living with HIV/AIDS unless they have been told by their parents or others that they should be afraid.)

j) **Hearing happy songs and listening to the radio or television is bad for people with HIV/AIDS who are sick, because it will remind them that others are living happy, normal lives.**
(Bad. On the contrary, people living with HIV/AIDS who are ill often love to be distracted and their favourite songs can bring back memories of happier times.)

**k) Visit a traditional healer when a person with HIV/AIDS gets sick because it is much cheaper than modern medicine.**

(Bad. Though some traditional healers can help with fevers, skin problems, pain and itching, many of their treatments are useless, especially when compared with what modern medicine can do for illnesses such as tuberculosis. Modern medicine is more reliable, though more expensive. A combination of modern and traditional medicine can sometimes be effective.)

**l) Clean liquids with salt added, such as chicken broth, coconut milk, rice water or oral rehydration solution (which already includes salt) should be given to people living with HIV/AIDS who often have diarrhoea.**

(Good. Some people mistakenly think that withholding liquids stops diarrhoea but it actually makes the situation much worse and can even cause death. Everyone with diarrhoea needs lots of clean liquids.)

**m) Cleaning clothes and bed linen often is a waste of time because they are only going to get soiled again.**

(Bad. Good hygiene practices reduce opportunistic infections, as well as improving the comfort and quality of life of the person with HIV/AIDS who is ill. Care should be taken when handling clothes or sheets with any blood on them. Use gloves. If no gloves are available, use plastic bags. If no plastic bags are available, wash hands immediately after handling the soiled clothing or sheets. If you have open cuts or sores, find someone else to launder the clothes or bed linen, if possible. Washing with soap or detergent is enough to kill HIV; therefore, washing blood-oiled clothes or sheets with other items is quite safe.)

**Step 5:**

Provide information on care and support services provided for people living with AIDS in the region.
Opportunistic infections and antiretroviral therapy

What can be done to extend the life of a person living with HIV/AIDS?

People with HIV can live for a long time if they take care of their bodies. There are three approaches to treating a person infected with HIV. All three are equally important and a person who uses all three approaches will likely live the longest. These approaches are:

- keeping the immune system strong;
- immediately treating any opportunistic infections; and
- undergoing antiretroviral therapy.

How can the immune system be kept strong?

A strong immune system is more effective at keeping the viral load (amount of HIV) low, as well as fighting off other infections. When the immune system becomes weak, a person suffers from opportunistic infections. The strong immune system can be strengthened by:

- eating a balanced, healthy diet;
- getting enough rest;
- exercising regularly;
- drinking plenty of clean water;
- maintaining a positive attitude;
- avoiding harmful substances such as tobacco and alcohol; and
- avoiding diseases such as sexually transmitted infections.

Why should opportunistic infections be treated immediately?

When there are opportunistic infections in the body, the immune system must work harder. If the immune system is working hard to eliminate opportunistic and other infections, it is easier for HIV to replicate (make more HIV). The immediate treatment of opportunistic infections helps support the immune system and minimize the viral load. Hospitals, clinics and private doctors have various treatments for most opportunistic infections.

How does the body fight opportunistic infections?

The body is protected by the immune system, which consists of white blood cells. There are different types of white blood cells, including CD4 cells (see below). The body is vulnerable to germs that cause bacterial infections (such as tuberculosis), viruses (such as HIV), parasites (such as malaria), and yeast overgrowths (such as thrush). The immune system then tries to fight off these germs so that the body does not get sick. Sometimes, however, the germs are strong and can weaken the body, causing it to feel sick for days or weeks. The immune system usually wins and the body becomes healthy again.

How does HIV affect the immune system?

HIV is a special virus that attacks the cells of the immune system specifically. Opportunistic infections are infections that only cause disease in persons with weak immune systems (such as those living with HIV, those receiving cancer treatment, or recipients of donor transplants). With the passage of time and in the absence of treatment,
the immune system gets weaker and weaker, and people living with HIV/AIDS become more and more vulnerable to opportunistic infections and AIDS-related illnesses, until their body can no longer resist them.

**What are CD4 cells?**

These are the cells responsible for attacking and killing many disease-causing germs. HIV attacks and destroys CD4 cells. In every drop of blood in the body, there are about 1,000 to 1,200 CD4 cells. When the CD4 cell count is very low (around or below 200), a person will begin to suffer from opportunistic infections, because the immune system is no longer strong enough to fight off disease. At this stage, a person is considered to have AIDS.

**What is the role of antibodies in HIV testing?**

Antibodies to HIV are the chemicals that the body produces to tell other white blood cells to mount an attack on HIV. They are the messengers. An HIV test detects antibodies to HIV and not the virus itself. It takes the body three weeks to three months to develop antibodies to HIV. This is called the window period. During the window period, an infected person will have HIV in the body, but there will not yet be antibodies to HIV, so the test for HIV will be negative. During this time, the person can still infect others with the virus.

**What are the most common opportunistic infections?**

Opportunistic infections attack HIV-positive people who have a weakened immune system. Some examples of opportunistic infections include tuberculosis, thrush in the mouth and throat, skin rashes, pneumonia, skin cancer, dementia (mental illness/forgetfulness), fever and night sweats, weight loss and herpes zoster. Many opportunistic infections can be treated with antibiotics and other medication. If a person suffers from an opportunistic infection, he/she should seek immediate treatment.

**What can be done about opportunistic infections?**

Once people have contracted some opportunistic infections, they may have to take medicines for the rest of their lives to prevent them from getting sick again. It is possible to have more than one opportunistic infection at a time and it may be necessary to take more than one medicine. It is very important to take the correct medication and to use it the right way to treat each opportunistic infection. Each opportunistic infection must be identified with the help of a health professional.

**What can be done to prevent opportunistic infections?**

Living healthy: Eating good food, getting enough sleep, not smoking or drinking alcohol, and exercising moderately can help prevent opportunistic infections in people living with HIV/AIDS.

Checking in regularly with the doctor: People with HIV should get regular check-ups at a clinic, even if they do not feel sick. Doctors can help them decide how often to come back – it may be once every month or only twice a year.
How can the impact of opportunistic infections be reduced?

Looking for symptoms of opportunistic infections and getting early treatment can reduce their impact. If they have symptoms or concerns, people should go to the clinic without waiting for their regular appointment. Medicines work best if they are taken right away. Here are some signs for people with HIV/AIDS to look for:

- Trouble breathing
- Dizziness when standing up
- Coughing for more than two days
- Pain when swallowing
- A sore mouth or tongue
- More than four watery or soft bowel movements a day
- Fever, shaking, chills or feeling hot for more than a day
- Losing weight for no reason
- Soaking the bed with sweat
- A very bad headache or stiff neck
- Being so tired that they cannot work or take care of themselves
- Changes in memory or moods
- Blurry vision, pain or floating spots in the eyes
- Feeling sick or throwing up.

Added to these are some important signs for women to look for:

- Severe stomach/abdominal pain
- Bumps, burning, itching, soreness, discharge or smell around the vagina
- Changes in menstrual cycle or menstrual flow
- Pain during sexual intercourse.

Do people with opportunistic infections die soon after getting them?

Opportunistic infections are not a sign that a person will soon die. They simply serve as a sign that the body's immune system is growing weaker. If these infections are treated, the person's immune system can get stronger. People who have AIDS (that is, those whose CD4 cells have dropped below 200 per drop of blood and who have had opportunistic infections) can live for many years as well. They must, however, take the necessary steps to fight opportunistic infections and to keep the immune system as strong as possible.

What is tuberculosis?

**Tuberculosis is the most common opportunistic infection.** Like other opportunistic infections, tuberculosis causes disease in people with weak immune systems. A person can carry tuberculosis in his/her body but not be sick, because the immune system is strong enough to control the infection. However, when the immune system gets weak, that person will develop tuberculosis.

**Tuberculosis spreads easily.** Tuberculosis is a bacterium that is airborne, which means it is spread easily through air particles. It can also attach itself to surfaces touched by infected people. People with immune systems not weakened by HIV are able to come in contact with tuberculosis without getting sick.
Signs of tuberculosis infection. Tuberculosis infects the lungs and causes people to develop a chronic cough and a generally weakened state. The lung infection also produces a lot of mucus that people cough up.

Tuberculosis treatment. Tuberculosis can be cured with proper treatment. It is very important for people with tuberculosis to finish the entire treatment. If they do not, the tuberculosis becomes resistant and the treatment is no longer effective. That is why those with tuberculosis are often required to take the daily treatment under the observation of health-care workers at clinics. This is called Direct Observation Therapy. The treatment is usually very effective and health improves rapidly, although the treatment requires several months.

The link with HIV. Since so many people have HIV but have never been tested, becoming sick with tuberculosis is often the first sign that they have been infected with HIV for a number of years and it is starting to weaken their immune systems. Anyone diagnosed with tuberculosis is encouraged to undergo HIV counselling and testing. If they find that they are infected with HIV, they can get help to cure the tuberculosis, and then get help preventing and treating other opportunistic infections.

What are the different stages of HIV infection?

Infection: The time when the virus enters the body.

Acute phase: This is the window period that immediately follows infection. During this phase, the amount of virus (called viral load) is very high. A person might feel sick or experience flu-like symptoms, usually between two and six weeks after infection. Because the viral load is so high during this time, it is very easy for the virus to be transmitted.

Sero-conversion: At this stage, there are enough antibodies to HIV for them to be detected by an HIV test. A person who is HIV-infected will test positive for the virus from this point on.

Chronic phase: During this phase, the CD4 cell count is high and the viral load is low. A person can look and feel healthy. This phase usually lasts a long time—many years—if a person takes the necessary steps to live a positive life. During this time, non-specific symptoms may occur, such as skin rashes, itching or infections that are easily treated. HIV is present in body fluids and can therefore be passed to another person. A chronic disease or illness is one that persists or lasts a long time.

AIDS: During this phase, the CD4 cell count drops to around or below 200 and opportunistic infections can occur.

How do antiretrovirals help HIV-positive people live longer?

Antiretroviral drugs are not a cure for HIV. Antiretroviral therapy attacks HIV directly and decreases the viral load. A combination of three different antiretrovirals is usually taken every day. People should not start antiretroviral therapy until their CD4 cell count is around 200. Once antiretroviral therapy has been started, it should continue for the rest of one’s life. Antiretrovirals can cause side effects, such as nausea, anemia, rashes and headaches, especially at the beginning of the treatment. Sometimes the combination of drugs taken has to be changed, if the reaction is too strong. People with HIV/AIDS must take antiretrovirals every day at the correct times. Antiretrovirals help strengthen the immune system and fight off opportunistic infections, enabling people to rebuild their strength and live healthy and normal lives. Some antiretrovirals can help reduce the
likelihood of mother-to-child HIV transmission if taken by pregnant HIV-infected women before, during and/or after birth, and by the baby after birth.

**What happens if antiretrovirals are not taken properly?**

If people with HIV/AIDS do not take all of their antiretroviral drugs every day at the right times, the therapy will not work. Taking all of the medicines every day at the right times is called ‘compliance’ or ‘adherence’. If people take the antiretroviral drugs, start to feel better, and then stop taking them, their health will start to deteriorate again. If they then resume taking the drugs, there is no guarantee that the drugs will work as effectively as they did the first time. Also, if people fail to adhere to their treatment programme, they may develop a resistant strain of the virus that is difficult to treat, and this virus may then be passed on to others.
Exercise 29: **Taking antiretroviral drugs**

**Objective**  
To better understand how to keep taking antiretroviral drugs and why people may decide to stop taking them

**Background**  
Taking antiretroviral drugs regularly for the rest of life is a big challenge for people living with HIV/AIDS, especially if they suffer side effects. There are different approaches to assisting individuals in taking their antiretrovirals regularly.

**Materials**  
Sheets of paper, flipchart paper or chalkboard (optional)

**Time**  
30 minutes

**Instructions**

**Step 1:**

Share with participants the antiretroviral information provided in the preceding section, then ask them to make a list of reasons why people living with HIV/AIDS might have difficulty taking antiretrovirals every day at the right times.

**Step 2:**

Compare their list with the one below:

- People naturally forget
- Drinking alcohol or using drugs makes people forget
- People are afraid that their HIV-positive status will be found out if they are seen taking lots of pills
- It is difficult to coordinate taking medicine with or without food
- Medication is too expensive
- Individuals get tired of the side effects of antiretrovirals
- Individuals get tired of always having to take antiretrovirals (‘pill-taking fatigue’)
- People may start to feel better and stronger and think that they have been ‘cured’ of AIDS
- Free antiretrovirals may no longer be available
- Antiretrovirals may only available at clinics and getting there to pick them up is too expensive
- People who are travelling forget to take their antiretrovirals with them
- People need money and sell their antiretrovirals to others in need of them
- The antiretrovirals run out and people forget to go to the pharmacy to get more.

**Step 3:**

Ask participants to make a list of things people living with HIV/AIDS can do to make it easier for them to take their antiretrovirals every day at the right time.
Step 4:

Compare their list with the one below:

- Get advice from a doctor and counsellor about the importance of adherence
- Only start antiretrovirals if there is access to the drugs every month (e.g., government programme or full medical aid coverage)
- Use memory aids: timers, alarm clock, cell phones, written schedule, pill boxes
- Recruit family, friends and peers to help remind them to take the tablets
- Take antiretrovirals together with other people living with HIV/AIDS
- Create an atmosphere at work and at home where it is okay to be HIV-positive, so that people need not fear negative reactions from others when taking medication.

Add:

- Live positively with HIV/AIDS
- Make plans for life
- Find people to talk to for emotional support
- Avoid tobacco, drugs, alcohol and other harmful substances
- Keep up daily hygiene
- Exercise regularly
- Get enough rest
- Avoid other infections
- Monitor your general health
- Seek spiritual and other counselling
- Devise a healthy eating plan

Step 5:

Provide information on care and support services provided for people living with AIDS in the region.
Preventing mother-to-child HIV transmission

How can a woman pass HIV to her child?

HIV can be transmitted through blood, semen, vaginal fluids and breast milk, because these fluids contain white blood cells—the cells that HIV infects. The three stages at which babies can become infected are as follows:

Pregnancy: The placenta is usually a good barrier between the mother and the baby and keeps infected white blood cells away from the baby. But if there is damage to the placenta, it is possible for the mother’s blood to come in contact with the baby during pregnancy.

Childbirth: During childbirth, the baby’s eyes, mouth or nose can come in contact with the mother’s blood and the virus can enter the baby. There are ways to reduce this risk, including elective caesarian sections and the use of antiretroviral drugs. HIV-positive women should consult a health-care professional once they know they are pregnant.

Breastfeeding: HIV can be transmitted through infected breast milk. This is especially true if the baby has an irritated stomach from a gastrointestinal infection caused by drinking contaminated water. The breast milk of infected women contains a small amount of HIV. If possible, an HIV-positive mother should not breastfeed, but should give her baby milk formula made with clean water. If replacement feeding is not possible, then a mother should exclusively breastfeed her child for six months (no water, juice, porridge or other food products). When the mother stops breastfeeding, she must stop entirely otherwise the baby's stomach may become irritated, thereby increasing the risk of HIV infection.

What factors increase the risk of mother-to-child HIV transmission?

- High viral load in the mother
- Advanced HIV disease (AIDS)
- Giving birth shortly after becoming infected with HIV
- Presence of other infections
- Genital infections from sexually transmitted infections
- Difficult childbirth, with use of metal instruments and lots of blood
- Prolonged duration of childbirth
- Bleeding wounds in the birth canal of the mother or on the baby’s body
- Breastfeeding, especially of newborns receiving breast milk together with other foods
- Breastfeeding with dry or cracked nipples
- Babies receiving breast milk together with other foods (such as water, juice, canned baby foods, etc.)

Can an HIV-positive man pass the virus to his unborn child?

HIV can be transmitted through semen. Many people do not realize that semen and sperm are not the same thing. In order for a woman to become pregnant, one sperm from the father will enter an egg in the mother’s body. It is only the sperm that enters the egg, not the semen itself. You can compare semen to soup. Like soup, semen is a liquid that contains many different things—many different types of cells. A soup may have tomatoes, potatoes, onions, salt, meat and water. If the onion is removed from the soup, the other ingredients still remain in the pot. The same is true with semen. When the sperm leaves the semen to enter the egg, the other cells (including HIV, if the man is infected) will remain outside of the egg. The woman could be infected with the virus, but the virus will not enter the egg and will therefore not infect the baby.
How can an HIV-positive woman give birth to an HIV-negative baby?

During pregnancy, the mother and baby do not normally share blood. Although the child receives nutrients, vitamins and other important substances from the mother, blood does not pass through the placenta into the baby's body. The placenta is a natural barrier that (unless damaged) prevents the virus from passing from the mother to the child.

What can be done to prevent mother-to-child HIV transmission?

Seek HIV counselling and testing. If women are aware of their HIV-positive status, they can take action to avoid pregnancy or reduce the chances that they will pass the virus on to their children.

Avoid pregnancy if HIV-positive. Some women decide to avoid pregnancy and not run the risk of infecting their children. If they do not have access to antiretrovirals, they may be concerned about the fate of their children if they become orphans.

Give birth in a health facility. The more complicated and difficult the birth, the greater the chances of mother-to-child HIV transmission occurring. If the mother loses a lot of blood during the birth and the baby suffers cuts as it is being extracted, it is likely that their blood will mix, increasing the risk of infection. Giving birth in a health-care facility decreases the chances of complicated and difficult births.

Seek a programme offering antiretrovirals for women. Antiretrovirals reduce the amount of HIV in the mother’s body, thereby decreasing the risk of HIV transmission to the baby during childbirth. A pregnant woman should try to find a facility that offers antiretrovirals and, if possible, give birth to her baby there.

Follow an exclusive breastfeeding regimen or use replacement feeding. The breast milk of infected women contains a small amount of HIV. If possible, an HIV-positive mother should not breastfeed, but should give her baby milk formula made with clean water. If replacement feeding is not possible, then a mother should exclusively breastfeed her child for six months (no water, juice, porridge or other food products). When the mother stops breastfeeding, she must stop entirely, otherwise the baby’s stomach may become irritated, thereby increasing the risk of HIV infection.
Exercise 30: Preventing mother-to-child transmission

**Objective**
To generate a better understanding of how to prevent mother-to-child HIV transmission

**Background**
Since mothers do not always pass on HIV to their unborn babies, there are things that people can do to greatly reduce the risk of babies becoming infected.

**Materials**
Sheets of paper, flipchart paper or chalkboard (optional)

**Time**
30 minutes

*Instructions*

**Step 1:**
Ask participants to list the things that they think HIV-positive mothers can do to reduce the chances that they will transfer the virus to their babies.

**Step 2:**
Compare the participants’ list with the list below and point out the things they have not listed.

**Go for an HIV test.** It is very important for a pregnant woman to be tested for HIV so that she can be counselled on how to prevent mother-to-child transmission.

**Avoid getting pregnant in the first place.** Once a woman is aware that she has been infected with HIV, she can decide whether or not she wants to have a baby and risk passing the virus on to the child. If she decides that she does not want to take that risk, she can take action to avoid pregnancy.

**Keep the immune system strong.** If a pregnant woman has a strong and healthy body, she is less likely to pass HIV on to her unborn child. If the immune system is strong, there is less chance that the placenta will be damaged, and less chance that the mother’s blood will come in contact with the baby.

**Take antiretrovirals.** Nevirapine is an antiretroviral that can greatly reduce the risk of mother-to-child HIV transmission. Nevirapine reduces the risk of transmission by 50 per cent. The mother takes one tablet of nevirapine in the early stages of labour and then one dose of nevirapine syrup is given to the baby within 72 hours of its birth. Antiretrovirals reduce the amount of HIV in the mother’s body, thereby decreasing the risk of HIV transmission to the baby (during childbirth).

**Follow an exclusive breastfeeding regimen or use replacement feeding.** The breast milk of infected women contains a small amount of HIV. If possible, an HIV-positive mother should not breastfeed, but should give her baby milk formula made with clean water. If replacement feeding is not possible, then a mother should exclusively breastfeed her child for six months (no water, juice, porridge or other food products). When the mother stops breastfeeding, she must stop entirely, otherwise the baby’s stomach may become irritated.
thereby increasing the risk of HIV infection.

**Step 3:**
Tell participants where they can receive information and counselling services for the prevention of mother-to-child transmission.
Exercise 31: ‘Prevention of mother-to-child transmission’ poster

<table>
<thead>
<tr>
<th>Objective</th>
<th>To get participants to consider why parents should be concerned about mother-to-child HIV transmission, by developing posters and slogans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Parents are often more concerned about their children’s health and welfare than they are about their own. A woman may be more motivated to use condoms to avoid infertility caused by a sexually transmitted infection than to avoid death from AIDS. A father may even be more concerned about the health of his children than that of his wife.</td>
</tr>
<tr>
<td>Materials</td>
<td>Sheets of paper, flipchart paper or chalkboard (optional)</td>
</tr>
<tr>
<td>Time</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

Instructions

Step 1:
Present background information on mother-to-child HIV transmission to participants, based on the basic facts presented above.

Step 2:
Write down on a flipchart, chalkboard or sheet of paper the following ideas for posters on mother-to-child HIV transmission, or read them aloud to participants.

“Mothers can pass HIV to their babies at birth. HIV counselling and testing helps you know whether or not it is safe to get pregnant” (photo of a woman having a baby).

“Do you want to be able to hold your grandchildren one day? Keep the virus out of your family. Seek HIV counselling and testing. Stay protected. Prevent mother-to-child HIV transmission” (photo of an older man and his daughter holding his grandchild).

Future mothers:

“The father of your children can give you HIV, if he strays. Protect him and yourself with condoms” (photo of a woman giving a man a condom as he walks out the door).
“Mothers can transmit HIV to their babies at birth, so get tested to ensure that your baby is born healthy” (photo of a man and woman going for testing together).

Future fathers:
“**You can give HIV to the mother of your children. Protect them from HIV. Use condoms if you stray**” (photo of a man in a bar with sex workers).

**Step 3:**
Ask participants to choose which poster ideas they like the best and which ones they do not like and explain why.

**Step 4:**
Ask participants to imagine that they are entering a poster contest and have to come up with ideas for images and slogans to be put on posters on the subject of mother-to-child HIV transmission. Explain to them that the idea of the posters is to motivate future parents to protect families and unborn babies from HIV.

**Step 5:**
Divide the participants into several different groups so that they can develop the poster ideas.

**Step 6:**
Have participants present their ideas and have the whole group choose which ones they like best and which ones they do not like.

**Step 7:**
Tell participants where they can receive information and counselling services to prevent mother-to-child transmission.
Wills and inheritance

What is a will and what is inheritance?
A will is a written document, voluntarily made by a person in which a person says what should happen to his/her property, or who should look after his/her minor children, after the person’s death. Inheritance refers to the property and belongings of an individual, which are passed on to someone else (usually family members) after that person’s death.

Why should all people have a will?
Death is inevitable for everyone, whether they are infected with HIV or not. It is best to prepare for the inevitable so that people can leave their property to whomever they choose. Those who are working and have accumulated wealth, such as a house and furniture, should create wills so that their wives or husbands and children are taken care of. If a person is not married, he or she may wish to leave their accumulated wealth to their live-in partner, a parent or even a friend.

What if both parents are infected with HIV?
The will can designate a guardian for minor children and see to it that they are financially secure. This is especially important if there is a chance that selfish or greedy relatives will take advantage of young children, stealing their inheritance and leaving them to fend for themselves.

Who can make a will and who benefits?
In many countries, anyone aged 16 or older can make a will, provided that he or she knows and understands what he/she is doing. In most cases, it is necessary to ensure that the will is signed by witnesses who are not the beneficiaries. However, each country has its specific laws and costumes and it is important to contact a lawyer or legal adviser to make sure that the will is valid.
Exercise 32: Will preparation

Objective
To get participants to understand how to prepare a will

Background
Most people do not like thinking about their own death, whether or not they are infected with HIV. But preparing a will is important to provide clear instructions about who benefits from insurance, pensions and even simple household items such as cooking utensils.

Materials
Sheets of paper, flipchart paper or chalkboard (optional)

Time
30 minutes

Instructions

Step 1:
Have the participants play the roles of the woman and her husband’s brothers in the following story. At the end of the role-play, ask the person playing the woman how she felt about what was happening to her and ask the men what could have led them to behave the way they did.

Maria’s husband recently passed away. She and her husband had a very good understanding and he always told her that, should he die, Maria should stay in their home, keep their children together, in school, and have access to all of his bank accounts and other properties. However, Maria’s husband did not write a will, so now she is dealing with her late husband’s family and their demands to take his property and the family’s belongings.

Right after Maria’s husband died, his brothers came to the house with a truck and started to take all the appliances and furniture. While Maria wept, they rummaged through her husband’s personal things, looking for bank books and any signs of investments and property deeds. A big argument ensued.

Step 2:
Ask the participants what could have been done to avoid the situation. Ask them to describe what should be included in a will.

Step 3:
Refer participants to professionals (lawyers or notaries), should they be interested in writing a will (in some cases, legal advice may be provided to people living with HIV through community-based organizations or NGOs).
Guide to Conducting Peer Education at the Workplace

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Appendix G: Sample materials for adaptation
Appendix A: Glossary

Note: Many of the terms below are paired with definitions that are specific to HIV/AIDS and behaviour change communication programmes.

**Acquired immune deficiency syndrome:** The late stage of HIV disease. AIDS involves the loss of function of the immune system, which allows the body to succumb to opportunistic infections.

**Antiretroviral therapy:** Antiretroviral drugs inhibit the replication of HIV. When antiretroviral drugs are given in combination, HIV replication and immune system deterioration can be delayed, and survival and quality of life improved.

**Asymptomatic:** Without signs or symptoms of disease or illness. Most people who are HIV-positive show no symptoms for five-to-ten years.

**Behaviour change:** The process of reducing high-risk behaviour and adopting positive, healthy practices.

**Behaviour change communication (BCC):** A strategy that involves various tactics such as peer education to inspire behaviour change.

**Behaviour choices:** Decisions people make regarding actions they take that may or may not put them at risk of HIV infection or other sexually transmitted infections.

**Code of conduct:** Rules for behaviour that groups of people agree to follow. Workplace codes usually involve a list of behaviours that employees are expected to follow.

**CD4 cells:** Cells that are responsible for attacking and killing many other disease-causing germs. These are the cells that HIV attacks and destroys.

**Discrimination in employment:** Any distinction, exclusion or preference made on the basis of HIV-positive status—real or perceived—which has the effect of nullifying or impairing equality of opportunity or treatment in employment and occupation. Any distinction, exclusion or preference based on the inherent requirements of a particular job shall not be deemed to be discrimination.

**HIV/AIDS programme:** A comprehensive initiative that can involve policy development, services and implementation of behaviour change communication strategies such as peer education.

**Human immunodeficiency virus (HIV):** The virus that causes AIDS. The virus remains in the body for five to ten years before the full symptoms of opportunistic infections or AIDS appear.
**Human rights:** Human rights are entitlements that are due to all individuals simply because they are human. All humans possess these rights, regardless of race, colour, sex, language, religion, political or other beliefs, national or social origin, disability, property, birth, age or other status, including real or perceived HIV-positive status. Human rights are recognized in several international instruments. Whatever their political, economic or social system, states are under the obligation to protect and promote all fundamental rights.

**ILO Code of Practice on HIV/AIDS and the world of work:** The ILO Code of Practice is the product of collaboration between the International Labour Office, governments, and workers' and employers' organizations. It provides practical guidance to policy-makers, employers, workers and their organizations for formulating and implementing appropriate workplace policy, prevention and care programmes, and for establishing strategies to address workers in the informal sector.

**Interpersonal communication:** Exchange between people regarding information or experience related to HIV/AIDS. Peer education is one example of interpersonal communication.

**Men who have sex with men:** Men who engage in sexual relations with other men. These men may be homosexual and only have sex with men or they may be bisexual, which means they have sex with both women and men.

**Monitoring:** The tracking of a programme’s progress to ensure that it is being implemented as planned and to make corrections, as needed.

**Mother-to-child transmission:** Passing of HIV from a mother to her baby during pregnancy, delivery or breastfeeding.

**Opportunistic infections:** Illnesses that afflict people with weak immune systems—such as those living with HIV. Common opportunistic infections include tuberculosis, certain kinds of pneumonia, fungal infections, viral infections and lymphoma.

**Participatory:** Involving the active participation of those taking part in interventions, usually through interactive communication.

**Participants:** The employees who take part in, and benefit from, peer education. Participants may also be referred to as beneficiaries or peers.

**Peers:** A group of people who share common characteristics such as age, gender, socio-economic status or occupation.

**Peer education:** A process that involves similar people learning informally together.
**Peer educator:** The person at the workplace who is trained to facilitate discussions on high-risk behaviour relating to HIV and leads his or her peers in the examination of solutions.

**People living with HIV/AIDS:** Those who have contracted the virus that causes AIDS.

**Record-keeping:** The preparation of regular reports on peer education and other forms of behaviour change communication.

**Role-playing:** Acting out the role of fictitious characters in a given scenario (usually based on a description provided by peer educators). A discussion of the scenario and its repercussions usually follows role-playing.

**Services:** Medical consultations and other elements offered by health-care workers, including voluntary HIV counselling and testing, and diagnosis and treatment of sexually transmitted infections.

**Sexually transmitted infection:** A virus or bacteria transmitted between sexual partners.

**Supervisor:** Part of the peer-education coordination team, the supervisor oversees peer educators, to ensure that they are working as planned and to offer feedback and guidance.

**Support materials:** Printed documents, sometimes including illustrations or photos, which peer educators can use to convey ideas and to stimulate discussion.

**Tuberculosis (TB):** A bacterium that is airborne (i.e., spreads easily through air particles). It is one of the most common opportunistic infections. Like other opportunistic infections, tuberculosis causes disease in people with weak immune systems. Tuberculosis infects the lungs and causes those who get sick to develop a chronic cough and a generally weakened state.

**Stigma:** Negative thoughts about a person or group, based on a prejudice.

**Universal precautions:** A set of standard infection-control practices to be used to minimize the risk of infection or disease from bloodborne pathogens.

**Voluntary counselling and testing (VCT):** A service consisting of an HIV test (a blood test to find out if HIV antibodies are present in the blood), with the full consent of the individual, and pre- and post-test counselling.
Appendix B: Exercises for training peer educators

Exercise 1: Assessing knowledge levels

<table>
<thead>
<tr>
<th>Objective</th>
<th>To generate a better understanding of the knowledge level of peer educators on HIV/AIDS, as part of the training assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Peer educators often have different levels of knowledge concerning issues and facts related to HIV/AIDS. They often are as misinformed as the general public on certain questions that need to be identified and corrected before they can become effective educators.</td>
</tr>
<tr>
<td>Materials</td>
<td>Flipchart or chalkboard (optional), copies of questionnaire, pens or pencils</td>
</tr>
<tr>
<td>Time</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Instructions

Step 1:

Gather peer educators or peer-educator trainees in a room, and distribute copies of the following questionnaire, along with pens or pencils.

Step 2:

Explain that the questionnaire is designed to measure general knowledge and prevailing attitudes about HIV/AIDS. If it is the educators’ second time completing the questionnaire, tell them that the goal is to measure any change in their knowledge and attitudes. Ask them to answer all questions as honestly as possible, reminding them that no names will be written on the questionnaire.

Step 3:

When educators have finished (after 30 to 45 minutes), go through the questionnaire with them and answer any questions they may have.
Self-administered workplace questionnaire on knowledge and attitudes about HIV/AIDS

Please circle or write in the correct answer to the questions below. This questionnaire is anonymous and fully confidential. You should not put your name on it. After completing the questionnaire, please hand it to the facilitator.

1. HIV and AIDS are the same.
   Yes
   No

2. You can get HIV from kissing.
   Yes
   No

3. Breastfeeding can transmit HIV.
   Yes
   No

4. Can people protect themselves from HIV by always using condoms during sex?
   Yes
   No

5. Can people protect themselves from HIV by only having sex with one faithful partner who is HIV-negative?
   Yes
   No

6. A person can get HIV from mosquito bites.
   Yes
   No

7. Faithful married women can get HIV.
   Yes
   No
8. Most people with HIV look sick.
Yes
No

9. Some condoms have invisible holes through which the virus can pass.
Yes
No

10. All children born to HIV-positive women will get HIV.
Yes
No

11. People with HIV can only do light work.
Yes
No

12. Tuberculosis can be cured in persons with HIV.
Yes
No

13. Some traditional healers can cure AIDS.
Yes
No

14. There are drugs that can cure AIDS.
Yes
No

15. People sometimes do not go for an HIV test because they are afraid of being rejected by family, friends or co-workers if they are HIV-positive.
Yes
No

16. Do you know where to go for an HIV test?
Yes
No
17. Do you know where to refer a person living with HIV for care and support services?

18. Do you know where low-cost condoms are distributed?

19. Do you know where to go for medical advice on the treatment of a sexually transmitted infection?
**Exercise 2: How to lead a peer-education session**

**Objective**: To improve skills for peer education

**Background**: The more skills that peer educators develop, the more effective they will be in their work. This session allows them to practise conducting a peer-education session.

**Materials**: Flipchart or chalkboard (optional)

**Time**: 1 hour

**Instructions**

**Step 1:**
Ask participants to split up into groups of five to ten.

**Step 2:**
Have each group choose one person to act as the peer leader.

**Step 3:**
Ask the peer educators of each group to role-play how they would approach a group of employees. They can choose any topic related to HIV/AIDS. The others in the group will play the role of peers. Topics might include:

- The importance of condoms for HIV prevention
- How HIV is spread from one person to another
- Why employees are vulnerable to HIV infection.

**Step 4:**
Have each group come forward and play the roles they have created.

**Step 5:**
Remind participants of the actions they should take when meeting a group for the first time:

- Greet them.
- Introduce yourself.
- Explain why you have come.
Step 6:
Write out and explain to participants some of the things they should remember when facilitating a group of peers:

- Be punctual at sessions.
- Have fun playing the games in a relaxed manner.
- Do not be judgemental and remember that everyone has his/her own views and beliefs.
- Try not to tell the group or person what to do. Rather, ask questions so that they can come up with their own answers.
- If your group is tired or loses its focus during the session, conduct a revitalizing exercise or reschedule the meeting.

Step 7:
Review the important points and ask for feedback from participants. Ask if they have any questions.
Exercise 3: Developing effective questioning skills

Objective
To increase skills in leading discussions through effective questioning.

Background
It is important to use probing questions to obtain meaningful information that will enhance awareness and understanding. Often participants in peer-education sessions will provide short answers or even try to give the answer they believe the educator wants to hear. A peer educator who is skilled at asking probing questions is better able to get to the reality of a situation and encourage frank and open discussion.

Materials
None

Time
20 minutes

Instructions

Step 1:
Explain to peer educators why developing skills for asking probing questions is important.
Ask them to provide some examples of probing questions, such as:

- Could you tell me more about that?
- What made you do that?
- How did you feel when that happened?
- Why do you think that is important?

Step 2:
Explain to peer educators that an open-ended question is a question that does not require a “yes” or “no” answer. Open-ended questions are useful to peers to get discussions started. Open-ended questions cannot be answered in a few words and usually begin with “how,” “why” or “could”.

Step 3:
Point out that closed questions usually get only a simple answer that does not require any significant reflection on the listener’s part. Answers to such questions are usually brief (“yes” or “no”) and usually begin with “is,” “are” or “do.” Ask each peer leader in turn to answer the following questions:

- Do you like rice?
- Do you drink beer?
- Do you like this training?
Step 4:
Now ask each peer leader in turn to answer the following open-ended questions:

- What are your favourite foods?
- What do you think of beer drinking?
- How could this training be improved?
- In what ways do you think men are emotionally different from women?

Step 5:
Remind participants that open-ended questions may be more valuable than closed ones because they increase participants’ involvement in peer-education sessions.
Exercise 4: Understanding barriers to effective communication

Objective
To promote understanding of common barriers to effective communication and increase knowledge on how to overcome them.

Background
A number of common barriers to effective communication greatly handicap peer education. These barriers can involve the peer educators themselves (personal barriers) or society in general (socio-cultural barriers), or they may be due to poor organizational skills (logistical barriers). It is important for peer educators to understand what the challenges are and how to overcome them.

Materials
Sheets of typing paper or flipchart paper (optional)

Time
1 hour

Instructions

Step 1:
A description of different barriers to effective communication follows. Read each one to the peer educators and ask them to think of different ways they could respond.

Step 2:
Share the strategies listed after each barrier if peer educators have not already mentioned them. You can write the barriers and strategies on flipchart paper, type and print them on sheets of paper, or write them on a blackboard. Make sure the barriers and strategies are presented separately.

a. Personal barriers:

Barrier 1:
Peer educators have difficulty answering questions.

Strategies:
Make sure your knowledge is up to date. If there are gaps in your knowledge, tell your peers that you will return later with the information they need.

Barrier 2:
Some young people do not feel comfortable with people much older than themselves, and some older people may not be comfortable discussing certain subjects with younger people.
Strategies:
Show respect to all participants. Identify yourself as a responsible person who deals sensitively with difficult topics. Discuss the possibility of scheduling a separate session facilitated by the peer-education coordinator, rather than the peer educator.

b. Socio-cultural barriers:

Barrier 1:
Sometimes religious and cultural backgrounds may differ and interfere with communication.

Strategies:
It helps to have background information on the religious and cultural beliefs of the people with whom you are working. Try to acknowledge when religious and cultural values might interfere with communication and deal with them head on. Do not ignore them. Respect people’s values even if you do not agree with them.

Barrier 2:
Some people prefer to communicate with people of the same sex, especially when dealing with sensitive subjects.

Strategies:
Acknowledge that the discussion might be embarrassing, but explain that sometimes it is necessary to discuss sensitive topics. Acknowledging embarrassment sometimes helps people overcome it. Discuss the possibility of working with the peer-education coordinator to programme peer-education sessions tailored to the specific needs of women and men, with a facilitator of the same sex.

Barrier 3:
Some people may misunderstand technical language, yet still remain polite and pretend to understand.

Strategies:
It is important to speak in terms that participants will understand and to use acceptable terminology. Also be aware of the possibility that not all participants are of English mother tongue. Keep language as simple as possible. Find out whether terms are familiar or if they require an explanation. If someone speaks a different language, find a reliable person to translate.
Barrier 4:
Younger recruits might find it hard to relate to a person who appears to be of another economic status or a much higher rank.

Strategies:
Show respect, no matter what the rank or age of the person might be. Avoid dressing too formally. Sit among the group members instead of standing over them or sitting apart. Dressing informally can help to break down barriers. Convene group meetings with the peer-education coordinator.

c. Logistical barriers:

Barrier 1:
If the meeting time is inconvenient, participants may not be able to listen effectively (or they may not attend).

Strategies:
Allow participants to choose the meeting time.

Barrier 2:
Noise, high temperatures and inadequate seating facilities can interfere with effective communication.

Strategies:
Make sure the venue is comfortable, well ventilated, quiet and accessible.
### Exercise 5: Understanding policy

<table>
<thead>
<tr>
<th>Objective</th>
<th>To generate a better understanding of the impact of HIV/AIDS on workplaces and to stimulate ideas for appropriate policy responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>HIV/AIDS affects the productivity of businesses and impacts the lives of employers and their families. Action at the workplace and the adoption of workplace policy can prevent and/or mitigate the impact of the disease.</td>
</tr>
<tr>
<td>Materials</td>
<td>Flipchart paper or chalkboard (optional), a copy of the ILO Code of Practice on HIV/AIDS and the world of work for each peer educator</td>
</tr>
<tr>
<td>Time</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

**Instructions**

**Step 1:**
Read Section on Workers’ rights and HIV/AIDS workplace policies.

**Step 2:**
Ask participants to split up into groups of five to ten.

**Step 3:**
Instruct them to list some of the real or potential effects of HIV/AIDS on their workplace.

**Some examples include:**
- Decrease in productivity
- Higher costs for medical-aid schemes and pension plans
- Loss of skilled workers due to sickness and/or death
- Increased costs for recruiting, training and employing new people
- Increased costs due to sick leave and days off for funerals
- Decrease in workplace morale.

**Step 4:**
Have the peer educator read the ten key principles of the ILO Code of Practice on HIV/AIDS and the world of work. You can specify that the key principles promoting the respect of human rights are the result of international consensus.

**Step 5:**
Have peer educators read their workplace policy (if one exists) or provide them with the sample given below.
Step 6:

Have peer educators consider whether the key principles of the ILO Code are reflected in the HIV/AIDS workplace policy and ask them which elements are missing or should be revised, in any. For example, the HIV/AIDS workplace policy of company X does not provide for the education of employees (prevention programmes) and no provisions protect the confidentiality of employees with regard to their HIV status.
Handout: Company X

Sample HIV/AIDS workplace policy

GENERAL STATEMENT

Company X recognizes the seriousness of the HIV/AIDS epidemic and its impact on the workplace. The company supports national efforts to reduce the spread of the infection and minimize the impact of the disease.

OBJECTIVE

The purpose of this policy is to ensure a consistent and equitable approach to the prevention of HIV among employees and their families, and to the management of the consequences of HIV/AIDS, including the care and support of employees living with HIV/AIDS. The policy has been developed and will be implemented in consultation with employees at all level.

POLICY FRAMEWORK AND GENERAL PRINCIPLES

The company recognizes the ten key principles of the ILO Code of Practice on HIV/AIDS and the World of Work as a basis for its action on HIV/AIDS. It takes into account the company's policy, which has been in effect since 1969, prohibiting discrimination and protecting the safety and health of workers.

While the company recognizes that there are circumstances unique to HIV infection, this policy rests on the principle that HIV infection and AIDS should be treated like any other serious condition or illness that may affect employees. It takes into account the fact that employees may live full lives for a number of years after becoming infected. The company’s commitment to maintaining a safe and healthy work environment for all employees is based on the recognition that HIV is not transmitted by casual contact.

SCOPE

This policy applies to management and all permanent employees.

SPECIFIC PROVISIONS:

1. PROTECTION AGAINST DISCRIMINATION, VICTIMIZATION AND HARASSMENT

All employees will be protected against discrimination, victimization or harassment based on their real or perceived HIV-positive status.
2. EMPLOYMENT OPPORTUNITIES AND TERMINATION OF EMPLOYMENT

No employee will suffer adverse consequences, whether dismissal or denial of employment opportunities, merely on the basis of HIV infection.

3. TESTING

HIV screening will not be required of job applicants or persons in employment. However, the company will promote and facilitate access to voluntary counselling and testing (VCT) for all employees. All VCT will comply with accepted national and international standards on pre- and post-test counselling, informed consent, confidentiality and support.

4. CARE AND SUPPORT FOR WORKERS AND THEIR FAMILIES

The company will treat employees who are infected or affected by HIV/AIDS with empathy and care. The company will provide some reasonable assistance, which may include counselling, time off, sick leave and information regarding the virus and its effect.

5. WORK PERFORMANCE

It is the policy of the company to respond to the changing health status of employees by providing suitable work sites for those infected with HIV. Employees may continue to work as long as they are able to perform duties safely and in accordance with performance standards accepted by the company. If any employee with AIDS is unable to perform his or her tasks adequately, the manager or supervisor must resolve the problem according to the company’s normal procedures regarding poor performance/ill health.

6. BENEFITS

Employees living with HIV/AIDS will be treated no less favourably than staff with any other serious illness/condition in terms of statutory and company benefits, workplace compensation, where appropriate, and other available resources.

7. HEALTH CARE

The company will help employees living with HIV/AIDS to find appropriate medical services in the community, as well as counselling services, professional support and self-help groups, if required. Reasonable time off will be given for counselling and treatment.

8. IMPLEMENTATION AND MONITORING

The company has established an HIV/AIDS committee to coordinate and implement its HIV/AIDS policy and programme. The committee will consist of eight-to-ten employees representing all constituents of the company, namely:
The implementation of this policy will confirm the company's normal disciplinary and grievance procedures. Confidentiality will be assured during any and all procedures.

In order to plan and evaluate its HIV/AIDS policy and programme effectively, the company will undertake a survey to establish baseline data and regular risk- and impact-assessment studies. The studies will cover knowledge, attitudes and behaviour/practices (KAB/P). Studies will be carried out in consultation with, and with the consent of, employees and their representatives, and in conditions of complete confidentiality.

The policy and related information on HIV/AIDS will be communicated to all the company's employees using the full range of communication methods available to the company.

This policy will be reviewed annually and revised as necessary in the light of changing conditions and the findings of surveys/studies conducted.

Signature

CHIEF EXECUTIVE OFFICER

Signature

WORKERS’ REPRESENTATIVE
Appendix C: Sample peer-education-training workshop

Sample basic training workshop for peer educators

<table>
<thead>
<tr>
<th>Objective</th>
<th>To provide planners of peer education training with a selection of background information and exercises to use in a five-day training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>For this training, planners can choose the appropriate background information and exercises from the Guide to Conducting Peer Education at the Workplace. The exercises listed below are an example of which elements to include in a five-day training course.</td>
</tr>
</tbody>
</table>

Instructions

Step 1:
Read the relevant sections from the guide, as well as the exercises listed below and decide whether they are appropriate for a five-day peer-education training course.

Step 2:
Organize a five-day workshop to train peer educators or trainers of peer educators and introduce the background information and exercises. Have those being trained conduct the exercises using each other or other workplace personnel as the participants.

Step 3:
Introduce the other sections of the guide and encourage peer educators to use it as a reference and inspiration for conducting other exercises not covered in the training.
Day 1: Role of a peer educator

Part 3: Making peer education participatory (Booklet 5 page 26)
Exercise 3: Developing effective questioning skills (Appendix B page B-7)
Exercise 4: Understanding barriers to effective communication (Appendix B page B-9)
Part 3: Overcoming barriers (page 29)
Exercise 20: Examining workplace policies (page 92)

Day 2: HIV, sexually transmitted infections and condoms

Part 4: Basic information about HIV/AIDS (page 35)
Exercise 1: True of false (page 40)
Exercise 2: The glove game (page 42)
Exercise 5: Personal risk assessment (page 48)
Part 4: Basic information about sexually transmitted infections (page 49)
Exercise 8: Sexually transmitted infections, true or false (page 56)
Part 4: Condom use, demonstration and negotiation (page 64)
Exercise 11: Demonstrating correct condom use (page 68)
Exercise 13: Demonstrating the reliability of condoms (page 72)

Day 3: HIV counselling and testing, alcohol and drug use, care and support

Part 4: Voluntary HIV counselling and testing (page 77)
Exercise 16: Exploring obstacles to voluntary HIV counselling and testing (page 80)
Exercise 19: Causes of stigma and discrimination (page 90)
Part 4: Alcohol and drug use (page 94)
Exercise 22: Alcohol and the workplace (page 99)

Part 4: Living positively with HIV/AIDS (page 121)
Exercise 28: Doing the right thing (page 124)

Day 4: Role-playing

Appendix F: Role-playing exercises

Day 5: Planning, record-keeping, supervision and monitoring

Part 2: Record-keeping, supervision and monitoring (page 58)
Appendix D: Sample pre- and post-training test

Instructions:
Please answer the following questions to the best of your ability.

1. What is a sexually transmitted infection?

2. What do the acronyms ‘HIV’ and ‘AIDS’ stand for and what is the difference between them?

3. Are the following statements true or false? Place an ‘x’ beside the correct answer.
   a. You can generally identify a person with HIV infection by looking at him or her.
      __ TRUE     __ FALSE
   b. All children born to HIV-positive women will get HIV.
      __ TRUE     __ FALSE
   c. Mosquitoes spread HIV.
      __ TRUE     __ FALSE
4. List four signs and symptoms of sexually transmitted infections.

5. List three ways in which HIV is spread.

6. List three ways in which HIV infection can be prevented.

7. What is voluntary HIV counselling and testing?

8. Can people with HIV stay healthy?
   ________yes ________no

9. What does the word ‘confidential’ mean?

10. What is a female condom?
### Appendix E: Peer-education monitoring and evaluation forms

#### Sample session discussion and preparation form

<table>
<thead>
<tr>
<th>Name of facilitator</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of event</td>
<td></td>
</tr>
<tr>
<td>Company/department or unit</td>
<td></td>
</tr>
<tr>
<td>Venue</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td></td>
</tr>
</tbody>
</table>

**Objectives of event:** By the end of this session, participants will be able to:

- [ ]
- [ ]
- [ ]
- [ ]

**Materials needed:** List posters, resource kits, pamphlets etc.

- [ ]
- [ ]
- [ ]
- [ ]

**Activities:** How will you present your topics and achieve your objectives? Clearly describe role-plays, games and other such methods for disseminating the information.

- [ ]
- [ ]
- [ ]
- [ ]

Signed by facilitator: ______________________________

Date: ______________________________

Checked by HIV/AIDS coordinator ______________________________

Date: ______________________________
Sample peer-educator diary

Peer-educator diary

Details of meeting

Name ___________________________ Date ___________________________
Department ___________________________________________________________________________
Facilitated by ___________________________ Monitored by ___________________________
Start time ___________________________ End time ___________________________
Group (peers) _________________________________________________________________________
Topic ________________________________________________________________________________

Attendance details

Total number of participants ________________ Males _______________ Females _______________
Number attending for the first time ______________________________________________________________________________________

Session details

Methods used:

☐ Pictures ☐ Role-plays ☐ Display of materials ☐ Video
☐ Discussion ☐ Guest speaker ☐ Quiz/questionnaire ☐ Condom demonstration

Number of questions asked by participants__________________________
Number of condoms distributed in session___________________________
Are condoms in stock this month? ☐ Yes ☐ No ___________________________

Key questions and concerns

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Since your last session

Male Female

Number of condoms distributed outside session__________________________
Number of one-on-one discussions conducted this week___________________
Number of HIV counselling and testing referrals________________________
Number of sexually transmitted infection referrals________________________

Signature: __________________________________________
**Sample condom stock card**

Condom stock card

Name of company  ______________________________

Year  ______________________________

Opening balance  ______________________________

<table>
<thead>
<tr>
<th>Month</th>
<th>Number issued</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Week 2</td>
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<td></td>
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<td>Week 3</td>
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<td>Week 4</td>
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<tr>
<td>Total</td>
<td></td>
<td>Total</td>
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</tbody>
</table>

ILQ/FHI: HIV/AIDS behaviour change communication - a toolkit for the workplace
[Trial version]
**Sample monthly data-collection form**

Monthly data-collection form

<table>
<thead>
<tr>
<th>Name of company</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of peer educator</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month/year</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Number provided with male condoms</th>
<th>Number supplied with female condoms</th>
<th>Number of referrals</th>
<th>Reason for referral (VCT, care and support, STI, and prevention-of-mother-to-child-transmission services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Females</td>
<td>Males</td>
<td>Females</td>
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</tbody>
</table>
Sample peer-educator referral sheet

Employer _____________________ Location _________________________

Workplace services:

Social workers:
Name:
Telephone number:
Location:

Medical service:
Name:
Telephone number:
Location:

Benefits for families of people with HIV/AIDS:
Name:
Telephone number:
Location:

HIV/AIDS enterprise focal-point:
Name:
Telephone number:
Location:

Workers’ representative responsible for HIV/AIDS issues:
Name:
Telephone number:
Location:

Community resources:

VCT services:
Name:
Telephone number:
Location:
Sites for treatment (antiretroviral therapy, CD4 status report):

Name:
TelephoneNumber:
Location:

Sites for condom distribution:

Name:
TelephoneNumber:
Location:

Care and support services:

Name:
TelephoneNumber:
Location:

STI services:

Name:
TelephoneNumber:
Location:

Services for the prevention of mother-to-child transmission:

Name:
TelephoneNumber:
Location:

Support services for people abusing alcohol:

Name:
TelephoneNumber:
Location:

Support services for violent persons:

Name:
TelephoneNumber:
Location:

Community-based AIDS service organizations (specify which services are offered)

Name:
TelephoneNumber:
Location:
Counsellors:

Name:
Telephone number:
Location:

Nurses/sisters:

Name:
Telephone number:
Location:

Pastors/ministers/religious leaders:

Name:
Telephone number:
Location:

Legal services (e.g., wills, rights):

Name:
Telephone number:
Location:

Funeral services

Name:
Telephone number:
Location:
## Sample peer-educator quality-assurance checklist

### Details of meeting

<table>
<thead>
<tr>
<th>Name of presenter</th>
<th>Name of observer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Company/department/unit</td>
<td></td>
</tr>
<tr>
<td>Total number of participants</td>
<td>Males</td>
</tr>
</tbody>
</table>

### Session details

<table>
<thead>
<tr>
<th>Methods used</th>
<th>□ Pictures</th>
<th>□ Role-plays</th>
<th>□ Display of materials</th>
<th>□ Video</th>
<th>□ Discussion</th>
<th>□ Guest speaker</th>
<th>□ Quiz/questionnaire</th>
<th>□ Condom demonstration</th>
</tr>
</thead>
</table>

### Environment

<table>
<thead>
<tr>
<th>Was the venue well lit, and away from noise and distractions?</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the audience mostly within five metres of the facilitator?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

### Facilitation

<table>
<thead>
<tr>
<th>Did the facilitator talk loudly enough for everyone to hear?</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the facilitator allow participants to express themselves freely, even at the risk of slowing down the session?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Were there at least 12 people in the audience?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did at least 60 per cent of the audience participate in the discussion?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Were at least 25 minutes allowed for discussion?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did members of the audience speak at least 60 per cent of the time?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did facilitators listen objectively, without showing facial disapproval or interrupting?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did the facilitator allow the audience to try answering questions before answering them him or herself?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

### Quality of discussion

<table>
<thead>
<tr>
<th>Did at least five people share their personal experience?</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the group had men and women, did at least 60 per cent of both men and women participate?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Were participants invited to ask for condoms, if they wished?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did the facilitator provide information on where to obtain HIV counselling and testing?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Did the facilitator provide information on where to get treatment for sexually transmitted infections?</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>

Signature:_________________________________
### Appendix F: Role-playing exercises

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>To explore real-life risky situations and the various behaviours associated with them, through short dramatizations created by participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>A one-minute, unresolved role-play involves getting people to complete a situation based on an introductory paragraph. The role-playing is followed by a discussion involving both the actors and the audience.</td>
</tr>
</tbody>
</table>

A small number of peer leaders who practise their dialogue in advance can perform the role-play. Alternatively, participants can improvise the role-play or make it up on the spot. The dialogues tend to be relatively easy to initiate and are dynamic. They also require no special equipment and can be visible to large groups. Because they are often humorous, they are usually enjoyable for those who develop and perform them. Participants also develop confidence and communication skills. A typical one-minute, incomplete role-play raises an important social issue related to HIV/AIDS and leaves it unresolved or frozen at a dramatic, emotionally-charged moment. The peer leader then turns to the audience and asks them to discuss the issue. A vigorous discussion usually follows.

<table>
<thead>
<tr>
<th><strong>Materials</strong></th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time</strong></td>
<td>10 minutes per role-play</td>
</tr>
</tbody>
</table>

### Instructions

**Step 1:**

Explain the concept of role-playing to participants. Choose participants to play the roles of the characters featured in the stories. If the group is made up of men only, have men play the parts of women.

**Step 2:**

Read the story aloud or have the participants read it to themselves. Ask participants to pretend that they are actors and to invent conversations between the characters.
Step 3:
After the dramatization, ask the other participants to comment on what they have seen. The following are possible questions to stimulate discussion after each scenario:

- What was going on in the role-play?
- What did you think the point of the role-play was?
- What do you think of the men’s reaction?
- What do you think of the women's reaction?
- How was this role-play related to HIV/AIDS?
- What do you think the characters in the role-play should have done differently?
- What does this role-play have to do with people at your workplace?

Role-play examples

1) Sexually transmitted infection
A long-distance truck driver comes home from a month-long intercountry trip. He is very happy to see his wife and is anxious to make love with her. After engaging in passionate lovemaking, she notices a small red sore on his penis. “What’s that? Have you been fooling around?” she asks. He gets angry and they shout at each other, blaming each other for the problem.

2) Condom found
A shoe factory floor manager had been out drinking the previous night with his male friends and came home very late. He is still sleeping when his wife finds a condom in his shirt pocket as she is preparing to clean her husband’s work clothes. Just then, the man wakes up and sees the condom in her hand and the accusatory expression on her face. A very heated argument follows.

3) Married couple and condoms
A young, married man employed at a sugarcane plantation comes home after work and greets his wife and children. He tells his wife that he learned a lot about HIV/AIDS from the health-service nurse in a meeting that afternoon, saying, “She told us that men should carry condoms just in case they or one of their friends need one and she gave us these condoms. We have been instructed to carry them in our pockets at all times.” The wife holds her newborn baby close to her and says, “What kind of crazy idea is that? What are you going to do with those condoms?” The man tries to explain why he has to carry condoms. He doesn’t want to tell his wife, but he knows why the condoms are needed.
4) **Girlfriend trouble**
The wife of a bank loan officer is in a taxi driving by the bank when she sees her husband warmly greeting a very sexy-looking young woman who works in the bank and handing her money. When the husband gets home, he finds that no dinner has been prepared, the house is a mess and his wife is fuming. “You’ve been telling me for weeks that your salary has been delayed and now I see you giving that young girl money,” the wife yells. “You had better not bring back any diseases to this house.”

5) **Teenage pregnancy**
The teenage schoolgirl and the apprentice mechanic have been meeting secretly in a pineapple field for months. This time, when they meet, she is crying. “What is the matter?” he asks. “I’m pregnant with your child,” she says. “Not only that, but they took a blood test and found that I have HIV, the virus that causes AIDS. What are we going to do?”

6) **Stolen goods**
The widow of a salesman for a food manufacturer is being comforted by a friend. The woman’s husband had spent many years travelling, promoting and distributing the company’s products. The friend tells her that, although it is tragic that her husband died of AIDS, at least she has a pension, a bank account and comfortable furniture, and doesn’t have the virus herself. She nods sadly. At this moment, there is a loud knock on the door and five men from the company burst in. They say, “Your husband took out a loan last year and hasn’t paid it back. We are going to have to take the bank account, bed, sofa, TV, stove, fridge and cooking utensils.” Screaming, the widow tries to stop them, but one holds her down as the others load up a truck with her things. The widow weeps on the shoulder of her friend. “I wish we had prepared a will. Now I have nothing.”

7) **How far do you have to go?**
Two graduates of a secretarial school talk excitedly about their first job interview in a government office, which is about to take place. The first one goes in and soon comes back out with tears in her eyes and announces that she will never work for that man. Her friend goes in next and takes much longer. Finally, she comes out, slightly flushed, with her hair out of place. Embarrassed, she tells her friend that she got the job and how she felt about what she had to do to get it.

8) **Coercion**
After their shift, two workers meet on a footpath behind a cotton plantation, which local people often take as a short-cut. “Have you seen anything?” one says. “Not much trespassing tonight.” Then they hear a rustling noise and catch sight of three women with heavy parcels. The women drop their goods and run but one falls and is captured. “Don’t tremble, my friend. We are not going to hurt you,” one man says. “If you follow me quietly, we can settle this right away.”
9) **Beer buddies**

Two men working at a remote construction site are ending a long, lonely month of work. They visit the nearest town for the first time in weeks. Their foreman had told them that they should use the buddy system and look after each other while in town. But they aren't worried. They are free to do what they want and just got paid. They are feeling confident and proud to be earning good money and doing the heavy construction work well and confidently. The think nothing could hurt them. At a local bar, several girls move towards them, sensing that they have money to spend. The men get more and more drunk. One is in a hurry to have sex with one of the girls but doesn't have a condom. His buddy tries to convince him to wait until they can find a condom.

10) **Wife finds condoms**

A married man working in an insurance company comes home from a three-day training course in another town. He is happy to see his wife again and greets her warmly. Then the wife tells the husband that he took the key to the kitchen cupboard when he went away. The husband says, “Yes, the key is in the side pocket of my bag.” The wife looks and says it is not there. The husband says it is, and tells her to shake out its contents. The wife does and condoms drop out. Their eyes meet.

11) **Share and share alike**

After work, a minibus driver meets a local girl selling fruit at the garage and offers her money to come back to his minibus that night. After he finishes having sex with the girl, another driver has sex with her. Some of the mechanics, having heard all the noise, come to the door of the minibus and also want to have sex with the girl. The first driver can see that the girl is feeling very uncomfortable and wants to go home. A big argument follows between those who want to have sex with the girl and those who think she should be allowed to go home.

12) **Tempting hitchhiker**

A logging company truck driver is driving along the road and sees a woman hitchhiking. He stops, and she says she is going to the market in town. He offers to give her a ride. She pauses and then agrees. She climbs in and he asks her if she is interested in a small gift. He adds that he could do with someone to keep him warm when he sleeps that night. She says she is interested but he will have to use a condom. He offers a million excuses as to why he never uses condoms.

13) **Lipstick on the collar**

A civil servant is on his way home from work. He meets a girlfriend who kisses him firmly and fondly on the cheek. The man explains that he must get home or his wife will be angry. They arrange to meet the following morning. He returns home and greets his wife, who is cleaning the house. She rises to greet him and takes his jacket. As she does, she notices something on his cheek. She looks more closely, and then angrily says, “lipstick.” The husband bows his head guiltily.
14) It wasn't me
A visibly pregnant teenager is looking for a worker in the tea plantation worker residences. She is anxious and embarrassed. She finally gets directed to the right section and knocks tentatively. Another woman, who is also pregnant, answers the door. She asks for the man of the house whom she had met in her village several months earlier. He comes to the door sleepily, sees the pregnant girl, and is visibly frightened. He slams the door, and shouts, “No, no, it wasn’t me!” The girl knocks again.

15) Daughter in trouble
The teenage daughter of a couple who both work for a soft-drink bottler is just starting to show the early stages of pregnancy. She is kneeling on the floor and crying. Her parents begin shouting at her after she tells them that she isn’t sure who the father is. Her father pulls her to her feet and tells her not to come back until she has found the father. The mother tries to console her but the father insists that she leave the house immediately.

16) Caught in the act
A seamstress working in a local factory gets out of a long-distance bus and walks to the door of her house. She unlocks the door and says, “Darling, I’m home early. My mother is much better.” She receives no reply, and says to herself that perhaps he’s asleep in the bedroom, and goes to check. She enters the bedroom and sees her husband on the bed, clothes disheveled, kissing and embracing the neighbour’s teenage daughter. Their eyes meet. There are no condoms in sight.

17) How embarrassing
A shy female accountant, who has never bought condoms before, goes to a store that sells them. She mumbles her request to the female sales clerk, who asks her to repeat it. Just then, some of the accountant’s co-workers come into the store and ask how she is doing and what she is shopping for today. Her friends tease her as the clerk asks her how many packages of condoms she wants. She makes up an excuse for what happened and ends up buying chocolate and no condoms.

18) Not getting the right help
A union steward has a burning sensation when he urinates. He suspects that he has a sexually transmitted infection, but doesn’t know what to do. He tells his friend that he is too embarrassed to go to the nearby clinic. He is worried about details of the infection going on his official medical record. His friend argues that buying pills at a pharmacy or in the market might not solve his problem.

19) Believer by day
A secondary-school teacher considers himself a devout Christian. He attends church regularly with his wife and four children. One evening, he is walking down a street in the company of women he has just met in a bar. He bumps into his pastor, who is very surprised to see him in this situation. A discussion about the moral values of pious Christians ensues between the two men.
20) **Short of money**

Due to an administrative problem, a male teacher was unable to get money to his family after he was transferred to another town. His wife borrowed some money but still did not have enough to feed her children. She decides to take matters into her own hands and goes out to a local bar with a man whom she knows wants to have sex with her in exchange for money. She enjoys herself until her husband’s brother comes into the place and sees her. He is furious, and tells her she is heading for a divorce. She pleads with him not to tell her husband.

21) **Short of cash**

A young secretary in a government office is proud of the way men look at her. She goes out of her way to dress in a sexy manner and spends all her money on fixing her hair and buying new clothes. Now she is short of cash to pay her monthly rent and decides to approach her new boss to see if he wants to give her money in exchange for sexual favours. He is tempted, but says he feels obliged to follow the office code of ethics, which discourages such things.

22) **Rumours abound**

A widow lost her husband to pneumonia last year. Those who know her in the garment factory where she works suspect that it was really AIDS that killed him. Now she is starting to lose weight and none of the other employees want to work next to her or use the same toilet. Their supervisor calls a meeting with her and the women who are treating her so poorly. The women express their fears and she tries to explain what stigma is and why it is unacceptable.
Appendix G: Sample materials for adaptation

Exercise G1: Picture story on risk

<table>
<thead>
<tr>
<th>Objective</th>
<th>To create an understanding of the impact of different behaviour choices on the sexual health of individuals and their families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Denial of the reality of risk of HIV infection exists among many who are at risk. This story allows participants to think about their attitudes towards high-risk behaviours and their vulnerability to sexually transmitted infections, including HIV. The story about a policeman named Benjamin and his wife Gloria tells how they deal with having a sexually transmitted infection.</td>
</tr>
<tr>
<td>Materials</td>
<td>27 picture cards the size of a sheet of paper, containing photographs and text</td>
</tr>
<tr>
<td>Time</td>
<td>1 hour</td>
</tr>
</tbody>
</table>

Instructions

Step 1:
Explain that you will be telling the story of Benjamin and Gloria. Show the pictures and tell the whole story without asking questions.

Step 2:
Then go back to the beginning of the story and ask questions to stimulate discussion as you retell the story. Encourage everyone to talk and to give their views during the second telling. Ask participants to put themselves in the place of the people in the story and consider how they would have behaved in the various situations.
Step 3:
At the end of the story, try to get participants to understand that everyone is responsible for her or himself. We all have to protect ourselves from AIDS. Go around the group, asking everyone to state the most important thing they learned from the story.

Card 1: Sexually transmitted infections
Introduce Benjamin, who is out on the town one Saturday night drinking beer and visiting the ladies.

Visual: A man in uniform in a bar with lots of beer and ladies at a club.

Text: You can get a sexually transmitted infection if you don’t use condoms.

Card 2: Signs and symptoms of sexually transmitted infections
Benjamin is not feeling well a few days later.

Visual: Kwame holding his genital area and grimacing.

Text: After a few days, Benjamin feels an itching and burning sensation in his genital area – a sign of gonorrhoea.

Card 3: At the market
Benjamin purchases antibiotics from a woman taking them out of a plastic bag at the market.

Text: Antibiotics bought from women in the market turn out not to be the right treatment, because a white discharge persists. He considers this a minor irritation and ignores it. He does not tell his wife.

Card 4: Benjamin’s wife complains of vaginal discharge and irritation
Gloria holding her side and complaining to Benjamin.

Text: Gloria contracts a sexually transmitted infection from her husband but does not seek treatment.
Card 5: Benjamin’s symptoms return and so do his bar visits

Visual: Benjamin with women at the bar with a worried look on his face.

Text: Benjamin does not consider having a sexually transmitted infection to be serious and continues his habits without using protection.

Card 6: Benjamin discusses the symptoms with another policeman

Visual: Benjamin talking to another policeman.

Text: As the symptoms do not go away this time, Benjamin listens to the advice of his friend who tells him to go to the clinic.

Card 7: The doctor diagnoses a sexually transmitted infection.

Visual: Benjamin being examined by a doctor.

Text: The doctor tells Benjamin that he has a sexually transmitted infection and praises him for seeking treatment in the clinic. He tells Benjamin to bring in his wife for treatment.

Card 8: Condoms are key to prevention

Visual: Doctor giving Benjamin condoms.

Text: Condoms prevent the transmission of sexually transmitted infection during sexual relations.
Card 9: Sexually transmitted infections contribute to HIV transmission

**Visual:** Benjamin in bed with his wife in one image and with another woman in a second image.

**Text:** HIV is spread in the same way as other sexually transmitted infections. If you have an irritation caused by an infection, it creates a window for HIV to enter your body. If you have an infection, you may already have contracted HIV.

Card 10: HIV in the immune system

**Visual:** Soldiers represent the fighter T-cells being taken over by HIV in the form of an enemy invader.

**Text:** HIV destroys your natural immune system, allowing diseases to take hold.

Card 11: What happens to your body over time?

**Visual:** A person looking healthy for the first eight years and beginning to get sick by year nine.

**Text:** HIV multiplies slowly in your body over time as it takes over your immune system. Eventually, your body succumbs to various diseases and infections.

Card 12: Mother-to-child HIV transmission

**Visual:** Benjamin with Gloria, who is visibly pregnant.

**Text:** You can pass on HIV without knowing it to many partners, even though you have no signs of HIV infection and feel perfectly healthy. It is possible to pass on HIV to your wife and for her to pass it to your unborn child.
Card 13: Why are police vulnerable?

Visual: Two policemen on patrol at night, arresting women.

Text: Policemen are exposed to many risks. They may accept sexual favours while on patrol, or they may drink heavily during operations away from home. Many do not use condoms and self-treat for sexually transmitted infections.

Card 14: Policemen need protection

Visual: Strong and fit policeman buying condoms at a chemist’s shop.

Text: Stay fit and strong: protect yourself from sexually transmitted infections by seeking treatment at the clinic, sticking to one faithful partner, and using condoms. Protect yourself and your family.

Card 15: Some wives promote the use of condoms

Visual: A woman gives her husband condoms as he leaves on a mission.

Text: Some wives and regular girlfriends try to ensure that their whole family is protected from HIV by giving their husbands or partners condoms when they leave on mission.
Exercise G2: Picture codes on alcohol

Objective
To generate awareness of the implications of alcohol abuse

Background
Showing pictures is an effective way to stimulate a discussion on a topic. These photos depict different situations involving alcohol.

Materials
Four photos

Time
15 minutes per photo

Instructions

Step 1:
Show the picture code and ask participants to look at the image and explain what they see. Discuss whether this represents a common situation for them and the significance of the action taken by the individuals depicted. To further stimulate discussion, ask the questions listed below. Be careful not to give away too much information. Let participants guess what they think the picture is about, first.

Image: A man visibly drunk, is surrounded by empty beer bottles.

- What is happening in this picture?
- Why is this man in this situation?
- What do you think he is feeling?
- Why is he drinking so much?
- What problems might this situation cause? (Prompt the group, if necessary, with the following: decisions to seek sex, hesitation to use condoms when drunk, money spent on beer is not spent on other things.)
- How is this situation related to HIV or other sexually transmitted infections?
- How does this happen in the uniformed services?
- What can be done to change this situation?

Image: A man is drinking beer in a bar with a young woman

- What is happening in this picture?
- Why is this man in this situation?
- What do you think he is feeling?
- Why is he drinking on the job?
- What problems might this situation cause? (If necessary, prompt the group with the following: decisions to seek sex, inability to use condoms when drunk, money spent on beer is not spent on other things.)
- How is this situation related to HIV or other sexually transmitted infections?
- How does this happen in the uniformed services?
- What can be done to change this situation?
**Image:** A man holding a beer bottle in one hand and raising his hand to strike his wife with the other

- What is happening in this picture?
- Why is this man in this situation?
- What do you think he is feeling?
- What do you think the woman is feeling?
- What problems might this situation cause? (Strained relationship between the couple; lack of confidence in the man; injury to the woman.)
- How does this happen to uniformed services personnel?
- What can be done to change this situation?

**Image:** Men and young girls in a bar

The table is full of empty bottles. The barman arrives with another round. One man reaches for his wallet to pay. Another one motions him to put his wallet away and hands the barman a wad of bills.

- What is happening in this picture?
- Why is this man in this situation?
- What do you think he is feeling?
- Why is he so anxious to spend his money?
- What problems might this situation cause? (Less money for other things; cannot support family properly; cannot buy friends.)
- How is this situation related to HIV and other sexually transmitted infections?
- Does this happen to people at your workplace?
- What can be done to change this situation?
### Exercise G3: Picture codes for women

**Objective**
To create an understanding of the vulnerability of women.

**Background**
Women are more vulnerable to HIV infection because, unlike men, their reproductive system is located inside their body rather than on the outside. Many women who are married do not realize to what degree they are vulnerable to HIV infection from their husbands. Single women who have sex with men often do not appreciate the fact that, although the man may be faithful to them, he may have been infected during previous sexual relations.

**Materials**
Picture cards the size of a sheet of paper containing photographs and text

**Time**
1 hour

#### Instructions

**Step 1:**
Convene a group of female participants, preferably with a female peer educator. Explain that you would like them to look at each photo and describe what they see. Then ask them about the situation of the people in each photo.

**Step 2:**
Ask the group to answer the questions related to each photo. Make sure that the same woman does not answer all the questions and that the more timid women have a chance to speak.

**Card 1: HIV is the virus that causes AIDS**

**Discussion questions:**
- What is HIV?
- What is AIDS?
- What is the difference between HIV and AIDS?
- How long does a person carry the virus before showing symptoms of AIDS?

**Comments:**
AIDS stands for acquired immunodeficiency syndrome. AIDS is the name of a group of fatal sicknesses caused by a virus called HIV—the human immunodeficiency virus. This virus weakens the body’s protection against disease and eventually causes AIDS-related illnesses and death. A person can look perfectly normal and healthy but still carry HIV and pass it to others. This period without symptoms can last for up to ten years. Women can be infected by their own husband without knowing it. If they get pregnant, they can then infect their baby during delivery and may only discover that both parents are infected when the baby dies of AIDS.
Card 2: Almost all HIV is sexually transmitted

Discussion questions:
- What are the three most important ways of contracting HIV?
- Are there other ways of contracting HIV that concern you?

Comments:
Sexual relations, mother-to-child transmission and blood transfusions are the most common means of getting infected with HIV. Mosquitoes, sharing toilet seats, eating or drinking implements, or casual contact pose no risk of HIV transmission. Even injections in clinics or contact with sharp implements present little to almost no risk at all.

Card 3: A mother can pass HIV to a baby at birth or by breastfeeding

Discussion questions:
- How can a baby get infected with HIV?
- How would you feel if you had a baby born with HIV?
- What do you think would happen to the baby?

Comments:
A man who gets infected with HIV from a casual sexual relationship can then infect his wife. If she gets pregnant, she has a one-in-three chance of passing the virus on to the baby. In most cases, the infected baby is weak from the start and dies before his or her second birthday. The chances of infecting a baby are greater if the mother loses a lot of blood or if surgical instruments are used to deliver the baby.

Card 4: Trusting a partner not to be infected

Discussion questions:
- Describe what a man looks like if he is someone who is not likely to be infected with HIV.
- Can a man be healthy, handsome and church-going and still be infected?
- How many lovers does a person have to have had in the past to risk infection?

Comments:
Many women and men mistakenly think that if a person is good-looking, looks strong and healthy, is nicely dressed, is pleasant and nice, and goes to church regularly, he or she could not possibly be infected with HIV. The truth is that anyone could be infected. Remember, when you have sex with one person, it is like having sex with everyone they have ever had sex with in the past. And it takes just one infected sexual partner from the past and a bit of bad luck to risk infection from even a regular boyfriend. He may be faithful now, but he has probably had a few girlfriends in the past.
Card 5: Condoms are reliable protection

Discussion questions:

- Do your partners use condoms if they have sex with other people?
- What do you think of the role of condoms in HIV prevention?
- How reliable do you think condoms are?

Comments:

If used correctly, condoms reliably prevent HIV and other sexually transmitted infections that can cause infertility. HIV and other sexually transmitted infections cannot pass through latex male condoms or polyurethane female condoms. Studies show that condoms very rarely break. If one does break, it is usually because the user has not put it on carefully.

Card 6: Men should carry condoms

Discussion questions:

- What do you think your reaction would be if you found that your husband or regular boyfriend had condoms and was not using them with you?
- Does it make sense to get upset when he is doing a good thing by protecting both himself and you?

Comments:

You probably feel jealous and angry. It might even confirm your suspicions that he has been unfaithful. However, finding condoms means that he is protecting himself, you and any future children you might want to have together, from HIV. It is better to be sure that condoms are around and being used rather than hoping that he is not seeing other women but suspecting that he is doing so, without your knowledge and without condoms.

Card 7: Encourage partners to use condoms during sex with other people

Discussion questions:

- Would it be possible to convince your partners to use condoms with you?
- How would you approach the idea of condoms being used?
- You probably prefer that your partner not have sex with other people. But, if he does, how can you convince him to protect himself and you?

Comments:

If it is difficult to get your partner to use condoms with you, getting him to use them with other sexual partners is the only way to protect him, you and any future children you might want, from HIV infection. Men sometimes do not think about the consequences of their acts. They may only be thinking about the pleasure of the moment. Reminding them of their responsibilities to protect you and future children may not be pleasant, but it is a matter of life and death.
Card 8: Treat both partners rapidly when a sexually transmitted infection appears

Discussion questions:
- Have you ever had a sexually transmitted infection?
- Has your partner ever had a sexually transmitted infection?
- How were they treated?
- Why is rapid treatment of sexually transmitted infections important?

Comments:
Having a sexually transmitted infection greatly increases the chances of becoming infected with HIV—the virus that causes AIDS. Women can contract a sexually transmitted infection and not even know it. If men have symptoms, both men and women should go to a clinic to be checked. Treating yourself is not a reliable method.

Card 9: Do not ignore HIV/AIDS

Discussion questions:
- What do you think is going to happen to this couple?
- Do you think they have prepared a will?
- Do you think they have prepared their finances?

Comments:
Many people deny that they are going to die from AIDS, even when they become ill. This can ruin the lives of those who are left behind if the finances of those with HIV/AIDS are not in order and a will has not been drawn up. Widows can be dispossessed of their homes and their belongings, and children can end up being forced to beg, steal or sell sex. Getting HIV counselling and testing as soon as possible allows you to plan the rest of your life, whether you are HIV-infected or not.

Card 10: Review what you have learned today

Discussion questions:
- What did you learn today about HIV and AIDS?
- How do you get HIV?
- How do you prevent it?
- What did you learn about condoms?
- What did you learn about sexually transmitted infections?
- What can you do to protect yourself and your family from HIV infection?
- What did you learn about HIV counselling and testing?

Comments:
Ignoring the reality of sexual relations outside of marriage will only bring heartache and even death to couples and families. It is better to take decisive action to protect yourself, your partner and your children. If your partner is not going to stop having sexual relations with other women, then he needs to use condoms, even if nobody is happy about the idea.


Tools for Monitoring and Evaluation of the Behaviour Change Communication Programme for the Workplace

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Appendix A: Sample workplace programme objectives and indicators

Appendix B: Sample monitoring forms for behaviour change communication programmes

Appendix C: Sample peer-education monitoring form for low-literacy peer educators
Case study: The Mumias Sugar Company, Western Province, Kenya

Kenya is one of many African nations with a serious HIV epidemic. The HIV prevalence nationwide is estimated to be 6.7 per cent (9 per cent among women and 5 per cent among men – Central Bureau of Statistics, 2003). Despite the lower-than-expected figure, the infection is still a generalized epidemic in Kenya, and efforts to bring it under control remain an urgent matter. One dramatic impact of AIDS-related deaths is the decline in life expectancy. The Kenyan Central Bureau of Statistics estimates that, without AIDS, life expectancy at birth would be about 65 years. However, because of the large number of AIDS-related deaths, life expectancy is currently only about 46 years and may decline to 45 years by 2010. Thus, almost 20 years of life expectancy have already been lost because of AIDS.

HIV infection is increasing rapidly in Kenya’s Western Province where the agro-industrial plantations are a zone of high transmission. Absenteeism due to AIDS-related illnesses, loss of experienced personnel, replacement and training costs, reduced productivity and increased medical expenditure threaten the viability of Western Province’s agro-industries.

Mumias Sugar Company is the largest single sugar factory in Kenya, with 2,500 employees. Starting as a government-owned enterprise in the early 1970s, the company has since been privatized and is listed on the Nairobi Stock Exchange. In 1999, Mumias began to work with Family Health International on the USAID-sponsored IMPACT project to implement a comprehensive HIV/AIDS workplace initiative targeting both workers and the surrounding residential community. These sites are particularly vulnerable to HIV infection, attracting large numbers of men who have disposable income, are away from their families, and are surrounded by low-income communities with disproportionate numbers of single women.

The programme includes behaviour change communication with a peer-education component, referrals for testing and treatment of sexually transmitted infections and voluntary HIV counselling and testing, as well as education, care and support in the community. The programme objectives are the following:

- Create better understanding of, and confidence in, condoms
- Create greater understanding of the risks of unprotected sex with multiple partners
- Increase faithfulness to one partner
- Increase the correct and consistent use of condoms
- Improve negotiation skills for condom use
- Increase use of HIV counselling and testing services
- Reduce sexually transmitted infection prevalence among the workforce.

Using the Mumias Sugar Company as an example, keep the following questions in mind as you read through this booklet:

- How can the company measure the progress of its programme implementation?
- Does its investment make a difference?
- What is the effect of the company’s intervention?
- How will the company track its prevention efforts?
- Does it help to reduce the impact of HIV/AIDS on the company?
- What kind of monitoring and evaluation plan should be developed?
1. What is monitoring and evaluation?

**Monitoring and evaluation** can be simply defined as the systematic tracking of programme activities and results.

**Monitoring** is the routine tracking on a regular basis of whether programme activities are taking place according to plan. For workplace HIV/AIDS programmes, monitoring assesses the extent to which prevention services are being used. Monitoring also helps implementers or managers assess the extent to which the programme is moving towards its expected objectives. For example, in the case of the Mumias Sugar Company programme (see case study above), if one of the objectives is to increase the utilization of HIV counselling and testing services, the senior management would assess whether this objective is being met by tracking HIV counselling and testing utilization. By tracking the number of workers that peer educators reach in each department, monitoring can assess the coverage of the peer-education programme. Monitoring answers the following question: Are we doing what we planned to do?

**Evaluation** measures whether the outcomes that the programme intends to influence are changing in the target population. For example, increased correct condom use is one of the outcomes expected in the Mumias programme. Evaluation can help programme operators determine whether condom use has changed and how much of the change is due to the programme. Evaluation answers the following questions: What outcomes are observed? Does the programme make a difference?

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### Examples of monitoring and evaluation questions, based on the Mumias Sugar Company case study

#### Monitoring questions

- What resources is the programme using (e.g., staff, funds, equipment)?
- How many peer educators have been trained? How many were males and how many were females?
- Are programme activities being carried out in compliance with guidelines and at the standard of quality anticipated?
- What has programme implementation cost, to date?
- How many workers have peer educators reached?
- How many workers have educators referred to sexually transmitted infection services?
- How many workers have educators referred to HIV counselling and testing services?
- Is the programme serving the segments of the population that it intended to serve?

#### Evaluation questions

- Are targeted workers’ attitudes changing towards abstinence, fidelity or condoms?
- Is consistent condom use increasing among the workforce?
- What is the effect of BCC activities on attitudes and beliefs about HIV/AIDS?
- Are the incidence and prevalence of HIV and other infections among the workforce decreasing overtime?
- What is the effect of BCC activities on stigma and discrimination against people living with HIV/AIDS at the workplace?
- Have negotiation skills for condom use improved?
2. Why should workplace HIV-prevention programmes be monitored and evaluated?

- To determine what works and what does not work
- To improve existing programmes
- To plan for future needs
- To track costs
- To allocate funds wisely
- To demonstrate success
- To lobby for greater efforts
- To answer to taxpayers and funders
- To assess coverage (how many people are being reached, and where)

Monitoring and evaluation contribute to effective programme management by providing a means of assessing and improving the performance of the programme over time.

In monitoring and evaluation, programme resources are referred to as inputs, programme activities or operations as processes, and results as outputs, outcomes or impact, depending upon whether they are measured internally within the programme (outputs) or in the programme’s target population (outcomes), and whether only results that are the direct result of the programme are to be considered (impact). These terms and concept are further defined below with examples in the context of a workplace HIV/AIDS BCC programme.

**Box 1: Sample programme components for a workplace HIV/AIDS BCC programme**

<table>
<thead>
<tr>
<th>Programme component</th>
<th>Activity or result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inputs</strong></td>
<td>Funding</td>
</tr>
<tr>
<td></td>
<td>Programme staff</td>
</tr>
<tr>
<td><strong>Processes</strong></td>
<td>Develop workplace BCC material</td>
</tr>
<tr>
<td></td>
<td>Implement formative assessment for workplace BCC programmes</td>
</tr>
<tr>
<td></td>
<td>Develop workplace policy and guidance for HIV prevention</td>
</tr>
<tr>
<td></td>
<td>Establish workplace HIV/AIDS committees</td>
</tr>
<tr>
<td></td>
<td>Recruit peer educators to provide HIV/AIDS information to workforce</td>
</tr>
<tr>
<td></td>
<td>Train peer educators</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>Number of workers who received BCC material</td>
</tr>
<tr>
<td></td>
<td>Number of committees established</td>
</tr>
<tr>
<td></td>
<td>Number of people reached by peer educators</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Proportion of workforce using condoms for high-risk sex (short-term)</td>
</tr>
<tr>
<td></td>
<td>Proportion of workforce frequenting sex workers (short-term)</td>
</tr>
<tr>
<td></td>
<td>Proportion of targeted workers who report having sex with a non-regular partner in the last 12 months</td>
</tr>
<tr>
<td></td>
<td>Prevalence of HIV infection at the workplace (long-term)</td>
</tr>
<tr>
<td></td>
<td>Prevalence of sexually transmitted infections</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>The proportion of the above-mentioned outcomes that can be attributed to a given programme</td>
</tr>
</tbody>
</table>
All workplace programmes should monitor inputs and processes, as well as evaluating programme effectiveness.

Input monitoring consists of routine and systematic collection of data on financial, human, physical and other resources that workplace programmes use. Input monitoring is an essential part of programme monitoring.

Output monitoring focuses on the direct products of programmes—for example, the number of peer educators trained.

Process monitoring consists of tracking whether programme activities are being performed on schedule and how well they are being performed. Examples of routine process-monitoring instruments include client records, monthly/quarterly staff reports, routine supervisory reports, and other records and reports maintained by staff on a regular basis.

Process evaluation tends to be qualitative in nature and focuses on how well programme activities are being carried out and the extent to which they conform to programme quality standards. Process evaluations sometimes also consider whether alternative operational procedures or approaches might be more efficient or effective.

Cost monitoring involves the measurement of the costs of delivering programme services and benefits to clients.

An effectiveness evaluation involves measuring the extent to which changes in short- or long-term outcome measures occurring in the programme’s target population are consistent with the programme objectives. In the case of HIV and sexually transmitted infections, programmes are often concerned with measuring prevalence. HIV prevalence is the overall percentage of HIV infection in a given population group, such as all employees. Another indicator could be the increase in the proportion of target workers who consistently use condoms in company X.
3. How to monitor and evaluate behaviour change communication workplace programmes

Monitoring and evaluation systems for workplace HIV/AIDS programmes depend ultimately on the scope and type of programme, as well as on the amount of funding available. As a rule, 10 per cent of the funding allocated to programmes should be budgeted for the monitoring and evaluation component. However, if funding is limited, a programme may choose to focus its efforts on monitoring alone. For example, if the scope of a programme is a factory of 20 employees with limited resources, it would be wise to concentrate on the monitoring component. A larger programme with sufficient funding could conduct an outcome, and even an impact, evaluation, in addition to monitoring, as did the Mumias Sugar Company (see case study). If a programme includes an impact evaluation, a monitoring and evaluation specialist would need to be consulted during the design phase to ensure that the programme has the capability to conduct such an evaluation.

Developing a monitoring and evaluation workplan

All programmes, whether they are single interventions or integrated projects, should have a monitoring and evaluation plan to assess progress made towards the achievement of goals and objectives and to inform key stakeholders and programme designers about evaluation results. Monitoring and evaluation workplans should guide evaluation design, highlight what information remains to be collected, and specify how best to gather that information.

A monitoring and evaluation workplan is a flexible guide to the steps used to document programme activities, answer monitoring and evaluation questions, and show progress made towards the achievement of programme goals and objectives. This guide should explain the goals and objectives of the monitoring and evaluation workplan, as well as the evaluation questions, methodologies, implementation plan, matrix of expected results, proposed timeline, and monitoring and evaluation instruments for gathering data.

It is essential that programme planners, evaluators, donors and workplace management staff be involved throughout the entire monitoring and evaluation process. Stakeholder involvement during the early phases helps ensure that evaluation results will be used. Involving members of the target audience also helps inform the process.
Step 1: Identify programme goal and objectives

The first step in designing a programme consists of defining its goal and objectives.

- Write a clear statement that identifies programme goal and objectives (and sometimes sub-objectives) and describes how the programme expects to achieve them. This makes it easy to develop an evaluation plan framework.

- State objectives and sub-objectives for each component of the programme and list the indicators that will be measured to determine progress.

Before you do that, review the following operational definition, to assist you in identifying the goal and objectives for your monitoring and evaluation plan.

Goal

The goal is the ultimate purpose of the intervention. For example, the goal of a workplace prevention programme may be to reduce HIV prevalence among the workforce and the surrounding community. Achieving this goal will help reduce absenteeism among the workforce and increase productivity.

Objectives

Objectives are more intermediate than the goal. Objectives are the pathways through which a programme can achieve its goal. Good programme objectives are ‘SMART’: Specific, Measurable, Achievable, Realistic and Time-bound. Specific objectives measure only one thing at a time. Measurable objectives are quantifiable and lend themselves to questions such as ‘how many’ and ‘how often’. Achievable objectives are those based on realistic timeframes; they do not, for example, try to measure behaviour change over a six-month period. Realistic objectives focus on which changes a programme can actually hope to accomplish rather than, for example, expecting the national government to create new policies as a result of the programme. Time-bound objectives allow for the assessment of programme progress at regular intervals.

The following are examples of SMART objectives for a workplace programme focused on HIV/AIDS-related behaviour change:

- By the end of year 1, train 75 workplace peer educators in HIV prevention.
- By the end of year 1, increase by 25 per cent the number of workers who can correctly identify three effective means of protecting themselves against HIV infection.
- By the end of the project, increase by 25 per cent the number of workers who report having only one sexual partner.
- By the end of the project, increase by 25 per cent the number of workers who used a condom the last time they had sex with a non-regular partner.

See Appendix A for more examples of workplace-oriented programme objectives.
Step 2: Determine monitoring and evaluation questions, indicators and feasibility

Once the objectives have been established, it is important to map out all activities being planned in order to achieve the objectives. One of the critical steps in designing and conducting monitoring and evaluation of objectives is selecting the most appropriate indicators. The following steps are recommended:

- Identify the most important evaluation questions, which should directly relate to the stated goals and objectives. Questions should come from all stakeholders, including programme managers, donors and members of the target populations. The questions should address each group’s concerns, focusing on the following areas:
  - What do we want to know at the end of this programme?
  - What do we expect to change by the end of this programme?
- Be prepared to revise the evaluation questions as the workplan evolves.

Determine which indicators you will use, keeping in mind that you will need two sets of indicators—one to measure outcome (immediate or short-term change) and another to measure impact (long-term change). In determining the indicators, use the following elements as a guide.

What is an indicator?

An indicator is a clue, sign, or marker that points to possible changes in the situation that may lead to the achievement of objectives. An indicator can be defined simply as a condition that can be objectively measured. Indicators provide objective criteria for assessing whether and how well programme activities have taken place and whether the programme has achieved its objectives. Box 2 below outlines the characteristics of a good indicator.

<table>
<thead>
<tr>
<th>Box 2: Characteristics of a good indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicators should be:</td>
</tr>
<tr>
<td>- operational (measurable or quantifiable using tested definitions and reference standards);</td>
</tr>
<tr>
<td>- reliable (produce the same results when used more than once to measure the same condition or event);</td>
</tr>
<tr>
<td>- valid (measure the condition or event they are intended to measure);</td>
</tr>
<tr>
<td>- specific (measure the condition or event under observation);</td>
</tr>
<tr>
<td>- sensitive (reflect changes in the state of the condition or event under observation);</td>
</tr>
<tr>
<td>- affordable (represent reasonable measurement costs); and</td>
</tr>
<tr>
<td>- feasible (achievable within the proposed data-collection system).</td>
</tr>
</tbody>
</table>
Tools for Monitoring and Evaluation of the Behaviour Change Communication Programme for the Workplace

Process indicators
- Number of peer educators trained
- Amount of medical supplies purchased
- Amount of drugs purchased

Output indicators
- Total number of targeted workers reached
- Percentage of interviewed workers who state that they have interacted with a peer educator in the last year

Short-term outcome indicators
- Number of targeted workers who can correctly identify three effective means of protection against HIV infection
- Number of targeted workers who reported having only one sexual partner over the past 12 months
- Number of targeted workers who reported using a condom the last time they had sex with a non-regular partner
- Number of people living with HIV/AIDS who are still working for the company one year after declaring their HIV-positive status
- Number of health-related absences per month
- Increase or decrease in medical costs, by type of cost
- Number of funerals among workers and workers’ family members

Long-term outcome indicators
- HIV prevalence at worksites
- Prevalence of sexually transmitted infections
- Number of workers who take medical retirement, over the life of the project

Impact indicators
- Percentage of workers that the programme has reached and that report an increase in condom use during their last sexual encounter, compared to workers that the programme has not reached
- Any of the above-mentioned indicators that can be directly linked or attributed to the programme.

See Appendix A for more examples of workplace-oriented programme indicators.
Step 3: Develop data-collection tools

After developing the programme goal, objectives and indicators, the next step is to develop forms and tools for collecting data. These forms and tools are used at several different levels of the programme and are key to the success of any monitoring and evaluation system. Programme staff members who interact with the target group need data-collection forms that they can complete every day. Staff supervisors need forms to keep track of weekly or monthly events as well as forms that enable them to summarize the daily data being collected by programme staff. The programme manager needs tools to synthesize all of this information into monthly and quarterly summaries.

It is important to know the skill and literacy level of staff members who will use the forms, and to develop them accordingly. The use of pictograms can be very useful. See Appendix C for a sample monitoring form for peer educators with low literacy levels.

Those who will be collecting programme data should be involved as much as possible in the design of forms and tools to ensure proper, effective usage. This also speeds up staff training and promotes staff cooperation in data collection. In any case, every programme should conduct a staff training session on how to collect good-quality data.

Input, process and output data come from programme-level data – for example, peer-educator records, databases, reports produced by programme staff and periodic special assessments. Outcome data are generally obtained from workforce-based data-collection methods, such as sample surveys. Some outcome indicators can be measured through routine data systems. For example, data on cases of HIV and other sexually transmitted infections can be obtained from clinic-based workplace programmes or from referral clinics, where peer educators may keep track of key biological and behavioural data from workers with whom they interact. See Box 3 below for more examples of data sources for monitoring and evaluation.

<table>
<thead>
<tr>
<th>Type of monitoring or evaluation</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input monitoring</td>
<td>Programme records</td>
</tr>
<tr>
<td>Process monitoring</td>
<td>Supervisory records&lt;br&gt;Routine client/beneficiary feedback&lt;br&gt;Routine self-assessment</td>
</tr>
<tr>
<td>Process evaluation</td>
<td>Special studies (client exit interviews, service observation, mystery client studies)</td>
</tr>
<tr>
<td>Output monitoring</td>
<td>Workforce member surveys in large factories</td>
</tr>
<tr>
<td>Outcome evaluation</td>
<td>The proportion of the above-mentioned outcomes that can be attributed to a given programme</td>
</tr>
<tr>
<td>Impact evaluation</td>
<td>Special impact studies</td>
</tr>
<tr>
<td>Cost monitoring</td>
<td>Programme records</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>Cost data and outcome/impact evaluation findings</td>
</tr>
</tbody>
</table>
Forms should be tested before they are finalized. One or two months of trial data collection can enable the programme operators to determine the quality and effectiveness of the tools and forms. After this time period, the forms and tools can be simplified or modified in accordance with staff input. (See Appendices B and D for additional examples of specific monitoring forms.)

If the programme is collecting personal information on members of the target population (names, ages, gender, address or anything else that might lead to the identification of a person), staff should ensure that the information is kept confidential. It is important to have a secure, locked space to house data-collection tools and data at all times. In summary, do the following:

- Outline the data-collection methods and plan to analyse the data as well as an overall timeline. It is crucial to clearly spell out how data will be collected in order to answer the evaluation questions. Here, the planning team determines the appropriate evaluation designs, outcome measures or indicators, information needs and the methods by which the data will be gathered and analysed. A plan must be developed to collect and process data and to maintain an accessible data system.

- Include the following data-collection questions in the plan:
  - What information is to be monitored?
  - How will the information be collected?
  - How will it be recorded?
  - How will it be reported to the central office?
  - What forms will be needed?

- For issues that require more sophisticated data collection:
  - Which study design will be used?
  - Will the data be qualitative, quantitative or a combination of the two?
  - Which outcomes will be measured?
  - How will the data be analysed and disseminated?
Step 4: Identify implementers and state how current and earlier evaluation data will be collected and analysed.

- State clearly who will be responsible for each activity and for collecting and analysing the data.
- Identify evaluation experts from planning and evaluation units of the Ministry of Health, academic institutions, non-governmental organizations and private consulting firms to assist with the plan and the final evaluation.
- Identify existing data sources and other evaluation activities, and determine if they have been done in the past, are ongoing or have been sponsored by other donors.
- At this stage, evaluators should determine whether other groups are planning similar evaluations and, if so, invite them to collaborate.
Step 5: Develop the monitoring and evaluation workplan matrix and timeline

- Develop a matrix to present the inputs, outputs, outcomes and impacts (and their corresponding activities) for each programme objective. This matrix summarizes the overall evaluation plan by including a list of methods to be used for collecting the data.

- Include a timeline that shows when each activity in the monitoring and evaluation workplan will occur.
Step 6: Develop a plan to disseminate and use evaluation findings

Monitoring and evaluation data can serve to document programme performance. Ask how the evaluation plan has been implemented and how the results have been used to improve workplace HIV-prevention programmes and policies. A plan to use the results of the evaluation and to best translate the results into viable programmes should be developed. The types of information that programmes can use to highlight performance include the following:

- Data on the programme’s reach or coverage
- Amount of staff participation
- Types of services delivered
- Reactions of participants to the services provided.

Documenting programme achievements might help justify the need for more staff, staff training and/or additional supplies.

Monitoring and evaluation data are also useful for:

- Feedback to programme staff (e.g., regular staff meetings, including field staff);
- Decision-making about a programme’s future direction (e.g., expanding services and coverage, identifying new services to add);
- Reporting to donors and policy-makers;
- Communicating a programme’s successes and challenges to the community (e.g., newspaper articles, press conference, town hall meeting); and
- Fundraising (proposal writing).

Workplace programme data can help improve programme implementation, decision-making and, if necessary, convince management of the need for ongoing HIV-prevention programmes. Data can provide feedback for workers and data collectors, motivating them to improve their performance, to participate in the programme (in the case of workers) and to change their behaviour. The following steps should be followed when developing a dissemination plan:
Programme reviews

Most programmes conduct a periodical review (once or twice a year) to assess their progress, share information, discuss issues of implementation, and find solutions to problems. Programme reviews consist of a systematic examination of key programme elements to assess performance, identify opportunities for positive change and provide information on lessons learned for other programmes. The following methods can be used to carry out programme reviews:

- Review of written documentation (e.g., quarterly reports, programme plans and financial records, peer-education training reports)
- Individual and group interviews with key stakeholders (e.g., managers, staff, clients and beneficiaries, donors, workplace representatives)
- Site visits
- Stakeholder workshops or meetings
- Informal discussions and brainstorming with selected workplace staff.

It is important to note that programme reviews are not programme evaluations, since they do not provide the comprehensive information of a formal evaluation, nor do they include rigorous study designs and methodologies.
Methods for workplace programme monitoring and evaluation

Monitoring of workplace HIV/AIDS behaviour change communication programmes is conducted using both quantitative and qualitative methods (see Box 4).

Quantitative methods measure the amount of things achieved or the amount of change observed, and document the numbers associated with a programme. These methods focus on which programme activities take place and how often they take place.

Quantitative methods examine such things as service statistics and distribution records. They help answer the following questions:

- How many staff members were reached?
- How many BCC materials (by type) were distributed?
- How many counselling sessions were held?
- How many peer educators were trained?

Qualitative methods are aimed at determining why things are happening and how well the elements of a programme are being carried out. Qualitative methods often take the form of in-depth interviews and focus group discussions. They help answer the following questions:

- How are peoples’ attitudes changing towards abstinence, fidelity or condoms?
- How effective is the programme in conveying intended messages to target populations?

Quantitative and qualitative methods can and should be used in a complementary way to investigate the same phenomena. For example, a programme might use open-ended, exploratory (qualitative) methods to investigate which issues are most important and the language to use in designing instruments for process evaluation and in designing workplace messages. Surprising survey results that cannot be explained by the data might be better interpreted through qualitative methods such as focus group discussions or in-depth interviews.

Many of the same tools are used to gather information about the target population before, during and after the BCC programme to monitor progress over time. Box 8 below lists examples of monitoring methods and tools for implementing each method. See also Booklet 2: Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace, for a more detailed description of tools for conducting a formative assessment. To read more about rigorous evaluation design, refer to the following web page: http://www.popcouncil.org/pdfs/horizons/ORHIVHndbkIntro.pdf.
<table>
<thead>
<tr>
<th>Quantitative methods</th>
<th>Quantitative tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing BCC material distribution</td>
<td>Distribution logbook</td>
</tr>
<tr>
<td>Periodic site visits</td>
<td>Checklist, questionnaire,</td>
</tr>
<tr>
<td>Periodic review of implementation reports (e.g., peer-supervisor reports, training reports)</td>
<td>peer-educator reports, educator activity sheet, client/patient referral form</td>
</tr>
<tr>
<td>Periodic compilation of service statistics</td>
<td>Tally sheet</td>
</tr>
<tr>
<td>Surveys, special studies, behavioural surveillance surveys among workers, knowledge, practice, attitude and behaviour surveys</td>
<td>Quantitative questionnaires</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Qualitative methods</th>
<th>Qualitative tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus group discussions</td>
<td>Focus group discussion guide</td>
</tr>
<tr>
<td>Direct participant observation</td>
<td>Observation checklist</td>
</tr>
<tr>
<td>In-depth interviews (e.g., to monitor and track changes in questions asked by target groups during the course of project implementation)</td>
<td>Interview guides</td>
</tr>
<tr>
<td>Content analysis of materials</td>
<td>Content analysis checklist</td>
</tr>
<tr>
<td>Pre-testing of materials with target population</td>
<td>Pre-test checklist</td>
</tr>
</tbody>
</table>
4. Ethical issues

In setting up monitoring and evaluation for workplace HIV/AIDS behaviour change communication, programmes should make sure that the design and, specifically, the forms and data-collection methods meet ethical standards. The principle of “do no harm” and other forms of protection of human subjects should be applied. Monitoring and evaluation design and implementation should protect employees’ rights, ethics and privacy. This means that any information procured directly from a member of the workforce should only be gathered with that person’s explicit, voluntary, non-coerced consent. The identity of any person providing the programme with information should be protected and never divulged. The programme should keep all information in a safe, locked space within its offices and maintain each individual’s right to complete privacy at all times.

If data collection includes surveys at the population level (involving interviews with members of the target group), there may be a need to obtain the approval of local and perhaps international internal review boards or committees on the protection of human subjects. As this depends on funding sources and national law, it is advisable to be fully informed about such issues.
5. Brief on data analysis

This booklet does not provide detailed information on how to analyse data. Data analysis is, however, an important component of the monitoring and evaluation process. Most programme managers will need to seek specialists to assist them with their data analysis.

Programme goals, objectives and benchmarks should serve as guidelines for data analysis. Data should serve to inform a programme about its progress towards achieving these elements. Data can be considered as pieces of a puzzle; once each piece is in place, the result is a full picture of what a programme has accomplished, how well it was done, and what were the outcomes and impact of its activities.

If a data set is relatively small, manual analysis is possible. For larger sets of data, Excel and Access are excellent computer software packages for quantitative data analysis. Many other statistical software packages exist for analysis of large data sets, including Stata, SPSS and EpiInfo. The manipulation of these software packages requires an expert.

Analysing monitoring data sometimes raises questions that require additional data collection. For example, if a programme has planned to reach 70 per cent of workplace employees through peer-education interventions within a year and, at the end of the year, the information compiled shows that the programme only achieved 10 per cent of its target, further analysis will have to be conducted to figure out why this happened and how to improve the situation.

After an analysis, programme staff or consultants should present the data in the form of a table or graph and write a narrative report. For more information on data analysis and use, programme planners can refer to the following web sites:

- http://www.popcouncil.org/pdfs/horizons/ORHIVHndbkIntro.pdf;
- http://www.fhi.org/NR/rdonlyres/i3iqcw5qda4tdclohfgdmqypsuvonddh3v5ptcc5xb334f56on7zdibh4umw4r6ttgpl7vhzl/31776textR1.pdf
References


6
Appendix

Contents

Appendix A: Sample workplace programme objectives and indictors

Appendix B: Sample monitoring forms for behaviour change communication programmes

Appendix C: Sample peer-education monitoring form for low-literacy peer educators
Appendix A: Sample workplace programme objectives and indicators

This set of objectives was developed within the framework of the ILO/USDOL HIV/AIDS Workplace Education Programme with the technical assistance of Management System International (MSI).

Development objective 1:
Reduced high-risk behaviour associated with HIV among targeted workers

- Number and percentage of targeted workers who report having fewer non-regular partners in the last 12 months
- Number and percentage of workers who report having used a condom during their last sexual encounter
- Number and percentage of targeted workers who report having sex with a non-regular partner in the last 12 months
- Among targeted workers who report having sex with a non-regular partner in the past 12 months, number and percentage who report using a condom the last time this occurred

Development objective 2:
Reduced level of employment-related discrimination against persons living with HIV/AIDS

- Number and percentage of people who have been open about their HIV-positive status who are retained on the job for more than one year
- Number and percentage of workers who request care and support services and are retained on the job for more than one year
- Number and percentage of worker complaints filed for employment-related discrimination against people living with HIV/AIDS (note that atmosphere of greater tolerance may result in more complaints at outset)
- Number and percentage of workplaces that do not require pre-employment HIV testing and that offer care and support services
- Number and percentage of targeted workers who report that they would fear losing their jobs if they were HIV-positive
Number and percentage of targeted workers who report that they would fear losing their jobs if they sought to obtain HIV counselling and testing services or information about such services

Number and percentage of targeted workers who report that they believe their employer keeps HIV-positive workers on the job

Number and percentage of targeted workers who report that they believe HIV-positive workers would be denied opportunities at the workplace

**Immediate objective 1:**
**Improved knowledge, attitudes and perception of norms related to high-risk behaviours associated with HIV**

Number and percentage of targeted workers who opt for healthy lifestyle (as evidenced by, for example, use of workplace recreation facility)

Number and percentage of targeted workers who correctly identify three or more modes of HIV transmission

Number and percentage of targeted workers who correctly identify three means of protection against HIV infection (having no penetrative sex, using condoms and having sex only with one faithful, uninfected partner)

Number and percentage of targeted workers who correctly identify three means of protecting against HIV infection from injecting drug use (switching to non-injectable drugs, avoiding sharing needles or syringes, and using sterile needles and syringes) [only where injecting drug use is an issue]

Number and percentage of targeted workers who correctly identify intoxication as a contributing risk factor [only where alcohol and drug use is prevalent]

Number and percentage of targeted workers who report that a person may get HIV by having unprotected sex with a person who looks healthy

Number and percentage of targeted workers who report a positive response to three aspects of condom use with a non-regular partner (attitude towards condom use, perceived norms for condom use, perceived skill in condom use).

**Immediate objective 2:**
**Increased use of available HIV/AIDS workplace services**

Number and percentage of targeted workers who report using specific services over the past 12 months
Immediate objective 3: Reduced stigma against persons living with HIV/AIDS

- Number and percentage of people living with HIV/AIDS actively involved in formal committees or groups at the workplace
- Number and percentage of targeted workers seeking HIV counselling and testing
- Number and percentage of targeted workers who indicate that a co-worker has told them he or she is HIV-positive
- Number and percentage of targeted workers who report an accepting or supportive attitude towards HIV-positive co-workers
- Number and percentage of targeted workers who report an accepting or supportive attitude towards HIV-positive persons outside the workplace

Immediate objective 4: Increased knowledge and understanding of HIV/AIDS workplace policies

- Number and percentage of targeted workers who report being aware that an HIV/AIDS policy exists at their workplace
- Number and percentage of targeted workers who correctly identify three or more of the key principles of the HIV/AIDS policy in their workplace
- Number and percentage of targeted workers/managers who report that HIV/AIDS policy is enforced at their workplace

Sub-immediate objective 1: Increased availability of HIV/AIDS workplace programmes

- Number and percentage of workplaces with HIV/AIDS services made available at or through the workplace

OR

- Number and percentage of workplaces with threshold number of HIV/AIDS programmes (threshold number to be defined)
- Optional: Quality of HIV/AIDS services delivered at the workplace
Sub-immediate objective 2: Improved workplace policies

- Number of workplaces that have incorporated 50 per cent of the principles of the ILO Code of Practice into their written HIV/AIDS policy
- Where the company uses employee contracts and/or collective bargaining agreements] Number of workplaces where recommended policy components appear in employee contracts or collective bargaining agreements

Sub-immediate objective 3: Increased levels of workplace collaboration and commitment by labour and management

- Number and percentage of targeted workers who have participated in the design and/or implementation of HIV/AIDS policy at the workplace
- Number and percentage of workplaces at which weekly/monthly management meetings address HIV/AIDS recommendations made by the workplace HIV/AIDS committee
- Number of workplaces that have a specific budget for implementation of HIV/AIDS programmes
- Number and percentage of workplaces with active joint committees addressing HIV/AIDS-related issues
- Number and percentage of workplaces that allocate official working hours for HIV/AIDS programme implementation
- Where there are worker organizations/representatives] Number and percentage of workplaces where the worker organization/representative has made a formal commitment to participate in the HIV/AIDS programme

Sub-immediate objective 4: Increased capacity of workplace to offer comprehensive HIV/AIDS policy and programmes on a sustained basis

- Number and percentage of workplaces with an HIV/AIDS resource person
- Number and percentage of workplaces that have a collaborative arrangement with external HIV/AIDS resource persons/organizations
- Number and percentage of workplaces in which an HIV/AIDS component is integrated into existing occupational safety and health services or human resources programmes
Appendix B: Sample monitoring forms for behaviour change communication programmes

Example 1: Programme monitoring form

Implementing organization:

Project title:

Month:_______/200..

Programme to reduce workplace discrimination in company X

<table>
<thead>
<tr>
<th>Performance indicators</th>
<th>Reporting month</th>
<th>Cumulative from when the project started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantitative methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of declared people living with HIV/AIDS who are retained on the job for more than one year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of worker complaints filed for employment-related discrimination against people living with HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of targeted workers who report that they would fear losing their jobs if they were HIV-positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of targeted workers who report that they would fear losing their jobs if they sought to obtain HIV counselling and testing services or information about such services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of targeted workers who report that they believe HIV-positive workers would be denied opportunities at the workplace</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Example 2:
Sample programme monitoring form for communication materials and services

Implementing organization:

Project title:

Month:_________/200..

Workplace programme in sugar factory

<table>
<thead>
<tr>
<th>Performance indicators</th>
<th>Reporting month</th>
<th>Cumulative from when the project started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of BCC materials developed (e.g., leaflets, posters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of copies of BCC materials produced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of articles in newspaper/newsletter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of radio spots aired (minutes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of radio spots aired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of community-based education/social events/exchange and sharing activities (e.g., theatrical performance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of attendees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments and suggestions:______________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Day _______ Month _______ Year 200 __

Project assistant’s signature _________________________
Appendix C: Sample peer-education monitoring form for low-literacy peer educators

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
<th>Session 7</th>
<th>Session 8</th>
<th>Session 9</th>
<th>Session 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/23</td>
<td>09:00</td>
<td>10:00</td>
<td>11:00</td>
<td>12:00</td>
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<td>17:00</td>
<td>18:00</td>
<td>19:00</td>
</tr>
<tr>
<td>01/02/23</td>
<td>09:00</td>
<td>10:00</td>
<td>11:00</td>
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</tr>
<tr>
<td>01/03/23</td>
<td>09:00</td>
<td>10:00</td>
<td>11:00</td>
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<td>14:00</td>
<td>15:00</td>
<td>16:00</td>
<td>17:00</td>
<td>18:00</td>
<td>19:00</td>
</tr>
</tbody>
</table>

*Note: The form includes spaces for various activities and discussions that occur during the sessions.*
Training in the Use of the HIV/AIDS Behaviour Change Communication Toolkit for the Workplace

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Five-day toolkit training agenda 6

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Day 3: Designing a Strategy 89

Day 4: Developing Materials 115

Day 5: Monitoring and Evaluation & Closing 143
Introduction

This is the seventh and last of the booklets that form the HIV/AIDS Behaviour Change Communication (BCC) Toolkit for the Workplace, produced for the International Labour Organization (ILO). Booklet 7 is a facilitators' guide to conducting a five-day training workshop on the development of HIV/AIDS workplace BCC programmes and the use of the toolkit. The workshop is designed for a target audience that includes representatives of non-governmental organizations that will be implementing the BCC component of an HIV/AIDS workplace programme, as well as representatives of employer organizations, worker organizations and government that will also play an active role in programme implementation. Ideally, participants will have some experience in BCC programming and/or HIV/AIDS training.

Workshop objectives

- To introduce participants to the toolkit resources and how to use them
- To increase understanding of the behaviour change process
- To increase the understanding, knowledge and skills required to plan, implement and manage a BCC HIV/AIDS programme for the workplace.

Workshop methodology

- Use of structured learning activities: presentations, group discussions, group work, role-playing and simulation exercises.
- High level of participation through active involvement of participants and small group work. Workshop participants will engage in a series of activities and exercises, allowing them to experience the steps involved in designing and implementing a targeted workplace BCC programme, using many of the resources available in the toolkit. The training is designed to take participants through this process, using the featured case study of a workplace programme in the Mumias Sugar Company in Kenya. Facilitators should use this case study unless a formative assessment has been conducted at a local workplace and the necessary data are available. Booklet 2 of the ILO/FHI Toolkit provides guidance on how to conduct this type of assessment.
- When the toolkit is used for actual implementation, formative assessments will be conducted at workplaces in targeted sectors prior to a BCC strategy design workshop (described in Booklet 3). During the workshop, participants will utilize the resulting formative assessment data to help design the BCC programmes that they will launch for their constituents.
Workshop logistics

Number of participants

To ensure a high level of participation, it is recommended that the number of workshop participants be limited to 30.

Training facilities, equipment, materials

Facilities: For the training session, it is preferable to have a room large enough to seat all participants and a seating plan that allows for face-to-face discussion. If possible, seat small groups of participants around tables facing the front of the room (in a horseshoe formation). Below is a suggested seating arrangement. It is very effective for both large group discussions and small group work. (Participants facing the back of the room for their group work simply turn their chairs around when they are in plenary.) This arrangement also makes it easier for the facilitators to monitor the work of the small groups.

Equipment and materials: The following equipment and materials are useful when organizing the course:

- Table-top name cards and participant name tags can help with introductions during the course. Facilitators should also distribute a list of participant names, addresses and affiliations at the start of the training session.
- An overhead projector and flipchart are essential for demonstrating key concepts and results of group work. Participants and facilitators can keep flipchart presentations in order to refer to points made in the course of the training. They can also detach important flipchart sheets and post them on the wall for easy reference. Facilitators may also want to make PowerPoint presentations, if the software and equipment are available.
- Coloured markers and masking tape can be useful for preparing presentations and posting them on walls.
How to use this booklet

The booklet provides practical guidelines to facilitators for implementing a five-day workshop to introduce participants to toolkit resources and how to use them. The booklet provides sample exercises for each day. The following are terms used throughout the workshop to define each session:

- **Time** indicates how long the session or activity should last.
- **Objectives** outline what the session aims to accomplish.
- **Materials** describe the equipment and supplies needed to conduct the session.
- **Room arrangement** indicates, where necessary, the most ideal set-up of furniture or materials for maximum participation or visibility.
- **Preparation** indicates any preparatory work that the facilitator may need to do in advance of the workshop.
- **Process** provides instructions to facilitators for working through each learning activity.

Facilitators can adjust the exercises and time frames presented in the booklet to suit the special needs and interests of participants and in accordance with the time available.

Copies of the toolkit should be distributed to workshop participants at the end of the workshop so as to maintain the element of surprise since many of the exercises used are drawn from the toolkit.

Good luck!
### Agenda

**DAY 1**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 8:45</td>
<td>Introduction</td>
</tr>
<tr>
<td>8:45 – 9:45</td>
<td>Objectives and expectations</td>
</tr>
<tr>
<td>9:45 – 10:30</td>
<td>The ILO’s response to HIV/AIDS. General presentation of the ILO Global Programme on HIV/AIDS and the World of Work, and the ILO Code of Practice</td>
</tr>
<tr>
<td>10:30 – 10:45</td>
<td>Break</td>
</tr>
<tr>
<td>10:45 – 12:45</td>
<td>HIV/AIDS in the world, the community and the workplace</td>
</tr>
<tr>
<td>12:45 – 1:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:45 – 2:15</td>
<td>Orientation on the BCC toolkit</td>
</tr>
<tr>
<td>2:15 – 3:15</td>
<td>Booklet 1: Overview of BCC Programming for the Workplace—Behaviour change process</td>
</tr>
<tr>
<td>3:15 – 4:30</td>
<td>Booklet 1: Overview—What is BCC?</td>
</tr>
<tr>
<td>4:30 – 4:45</td>
<td>Break</td>
</tr>
<tr>
<td>4:45 – 5:45</td>
<td>Booklet 1: Overview—Steps in BCC strategy development</td>
</tr>
</tbody>
</table>

**DAY 2**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>9:00 – 10:15</td>
<td>Sensitization and advocacy: Involving stakeholders</td>
</tr>
<tr>
<td>10:15 – 10:45</td>
<td>Stating programme goals</td>
</tr>
<tr>
<td>10:45 – 11:00</td>
<td>Break</td>
</tr>
<tr>
<td>11:00 – 12:15</td>
<td>Booklet 2: Gathering Data—Identifying and segmenting target populations</td>
</tr>
<tr>
<td>12:15 – 1:15</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:15 – 2:30</td>
<td>Booklet 2: Gathering Data—What do you need to know?</td>
</tr>
<tr>
<td>2:30 – 3:30</td>
<td>Booklet 2: Gathering Data—What existing information can you use?</td>
</tr>
<tr>
<td>3:30 – 3:45</td>
<td>Break</td>
</tr>
<tr>
<td>3:45 – 4:30</td>
<td>Booklet 2: Gathering Data—How to find the additional information required</td>
</tr>
<tr>
<td>4:30 – 5:30</td>
<td>Booklet 2: Gathering Data—Creating a formative assessment plan, part 1</td>
</tr>
</tbody>
</table>
## Agenda

### DAY 3

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>9:00 – 10:00</td>
<td>Booklet 2: Gathering Data—Creating a formative assessment plan, part 2</td>
</tr>
<tr>
<td>10:00 – 10:15</td>
<td>Session 1</td>
</tr>
<tr>
<td>10:15 – 11:30</td>
<td>Session 2: Designing a Strategy—Target audience</td>
</tr>
<tr>
<td>11:30 – 12:45</td>
<td>Session 3: Designing a Strategy—BCC objectives</td>
</tr>
<tr>
<td>12:45 – 1:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:45 – 3:30</td>
<td>Session 4: Booklet 3: Designing a Strategy—Key benefit statements and barriers</td>
</tr>
<tr>
<td>3:30 – 3:45</td>
<td>Break</td>
</tr>
<tr>
<td>3:45 – 5:15</td>
<td>Session 5: Booklet 3: Designing a Strategy—Effective messages</td>
</tr>
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</table>

### DAY 4

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>9:00 – 10:15</td>
<td>Session 1: Booklet 3: Designing a Strategy—Themes</td>
</tr>
<tr>
<td>10:15 – 10:30</td>
<td>Break</td>
</tr>
<tr>
<td>10:30 – 11:45</td>
<td>Session 2: Booklet 3: Designing a Strategy—Communication channels</td>
</tr>
<tr>
<td>11:45 – 12:45</td>
<td>Lunch</td>
</tr>
<tr>
<td>12:45 – 1:45</td>
<td>Session 3: Booklet 3: Designing a Strategy—Analysis of materials</td>
</tr>
<tr>
<td>1:45 – 3:00</td>
<td>Session 4: Booklet 4: Developing Materials</td>
</tr>
<tr>
<td>3:00 – 3:15</td>
<td>Break</td>
</tr>
<tr>
<td>4:00 – 4:15</td>
<td>Summary: A brief summary of the day’s activities</td>
</tr>
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</table>

### DAY 5

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 8:45</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>8:45 – 10:45</td>
<td>Session 1: Booklet 5: Peer Education</td>
</tr>
<tr>
<td>10:45 – 11:00</td>
<td>Break</td>
</tr>
<tr>
<td>11:00 – 12:00</td>
<td>Session 2: Booklet 6: Monitoring and Evaluation: Monitoring, part 1</td>
</tr>
<tr>
<td>12:00 – 1:00</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 – 2:00</td>
<td>Session 3: Booklet 6: Monitoring and Evaluation: Monitoring, part 2</td>
</tr>
<tr>
<td>2:00 – 3:00</td>
<td>Session 4: Booklet 6: Monitoring and Evaluation: Evaluation</td>
</tr>
<tr>
<td>3:00 – 3:15</td>
<td>Break</td>
</tr>
<tr>
<td>3:15 – 4:00</td>
<td>Session 5: Action planning</td>
</tr>
<tr>
<td>4:00 – 5:15</td>
<td>Session 6: Next steps</td>
</tr>
<tr>
<td>5:15 – 5:30</td>
<td>Session 7: Final evaluation and closing</td>
</tr>
</tbody>
</table>
# Day 1: BCC Strategy Development

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>8:30 – 8:45</td>
<td>Introduction</td>
</tr>
<tr>
<td>Session 2</td>
<td>8:45 – 9:45</td>
<td>Objectives and expectations</td>
</tr>
<tr>
<td>Session 3</td>
<td>9:45 – 10:30</td>
<td>The ILO’s response to HIV/AIDS. General presentation of the ILO Global Programme on HIV/AIDS and the World of Work, and the ILO Code of Practice</td>
</tr>
<tr>
<td>Break</td>
<td>10:30 – 10:45</td>
<td></td>
</tr>
<tr>
<td>Session 4</td>
<td>10:45 – 12:45</td>
<td>HIV/AIDS in the world, the community and the workplace</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
<td></td>
</tr>
<tr>
<td>Session 5</td>
<td>1:45 – 2:15</td>
<td>Orientation on the BCC toolkit</td>
</tr>
<tr>
<td>Session 6</td>
<td>2:15 – 3:15</td>
<td>Booklet 1: Overview of BCC Programming for the Workplace—Behaviour change process</td>
</tr>
<tr>
<td>Session 7</td>
<td>3:15 – 4:30</td>
<td>Booklet 1: Overview—What is BCC?</td>
</tr>
<tr>
<td>Break</td>
<td>4:30 – 4:45</td>
<td></td>
</tr>
<tr>
<td>Session 8</td>
<td>4:45 – 5:45</td>
<td>Booklet 1: Overview—Steps in BCC strategy development</td>
</tr>
</tbody>
</table>
Day 1, session 1: Introduction

**Objective**

By the end of the session, participants will understand why HIV/AIDS is a workplace issue.

**Process**

**Step 1**: (optional, 5 minutes). If possible, a local government official should say a few words to open the workshop.

**Step 2**: (10 minutes) Welcome participants and use some form of the introduction below to open the workshop.

Over 40 million people around the world are infected with HIV. At least 26 million are workers aged 15 to 49, in the prime of their working lives. The effects are felt by enterprises and national economies as well as workers and their families. HIV is a workplace issue and it should be treated like any other serious illness or condition in the workplace. This is necessary not only because it affects the workforce, but also because the workplace, as part of the local community, has a role to play in the broader struggle to limit the spread and effects of the HIV/AIDS epidemic.

In the most affected countries, the epidemic is eroding decades of development gains, undermining economies, threatening security and destabilizing societies. In sub-Saharan Africa, where the epidemic has already had a devastating impact, the crisis has created a state of emergency. Beyond the suffering it imposes on individuals and their families, the epidemic is profoundly affecting the social and economic fabric of societies. HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force, reducing earnings, and imposing huge costs on enterprises in all sectors through declining productivity, increasing labour costs and loss of skills and experience. In addition, HIV/AIDS is affecting fundamental rights at work, particularly with respect to discrimination and stigmatization aimed at workers and people living with, or affected by, HIV/AIDS. The epidemic and its impact strike hardest at vulnerable groups, including women and children, thereby increasing existing gender inequalities and exacerbating the problem of child labour.

Effective workplace programmes need the support of employers and their organizations, workers and their organizations, and government. They require the involvement of each of these groups in terms of programme development and implementation. We know that those of you who have come here today are committed to doing what you can to halt the
epidemic and, specifically, to ensure that effective programmes are implemented at the workplaces you represent. This workshop will give you the tools to do just that.

All of us have been affected by HIV/AIDS at the workplace. Let us take a minute to think about how we are affected.

If you have worked with someone who died of AIDS, please stand.

If you work with someone who is HIV-positive or has AIDS, please stand.

If you work with someone who has a family member who has died of AIDS, please stand.

If you work with someone who has a family member who has HIV or AIDS, please stand.

If you have had to take some responsibility for the child of a co-worker or employee who died of AIDS, please stand.

If you know of a worker who has been infected or affected by HIV/AIDS, please stand.

Now look around. We are all standing together.

Please be seated.

The ILO Global Programme on HIV/AIDS and, specifically, this workshop will familiarize you with the HIV/AIDS Behaviour Change Communication (BCC) Toolkit for the Workplace and prepare you to use it to initiate and manage behaviour change communication programmes at the workplaces that you represent. You will learn how the toolkit is structured and experience how it can be used.
Day 1, session 2: Objectives and expectations

**Objective**

By the end of this session, participants will have got to know one another and will understand the objectives of the meeting.

**Process**

**Step 1:** 35 minutes
- Invite participants to divide into pairs and obtain the following information from each other: Name, job title, organization and expectations of the workshop, as well as something that they like to do outside of work that most people do not know about. Participants then introduce their partner to the entire group. List participants’ expectations on a flipchart.

**Step 2:** 5 minutes
State the objectives of the workshop:
- To introduce participants to toolkit resources and how to use them
- To increase understanding of the behaviour change process
- To increase the understanding, knowledge and skills required to plan, implement and manage a BCC HIV/AIDS programme for the workplace.

**Step 3:** 10 minutes
- Compare the objectives to the group’s expectations. Reach a consensus on what will be achieved during the five-day workshop.

**Step 4:** 10 minutes
- Provide an overview of the agenda for the next five days and review the agenda for Day 1.
Day 1, session 3: The ILO’s response to HIV/AIDS

1 hour and 30 minutes

PowerPoint presentation or equivalent, depending on equipment available

Objective

By the end of this session, participants will have got to know one another and will understand the objectives of the meeting.

Process

Step 1: (45 minutes) If possible, a representative from the ILO should make a presentation on the ILO Global Programme and the World of Work, and the ILO Code of Practice. (Alternatively, the facilitator should present the ILO Programme.)

Step 2: (30 minutes) Presentation of the ILO technical cooperation project in the country where the workshop is held, by the ILO/AIDS National Project Coordinator.

Step 3: (15 minutes) The facilitator will review the key components of a comprehensive HIV/AIDS workplace programme and explain how the BCC toolkit fits into the overall programme objectives.
Day 1, session 4: HIV/AIDS in the world, the community and the world of work

**Process**

[Note: It is important for participants to talk about how underlying causes lead to high rates of HIV. For example, poverty can force some women to trade sex for material goods or favours (not necessarily prostitution), and it forces some rural men to go to cities to find work. When men are away from their wives and families for long periods of time, they may have sex with prostitutes or other women who have sex with many men. These men may become infected with HIV, then return home and have unprotected sex with their wives, who then also become infected. Poverty, in itself, does not cause HIV; however, it can be part of a vicious circle whereby individuals are forced to take risks that may expose them to HIV, which can, in turn, result in illness and even greater poverty. Looking at how the process works can help identify ways of interrupting this cycle.]
Day 1, session 4, activity 1: Agree/Disagree

**Process**

- Post the ‘AGREE’ and ‘DISAGREE’ signs at opposite sides of the front of the room.
- Read each of the statements given below and ask participants to go to the ‘AGREE’ or ‘DISAGREE’ sign, depending on their response to the statement. You may need to read the statement more than once. You may also put the statements on cards or small pieces of paper (see handout at the end of this activity, page XX), hand these out, and ask each participant to read the one he or she has.
- Ask one person from each side to explain why they responded the way they did.
- Repeat this process for each statement.

**Statements:**

1. About 40 million people worldwide are infected with HIV; more than half of them live in sub-Saharan Africa.
2. Very few people in the United States of America have HIV or AIDS.
3. Only people living in poor countries have HIV/AIDS.
4. Asia is not very affected by the HIV/AIDS epidemic.
5. All of Africa has a big HIV/AIDS problem.
6. Southern Africa has the most severe HIV/AIDS crisis of any region in the world.
7. HIV/AIDS is not a big problem in West Africa.
8. Eighty per cent of the children who have been orphaned by AIDS live in sub-Saharan Africa.
9. Two-thirds of AIDS-related deaths occur in sub-Saharan Africa.
10. All those living with HIV/AIDS around the world are receiving the treatment they need.
11. The number of new HIV infections worldwide has now been greatly reduced.
12. Men get infected with HIV more than women.
13. Only 20 per cent of people living with HIV/AIDS are of working age.

[Note: These statements can be modified to reflect the HIV/AIDS crisis in the country or countries of workshop participants. It may also be helpful to tell participants that these statistics came from the UNAIDS web site (www.unaids.org), where they may find data specific to their country.]

**Answers (to be read only after participants have provided their own answers and explanations to all statements):**

1. True. There are approximately 40 million cases of HIV infection worldwide and 25 million cases in sub-Saharan Africa.

2. False. While the HIV rate is lower in the United States than in other regions, about 1 million people are infected with HIV in that country.

3. False. Although poor countries are disproportionately affected, HIV/AIDS is not limited to these countries. There are approximately 1.6 million people living with HIV/AIDS in high-income countries. However, 95 per cent of new infections in 2003 occurred in low- or middle-income countries.

4. False. There were 1.1 million new HIV infections in Asia in 2003. With 5 million infections, India has the largest number of cases of HIV/AIDS outside of sub-Saharan Africa.

5. Hard to answer. HIV/AIDS is a major problem in Africa. However, certain regions have much higher infection levels than others.

6. True. However, other parts of the world have new infection rates that are increasing more quickly than the new infection rates in Southern Africa (e.g., some countries in Asia, some countries in Eastern Europe).

7. Hard to answer. HIV is more widespread in most parts of Southern Africa than in most parts of West Africa. But some countries of West Africa have high rates of HIV infection (e.g., Côte d’Ivoire and Nigeria).

8. True. Worldwide, in 2003, there were 15 million children who had been orphaned by AIDS, 12 million of them in sub-Saharan Africa.


10. False. In 2003, only 7 per cent of people needing antiretroviral therapy worldwide were receiving it.

11. False. In 2003, there were 14,000 new infections per day, worldwide.


13. False. Ninety per cent of those living with HIV/AIDS (or 36 million people) are of working age.
1. About 40 million people worldwide are infected with HIV; more than half of them live in sub-Saharan Africa.
2. Very few people in the United States of America have HIV or AIDS.
3. Only people living in poor countries have HIV/AIDS.
4. Asia is not very affected by the HIV/AIDS epidemic.
5. All of Africa has a big HIV/AIDS problem.
6. Southern Africa has the most severe HIV/AIDS crisis of any region in the world.
7. HIV is not a big problem in West Africa.
8. Eighty per cent of the children who have been orphaned by AIDS live in sub-Saharan Africa.
9. Two-thirds of AIDS-related deaths occur in sub-Saharan Africa.
10. All those living with HIV/AIDS around the world are receiving the treatment they need.
11. The number of new HIV infections worldwide has been greatly reduced.
12. Men get infected with HIV more than women.
13. Only 20 per cent of people living with HIV/AIDS are of working age.
Handout 2: ‘Agree/disagree’

1. True. There are approximately 40 million cases of HIV infection worldwide and 25 million cases in sub-Saharan Africa.

2. False. While the HIV rate is lower in the United States than other regions, about one million people are infected with HIV in that country.

3. False. Although poor countries are disproportionately affected, HIV/AIDS is not limited to these countries. There are approximately 1.6 million people living with HIV/AIDS in high-income countries. However, 95 per cent of new infections in 2003 occurred in low- or middle-income countries.

4. False. There were 1.1 million new HIV infections in Asia in 2003. With 5 million infections, India has the largest number of cases of HIV/AIDS outside of sub-Saharan Africa.

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11. False. In 2003, there were 14,000 new infections per day.


13. False. Ninety per cent of those living with HIV/AIDS (or 36 million people) are of working age.
Handout 3: Maps and graphs for session 4, activity 1

### Global estimates of HIV and AIDS as of end 2003

![World map showing HIV/AIDS estimates](image)

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>North America</td>
<td>1 000 000</td>
</tr>
<tr>
<td>Caribbean</td>
<td>430 000</td>
</tr>
<tr>
<td>Latin America</td>
<td>1 600 000</td>
</tr>
<tr>
<td>Eastern Europe &amp; Central Asia</td>
<td>1 300 000</td>
</tr>
<tr>
<td>South &amp; South-East Asia</td>
<td>6 500 000</td>
</tr>
<tr>
<td>North Africa &amp; Middle East</td>
<td>480 000</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>25 million</td>
</tr>
<tr>
<td>Total number</td>
<td>38 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>35.7 million</td>
</tr>
<tr>
<td>Women</td>
<td>17 million</td>
</tr>
<tr>
<td>Children &lt;15 years</td>
<td>2.1 million</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People newly infected with HIV in 2003</th>
<th>Total</th>
<th>4.8 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>4.1 million</td>
<td></td>
</tr>
<tr>
<td>Children &lt;15 years</td>
<td>630 000</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AIDS deaths in 2003</th>
<th>Total</th>
<th>2.9 million</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td>2.4 million</td>
<td></td>
</tr>
<tr>
<td>Children &lt;15 years</td>
<td>490 000</td>
<td></td>
</tr>
</tbody>
</table>

Source: UNAIDS/WHO 2004
Handout 3: Maps and graphs for session 4, activity 1


Source: UNAIDS/WHO, 2004
Handout 3: Maps and graphs for session 4, activity 1
Handout 3: Maps and graphs for session 4, activity 1

Young people (15–24 years old) living with HIV, by region, end 2003

- Sub-Saharan Africa: 62%
- Asia: 22%
- Eastern Europe & Central Asia: 6%
- High-income countries: 2%
- North Africa & Middle East: 1%
- Latin America & Caribbean: 7%

Total: 10 million

Source: UNAIDS/UNICEF/WHO, 2004
Handout 3: Maps and graphs for session 4, activity 1

Global resources needed for prevention, orphan care, care and treatment and administration and research 2004–2007 (in US$ million)

Source: UNAIDS, 2004

Projected annual HIV and AIDS financing needs by region, 2004–2007 (in US$ million)

Source: UNAIDS, 2004
Handout 3: Maps and graphs for session 4, activity 1

**Antiretroviral therapy coverage for adults, end 2003**
400 000 people on treatment: 7% coverage

Source: UNAIDS/WHO, 2004

**About 14 000 new HIV infections a day in 2003**

- More than 95% are in low- and middle-income countries
- Almost 2000 are in children under 15 years of age
- About 12 000 are in persons aged 15–49 years, of whom:
  - almost 50% are women
  - about 50% are 15–24 year olds

Source: UNAIDS/WHO, 2004
Day 1, session 4, activity 2: Creating family silhouettes and working through the scenarios

1 hour

Flipchart, index cards, markers, handout
4 of two family scenarios

Objectives

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

- explain the impact of HIV infection on individuals, families and the workplace, as well as the implications for workplace policies and programmes;
- explain that BCC functions in the context of commodities and services; and
- clarify the concept of the HIV/AIDS continuum of prevention, care and support.

Process

Step 1: (5 minutes) Tell participants that the point of this exercise is to better understand the impact of HIV/AIDS on individuals, families and workplaces. To do this, they will be looking at what happens over time to a family not affected by AIDS as compared to the same family when it is affected by AIDS.

Step 2: (15 minutes): Divide participants into groups of six people each. Give half of the groups a description of one family and the other half the description of the other family (see examples below). You can modify these descriptions to suit the country context. Have the groups project what each family’s situation will be in five years’ time (in the absence of AIDS).

Step 3: (15 minutes) Continuing in groups, ask participants to assume that one or two members of each family are infected with HIV, including the main breadwinner. Ask the groups to project what will happen to each family over a five-year period, given the dynamics of illness and discrimination. Also have groups project what impact this will have on their workplace.

Step 4: (20 minutes) Plenary discussion. Ask each group to present the family scenarios in plenary. Invite one group to draw out the implications for the workplace and for workplace policies and programmes. Ask reporters from other groups to provide any different responses or expand on the response from the first group, but to avoid repeating information that has already been shared.
Step 5: (5 minutes) Summarize the discussion, taking note of the impact of the HIV-positive employee on the workplace and on the family, in terms of stigma as well as care and support. Outline the services needed for a comprehensive HIV/AIDS programme – sexually transmitted infection services, voluntary HIV counselling and testing, links to services in the community.
Handout 4: Family scenarios

Family of a truck driver. Kwame Lamptey works as a long-distance truck driver for the Ghana Trucking Company. He mostly works the route between Accra and Abidjan and is away from home 50 per cent of the time. He has been working as a truck driver for this firm for 12 years. He is married in Accra to Nana, who is ten years younger and works in the local branch of a bank. They have three children – James, who is 15; Immaculate, who is 12; and Jennifer, who is turning nine. Kwame has two other ‘wives’ whom he visits regularly on his route. They are a happy and prosperous family, belong to the local church, and have hopes and aspirations for the future. They especially want to see their children educated and married well.

Family of a miner. Moses works in the mines in Botswana. He is away from home for three months at a time. He has been married for two years, and his wife is now pregnant with their first child. While at the mines, he spends his leisure time drinking with his buddies in the local town. He hopes to save enough money to open a business in his home town.
Day 1, session 5: Orientation on the BCC toolkit

**Objectives**

By the end of this session, participants will understand the purpose of the BCC toolkit and how to use it.

**Process**

**Step 1:** (20 minutes) Give presentation on the BCC toolkit using PowerPoint, an overhead projector or flipchart. (See presentation points on page 35.)

**Step 2:** (10 minutes) Conduct a brief question-and-answer session about the toolkit.
Presentation on the HIV/AIDS BCC Toolkit

Slide (or point) 1
The HIV/AIDS Behaviour Change Communication Toolkit for the Workplace

Slide (or point) 2
Why a BCC Toolkit?
- Complements the ILO Code of Practice
- Provides a step-by-step process for reaching workers with behaviour change communication programming for HIV/AIDS

Slide (or point) 3
Who are the intended users?
- Employers' organizations
- Workers' organizations
- Government
- ILO/AIDS National Project Coordinators
- Non-governmental organizations

Slide (or point) 4
What is BCC?
Behavior change communication is:
- an interactive process with communities
- integrated into an overall programme
- made up of tailored messages and approaches using a variety of communication channels
- intended to promote positive and sustained behaviour change

Slide (or point) 5
What is the role of BCC in behaviour change?
- To inspire behaviour change that is then sustained long term
- To stimulate dialogue
- To create demand for information and services
- To promote advocacy
- To increase knowledge
- To reduce stigma, fear and discrimination
- To promote services for prevention and care
Slide (or point) 6
What are the steps involved in developing a BCC programme?
- Step 1: Advocacy and stakeholder involvement
- Step 2: Identification and segmentation of the identified target populations
- Step 3: Formative BCC assessment to find out why people behave the way they do
- Step 4: Development of a BCC strategy

Slide (or point) 7
What are the steps involved in developing a BCC programme? (continued)
- Step 5: Development of communication support materials
- Step 6: Implementation of the BCC strategy and activities – peer education, training programmes, workplace events
- Step 7: Monitoring and evaluation
- Step 8: Feedback and revision

Slide (or point) 8
How can the BCC toolkit help with these steps?
- It provides tools for developing the elements of a BCC programme
- It provides tips, learning activities, sample forms, and case studies from different workplace programmes
- It enables BCC practitioners to learn how to use of the toolkit

Slide (or point) 9
Booklet 1: Overview of Behaviour Change Communication Programming for the Workplace
- Provides an overview on behaviour change communication
- Highlights the key steps involved in implementing a BCC programme
- Introduces the implementation tools
- Provides a case study on using the toolkit

Slide (or point) 10
Booklet 2: Gathering Data
- Provides a step-by-step approach to gathering data at the workplace for the development of BCC programming
- Provides generic formative assessment guides that can be easily adapted to each workplace setting

Slide (or point) 11
Booklet 3: Designing a Strategy
- Provides a facilitators’ guide for a participatory workshop to develop a BCC strategy for the workplace
- Provides guidance for a BCC practitioner on the elements needed for a BCC strategy
Slide (or point) 12
Booklet 4: Developing Materials
A step-by-step process for developing printed matter to support a BCC strategy, including tips on:
- materials development;
- pre-testing; and
- design.

Slide (or point) 13
Booklet 5: Peer Education
- Provides guidance to peer educators for the development of workplace peer-education programmes and the preparation and training of peer educators
- Includes a set of guidelines for peer educators on how to organize and conduct peer education
- Provides a generic peer-education-training manual that can be adapted for local settings

Slide (or point) 14
Booklet 6: Monitoring and Evaluation
Simple-to-use monitoring and evaluation tools linked to behaviour change communication objectives

Slide (or point) 15
Booklet 7: Training on the Use of the Toolkit
A facilitators’ guide to training BCC practitioners on the use of the toolkit
BCC programmes are one component of a comprehensive HIV/AIDS programme as outlined in the ILO Code of Practice, and they include:
- care and treatment;
- voluntary HIV counselling and testing; and
- support policies.
Day 1, session 6: Behaviour change process

Objectives

By the end of the session, participants will understand the process of behaviour change.

Process

Step 1: Plenary discussion (10 minutes)

- Discuss the issue of people engaging in different behaviours and how they may seek to change or modify them in the course of their lives.
- Ask for examples from participants’ lives that may represent personal examples of health-related behaviour change (e.g., those relating to eating habits, smoking, drinking, exercise).
- Next, ask participants to give examples of how they made those changes, what factors helped them, and what factors hindered them.
- Now that you have some examples from participants, pick two participants who successfully changed a behaviour (not related to sex or sexuality) for the group exercise. Be sure to place the two individuals in separate groups.

Step 2: Small group work (20 minutes)

- Divide the participants into two groups. Have the members of the group ‘interview’ the volunteer. They should ask the following questions:
  - What was the behaviour you wanted to change?
  - Why did you decide on that behaviour?
  - Why did you want to change this behaviour?
  - What were your strategies (a systematic plan) and tactics (actions designed to accomplish the plan) for changing your behaviour?
  - What resources did you use (family, friends, support groups)?
  - What problems did you run into?
  - In what ways did you succeed?
  - How did you track your achievements?
  - What explicit or implicit theory guided all of your plans and actions?
Step 3: Group presentations (15 minutes)
- Ask each group to present their findings.

Step 4: Plenary discussion (15 minutes)
- End this session by asking questions about HIV-related behaviour change. Ask the whole group to identify one or two behaviours that, if changed, might prevent infection. What barriers might there be to changing these behaviours?
- Write the behaviours and barriers on flipcharts and save these pages for the next session.
Day 1, session 7: What is behaviour change communication?

**Objectives**
By the end of this session participants will be able to:

- define behaviour change communication; and
- distinguish behaviour change from behaviour change communication.

**Process**

**Step 1:** (30 minutes) Brainstorming and discussion. Tell participants that the goal of the exercise is to arrive at a shared definition of behaviour change communication and to understand the difference between behaviour change and behaviour change communication.

Ask participants for ideas or phrases that come to mind when they think about behaviour change for HIV/AIDS prevention, care and support. List their responses on the flipchart with the heading, “What is Behaviour Change?”.

- Post (or show slide of) the following definition of behaviour change.

**Behaviour change** means modifying practices to reduce the risk of HIV transmission, reduce discrimination, and support workers who are living with HIV/AIDS.

- Ask participants to compare and contrast their ideas with the definition. Highlight accurate concepts and point out any elements that were missing from ideas mentioned by participants.
- Ask participants for ideas or phrases that come to mind when they think about behaviour change communication for HIV/AIDS prevention, care and support. List their responses on the flipchart with the heading, “What is Behaviour Change Communication?”.
- Post (or show slide of) the following definition of behaviour change communication.

**Behaviour change communication:**

- is an interactive process carried out with communities;
- is integrated into an overall programme;
- develops tailored messages and approaches using a variety of communication channels; and
- aims to promote behaviour change that is sustained long term.

Two flipcharts, on stands (one with the heading, “What is Behaviour Change?” the other with the heading, “What is Behaviour Change Communication?”); definitions of behaviour change and behaviour change communication on flipchart or PowerPoint slide; and PowerPoint slides and projector or PowerPoint information on overhead slides and overhead projector or PowerPoint information on flipcharts.
Day 1

- Ask participants to compare and contrast their ideas with the definition. Confirm accurate concepts and point out any elements that were missing from ideas mentioned by participants.
- Highlight the key difference between behaviour change as a goal to reduce high-risk practices and behaviour change communication or the strategies to encourage changes in behaviours that increase the risk of HIV.
  - Ask participants for an example of a behaviour that they would like to change in order to reduce the risk of HIV infection (e.g., having sex without a condom).
  - Ask for an example of a behaviour change communication activity that you might implement to try to inspire your target audience to change their high-risk behaviour (e.g., promoting condom use through peer-education sessions with coworkers).

Step 2 (15 minutes):

- Highlight the following points, and ask the group for one example to illustrate each one:
  - The role of behaviour change communication is to:
    - inspire and sustain behaviour change;
    - stimulate dialogue;
    - create demand for information and services;
    - promote advocacy for improved HIV/AIDS services and programmes;
    - increase knowledge;
    - reduce stigma, fear and discrimination; and
    - promote existing services for prevention and care.

  Examples may include:
  - promoting condom use;
  - promoting safer injection practices;
  - encouraging prompt and appropriate treatment of sexually transmitted infections;
  - changing perceptions about the importance of obtaining HIV counselling and testing;
  - stimulating discussion between parents and children about the risks of HIV/AIDS; and
  - promoting policies at the workplace that protect against discrimination.

- Conclude by stating that behaviour change communication relates to all of these things. It should not be a collection of isolated communication tactics, but rather a framework of linked approaches that function as part of an ongoing and interactive process.
Day 1, session 8: Steps in developing a BCC strategy

**Objectives**

By the end of the session, participants will understand the steps involved in developing a BCC programme.

**Process**

**Step 1:** Explanation of the steps involved in developing a BCC strategy (15 minutes)

- Explain to participants that developing a plan is essential to the success of BCC activities. Each step of the plan should take place in a particular order.
- Distribute the handouts for the exercise (background information on the Mumias Sugar Company and corresponding questions). Explain that this case study will be used throughout the training to illustrate the different steps involved in designing a BCC strategy. Tell participants that they will be receiving multiple handouts and worksheets on the Mumias Sugar Company during the week and that they should save these handouts each day and keep them together because they will be used throughout the training. Have participants take a few minutes to read the background information.
- Ask the group to read the handout questions and think about the steps involved in creating a BCC programme:
  - What is the first thing you need to do/consider?
  - What behaviours, engaged in by the workers and community residents, would affect their risk of getting HIV? Why?
  - Which behaviours might you want to try to influence? How will you decide?
  - Who would benefit from a BCC programme?
  - Who is the audience?
  - What do you need to know about the audience, the workplace and related issues?
  - How will you reach your audience?
  - What materials will you use?
  - What methods will you use?
  - What results do you expect?
  - How will you know whether your plan is working?
Step 2: Small group work (15 minutes)
- Divide participants into groups of six.
- Distribute a marker and eight sheets of paper (8 ½” x 11” or A4 format) to each group.
- Explain the exercise. Ask the groups to brainstorm about the steps involved in creating a BCC programme. Tell them there are eight steps. When they have identified the eight steps, ask them to write each one on a piece of paper. Instruct them to write the steps using few words and large letters so they can be seen when posted on the wall. They should then order the steps according to how they plan to implement their programme.

Step 3: Group discussion (15 minutes)
- Ask a representative of each group to post the group’s set of steps. Post steps parallel to each other. Try to get a consensus on what the correct steps and sequence should be.

Step 4: If there is an ILO technical cooperation project in the country, explain how steps identified by participants fit into the ILO project strategy and workplan (15 minutes).

Steps for developing a behaviour change communication programme
1. Advocacy and stakeholder involvement
2. Identification and segmentation of the identified target populations
3. Formative BCC assessment to find out why people behave the way they do
4. Development of a BCC strategy
5. Development of communication support materials
6. Implementation of the BCC strategy and activities—peer education, training programmes, workplace events
7. Monitoring and evaluation
8. Feedback and revision

Step 5: Refer participants to Booklet 1: Overview of HIV/AIDS Behaviour Change Communication Programming for the Workplace for more information on the behaviour change process and the steps for developing a behaviour change communication programme.
Handout 5: Background information on the Mumias Sugar Company, for day 1, session 8

Instructions: Read the background information about the Mumias Sugar Company. Your task is to identify the eight steps involved in the development of a behaviour change communication programme for the company. Use the list of questions about developing a behaviour change communication programme to brainstorm about the list of steps you might take. When your group has reached a consensus on the eight steps, write each step on a piece of paper using few words and large letters so that the steps can be easily read when posted on the wall. Then order the steps according to how you plan to implement the programme.

Mumias Sugar Company, Western Kenya

Kenya is one of many African nations with a serious HIV epidemic. The HIV prevalence nationwide is estimated to be 6.7 per cent (9 per cent among women and 5 per cent among men) (Central Bureau of Statistics, 2003). Despite the lower-than-expected figure, the infection is still a generalized epidemic in Kenya, and efforts to bring it under control remain an urgent matter. One dramatic impact of AIDS-related deaths is the decline in life expectancy. The Kenya Central Bureau of Statistics estimates that, without AIDS, life expectancy at birth would be about 65 years. However, because of the large number of AIDS-related deaths, it is actually only about 46 years and may decline to 45 years by 2010. Thus, almost 20 years of life expectancy have already been lost because of AIDS.

The Mumias Sugar Company is the largest single sugar factory in Kenya, with 2,500 employees. Starting as a government-owned enterprise in the early 1970s, Mumias Sugar Company has since been privatized and is listed on the Nairobi Stock Exchange. The company feels that it is time to consider implementing a comprehensive HIV/AIDS workplace initiative.
Handout 6: Questions on developing a behaviour change communication programme

Try to answer the following questions about developing a BCC strategy. Use your answers to these questions to guide you in formulating a list of steps for designing a BCC programme.

1. What is the first thing you need to do/consider?
2. What behaviours do the workers at the Mumias Sugar Company engage in that affect their risk of getting HIV/AIDS? Why?
3. Which behaviours might you want to try to influence? How will you decide?
4. Who would benefit from a BCC programme?
5. Who is the audience?
6. What do you need to know about the audience, the workplace and related issues?
7. How will you reach your audience?
8. What materials will you use?
9. What methods will you use?
10. What results do you expect?
11. How will you know whether your plan is working?
# Day 2: Gathering Data

<table>
<thead>
<tr>
<th>DAY 2</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of day 1</td>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>Session 1</td>
<td>9:00 – 10:15</td>
<td>Sensitization and advocacy: Involving stakeholders</td>
</tr>
<tr>
<td>Session 2</td>
<td>10:15 – 10:45</td>
<td>Stating programme goals</td>
</tr>
<tr>
<td>Break</td>
<td>10:45 – 11:00</td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td>11:00 – 12:15</td>
<td>Booklet 2: Gathering Data—Identifying and segmenting target populations</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:15 – 1:15</td>
<td></td>
</tr>
<tr>
<td>Session 4</td>
<td>1:15 – 2:30</td>
<td>Booklet 2: Gathering Data—What do you need to know?</td>
</tr>
<tr>
<td>Session 5</td>
<td>2:30 – 3:30</td>
<td>Booklet 2: Gathering Data—What existing information can you use?</td>
</tr>
<tr>
<td>Break</td>
<td>3:30 – 3:45</td>
<td></td>
</tr>
<tr>
<td>Session 6</td>
<td>3:45 – 4:30</td>
<td>Booklet 2: Gathering Data—How to find the additional information required</td>
</tr>
<tr>
<td>Session 7</td>
<td>4:30 – 5:30</td>
<td>Booklet 2: Gathering Data—Creating a formative assessment plan, part 1</td>
</tr>
</tbody>
</table>
Day 2, session 1: Sensitization and advocacy: Involving stakeholders and other key people

[Note: Explain to participants that the following sections of the toolkit explore each step of the BCC process.]

Objectives

By the end of this session participants will:
- understand the important roles that stakeholders and other key people play in the success of a behaviour change communication intervention; and
- understand what can be done to promote collaboration with stakeholders and other key people.

Process

Step 1: Begin by telling the participants that the goal of this exercise is to enhance their understanding of how advocacy and collaboration with stakeholders and other key people can play a pivotal role in the success of their behaviour change communication intervention.

Step 2: Presentation and group discussion (15 minutes)
- Tell participants that you will begin by defining some terms. As you introduce each word or concept, post the appropriate image (see below) as you explain it. Post the images above a flipchart page posted on the wall.
- Tell participants that you will begin by defining some terms. As you introduce each word or concept, post the appropriate image (see below) as you explain it. Post the images above a flipchart page posted on the wall.
- **Stakeholder**: The word ‘stakeholder’ was originally a gambling term, which referred to the person who held the stakes, or wagers, of (for example) two people who were gambling on a horse to win a race. ‘Stakeholder’ has now come to mean a person, group or institution with an interest in the outcome of a particular programme or initiative.

- **Decision-maker**: Here, we are speaking of the person, group or institution with the power to make significant decisions about particular issues, such as those relating to company policies, procedures and budget, for example.

- **Gatekeeper**: Literally, this term refers to the person who guards the entrance to a building, or has power to let certain people through a gate to a protected property. The term is also used metaphorically to designate the person, group or institution with the authority to allow (or not allow) something to happen.

Tell participants that these are key people with whom they can collaborate to ensure the success of a behaviour change communication programme.

- **Other key people include:**
  - Influential people/opinion leaders: These are people or institutions that can influence the behaviour of significant numbers of other people, including target populations.
  - Policy-makers: These are the people or institutions in charge of establishing official policies within organizations or at government, regional or community level.
Step 3: Small group work (15 minutes)

- Divide participants into groups of six.
- Distribute a set of index cards to each group. (See cards on pages 54 to 56. You should photocopy and cut up enough sets of cards for each group prior to this activity.) The cards will have examples of categories of people on them (e.g., workers, spouses, girlfriends, boyfriends, sex workers, workplace managers, workplace owners, union leaders, local health officials, religious leaders, health-care providers, children of workers, representatives from Family Health International, UNAIDS and the ILO, elected officials [local], elected officials [national]).
- Distribute the two handouts on the National Bank of Ghana (see pages 57 to 59).
- Have the groups place the cards on the flipchart page where they think they belong (stakeholder, decision-maker, gatekeeper, etc.) Give them about five minutes to do this.
- Sample results are listed in the chart below. Ask participants to note that certain people may play a different role depending on the situation. For example, the owner of a large company may be able to impact policy, make decisions on budgets for workplace programmes and prevent certain activities from taking place in the company (or serve as a gatekeeper).

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Decision-maker</th>
<th>Gatekeeper</th>
<th>Influential people/opinion leaders</th>
<th>Policy-maker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worker</td>
<td>Manager</td>
<td>Owner</td>
<td>Manager</td>
<td>Owner</td>
</tr>
<tr>
<td>Spouse</td>
<td>Owner</td>
<td>Union leader (national)</td>
<td>Union leader (local)</td>
<td>Union leader (national)</td>
</tr>
<tr>
<td>Sex worker</td>
<td>Union leader</td>
<td>Elected officials</td>
<td>Health workers</td>
<td>Elected officials (national and local)</td>
</tr>
<tr>
<td>Boyfriend</td>
<td>Elected officials</td>
<td></td>
<td></td>
<td>Local health officials</td>
</tr>
<tr>
<td>Workers with HIV/ AIDS</td>
<td></td>
<td></td>
<td></td>
<td>Elected officials</td>
</tr>
<tr>
<td>People living with HIV/AIDS</td>
<td></td>
<td></td>
<td>FHI representative</td>
<td></td>
</tr>
<tr>
<td>Female workers</td>
<td></td>
<td></td>
<td>Religious leaders</td>
<td>National health officials</td>
</tr>
</tbody>
</table>

- Now have the groups refer to the National Bank of Ghana case study. Have them determine who the stakeholders, decision-makers, gatekeepers, opinion leaders and policy-makers are.
- In plenary, discuss the following points:
  - Why did some people end up in a particular category?
  - Do some people belong in multiple categories?
  - Reach consensus on who belongs where.
  - What are the possible consequences of not advocating to, or involving, these key people early and at each step of the programme?
Sample responses include the following:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Decision-maker</th>
<th>Gatekeeper</th>
<th>Influential people/opinion leaders</th>
<th>Policy-maker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workers</td>
<td>Management</td>
<td>Management</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>People living with HIV/AIDS at the bank</td>
<td>Bank owner</td>
<td>Health-care providers</td>
<td>Local NGO</td>
<td>Community health centre where employees may go for HIV/AIDS services</td>
</tr>
<tr>
<td>Inspectors, auditors, drivers, laboratory workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 4: Discussion (10 minutes)**

- Invite a few participants to share some of their experiences or those of their colleagues (about behaviour change communication programmes or other programmes), by asking, “Would anybody like to share an experience of a situation in which key stakeholders, policy-makers, decision-makers, opinion leaders or gatekeepers were not approached or not included in a process, and what effect or impact that had on the success of the programme?”
- Tell participants, “So you can see why it is best to include these people on your ‘team’ very early on in the design and development stages, and throughout the implementation of the programme and evaluation stages, as well. If you do not advocate BCC HIV/AIDS programmes, your workplace may never have such a programme.”

**Step 5: Small group work (20 minutes)**

- Divide participants into small groups to discuss the stakeholders’ relations for different target groups (e.g., managers, cashiers, secretaries, mechanics, etc.). Limit the number of target populations to 4 or 5.
- Ask each group to divide a sheet of flipchart paper into quarters, as depicted below.
- Now ask each group to think silently for a moment about stakeholders – individuals and organizations – that could help them reach out to, and conduct interventions and programmes on behaviour change with, their specific target population.
- After allowing for a few moments of reflection, tell the groups that they will have 15 minutes for the next part of the exercise, which involves:
  - selecting four of these important stakeholders;
  - writing the name of each in the top of a quadrant on their flipchart paper; and
  - under each name, listing the strategies they will use to approach these stakeholders and secure their collaboration.

[Note: While groups are working, circulate among them. If they get stuck on one part of the activity, encourage them to, for example, just select any four stakeholders they have]
been discussing, then move on to list a few strategies in a quadrant they have not filled in. Five minutes before the end of the allotted time for this activity, visit each group and let them know that the time is almost up. When the 20 minutes are up, reconvene the large group. Repeat this process for all small group activities.]

**Step 6:** Small group presentations and discussion (15 minutes)

- Ask for one volunteer from each group to present the results of that group to participants.
- Have each one come to the front of the room and help them post their flipchart paper on the wall.
- Thank each presenter and, between each presentation, encourage participants to briefly point out strategies or issues that made them think or that they feel would be particularly interesting or effective.

**Step 7:** Summary statement

- Tell participants, “As we have learned, and as many of us have experienced in our lives or in our work, involving stakeholders, opinion leaders, decision-makers, policy-makers and gatekeepers at every level of a behaviour change communication programme (from initial planning and design, through implementation and evaluation) can be the key to ensuring the success and effectiveness of the programme. Discussing strategies, activities and partnerships with a view to involving these key players is an essential first part of your programme.”
Photocopy and cut up the following to make cards for use in step 3 of day 2, session 1.

- Worker
- Spouse
- Girlfriend
- Boyfriend
- Sex workers
- Managers
- leaders(local)
- Union leaders
  (national)
Photocopy and cut up the following to make cards for use in step 3 of day 2, session 1.

<table>
<thead>
<tr>
<th>Union leaders (national)</th>
<th>Health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children of workers</td>
<td>Families of workers</td>
</tr>
<tr>
<td>UNAIDS rep.</td>
<td>ILO rep.</td>
</tr>
<tr>
<td>Elected officials (national)</td>
<td>Elected officials (local)</td>
</tr>
</tbody>
</table>
Photocopy and cut up the following to make cards for use in step 3 of day 2, session 1.

<table>
<thead>
<tr>
<th>Religious leaders</th>
<th>Local health officials</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health officials</td>
<td>People living with HIV/AIDS</td>
</tr>
<tr>
<td>Workers with HIV/AIDS</td>
<td>Family Health International rep.</td>
</tr>
<tr>
<td>Co-workers</td>
<td>Female workers</td>
</tr>
</tbody>
</table>
In 1996, the National Bank of Ghana became a publicly owned institution. The Bank specializes in consumer banking and home credit services for middle- and lower-middle-income customers. The Bank has a staff of 2,100, with a 130 branches.

Among the core values that guide the Bank in its operations are the recruitment and retention of the best human resources to carry out its mandate, and to ensure that staff are well motivated and have a work environment that is conducive to employees’ good health. These values and policies are a demonstration of the Bank’s commitment to its employees as one of its key stakeholders.

In recent years, HIV has spread in the country and among the workforce. There is an estimated adult HIV prevalence rate of 3.6 per cent in Ghana, with 360,000 people living with HIV and 52,961 AIDS cases. As many as 28,000 Ghanaians have already died as a result of the epidemic. The national HIV prevalence rate is projected to increase to 9.5 per cent by the year 2014, if the current trend continues. The peak ages for infection are 25–29 years for females and 30–34 years for males—the age groups representing the most productive segment of the population.

Currently, there are nine recorded cases of HIV infection among Bank workers. Cases were diagnosed when workers sought care at the staff clinic. Faced with the threat of increased AIDS-related illnesses, the loss of experienced personnel, reduced productivity and increased medical expenditures for the company, the workers and their families, the Bank has decided to introduce a workplace HIV/AIDS behaviour change communication programme, which would be aimed at providing staff members with correct information on HIV transmission and prevention and the promotion of healthy behaviours. In order to develop a programme that meets the needs of the workforce, the Bank will conduct a workplace assessment.
Susceptible employees

Employees who are most vulnerable to HIV are those who transfer, leaving their spouses behind. Respondents mentioned, inspectors, auditors and drivers, who very often travel outside their station. The Bank’s health-care personnel (especially the laboratory staff and those in the treatment room who handle sharp instruments, specimens, needles and syringes) were also mentioned. A few expressed the opinion that senior male employees coerce young women, particularly employees who were assisted to get a job or promotion, into having sex.

People living with HIV/AIDS at the Bank

Further investigation indicated that, within the past nine years, nine staff members have tested positive: six males and three females. However, no reliable data exist on the HIV prevalence in the workforce. Most staff members do not know their HIV status, but are reluctant to undergo a test. Those who may know their status would not disclose it, for fear of being stigmatized.

Available health-care services

The Bank has a clinic that all employees and their dependants are entitled to use for medical care services. It provides treatment, laboratory services and referral services, but no specific HIV/AIDS interventions. Records at the clinic indicate that a monthly average of seven employees—both male and female—report to the clinic with a sexually transmitted infection.

HIV-prevention interventions

The clinic has placed an order for educational aids regarding condoms. They have also acquired a few educational videos on HIV/AIDS to be shown in the clinic waiting room. There is no HIV/AIDS policy at the Bank.

Print media and meetings

Members of the Bank administration have suggested that workplace HIV/AIDS education could be made part of in-house programmes, such as weekly staff meetings and tutorials at all branches, and the Quarterly Zonal Review Meetings.

Training programmes

The Bank has its own training school where members of the Board and all categories of staff (except non-core workers) are given the opportunity to attend in-house training programmes once a year in practical banking issues, depending on the training needs of the individual.
Canteen
The Bank has a canteen, which all staff members use.

Religious beliefs and practices
There is no evidence that employees’ beliefs and practices would present an obstacle to HIV programming.
Day 2, session 2: Stating programme goals

Objectives
By the end of the session, participants will be able to:
- state the goal of a BCC programme; and
- understand how the BCC strategy is tied to other elements of the overall workplace programme.

Process

Step 1: (20 minutes)
- In plenary, ask participants for examples of the goals for the ILO technical cooperation project in the country.
- Explain that the goals are the overall outcomes one hopes to achieve through a programme, while objectives are the concrete accomplishments to be attained. The objectives should be ‘SMART’: Specific (involving only one thing at a time), Measurable (so that you can measure to what extent your accomplishments have been attained), Achievable (given the timeframe and available resources), Realistic (with parameters that are not too ambitious for the programme to be successful), Time-bound (with a specific timeframe). (See booklet 6 page 6 for more examples of SMART objectives.)
- Explain that behaviour change communication objectives need to be developed in the context of overall programme goals. Goals are developed from:
  - HIV/AIDS behavioural data;
  - epidemiological data; and
  - the HIV/AIDS-situation assessment.

For example, the overall goal stated in the national HIV/AIDS strategic plan may be to reduce the prevalence of HIV among the workforce. A national BCC goal may be to increase the demand for condoms among the workforce. Based on this goal, a SMART BCC objective might be to increase the demand for condoms by 25 per cent over a one-year period among the workers of the target enterprises.

The facilitator should tell the participants that more information about behaviour change (BC) and behaviour change communication (BCC) objectives will be provided in the following sessions.
Day 2

- The function of programme goals is:
  - to provide an organizing principle or focus around which to design a programme; and
  - to organize measurable objectives.

Step 2: (10 minutes) In plenary, use a programme goal that one of the participants has suggested. Invite the group to brainstorm about BCC objectives for this programme goal.
Day 2, session 3: Identifying and segmenting target populations

**Objectives**

By the end of this session participants will:
- understand the definitions of and distinguish between primary and secondary target populations; and
- understand why and how they should segment populations.

**Room arrangement**

Small group tables.

**Process**

**Step 1:** Presentation (45 minutes). Incorporate the following points into a presentation for participants.
- The goal of this exercise is to understand what primary and secondary target populations are, and to know how to segment those populations into smaller groups, as necessary. Target groups should have similar needs, behaviours and levels of knowledge. Dividing populations into segments facilitates the design and delivery of appropriate programmes for specific groups.
- ‘Target population’ refers to a population for which a specific programme is designed. The population is identified on the basis of epidemiological and other data that outline:
  - their risks and vulnerabilities to HIV/AIDS;
  - their influence on others at risk;
  - the impact of the virus on their lives; and
  - donor considerations and available resources.
Assessing the HIV/AIDS prevention, care and support needs of potential target populations is crucial. This information (as well as more practical information on the available human, financial and material resources and capacities) will guide decisions about:

- the objectives of the communication strategy;
- the communications approach;
- the content of the messages that are to be communicated; and
- the stakeholders.

In essence, the careful description and definition of target populations determine the appropriateness and effectiveness of communication programming.

Introduce the concepts of ‘primary population’ and ‘secondary population’, and post sheets of paper on the wall or flipchart to illustrate how the primary population (top sheet) can be sub-divided into secondary populations (bottom two sheets), as per the graphic below:

**Step 2 (15 minutes):** Distribute one set of index cards to each group. Ask the groups to post the cards with the names of the key groups identified earlier (stakeholders, policymakers, etc.) under primary or secondary target populations.

Tell participants that, to be most effective, communication programming must target a variety of people.

Define primary and secondary target populations for participants:

- Primary target population: This is the main group of individuals whose behaviour a particular programme aims to influence and support. In the context of a BCC strategy, the primary target population is the group of workers for whom the strategy is designed—e.g., secretaries, laboratory technicians, miners, etc.
- Secondary target population: This population is affected by BCC activities, even though the activities were not specifically designed with a view to reaching them.

The design of behaviour change communications strategies should consider secondary populations. BCC design can sometimes have an adverse effect on secondary populations. The design can also win their support or incite a negative response, making a difference in whether or not the primary audience responds to the communication messages.

Secondary populations can include opinion leaders (e.g., government officials), policymakers and/or relatives, friends and actual or potential sexual partners of the primary target population.

Secondary populations can also include those who are vulnerable, at risk and associated with the primary audience, but who are not necessarily the main beneficiaries of the BCC intervention. If vulnerable men were identified as the primary target population, then their wives and/or girlfriends might be a secondary population.

Secondary populations can also include gatekeepers—people who may influence the primary audience and often have some kind of power over them. Gatekeepers may also include those whose support or neglect can make a difference in whether the primary audience responds to the communication messages. For example, if the primary target population is secretaries, their bosses might be considered the gatekeepers.
Whether they are primary or secondary target populations, all of these people have a stake in the outcome of BCC HIV/AIDS programmes for the workplace and thus constitute stakeholders. The more communication strategies are designed to understand them, include them and involve them, the more successful and sustainable these strategies will be.

**Step 3 (15 minutes):** Now review participants’ index cards and discuss their choices for primary and secondary populations. Help them come to a consensus.

**Step 4: Small group work (20 minutes)**

- Divide participants into small groups. Ask them to refer to the description of the Mumias Sugar Company, handout 5, on page 45.
- Ask the groups to answer the following questions (prepared ahead of time on a flipchart):
  - Who is the primary target population?
  - Who is/are the secondary target population(s)?
  - How are these populations different?
  - What kinds of behaviour change communication messages will you need to convey to each one?
  - How will you reach both populations?
  - Who do these audiences listen to?

**Step 5: Group discussion of results (10 minutes)**

- Reconvene the participants.
- Invite a response from one group to the first question.
- Ask whether other groups have different responses.
- Summarize the responses and proceed to the next question. Allow a different group to initiate the discussion.
- Continue in this way until all the key questions have been answered.
Day 2, session 4: Gathering data: What do you need to know about the target population?

**Room arrangement**

Small group tables. At each table, post two pages of flipchart paper on the walls. Then set two markers of different colours on the floor at each ‘station’.

**Process**

**Step 1:** Tell participants that the goal of the exercise is to help them identify what information about their target population would be useful in designing a behaviour change communication strategy.

**Step 2:** Presentation (5 minutes). Cover the following points:

- When preparing to develop a behaviour change communication strategy, the first steps are to:
  - set up programme goals;
  - invite the key stakeholders with whom you need to collaborate; and
  - identify the target groups on which to focus programme efforts.
- Donors or government sources may have already supplied information identifying the primary target populations in the region.
- Write the words ‘Formative assessment’ on a pre-posted flipchart page.
Tell participants that formative assessments are the process whereby they can gather information about their target population. In this way, when they design behaviour change communication interventions, they will be working from actual knowledge rather than impressions or assumptions about a particular population. The information gathered in this process ensures that the intervention is appropriate and meets the target population’s needs.

Refer to each word on the flipchart as you mention it] ‘Formative’ means forming (developing and growing) a body of information from which to ‘assess’ (or determine) the nature and needs of a population.

Formative assessments yield information on how to further segment a target population, allowing programmers to identify which specific and different messages may be useful for different population segments.

The information obtained through a formative assessments also enables programmers to identify not only the primary target populations (such as miners and their wives, girlfriends and/or sexual partners), but also the secondary target populations (such as the miners’ children and/or the miners’ bosses).

Proper investigation and gathering of information about target populations, their behaviours, lives and motivations provide the basis for the development of messages and themes, while indicating which channels of communication will most resonate with them, be understood and capture their attention. The ultimate goal of the programme is to have the target group take notice and begin the process of behaviour change.

Once the BCC formative assessment is complete, the next step in the behaviour change communication design is strategy development.

Step 3: Small group work (30 minutes)

Using the example of the Mumias Sugar Company (handout 5), remind participants of the following: When the project was initiated in late 1999, the company had just over 4,700 employees. This number was gradually reduced to about 2,500. The primary target population of the behaviour change communication initiative of the Mumias Sugar Company is its permanent workers. The secondary target population is made up of the workers’ dependants, who also live within the Mumias community, but are not necessarily employees of the company.

The target population has been refined as activities have unfolded. This approach has, for instance, enabled the programmers to identify high-risk sectors within the larger workforce, such as mobile sales and transport staff.

Tell participants the following: “The goal of this activity is to think of all the information you need about your target population in order to understand their behaviours, motivators and environment, and to identify their hopes, fears and attitudes about things that may have an impact on their ability to choose healthier behaviours. Think of all the things you need to know and list them on the flipchart pages.”

Have participants reform their small groups.

Step 4: Small group work (20 minutes)

Tell participants that you will be passing out a list of questions to two people in each group. These are questions that many formative assessments for behaviour change communication seek to answer about target populations in designing behaviour change communication strategies.

Identify two volunteers from each group and give them copies of the handout 10 on page 73.
Tell the volunteers: “You are going to pretend to be two individuals (either a worker and his or her spouse or girlfriend/boyfriend of a worker or two workers) sitting in a café or bar (somewhere you would be free to have an open, honest conversation). Read the questions in the handout and have a conversation, using the answers to the questions.” Tell the volunteers that they should try to portray some of the answers to the questions, such as talking about risky behaviours and what they think is risky. For example, one male worker could say to his co-worker, “I spend so much time on the road. I have to have some fun sometimes. There’s a nice bar near the mine with some pretty girls.” His co-worker could respond, “I don’t blame you. I do the same thing, but some people say that’s a good way to get AIDS”. His co-worker responds, “Don’t listen to them. Just be sure to go with the clean girls.”

Suggest that participants talk about issues relating to spending time away from one’s spouse, thinking one’s spouse is unfaithful, not knowing where to go for HIV counselling and testing or treatment of sexually transmitted infections, what they hope to accomplish in the next few years, etc.

Point out that the volunteers should not try to tell the rest of the group which things they should add to their list of items for formative assessments. The other participants must figure it out on their own by listening to the role play. Give a few minutes to the role players to prepare.

Tell the other group members: “Your goal is to see if you can identify items you want to investigate as you listen to the role players. If you have already listed these things during the previous exercise, fine. If not, add them to your list as you discover them.”

“During the role play, identify any new ideas and add them to your list, seeing how many you can identify.”

**Step 5: Group discussion (20 minutes)**

- Have participants return to their seats if they seem tired of standing, or they may remain at their group stations, if this is more convenient and they can hear everyone else from there.

- Elicit discussion among all participants as you ask them the following questions:
  - What was the experience like for the role players?
  - What was the experience like for the teams?
  - What did you notice?
  - What surprised you?
  - What sorts of things were most often missing from your original list?
  - What items on your lists could result in a negative outcome if the behaviour change communication team did not know about them when creating their strategy (in the form of messages, materials, themes and the channels chosen to spread that information)?
  - What kinds of things could go terribly wrong in the situations that your colleagues role-played for you?
  - What direct connection might you make with the target audience that would resonate with them, capture their attention and inspire them to begin changing their behaviour?
- Ask anyone who wishes to share examples of programmes or campaigns that they may know of that showed either full knowledge of a target population or a surprising lack of knowledge about a target population.

**Step 6:** Summarize by reminding participants of how important it is to think of all they may need to know about their target population as a first step, in order to:

- identify existing sources of that information;
- determine what information they may still need; and
- design a strategy to obtain any missing information.
Handout 9: What you need to know about your target population  
(conducting a formative assessment)

1. Demographic information  
   a. Gender  
   b. Sexual orientation  
   c. Race/ethnicity  
   d. Age  
   e. Religion  
   f. Education  
   g. Literacy  
   h. Language(s)  
   i. Marital status or relationship category (e.g., seeing one person seriously, while having casual encounters with several others)  
   j. Living arrangements  
   k. Income  
   l. Perceived hierarchy of health needs/current health-seeking behaviour

2. Knowledge  
   a. What do they know about HIV/AIDS (e.g., transmission, prevention, treatments and natural history of disease)?  
   b. What would they like to know?  
   c. What common misconceptions or misperceptions do they have?  
   d. What sources of information do they rely on?  
   e. Who do they trust for information in the community and the workplace?

3. Skills or self-reporting of skills  
   a. Universal precautions  
   b. Safer sexual practices  
   c. Drug use and 'sharps'

4. Attitudes/beliefs  
   a. What is their attitude towards people living with HIV/AIDS (PLWHA)?  
   b. What is their attitude regarding their own risk of HIV infection?  
   c. Social norms/taboo  
   d. Motivating factors

5. Social/support networks (either in the workplace or the community)  
   a. Who can they turn to for support?  
   b. Who can they go to for assistance?
c. Who has a positive influence on their behaviour?
d. Who has a negative influence on their behaviour?
e. Potential high-risk settings

6. Access
   a. Condom availability
   b. Medical care
   c. Voluntary counselling and testing (for HIV and related conditions)

7. Behaviours and practices
   a. High-risk sexual behaviours
   b. Drug use
   c. Prior history of sexually transmitted infections (STIs)
   d. Other high-risk behaviours (e.g., use of ‘sharps’, inadequate health care)

8. Workplace
   a. Level of interest in developing HIV/AIDS programs
   b. Awareness of current programmes
   c. Existence of people who are HIV-positive and open about their status at the workplace
   d. Treatment of/attitude towards PLWHA at the workplace
   e. Potential high-risk settings
   f. Channels/sources of information

9. Existing company policy on
   a. HIV and AIDS
   b. Universal precautions
   c. Workplace safety

How to collect this type of information
1. Interviews (with key informants, employees and management)
   a. One on one
   b. Small groups (of 2 to 4) using group interview techniques
   c. Focus groups (of 8 to 12)
      i. Using reactions to broad query (e.g., What do you think about health? What do you think about HIV?)
      ii. Using reactions to stimuli (e.g., video, brochure, etc.)

2. Questionnaires/surveys

3. Observational methods
Volunteers: While playing your roles, see if you can get your team to think of the following to add to their brainstorming list. Be sure not to give them this information directly. Instead, pretend you are two people from the target population having a conversation. Move quickly through your conversation and feel free to jump to anything on this list that you think you can easily portray and get them to identify.

- How do you feel about HIV/AIDS and about people living with HIV/AIDS?
- What are your social and psychological behaviours?
- What are your risk behaviours?
- What are your current and desired behaviours?
- Are there secondary target populations associated with this population?
- What do you know about HIV and other sexually transmitted infections?
- What are your perceptions of risk?
- What are your barriers to behaviour change?
- What motivates you to change?
- What are your hopes and fears for the future (five years from now)?
- How many partners do you have? Why that number of partners?
- Do you have personal power? Do you have a sense of your own personal power?
- What are your media habits?
- What are the primary information sources at the workplace?
- If you had a problem related to your health, would you consult anyone at work?
- What are your entertainment habits?
- Where do you seek health-care services? For what type of problems?
- What are your purchasing habits?
- Where do you live?
- How do you make a living?
- Who are your opinion leaders and role models?
- What are your existing community resources?
- What sorts of networks do you belong to?
- Who are your potential partners?
- What is the state of their community’s infrastructure (basic facilities, services, transport, communication systems, public institutions)?
- Does your work take you away from home? If so, for how long?
- Do you have more or less money than others living in the community?
Do women earn enough to make ends meet?
Do bosses pressure female employees to have sex?
Do workers feel they need to/can trade sex in order to get hired, be promoted or keep their job?
Whom do you trust for information at the workplace?
Do you know where to go for HIV counselling and testing and services for other sexually transmitted infections?
Where do you get condoms?
Are condoms distributed at work?
How does your job influence/affect your sexual relationships?
Do they know of any co-workers who have HIV/AIDS? How do you feel about them?
How are they treated?
Do you live with your spouse?
Does the work environment have an impact on your ability to implement safer behaviours?
If so, in what way?
Day 2, session 5: Gathering data: What existing information can you use?

Flipchart, markers, activity sheets (for note-taking), handouts 11, 12 and 13 (see pages 79 to 81). Be sure to have two copies of handout 13 for each person.

Objectives
By the end of this session participants will have an understanding of how to identify information about a target population from existing sources of data.

Room arrangement
Small group tables

Preparation
Prepare activity sheets and handouts so that, when it is time to distribute them, you have counted out enough of each and stacked them, ready to give each table (all participants) activity sheets and reports corresponding to one target population. Use formative assessment data on the workplace target populations, when available.

Process
Step 1: Tell participants the following: “The goal of this exercise is to help you understand how to identify information from existing sources of data about a target population – information that your programme can gather as part of the formative assessment process.”

Step 2: Presentation (15 minutes)
Cover the following points:

[Note: If you are presenting these exercises in order, you may wish to refer to the brainstorming charts created by the participants in the previous exercise as you indicate the full scope of information necessary for building a realistic picture of a target population.]

- During the formative assessment stage, programmers should gather data that provide a full picture of the target population, rather than making assumptions or projections about what the lives and needs of that population. This helps ensure that the programme works with population-specific information.

- After determining the full scope of information needed about the target population, the next step is to obtain data from existing studies or other documents, rather than spending time and resources rediscovering things that are already known.
Write ‘Sources of existing data’ at the top of a flipchart page.

Ask participants: “What existing sources of information might you use in order to obtain the necessary data about your target population?”

As participants respond, add those sources to the flipchart list.

Elicit participants’ responses to the following questions:

- Might there be public health department records that track some data of interest on your specific population?
- Are there any data from ‘knowledge, attitude, practice’ (KAP) surveys conducted with workers of the target population (such as data from the workers’ survey conducted in enterprises by the ILO technical cooperation project)?
- Does your donor have data from other work it has already done?
- Is there country or regional surveillance information that might be useful?
- Has someone else conducted focus group discussions with the same population?
- Do local universities have masters or dissertation theses on your topic of interest?

Ask participants how they would locate these sources and obtain the documents identified. Note ideas on a flipchart.

Answers might include (but are not limited to) the following:

- Meet with workplace administrators.
- Meet with government and non-governmental organization staff.
- Make phone calls to specific individuals.
- Visit agencies in country.
- Ask collaborating partners and stakeholders for suggestions about what documents to consult.

Tell participants the following: “Your materials may come in bits and pieces – a survey here, a report there – and your team can look over each document to see what, within it, might be helpful.

“Remember to set a realistic time frame within which you feel you can gather all the information that currently exists. You should also allow time for a review of that information. In reviewing the information, select the data that answer the questions you have identified in order to better understand this particular population.

“There may be a lot of information available about the target population that you chose. If so, it will be necessary to set a timeline and benchmarks on what will need to be accomplished and by when.

“Each of you has a different style of noting and gathering relevant data with which to eventually build your formative assessment (which will ultimately form a report that you can share with management, workers and others who will help you design your BCC strategy). Some of you will want to create a chart, listing what you know and what is still missing; others will just take notes to inform the eventual writing of that final document.
“One strategy for organization the data you gather for your formative assessment includes developing an outline of all the things you want to know about your target population. When you find that information in existing documents, you can make copies, and cut and paste it into your outline. You can then identify the information gaps easier by reviewing the outline and seeing where there are blanks.

“Each individual and team will have their own system. Choose the one that is best for you.”

**Step 3:** Small group work (15 minutes)
- Tell participants the following: “Let’s use the example of this report on the Mumias Sugar Company in Kenya. Assuming that workers in a company similar to Mumias are your target population and using this worksheet, take notes of data you think could be relevant for a formative assessment.”
- Distribute copies of Report no. 1 (handout 11) and the worksheet (handout 13) to all participants (see pages XX and XX).

**Step 4:** Group discussion (5 minutes)
- Reconvene participants and ask them if they found some helpful information for the formative assessment from this general report.
- Moderate a brief discussion based on their answers.

**Step 5:** Small group work (15 minutes)
- Tell participants the following: “Still using the Mumias Sugar Company example, let’s look at a second report that identified some problems in getting the target population to use services related to HIV and other sexually transmitted infections. As a group, read and discuss the report and make a note of any information that may answer more of your formative assessment questions.”
- Distribute copies of Report no. 2 (handout 12) (see page 80) and the worksheet (handout 13) (second copy) to all participants.

**Step 6:** Group discussion (10 minutes)
- Reconvene participants and ask them if they found some helpful information for the formative assessment from this more detailed report.
- Moderate a brief discussion based on their answers.
- Ask each group to identify one gap in the information needed to develop a profile of the sample target population (workers similar to those of the Mumias Sugar Company).
- Note all the gaps on the flipchart.

**Step 7:** Summary statement
- Tell participants the following: “Finding existing sources of information about target populations can answer a lot of questions. It can also provide a picture of the target population as you prepare to develop your behaviour change communication strategy. However, existing sources may not answer all of the questions you have about your
target population. You may need to determine what information is still missing and how to obtain it.”

- Tell participants to keep their worksheets to refer to in the next exercise.
HIV infection is increasing rapidly in Kenya’s Western Province, where agro-industrial plantations are a zone of high transmission. Absenteeism due to AIDS-related illnesses, loss of experienced personnel, replacement and training costs, reduced productivity and increased medical expenditure threaten the viability of Western Province’s agro-industries.

These sites are particularly vulnerable to HIV infection, as they attract large numbers of men who have disposable income, are away from their families and are surrounded by low-income communities with disproportionate numbers of single women.

Since 1988, the company had been making an effort to create general awareness about HIV/AIDS using traditional information, education and communication approaches (e.g., occasional lectures, brochures, etc.). These efforts were initiated by the company’s medical officer and directed at the primary target population – unionized staff (approximately 1,500 front-line workers). The programme was implemented in collaboration with the Kenya Union of Sugar Plantation Workers (Mumias branch). Management and the families of all the workers comprised the secondary target population. But the company found it difficult to go beyond the stage of raising awareness about these issues.

When the programme began, staff worked with the lower cadres, since they comprised the largest percentage of the workforce. Most of the peer educators were drawn from the lower cadres. As the programme grew, more and more middle management and senior staff became involved in HIV/AIDS-related activities. For instance, the company medical doctor heads the Mumias AIDS committee, of which the company legal officer is also a member.

The programme used a variety of data-gathering methods during the baseline study. These included a structured questionnaire, key informant interviews, in-depth interviews and focus group discussions. About 90 per cent of the workforce is male. The few female employees work within the administration department. The nature of the company’s work probably explains the gender imbalance.

The workplace clinic currently provides no HIV/AIDS-related services.

Records at the clinic indicate that a monthly average of seven employees—both males and females—report to the clinic with sexually transmitted infections.
Handout 12: Report no. 2 – Findings from a formative assessment conducted at Mumias Sugar Company

The main findings of the assessment were the following:

- Most workers had inadequate knowledge about how HIV is transmitted and how to protect themselves from infection.
- The majority of workers (about 90 per cent) were male.
- Most workers had a negative attitude about HIV/AIDS, especially with regard to people with AIDS. This led to stigma and, to some extent, discrimination. For example, employees did not want to “mix” with someone they thought might have HIV.
- Condoms were not readily available or distributed by the company. Knowledge of condom use was limited. For example, some thought that the use of three condoms at one time would increase their effectiveness.
- Nearly all workers who had had a sexually transmitted infection avoided seeking treatment at the company clinic. The company policy prohibited treatment of sexually transmitted infections, labelling them “self-inflicted”. This led to poor health-seeking behaviour by those affected, since they resorted to cheap, and often ineffective, treatment options from traditional health practitioners in the village.
- The main sources of information for workers were the national media, friends and written materials.
- Most workers (particularly males) had disposable income, which they used mainly for leisure purposes.
- Many workers (particularly males) lived away from their families, and often engaged in risky (unprotected) sex with female sex workers and with women from low-income settings living in surrounding communities.
- In some cases, female workers were at risk, due to the sexual advances of more senior male employees in positions of power.
- The workers trusted their colleagues and the union, but not management, on matters related to HIV/AIDS. This was particularly true of the lower cadres – the union staff.
- There was no company policy on HIV/AIDS. Treatment for HIV-positive workers was considered on a case-by-case basis and generally available only to top management and chief executives.
## Handout 13: Worksheet – Collecting existing information

<table>
<thead>
<tr>
<th>Knowledge levels</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk behaviours</td>
<td></td>
</tr>
<tr>
<td>Human resources</td>
<td></td>
</tr>
<tr>
<td>Stigma/discrimination</td>
<td></td>
</tr>
<tr>
<td>Barriers to HIV/AIDS programmes</td>
<td></td>
</tr>
<tr>
<td>Possible collaborators</td>
<td></td>
</tr>
<tr>
<td>Areas for improvement</td>
<td></td>
</tr>
</tbody>
</table>
Day 2, session 6: Gathering Data—How to find the additional information required

45 minutes

Flipchart, markers and cards or sheets of papers featuring questions for the target population—company employees, handout 14 (see page 86)

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

- identify different methods used to conduct formative assessments;
- explain what can be learned from quantitative and qualitative methods and what role focus group discussions and in-depth interviews play in a BCC formative assessment; and
- explain the difference between quantitative and qualitative methods of assessment.

Room arrangement
Small group tables

Process

Step 1: Tell participants the following: “The goal of this exercise is to learn about different methods of conducting formative assessments (to gather information) when developing behaviour change communication strategies.”

Step 2: Presentation (20 minutes)

- Cover the following points:
  - The preceding exercise yielded some important information about a sample target audience.
  - At this stage of the formative assessment, you are still gathering information. You have already searched for, found, and read through, existing sources of information on your target population, and you have taken notes to answer all the questions you have, in order to build a good realistic picture of your target population.
  - You may have answered all the questions you had. However, you may still see some gaps. Is this missing information still needed, given the picture you have created so far with your data gathering? If you feel some essential pieces of information are still unknown, now is the time to decide how you will find them.
  - Think about the best way of obtaining that information. It might be through a survey or by direct observation, for example.
  - There are many different quantitative and qualitative methods you could use to conduct a formative assessment.
- Ask participants to give examples of research methods that might be used to gather information about target groups (e.g., surveys, mapping, observations, interviews, focus groups). Write them down on a flipchart.
- Define qualitative and quantitative methods:
  - Quantitative assessment: A research methodology designed to deliver pre-specified numerical outcomes. Typical quantitative research techniques include surveys, questionnaires and KAP (knowledge, attitude, practices) studies with closed questions – that is, the answers are given and the person answering the questions must pick one of the answers; there are no open-ended questions.
  - Other kinds of quantitative assessment include HIV prevalence studies and demographic information (how many workers are male, how many female, their ages, etc.).
  - What is the purpose of quantitative assessments?
    - To generalize results to a larger population
    - To compare groups in controlled situations
    - To summarize and demonstrate impact
    - To understand the end results.
  - Qualitative assessment: A research methodology designed to provide deeper understanding of a target population and the process required for behaviour change. Typical qualitative research techniques include focus groups, in-depth interviews, observation and case studies.
  - What is the purpose of qualitative assessments?
    - To rapidly gain insights into a target population
    - To understand why target populations behave the way they do and to obtain insights into specific actions and how frequently they occur.
- You may wish to use the following chart to further illustrate the difference to participants:

<table>
<thead>
<tr>
<th>Qualitative vs. Quantitative Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualitative</td>
</tr>
<tr>
<td>Provides depth of understanding</td>
</tr>
<tr>
<td>Studies motivations</td>
</tr>
<tr>
<td>Is subjective; probes individual reactions to discover underlying motivations</td>
</tr>
<tr>
<td>Enables discovery</td>
</tr>
<tr>
<td>Is exploratory</td>
</tr>
<tr>
<td>Allows insights into behavior and trends</td>
</tr>
<tr>
<td>Interprets</td>
</tr>
</tbody>
</table>


- Tell participants that detailed descriptions of the research methods are available in Booklet 2 of the toolkit.
Step 3: Small group work (15 minutes)

- Divide participants into two groups. Distribute handout 14, ‘Questions for the target population—company employees’ (see page X86)
- Ask the groups to decide which methods they would use to answer each question, choosing among those listed on the flipchart during the previous step. After a consensus has been reached, have the groups identify which methods are qualitative and which are quantitative.

Step 4: Group discussion (10 minutes)

- Reconvene participants and have one group present its results. Have another group comment on any differences in its data-collection plan.
Handout 14: Questions for the target population
company employees for day 2, session 6, step 3

What are their perceptions of risk?
What are their barriers to behaviour change?
What are their motivations for making changes?
What are their hopes and fears (including their hopes for five years into the future)?
What attitudes do they have that may help you understand their behaviour or motivators?
Do they have personal power? Do they have a sense of their own personal power?
Who are their potential partners?
How many partners do they have?
Why do they have the number of partners they do?
Are there secondary target populations associated with this population?
What are their risk behaviours and other current behaviours?
What are their media habits?
What are their entertainment habits?
What are their health-care-seeking behaviours?
What are their purchasing habits?
Where do they live?
How do they make a living?
Who are their opinion leaders and role models?
What do they know about HIV and other sexually transmitted infections?
What is the state of their community’s infrastructure (basic facilities, services, transport, communication systems, public institutions)?
Are they aware of their existing community resources?
Examples of possible answers to questions for the target population (company employees), for use by the facilitator on day 2, session 6, step 3

What are their **perceptions of risk**?
- Methods used: Focus group (qualitative), in-depth interviews (qualitative), survey questionnaire (quantitative)

What are their **barriers** to behaviour change?
- Methods used: Focus group (qualitative), in-depth interview (qualitative)

What are their **motivations** for making changes?
- Methods used: Focus groups (qualitative), in-depth interview (qualitative)

What are their **hopes and fears** (including their hopes for five from now)?
- Methods used: Focus groups (qualitative), in-depth interview (qualitative)

What **attitudes** do they have that may help you understand their behaviour or motivators?
- Methods used: Focus group (qualitative), in-depth interviews (qualitative), survey questionnaire (quantitative)

Do they have **personal power**? Do they have a sense of their own personal power?
- Methods used: Focus group (qualitative), in-depth interviews (qualitative), survey questionnaire (quantitative)

Who are their **potential partners**?
- Methods used: Focus group (qualitative), in-depth interviews (qualitative), survey questionnaire (quantitative), case study (qualitative)

**How many partners** do they have?
- Methods used: Survey questionnaire (quantitative)

Why do they have the **number of partners** they do?
- Methods used: Focus group (qualitative), in-depth interview (qualitative)

Are there **secondary target populations** associated with this population?
- Methods used: Focus group (qualitative), in-depth interview, observation
What are their high-risk behaviours and other current behaviours?
- Methods used: Questionnaire, KAP survey (quantitative), focus group (qualitative), in-depth interview (qualitative)

What are their media habits?
- Methods used: Questionnaire, KAP survey (quantitative)

What are their entertainment habits?
- Methods used: Questionnaire, KAP survey (quantitative)

What are their health-care-seeking behaviours?
- Methods used: Questionnaire, KAP survey (quantitative)

What are their purchasing habits?
- Methods used: Questionnaire, KAP survey (quantitative)

Where do they live?
- Methods used: Questionnaire, KAP survey (quantitative), census data, employee records at company

How do they make a living?
- Methods used: Questionnaire (quantitative)

Who are their opinion leaders and role models?
- Methods used: Questionnaire, KAP survey (quantitative), focus group (qualitative), in-depth interview (qualitative)

What do they know about HIV and other sexually transmitted infections?
- Methods used: Questionnaire, KAP survey (quantitative)

What is the state of their community’s infrastructure (basic facilities, services, transport, communication systems, public institutions)?
- Methods used: Community mapping, data from municipality and/or Ministry of Health

Are they aware of their existing community resources?
- Methods used: Questionnaire, KAP survey (quantitative)
Day 2, session 7: Gathering Data—Creating a BCC formative assessment plan, part 1

Flipchart, markers, six sheets of flipchart paper for posting around the room, signs, handout 15 on the Mumias Sugar Company IMPACT Project, handouts 16-21 on each of the formative assessment plan components (see page 92 to 98), lists of what each group needs to know, of the existing data, of the data needed, and of how the data will be collected (from previous exercises relating to the Mumias Sugar Company).

**Objectives**
By the end of this session, participants will be able to plan a formative BCC assessment.

**Room arrangement**
Small group tables

**Preparation**
Post enough flipchart sheets around the room for each group. They will be discussing six categories, so each group may need additional flipchart paper.

**Step 1:** Begin by telling participants that, “The goal of this exercise is to help you create a formative assessment plan for behaviour change communication.”

**Step 2:** Presentation (15 minutes)
- Cover the following points:
  - Let’s assume that, by now, you have identified what you need to know about your target population, found further existing data to describe it, identified what information you still need to obtain, and which methods you will use to gather those additional data. What is your plan going to be for procuring the missing information?
[Note: As you mention the following points, write them on a flipchart page, under the heading, ‘Formative assessment plan’.]

- A formative assessment plan should include planning for:
  - The overall timeline and each step along this timeline;
  - The overall budget and each task or item that costs money;
  - There may be other items that you will need to plan for.

**Step 3:** Small group work (45 minutes)

- Tell participants the following: “A good way to create a formative assessment plan is to construct a worksheet that includes all components of the areas you need to design and track your plan. In this exercise, you will create a separate worksheet for each of the following components:
  - Timeline
  - Budget
  - Human resources
  - Logistics
  - Methods
  - Research protocols.
- Provide groups with sufficient copies of the following, from previous exercises:
  - Lists of what they need to know about the target population
  - A list of the existing data
  - A list of the data they still need and how they plan to get them.
- Provide groups with sufficient copies of the background information on the Mumias Sugar Company, including the information on steps 1, 2 and 3, and the formative assessment findings (Handout 15).
- Encourage the groups to use their notes from previous sessions focusing on the example of the Mumias Sugar Company. Invite participants to share the information on the activity sheet with their group and brainstorm about all the items that they might want to put on their formative assessment plan worksheets. They can use the formative assessment plan component handouts as guides and then write their ideas on the flipchart to create six different worksheets.
- Distribute sufficient copies of the six component handouts to each group so that they can think about each topic (see handouts 16 to 21, pages 96 to 98). Tell them that they will have about seven minutes to work on each topic.
Handout 15: Case study of an HIV/AIDS programme with the Mumias Sugar Company IMPACT Project, Western Kenya

United States Agency for International Development/Family Health International

Kenya is one of many African nations with a serious HIV epidemic. The HIV prevalence nationwide is estimated to be 6.7 per cent (nine per cent among women and five per cent among men – Central Bureau of Statistics, 2003). Despite the lower-than-expected figure, the infection is still a generalized epidemic in Kenya, and efforts to bring it under control remain an urgent matter. One dramatic impact of AIDS-related deaths is the decline in life expectancy. The Kenyan Central Bureau of Statistics estimates that, in the absence of AIDS, life expectancy at birth would be about 65 years. However, because of the large number of AIDS-related deaths, it is actually only about 46 years and may decline to 45 years by 2010. Thus, almost 20 years of life expectancy have already been lost because of AIDS.

The number of new HIV infections is increasing rapidly in Kenya's Western Province where the agro-industrial plantations are a zone of high transmission. Absenteeism due to AIDS-related illnesses, loss of experienced personnel, replacement and training costs, reduced productivity and increased medical expenditure threaten the viability of Western Province’s agro-industries.

Mumias Sugar Company (MSC) is the largest single sugar factory in Kenya, with 2,500 employees. Starting as a government-owned enterprise in the early 1970s, Mumias Sugar Company has since been privatized and is listed on the Nairobi Stock Exchange. In 1999, the company began to work with Family Health International on the USAID-sponsored IMPACT project to implement a comprehensive HIV/AIDS workplace initiative, targeting both workers and the surrounding residential community. These sites are particularly vulnerable to HIV infection, attracting large numbers of men who have disposable income, are away from their families, and are surrounded by low-income communities with disproportionate numbers of single women.

The programme includes behaviour change communication with a peer-education component, referrals for testing and treatment of sexually transmitted infections and voluntary HIV counselling and testing, as well as education, care and support in the community.

**Step 1: Advocacy and stakeholder involvement**

When the project began with the Mumias Sugar Company in 1999, HIV/AIDS programming was limited within the company. However, since 1988, the company had been making an effort to create general awareness about HIV/AIDS using traditional information, education and communication approaches (e.g., occasional lectures, brochures, etc.). The company medical officer initiated these efforts, which were directed at the primary target population – unionized staff (approximately 1,500 front-line workers). The project was implemented in collaboration with the Kenya Union of Sugar Plantation Workers (Mumias branch). Management and the families of workers comprised the
secondary target population. But the company found it difficult to go beyond the stage of creating awareness about the issues.

When the IMPACT project team approached the management at Mumias to talk about developing a more comprehensive HIV/AIDS programme at their workplace, they met with some resistance. The team then sought the involvement of a number of top-level players and power-brokers to persuade the Mumias management to implement a workplace HIV/AIDS programme. The stakeholders to whom the project team spoke were:

- the Kenya Sugar Authority – the supreme sugar regulatory body in Kenya; and

- the provincial medical officer of health, responsible for all regional health matters, who spoke to the chief executive officer of Mumias and arranged an appointment for the team to meet him in person.

The chief executive officer and all eight departmental heads attended the meeting. The project team gave a presentation on why an HIV/AIDS programme at their workplace would be beneficial. One of the most influential points raised was the Kenyan HIV prevalence data. Another convincing aspect of the presentation that had an impact on management’s decision was the experience from other worksites that showed the benefits of implementing an HIV/AIDS programme in large companies. The chief executive officer concluded the meeting by directing the company doctor to accord the project team all the support that it required.

Once they had launched the Mumias programme, team members organized further briefing sessions for various section and departmental heads, to inform them of the planned intervention, its design and the benefits of the programme for the workers and the company. After presenting these points, the project team asked for, and received, managerial support.

The project team also advocated prevention education and referral to other services (such as HIV counselling and testing and treatment for sexually transmitted infections). In addition, they advocated for the company to provide free and unrestricted treatment to all HIV-positive employees. The treatment included medication for opportunistic infections and antiretroviral drugs.

**Step 2: Identification and segmentation of the target population**

When the Mumias programme was initiated in late 1999, the company had slightly over 4,700 employees. This number was gradually reduced to about 2,500.

The primary target population for the behaviour change communication programme at Mumias is its permanent workers. The secondary target population is made up of the workers’ dependants, who also live within the Mumias community, but are not necessarily employees of the company.
Segmentation

The programme has refined the target population over time. This approach has, for instance, enabled the programme to identify high-risk sections within the larger workforce, such as the mobile sales and transport staff.

When the programme began, it focused on the lower cadres, since they comprised the largest percentage of the workforce. Most of the peer educators were drawn from the lower cadres. As the programme grew, more and more middle management and senior staff became involved in HIV/AIDS-related activities. For instance, the company medical doctor heads the company AIDS committee, of which the company legal officer is a member.

Step 3: Formative BCC assessment

The programme conducted a baseline survey to establish employees’ knowledge, attitudes and practices with regard to HIV/AIDS. This assessment also examined the Mumias Sugar Company as a whole, in terms of its structure, geographical location, social settings and risk factors both within and around the company.

The programme used a variety of data-gathering methods during the baseline study. These included a structured questionnaire, key informant interviews, in-depth interviews, and focus group discussions. About 90 per cent of the workforce is male. The few female employees work within the administration department. The nature of work in the company probably explains the gender imbalance.

Findings

The main findings of the assessment included the following:

- Most workers had inadequate knowledge about HIV transmission and how to protect themselves from HIV infection.
- The majority of workers (about 90 per cent) were male.
- Most workers had a negative attitude about HIV/AIDS, especially with regard to people living with AIDS. This led to stigma and, to some extent, discrimination. For example, employees did not want to mix with someone they thought might have HIV/AIDS.
- Condoms were not readily available or distributed by the company. Knowledge of condom use was limited. For example, some thought that using three condoms at one time would increase their effectiveness.
- Nearly all workers who had had a sexually transmitted infection avoided seeking treatment at the company clinic. Company policy prohibited treatment of sexually transmitted infections, labeling them “self-inflicted”. This led to poor health-care-seeking behaviour by those affected, since they resorted to cheap, and often ineffective, treatment options from traditional health-care practitioners in the village.
- The main sources of information for workers were the national media, friends and written materials.
- Most workers (particularly males) had disposable income, which they used mainly for leisure purposes.
Many workers (particularly males) lived away from their families, and often engaged in risky (unprotected) sex with female sex workers and with women from low-income surrounding communities.

In some cases, female workers were at risk due to the sexual advances of more senior male employees in positions of power.

The workers trusted their colleagues and the union, but not management, on matters related to HIV/AIDS. This was particularly true of the lower cadres – the union staff.

There was no company policy on HIV/AIDS. Treatment for HIV-positive workers was considered on a case-by-case basis and generally available only to top management and chief executives.
Handout 16: Component 1 – Timeline

As you brainstorm, ask each other these and other questions that come to mind:

- By when do you aim to complete the formative assessment?
- What is your sample size?
- How long will it take to interview this sample?
- Have you located a research coordinator?
- How long will it take you to find one?
- Once the interviews are complete, how long will it take you to analyse these?
- How long will it take you to write the report?
- How long will it take you to disseminate the results of the report?
- By when do your donor and/or community want to see the programme begin?

Handout 17: Component 2 – Budget
(How much will the programme cost?)

As you brainstorm, ask each other these and other questions that come to mind:

- What will be the cost of time and other resources used by programme staff?
- What will be the cost of materials?
- What will be the cost of possible incentives for participants?
- For each method you may use, what will be the cost of logistics, printing, administration, analysis and review?

Handout 18: Component 3 – Human resources
(Who will do the work?)

As you brainstorm, ask each other these and other questions that come to mind:

- What would you want to plan for and include on your planning worksheet as you seek out, gather and analyse the information you need for your formative assessment?
- Who will be working on your project? Will you include staff, volunteers, academics, consultants, social scientists, advertising and marketing and/or research organizations? Will you hire these people?
- Do you need a consultant or research organization to oversee the entire process or manage a particular aspect of it? (The consultant or research organization must have the necessary skills and experience to ensure a high-quality product.)
- Who will be the interviewers? Who will train them? What are the criteria that you will use to hire them? Who will supervise them? Who will transcribe, translate and enter transcriptions into the software package, if you plan to use one?
- Who is going to manage the process?
Handout 19: Component 4 – Logistics

(The logistics are the detailed organization and implementation of a plan or operation, which, in this case, might involve reserving focus group rooms or identifying how you will transport a huge box of questionnaires to a university site.)

As you brainstorm, ask each other these and other questions that come to mind:

- Who will go to the selected sites and talk to stakeholders?
- How will the interviewers get to the research sites?
- Who will collect the transcribed interviews?
- Will there be computers for data entry? If so, where will the computers for data entry be located and who will set these up? If not, how will data entry be managed?

Handout 20: Component 5 – Methods

As you brainstorm, ask each other these and other questions that come to mind:

- Which methods will you use—focus group, in-depth interviews, or others?
- Will you need to prepare a written questionnaire for participants or a guide to help interviewers conduct the interviews? (Questionnaires often need to be pre-tested.)
- Developing tools such as questionnaires can take time and they work best with the help of technical people who are experienced in this sort of design. Questionnaires have to achieve the right balance between including enough questions to meet the project’s objectives and avoiding too many questions, which takes too much time and burdens the person being interviewed. Each question in the questionnaire needs to get to the root of the issue, and the interviewer must often probe deeper to get valuable data.
Handout 21: Component 6 – Research protocols (procedures)

As you brainstorm, ask each other these and other questions that come to mind:

- What research protocols will you use (procedures for how research will be conducted)?
- You will want to develop a realistic procedure (protocol) that defines the objectives, sites, target populations, research methods and sample size (number of people you will observe, interview or otherwise gather data from, in order to draw conclusions about this population). These factors will inform the other components you include in your plan, such as how many people will be needed for which steps, how many person-hours each step may take, and what your budget will be (including printing, mailing, travel expenses for visiting sites for observation, etc.).
- How will you manage the process?
- Who will be responsible for each step?
- How will you ensure confidentiality?
- How will consent be granted?
- Who will analyse the data you gather?

(If you develop an instrument, such as a survey, you will need to develop it, pre-test it and oversee its implementation and analysis.)

You may still need more information about your target population, including the following:

- Time off: Where do members of the target population go when they are not working?
- Living space: Where do they live?
- Economics: What is their economic status?
- Recreation: Where do they go to enjoy themselves?
- Social circles: Who are their friends?
- Role models: Who do they respect?
## Day 3: Designing a Strategy

<table>
<thead>
<tr>
<th>DAY 3</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of day 2</td>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>Session 1</td>
<td>9:00 – 10:00</td>
<td>Booklet 2: Gathering Data—Creating a formative assessment plan, part 2</td>
</tr>
<tr>
<td>Break</td>
<td>10:00 – 10:15</td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>10:15 – 11:30</td>
<td>Booklet 3: Designing a Strategy—Target audience</td>
</tr>
<tr>
<td>Session 3</td>
<td>11:30 – 12:45</td>
<td>Booklet 3: Designing a Strategy—BCC objectives</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:45 – 1:45</td>
<td></td>
</tr>
<tr>
<td>Session 4</td>
<td>1:45 – 3:30</td>
<td>Booklet 3: Designing a Strategy—Key benefit statements and barriers</td>
</tr>
<tr>
<td>Break</td>
<td>3:30 – 3:45</td>
<td></td>
</tr>
<tr>
<td>Session 5</td>
<td>3:45 – 5:15</td>
<td>Booklet 3: Designing a Strategy—Effective messages</td>
</tr>
</tbody>
</table>
Day 3, session 1: Creating a formative assessment plan for BCC, part 2

**Objectives**

By the end of this session, participants will be able to plan a formative BCC assessment (continuation of the objective for the last session of the previous day).

**Process**

**Step 1 (1 hour):** Invite the groups to present their information in the following order:

- Timeline
- Budget
- Human resources
- Logistics
- Methods
- Research.

**Step 2:** Summary statement

- Tell participants the following: “Making a realistic plan for gathering your assessment data takes into account all these things; this will all go into the final summary report for you and your partners as you move forward to develop your behaviour change communication programme and strategy.”
- Refer participants to the ILO/FHI Toolkit, Booklet 2: Gathering Data for the Development of a Behaviour Change Communication Programme for the Workplace for more information on gathering assessment data as well as sample questionnaires and interview formats.
Day 3, session 2: Developing a strategy—Target audience

**Objectives**

By the end of this session participants will:

- understand what is known and not known about target populations; and
- experience a creative process to develop the groundwork for communication with a target population.

**Process**

**Step 1:** Begin by telling participants the following: “The goal of this exercise is to understand what is known and what is not known about target populations – and also to introduce you to a creative process for developing communication activities for your target population.”

**Step 2:** Small group work on target population profiles (35 minutes)

- Place two sheets of flipchart paper and two different-coloured markers at each table, and distribute enough copies of the handouts (see pages 105 to 107) for all participants.
- Tell participants that they will be identifying the kinds of information they will need in order to complete a behaviour change communication assessment for their target population.
- They should first read the handout about sample data on transport workers to see what kind of information an assessment can yield.
- As they go through the questions on their handout, they should list the answers on flipchart pages.

**Step 3:** Small group work on development of role plays (20 minutes)

- Invite the groups to develop a two-minute role play that will depict aspects of the lives of the target population that could lead to increased high-risk behaviours. For example, a lot of time spent away from home, lack of knowledge about HIV transmission, lack of a workplace HIV/AIDS programme, getting drunk, not being able to negotiate when or under what circumstances to have sex, etc. The object of the role play is to show the rest of the group the things they need to know about their target population in order to develop a BCC programme with them. Tell the groups that they will have 20 minutes to develop, make materials for, and rehearse, their role play.
Step 4: Group presentations and discussion (20 minutes)

- Invite each team to come to the front of the room or gather participants at each team’s workplace for presentations about the target populations, including their two-minute role plays.
- Engage participants in a discussion about precipitating factors for high-risk behaviour, in the context of HIV, in the lives of the target population.

Step 5: Summary statement

Tell participants the following: “Gathering information about a target population and forming a profile of that population are crucial for the success of your behaviour change communication programme. This will help you learn how to work with the population and design effective communication strategies to meet its needs.”
Handout 22: Developing target population profiles, for day 3, session 2, step 2

Answering these questions will provide more in-depth information about your target populations.

Write the following words on one side of your first flipchart sheet, leaving plenty of room for notes on the other side:

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>WORK</th>
<th>TIME OFF</th>
<th>LIVING SPACE</th>
<th>LIVING ARRANGEMENTS</th>
<th>TRAVEL FOR WORK</th>
<th>ECONOMIC</th>
<th>MEDICAL CARE</th>
<th>KNOWLEDGE ABOUT HIV/AIDS</th>
<th>HIGH-RISK BEHAVIOURS</th>
<th>COUNSELLING/TESTING FOR HIV AND OTHER SEXUALLY TRANSMITTED INFECTIONS</th>
<th>CONDOM USE/DISTRIBUTION</th>
<th>TREATMENT FOR HIV AND OTHER STIS</th>
</tr>
</thead>
</table>

Write this set of words on one side of your second flipchart sheet, again making sure to leave plenty of room for notes on the other side:

<table>
<thead>
<tr>
<th>CLUBS</th>
<th>HOPES/FEARS</th>
<th>ENJOYMENT</th>
<th>FRIENDS</th>
<th>CO-WORKERS</th>
<th>CLOTHES</th>
<th>ROLE MODELS</th>
<th>SOURCES OF INFORMATION</th>
<th>WORKPLACE HIV/AIDS PROGRAMME</th>
<th>WORKSITE HEALTH CARE</th>
<th>CONFIDENTIALITY OF CARE</th>
<th>HIV/AIDS STIGMA AT THE WORKPLACE</th>
</tr>
</thead>
</table>
Write answers to the following questions to the right of the key words on your flipchart sheets.

**Description:** Describe typical members of your target population by listing adjectives that describe them. For example, men at the workplace may be “stable, secure, family men,” and so on.

**Work:** What kind of work do they do or what are their sources of income?

**Time off:** Where do they go when they are not working/making money?

**Living space:** Where do they live?

**Living arrangements:** Do they live at home when they are working or do they live away from home to be closer to the job site? Do they live with anyone when they are away from home?

**Travel for work:** Do they spend a lot of time on the road away from their families?

**Economic:** What is their economic status?

**Medical care:** What access do they have to medical services?

**Knowledge:** What do they know/believe about HIV/AIDS, other sexually transmitted infections, and high-risk behaviour?

**Risk behaviour:** Do they regularly engage in activities that increase their risk of acquiring HIV and other sexually transmitted infections?

**HIV counselling and testing:** Do they have access to, or utilize, counselling and testing services for HIV and other sexually transmitted infections? Is there a programme at the workplace for HIV counselling and testing? Do they trust the workplace services?

**Condom distribution:** Do they use condoms? Where do they get them? Do they get them free or do they buy them? Are condoms distributed at the workplace?

Treatment for HIV and other sexually transmitted infections: Where do they go for treatment of HIV or other sexually transmitted infections? Is there a programme available at the workplace? Do they use/trust the workplace programme?

**Clubs:** What clubs or organizations do they belong to?

**Hopes/fears:** What are their hopes and fears about the future?

**Enjoyment:** Where do they go to enjoy themselves?

**Friends:** Who are their friends?

**Co-workers:** To their knowledge, are any of their co-workers HIV-positive?

**Clothes:** What kind of clothes do they wear?

**Role models:** Whom do they respect?

**Sources of information:** Whom do they trust at work to provide them with information? Whom do they trust to share their personal information with?

**Worksite health care:** Which medical services are offered at the worksite? Who has access to them?

**Confidentiality of care:** To what degree is workers’ health status kept confidential? Who has access to the information? Do people trust the health-care workers?

**HIV/AIDS stigma at the workplace:** How are workers living with HIV/AIDS treated by supervisors? By co-workers?
Handout 23: Sample data on transport workers

Profile

The transport workers interviewed are males aged 20 to 48. More than 30 per cent are unmarried, and all are Christians.

Attitudes of target population towards HIV and other sexually transmitted infections

Transport workers believe that sexually transmitted infections are common, but that HIV is not as common. They believe HIV is deadly and that anyone who becomes infected with the virus is “as good as dead”. Because of the nature of their job, they believe that contracting a disease is inevitable.

All key informants believe that, “HIV is God’s way of redirecting people towards Him because HIV is a venereal disease and it is deadly”.

Sex work within and around the target population

Sex work within and around the target population remains intense, especially when workers are out of their home areas. They begin sexual activity at an early age—15–18. Transport workers actively and indiscriminately engage in sex for the following reasons:

- High alcohol and cannabis consumption
- The availability of cheap sex away from ‘base’.

They commonly have a number of regular sexual partners in different towns or cities where they travel.

Availability of condoms and preferences for condom outlets

Condoms are very accessible. They can be obtained from pharmacies, hawkers in the park, and provision stores. Transport workers prefer to buy condoms from the park hawkers.

Health-seeking behaviour for sexually transmitted infections

Transport workers generally prefer to go to traditional doctors; very few go to the hospitals.

High-risk behaviour associated with HIV and other sexually transmitted infections, and risk-reduction methods

Transport workers believe that high-risk behaviours include eating from the same bowl as a person infected with HIV, having sex without a condom, and using unsterilized instruments. To reduce their risk, they “use condoms or have sexual intercourse with the same partners”.

Target population’s attitudes towards free condoms, purchase of condoms and condom use

This target group endorses the distribution of free condoms. They believe that giving free condoms to them and others should be highly encouraged. They know that condom use helps prevent sexually transmitted infections.

Communication about HIV and other sexually transmitted infections among peers and associates

Sex and sex-related issues are freely discussed among peers and close friends.

Appropriate channels of communication favoured by target population

They prefer radio programmes in the local language.
Day 3, session 3: Designing a Strategy—Behaviour change communication objectives

**Objectives**

By the end of this session participants will be able to articulate the behaviour change communication objectives for a particular target population.

**Process**

**Step 1:** Presentation (25 minutes)

- Begin by telling participants the following: “The goal of this exercise is to help you learn to define the behaviour change communication objectives for a particular target population, in order to be able to answer the following question: What do we want to accomplish with the communication?
- Provide an example of a behaviour change communication programme’s goal such as reducing HIV prevalence among miners in worksite X. [Write this goal on the flipchart.] Remind participants that the goal is the result that they hope to achieve through their programme.

**Programme goal:**

Decrease HIV prevalence among miners at worksite X

- From the goal, participants will need to define a behaviour change objective. [Write ‘behaviour change objective’ on the flipchart.]

**Programme goal:**

Decrease HIV prevalence among miners at worksite X

**Behaviour change objective:**
- An objective must be a specific, measurable result.
- Ask participants what their behaviour change objective should be, and what behaviour changes the programme intends to achieve.
- Invite participants to recommend behaviour change objectives. List several of these on the flipchart.

**Programme goal:**
Decrease HIV prevalence among miners at worksite X

**Behaviour change objective:**
Increase condom use.
Decrease number of partners.

- Answers may include (but are not limited to) the following:
  - Increase condom use
  - Increase demand for appropriate treatment of sexually transmitted infections
  - Reduce number of partners.
- This is a behaviour change objective. What is a behaviour change communication objective?

[Note: Add more flipchart sheets, as needed, to continue writing throughout this section.]

- Allow participants to respond, note appropriate responses, then add the following:
  “Behaviour change communication objectives identify the knowledge, attitudes and skills that the target population may need to change or acquire in order to promote an environment more conducive to behaviour change. These might include creating or increasing demand for, perception of, interest in, discussion about, and/or acceptance of, services and healthy behaviour.”
Invite participants to recommend behaviour change communication objectives and list several of them on the flipchart.

- Increase perception of risk or change attitudes about condoms
- Increase demand for services
- Create demand for information about HIV/AIDS
- Create demand for appropriate sexually transmitted infection services
- Interest policy-makers in investing in miner-friendly HIV counselling and testing services.

Point out to participants that such services must be in place to meet the demand and interest being created.

**Step 2:** Small group activity (20 minutes)

- Tell participants that the goal of this exercise is to distinguish between behaviour change objectives and behaviour change communication objectives.
- Each group will receive a list of objectives. Instruct them to work together to sort out which are behaviour change objectives and which are behaviour change communication objectives.
- Give each group an envelope with a full set of objectives (see pages 113 and 114).

**Step 3:** (5 minutes)

- Distribute handout 25, ‘Examples of behaviour change and behaviour change communication objectives’ (see page 115).
- Give the groups about five minutes to discuss their results.
- Ask participants to point out the difference between these two things.
- Answers may include (but are not limited to) the following:
  - A behaviour change objective defines the changes in behaviour that the programme intends to achieve.
  - A behaviour change communication objective defines the knowledge, attitudes and skills that a programme may need to change to promote an environment more conducive to behaviour change.

Tell participants the following: “This handout may help you as you review your formative assessment summary and decide what your programme objectives will be.”
Step 4: Small group activity (20 minutes)

- Give each group a sheet of flipchart paper and some markers.
- Tell participants the following: “Your goal for this exercise is to write the behaviour change communication objectives for the desired behaviour change indicated on your activity sheet. Be sure that your objectives are measurable, because you will be working with these same objectives in a behaviour change communication monitoring session. A measurable objective is one whose success you can clearly determine.”
- Hand out one activity sheet to each group (see page 116).

Step 5: Group presentations and discussion (20 minutes)

- Have each group post its diagram on the wall so that all participants can see the various behaviour change communication objectives.
- After each presentation, ask participants to add comments and insights, if they wish. Ask if certain objectives are measurable and how they would be measured.

[Note: Be sure to label and save each group’s flipchart diagrams, as they will be used in a later exercise on monitoring.]

Step 6: Summary statement

- Tell participants that it is important to keep in mind the following:
  - Behaviour change communication alone does not lead to behaviour change.
  - To be effective, behaviour change communication must include other strategies, activities and approaches.

Understanding your programme objectives, behaviour change objectives and communication objectives is essential, because it tells you where you are going and
Handout 24: Behaviour change objectives and behaviour change communication objectives, for day 3, session 3, step 2

Facilitator: Make six copies of this sheet (or as many copies as you have groups). Cut each sheet into slips of paper, with one objective on each slip. Mix up each set and place a full set in each envelope. Give one envelope to each group for them to distinguish between behaviour change or behaviour change communication objectives.

Increase condom use

Decrease stigma associated with HIV/AIDS

Increase demand for appropriate treatment of sexually transmitted infections

Delay sexual debut

Promote acceptance among communities of youth about sexuality and the value of reproductive health services for youth (services must be in place)

Reduce number of partners

Increased safer sexual practices (more frequent condom use, fewer partners)

Increase in discussion about HIV/AIDS and other sexually transmitted infections

Increase confidence in condom use

Create demand for information about HIV/AIDS

Increase use of universal precautions to improve blood safety

Interest policy-makers in investing in youth-friendly HIV counselling and testing services (services must be in place)

Increase perception of risk or change attitudes towards condoms
Increase utilization of HIV counselling and testing services

Increase consistent condom use

Increase blood donations (where appropriate)

Increase and deepen knowledge about services for sexually transmitted infections and HIV counselling and testing

Improved compliance with drug treatment regimens

Improve adherence by medical practitioners to treatment guidelines

Improve attitudes and behaviour among health-care and other service providers who interact with people living with HIV/AIDS, sex workers, intravenous drug users and other marginalized groups

Increase use of new or disinfected syringes and needles by injecting drug users

Reduce incidence of discriminatory activity directed at people living with HIV/AIDS and other high-risk groups

Increase self-assessment of risk

Increase demand for, and knowledge about, services for HIV and other sexually transmitted infections

Increase knowledge about universal precautions
Handout 25: Examples of behaviour change and behaviour change communication objectives, for day 3, session 3, step 3

Programme goal: Reduce HIV prevalence among miners at worksite X

**Behaviour change objectives:**

- Increase condom use
- Increase demand for appropriate treatment of sexually transmitted infections
- Delay sexual debut
- Reduce number of partners
- Increase safer sexual practices (more frequent condom use, fewer partners)
- Increase use of universal precautions to improve blood safety
- Increase utilization of HIV counselling and testing services
- Increase consistent condom use
- Increase blood donations (where appropriate)
- Improve compliance with drug treatment regimens
- Increase adherence by medical practitioners to treatment guidelines
- Increase use of new or disinfected syringes and needles by injecting drug users
- Decrease stigma associated with HIV/AIDS
- Reduce incidence of discriminatory activity directed at people living with HIV/AIDS and other high-risk groups.

**Behaviour change communication objectives:**

- Increase perception of risk or change attitudes towards condoms
- Increase demand for services
- Create demand for information on HIV/AIDS
- Create demand for appropriate sexually transmitted infection services
- Interest policy-makers in investing in youth-friendly HIV counselling and testing services (services must be in place)
- Promote acceptance among communities of youth about sexuality and the value of reproductive health services for youth (services must be in place)
- Increase self-assessment of risk
- Increase confidence in condom use
- Increase demand for, and knowledge about, services for HIV and other sexually transmitted infections
- Increase discussion about HIV and other sexually transmitted infections
- Increase knowledge about universal precautions
- Increase and deepen knowledge about services for sexually transmitted infections and HIV counselling and testing
- Improve attitudes and behaviour among health-care and other service providers who interact with people living with HIV/AIDS, sex workers, intravenous drug users and other marginalized groups.

Note: Indicators should be based on BCC objectives.
Handout 26: Activity sheets with behaviour change objectives, for day 3, session 3, step 4

Cut the following activity sheets into separate slips and distribute one to each group.

First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your **behaviour change objective**):

reduce number of sexual partners

Now, around the outside of the figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.

First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your **behaviour change objective**):

increase condom use

Now, around the outside of the figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.
First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your behaviour change objective):

**increase use of health-care services**

Now, around the outside of this figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.

First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your behaviour change objective):

**increase access to, and use of, voluntary HIV counselling and testing**

Now, around this figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.

First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your behaviour change objective):

**reduce the incidence of discrimination directed at people living with HIV/AIDS**

Now, around this figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).
Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.

First, draw an outline of a person in the centre of your paper, with plenty of space around it and also room to write a bit inside.

Inside your drawing, write down the behaviour you would like your target population to adopt (your behaviour change objective):

improve providers’ and clients’ compliance with drug treatment regimens

Now, around this figure on your flipchart paper, write behaviour change communication objectives for this desired behaviour (supporting people in their intention to act in this way).

Be sure that the objectives you choose are measurable (i.e., be sure you have a way of determining whether members of your target population have adopted this new behaviour), because in a future exercise you will be working with these same objectives to learn how to monitor them.
Day 3, session 4: Designing a Strategy—Key benefit statements and barriers

1 hour 45 minutes

Flipchart, markers, six flipchart sheets with ‘Barriers to adoption of a new behaviour’ written at the top.

Objectives

By the end of this session participants will be able to develop clearly articulated statements that show the perceived and real benefits of changing behaviours and barriers to change.

Process

Step 1: Presentation and discussion (30 minutes)

- Begin by telling participants the following: “The goal of this exercise is to help you identify and understand both the perceived and real benefits for a target population of changing high-risk behaviours.”
- Cover the following points:
  - Finding out what might help motivate a person or a community to change is an important step in developing an effective and convincing message. You can use the data from your formative assessment and target population profiles – including information about their hopes and fears – to develop key benefit statements.
  - Before beginning to identify benefits of behaviour change, you must have a clear understanding of, and agreement on, three things:
    - your defined target population;
    - communication objectives; and
    - a desired action response (behaviour change objective).
Day 3

- Behaviour change messages have two components [write ‘Desired behaviour’ on one side of a flipchart page]:

  Desired behaviour

- An example of a ‘desired behaviour’ might be seeking treatment for a sexually transmitted infection. [Now write ‘Key benefit’ on the other side of the flipchart page.]

  Desired behaviour  Key benefit

- And an example of a ‘key benefit’ might be (for a man) avoiding his wife’s anger if he behaves in a certain way (“If I do ‘x’, then I will benefit by getting ‘y’”).

- Share some examples with the participants:

  [Note: As you cover the following information, point to either ‘desired behaviour’ or ‘key benefit’ on the flipchart as you explain the concepts with examples. This physical reference will help your participants remember the definition and concepts as you highlight them.]

  The example used above is from research with truck drivers showing that they would be motivated to seek treatment for sexually transmitted infections (the desired behaviour) to avoid the anger of their wives when they returned home (key benefit). The key benefit was a happy wife.

  What kind of approach might not work with truck drivers? In other words, what might sound good as a public health message but would not relate to the truck drivers’ hopes and fears?

  Answers may include (but are not limited to) the following (which may be good reasons for seeking treatment, but not necessarily effective motivators for truck drivers):

  - ‘Get treated for sexually transmitted infections because it’s the right thing to do.’
  - ‘Take good care of yourself by getting treated.’
  - ‘Take care of your wife by getting treated.’

  Sex workers in Kamatipura, Mumbai, India, are especially concerned about their children. So the key benefits to seeking treatment for sexually transmitted infections and using condoms need to be related to their fear of infertility and their fear of not staying healthy for their children.
What would not be a good approach to use with these sex workers? In other words, might sound good as a public health message but does not link to sex workers’ hopes and fears?

Answers may include (but are not limited to) the following:

- ‘Get treated for sexually transmitted infections to keep our community healthy.’
- ‘Take good care of yourself by getting treated.’
- ‘Get treated because it is bad to spread infection to your clients.’

When campaigning, many politicians target their speeches to the communities to which they are catering. So if they are in a town with factories, they may say ‘vote for me (desired behaviour) and I will make sure the factory gets contracts (therefore jobs).’ The key benefit for the voter is the promise of more jobs.

Ask participants to come up with some more examples from their workplace or local community. The examples do not have to be related to HIV/AIDS.

**Step 2: Small group work (45 minutes)**

- Divide participants into their small groups.
- Invite the participants to do the following, as you demonstrate on your flipchart:

  - “Write the words ‘Desired behaviour’ at the top and ‘Perceived benefits’ in the middle.
  - “Now, confer with your group to decide on the main behaviours that the target population needs to adopt. Discuss and list what might be the target population’s perceived benefits in changing its behaviour. Use a separate sheet for each major behaviour.”
  - If participants are not working on a common target population, let them use the Mumias Sugar Company case study as a basis for choosing behaviours that they want to change and deciding on the perceived benefits of those behaviour changes.

**Step 3: Group presentations and discussion (15 minutes)**

- Ask for one volunteer from each group to present the group’s results to the other participants.
- After each presentation, briefly ask if anyone has questions for the presenting group to answer.
Step 4: Small group work (30 minutes)

- Tell participants the following: “Although people may want to change their behaviour or adopt a new one, they often have trouble attaining this goal. Just as there are factors that motivate change, some factors discourage or stop people from changing. These factors are barriers to the adoption of a new behaviour.”
- Invite participants to re-form their small groups. They should use flipchart paper to identify barriers to the desired behaviour for which they identified perceived benefits in the previous exercise.

Step 5: Group presentations and discussion (15 minutes)

- Have each group present the barriers it has identified to the desired behaviour.
- After each presentation, briefly ask if anyone has questions for the presenting group to answer.

Step 6: Summary statement

- Tell participants the following: “Finding out what could help motivate a person or a community to change is an important step in developing an effective and convincing message. Data from your formative assessment can help you identify the hopes and fears of your target population as well as what they might see as the benefits of adopting a new behaviour – so you can create messages that are true motivators towards desired behaviours and actions.”
Day 3, session 5: Designing a Strategy—Effective messages

1 hour 30 minutes

Flipchart, markers, handout 27 on messages (see page 126), information on target populations from previous exercises on target population profiles and formative assessment. The facilitator may need to prepare this information from the flipchart pages, typing and photocopying it, or copying it onto new flipchart pages in a more orderly fashion. Use the handout 23 on transport worker data (on page 107) as a model for which information to include.

Objectives

By the end of this session, participants will be able to develop key messages based on BCC objectives and key benefit statements.

Process

To create key messages for their target populations, participants will use much of the information they developed in previous small group sessions, including the following:

- Formative assessment data
- Target population profiles
- Behaviour change and behaviour change communication objectives
- Desired behaviours and key benefits
- Barriers to adopting a new behaviour.

Step 1: Small group work (20 minutes)

- Tell participants that they will be re-forming their small groups to develop a key message for one of the desired behaviours they identified earlier, keeping in mind the other information, especially related key benefits and barriers to adopting new behaviour.
- Remind participants of the sample messages covered in the previous session, as follows:
  - Truck drivers: “Take care of your sexually transmitted infections on the road and come home to a happy wife.”
  - Sex workers in India: “Use condoms to ensure you are healthy and able to take care of your child.”
  - Politicians: “Vote for me and I will make sure you get a job.”
- Emphasize the fact that messages must explain why someone should undertake a certain action. “Visit the HIV counselling and testing centre and find out your HIV status.” Why? “So that you can plan for family’s future.”
Review characteristics of effective messages (see below). After each characteristic, ask participants for an example of an effective message they have seen on TV or a billboard, heard on the radio or in a public presentation, or read in a newspaper, pamphlet or brochure. These messages can be ads for products or something else. They need not necessarily be health messages. In each case, identify the desired behaviour and the benefit. Ask if the action and benefit are clearly stated.

### Characteristics of effective messages

<table>
<thead>
<tr>
<th>Command attention:</th>
<th>An effective message should stand out and get noticed above anything else</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify the message:</td>
<td>“Kiss” – Keep It Short and Simple. Most messages lack impact because the message is not clear.</td>
</tr>
<tr>
<td>Communicate a benefit:</td>
<td>Messages that communicate a benefit are more likely to appeal to the intended audience.</td>
</tr>
<tr>
<td>Create consistency:</td>
<td>A message repeated over time consistently creates an impression of the truth.</td>
</tr>
<tr>
<td>Cater to the heart and the mind:</td>
<td>The most inspiring messages are those that appeal to the emotions (heart), thereby making individuals think more and more about the problem (with the mind).</td>
</tr>
<tr>
<td>Create trust:</td>
<td>People will trust what makes sense to them. A message must be believable and consistent with reality.</td>
</tr>
<tr>
<td>Call for action:</td>
<td>The purpose of any message is to change people’s behaviour—that is, to enable people to change from behaviour A to behaviour B. Therefore, a message without a call for action is incomplete and its impact is usually not measurable.</td>
</tr>
</tbody>
</table>

**Step 2:** Group presentations and discussion (30 minutes)

- Reconvene participants.
- Move participants to the part of the room where each group has posted its messages, as that particular group makes its presentation.
- Keep track of common messages for use in the theme development session.

**Step 3:** Small group work (20 minutes)

- Have participants re-form their small groups.
- Instruct them to develop key messages based on the knowledge, attitudes and practices of the target population. They should revise them and adapt the messages so that they reflect the BCC objectives and key benefit statements and barriers.
- Remind the participants of the following:

  Effective messages help the target audience to:
  
  - Make a personal commitment to make the desired changes
  - Acquire the skills to implement the changes
  - Create a supportive environment for practising the behaviour.
  
- Distribute handout 27, ‘Developing successful messages’ (see page 126).
  Each participant will fill out the chart as they develop messages. Instruct them to copy their final messages onto a flipchart for presentation.
Step 4: Group presentations and discussion (20 minutes)

- Have each group post its flipchart pages and present its messages. When all groups have finished presenting, ask participants to select those that best meet the criteria for effective messages and discuss why.
- Keep track of common messages for use in the theme development session.
### Handout 27: Developing successful messages, for day 3, session 5, step 3

<table>
<thead>
<tr>
<th>TIP</th>
<th>EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the benefit (s) of making the desired behaviour change</td>
<td>“Your health matters. Use a condom with every partner”</td>
</tr>
<tr>
<td>Support the benefits with relevant information</td>
<td>“Get the family you have dreamed. Untreated or improperly treated STIs may cause infertility. Go to the health centre for treatment”</td>
</tr>
<tr>
<td>Make the messages clear and simple</td>
<td>“Everybody is at risk. Use a condom every time against STI and HIV”</td>
</tr>
<tr>
<td>Highlight the main points</td>
<td>“Treat that STI now!”</td>
</tr>
<tr>
<td>Create a feeling appropriate with the message you are delivering</td>
<td>“We care for each other. Abstinence is our choice against STI &amp; HIV”</td>
</tr>
<tr>
<td>Find credible sources to deliver your message</td>
<td>“Keep your dreams alive. Use a condom every time.” (Message delivered by known football player)</td>
</tr>
</tbody>
</table>

### MESSAGES

<table>
<thead>
<tr>
<th>MESSAGES</th>
<th>What benefits will the target audience get by following the message?</th>
<th>Is the message simple?</th>
<th>What do you want the audience to feel when they read the message?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Having sex does not make an adolescent an adult.</td>
<td>There is no pressure to grow up too quickly. Enjoy yourself now.</td>
<td>✓</td>
<td>Adolescents should feel that there is nothing wrong with indulging in sex.</td>
</tr>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
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<td>b)</td>
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<tr>
<td>a)</td>
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</tbody>
</table>
**Day 4: Developing Materials**

<table>
<thead>
<tr>
<th>DAY 4</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of day 3</td>
<td>8:30 – 9:00</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>Session 1</td>
<td>9:00 – 10:15</td>
<td>Booklet 3: Designing a Strategy—Themes</td>
</tr>
<tr>
<td>Break</td>
<td>10:15 – 10:30</td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>10:30 – 11:45</td>
<td>Booklet 3: Designing a Strategy—Communication channels</td>
</tr>
<tr>
<td>Lunch</td>
<td>11:45 – 12:45</td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td>12:45 – 1:45</td>
<td>Booklet 3: Designing a Strategy—Analysis of materials</td>
</tr>
<tr>
<td>Session 4</td>
<td>1:45 – 3:00</td>
<td>Booklet 4: Developing Materials</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
<td></td>
</tr>
<tr>
<td>Summary</td>
<td>4:00 – 4:15</td>
<td>A brief summary of the day’s activities</td>
</tr>
</tbody>
</table>
Day 4, session 1: Designing a Strategy—Themes

Objectives
By the end of this session, participants will be able to develop themes to unite BCC programmes for a variety of target populations.

Process

Step 1: Tell participants the following: “The goal of this exercise is to help you develop themes that can unite BCC programmes for a variety of workplace target populations.”

Step 2: Presentation and discussion (20 minutes)

- A theme is a global statement that encompasses the entire content of a behaviour change communication programme and stimulates interest. The purpose of a theme is to capture the attention of a target population or populations and to unite campaigns and activities within a programme in the minds of that community of target populations.
- Some examples of themes:
  - “Ready body – is it really ready?” This was developed in Guyana to unite a variety of BCC programmes with segmented youth populations. It was successful in getting young people’s attention.
  - “Men can make a difference.” This theme was developed by the International Planned Parenthood Federation to mobilize men to be active with regard to reproductive health issues.
  - “Care for a healthy family.” Family Health International developed this theme in Kano, Nigeria. It links work with a variety of high-risk and vulnerable populations and builds on the strong Islamic belief that the family is the centre of the cultural and social world. HIV/AIDS messages have been developed and are being disseminated and discussed through a variety of channels and social networks.
- Take participants through a discussion of the elements used in developing a theme:
  - Image: Do the images used in messages convey the central theme? Do they help express the theme in a positive way that will inspire people to take action?
  - Colour: Are common colours used in messages? Is there a central reason for using them? Do they help support a common theme?
Day 4

- Language: Is the language used in different messages recognizable as supporting a common theme? Is it ‘proactive’ language—i.e., language that makes people want to act (to find out more about the issues, to consider changing their high-risk behaviour, or to obtain help in making those changes)?

Step 3: Small group work (30 minutes)

- For this activity, divide participants into different small groups so that they have an opportunity to work with other participants. Each group should have a flipchart and markers to work with.
- Have the groups consult all of the messages developed for specific target populations in the previous exercise. Have these posted on the walls of the room. Participants should look for cross-cutting themes that might be relevant for all target populations. Ask them to brainstorm about themes that could get the attention of their target populations, perhaps relating to common cultural issues, common risk issues or common geographical issues.

Step 4: Group presentations and discussion (25 minutes)

- Reconvene participants, and ask each group to present its themes. Help participants reach a consensus on the top three themes for pre-testing with the broader community.

Step 5: Summary statement

- Conclude by saying: “By creating common cross-cutting themes in your BCC strategy for several target populations within a geographical community, you can link the messages for each group to ensure that all channels and social networks are working together.”
Day 4, session 2: Designing a Strategy—Communication channels

1 hour 15 minutes   Flipchart, markers, handouts 28–31 (see pages 135 to 141)

Objectives

By the end of this session, participants will be able to identify the most effective combination of channels for effectively reaching the target population.

Process

Step 1: Tell participants the following: “The goal of this exercise is to help you identify the combination of communication channels that will most effectively reach your target population.”

Step 2: Full group presentation and discussion (15 minutes)

- Begin by defining communication channels: Communication channels are the vehicles that carry, present and deliver messages.
- Invite participants to brainstorm about the following:
  - Where they have received messages about health-related issues such as:
    - the importance of washing one's hands;
    - immunizations;
    - safe drinking water; and
    - HIV/AIDS-related messages.
  - What channels people have for getting information at their workplaces. For example:
    - How would people find out if workers were going to be laid off or hired?
    - How would they find out if the workplace policy on sick leave were changing?
    - How are these channels different from those used to convey health messages?
    - How are they different from those used to advertise products such as infant formula or Coca-Cola?
[Note: Rather than answering these questions, elicit responses from the participants so that they are the source of the information, drawing on their personal experiences with messages. You can add more sources to fill out the list after you elicit all you can from them. You can also draw out answers they may not think of by asking questions such as, “What about when you walk down a street/drive a car/get something in the mail? Where and how do you see messages and what is the vehicle for these messages?”]

- As you name each of these areas, list the main vehicle type on a flipchart:

<table>
<thead>
<tr>
<th>CHANNELS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mass media (radio, TV)</td>
</tr>
<tr>
<td>Small media (booklets, video cassettes)</td>
</tr>
<tr>
<td>Group media (flipcharts, picture books)</td>
</tr>
<tr>
<td>Interpersonal communication (peer education, meetings, etc.)</td>
</tr>
</tbody>
</table>

- Use of mass media involves widespread diffusion to a large number of people. Mass media forms include:
  - radio, television, newspapers;
  - mass media advertisements; and
  - billboards, posters, stickers, calendars.

- Small media reach fewer people and may include:
  - printed materials: booklets, pamphlets, comic books, photo novellas
  - audio and video cassettes
  - exhibits
  - traditional media (street theatre, puppet shows, mime, etc.).

- Group media consist of materials used to enhance interpersonal communication, and include:
  - flipcharts;
  - picture books;
  - flash cards;
  - slides and filmstrips;
  - models; and
  - exhibits.
Interpersonal communication is used with individuals or small groups. It includes anything that brings people together, face to face, such as:

- peer education and peer leadership;
- meetings;
- counselling;
- training sessions;
- events;
- role-playing and drama; and
- home and site visits.

Ask participants how they would select which communication channels to use when, reminding them that a combination of channels often works best. Communicating the same message through different channels increases its overall effectiveness.

Point to each of the channels you have written on the flipchart as you make the following statements:

- “Mass media reach many people rapidly.”
- “Small media reach small groups with specific messages.”
- “Interpersonal communication with interactive group media is very persuasive and credible.”

What about cost-effectiveness? It is important to choose the right channels and to use resources that maximize changes in high-risk behaviours. For example:

- Mass media get the message out quickly and have a low per-person cost.
- Television is powerful, but it is an expensive tool.
- Pamphlets are detailed and reusable, but can be hard to distribute.

Evaluating communication channels takes places by observing how much of the target population they reach, how often the target population is exposed to the channel, how much it costs to produce and disseminate the message, and what is required in terms of human resources to use this channel.

If certain forms of interpersonal communication (such as peer education, meetings, training sessions, events and drama) and mass media (such as radio, newspapers, posters and stickers) are effective, which is better?

A combination usually works best. Mass media set the stage and create demand for services, and interpersonal communication provides detail and interactivity.

**Step 3: Small group work (30 minutes)**

Have participants re-form their small groups. Place a sheet of flipchart paper and some markers at each group table.

Tell participants that the goal of this exercise is to identify the appropriate communication channels to use for the target population of truck drivers in Ngongi and to list the communication products or materials needed to support the identified channels.

Distribute handouts 28, 29 and 30, relating to Ngongi, as well as the activity worksheet (handout 31) (one copy for each participant – see pages 135 to 141).

Instruct participants to go through the questions on the worksheet, handout 25, and list the answers on their flipcharts.

**Step 4: Group presentations and discussion (30 minutes)**

Invite one group to respond to the first question. Ask whether other groups have different responses. Summarize and proceed to the next question. Allow a different group to initiate the discussion and continue in this way until all the questions have been answered.
Day 4

**Step 5: Summary statement**

- Tell participants the following: “So we have learned that there are many different communication channels that we can use to carry messages to our target populations.” Add that in the context of the ILO technical cooperation activity, the peer-education programme will be an important channel of communication in most of the targeted workplaces.

- Explain that peer education is one of the most effective ways of inspiring behaviour change and conducting HIV/AIDS-related education at the workplace. Peer education is based on the idea that individuals are most likely to change their behaviour if people they know and trust persuade them to do so. It helps to break down barriers by allowing people to discuss sensitive matters without fear. Refer them to the ILO/FHI Toolkit, Booklet 5 for more information about peer education.

Refer participants to **Booklet 3: Designing a Behaviour Change Communication Strategy** for an outline of the BCC Strategy Design Workshop that will be part of the implementation of the ILO technical cooperation project.
General overview
The city of Ngongi is a regional capital located in an African country. It is 400 miles/250 kilometres from the national capital. The population has grown rapidly to 2 million, largely due to the influx of rural people who have come seeking employment or to continue their education. Many of the new arrivals live in shantytowns on the outskirts of the city, where social services are limited.

Geography
Ngongi is located in a sloping valley and is surrounded by forests and rolling hills.

Commerce and transportation
Ngongi is a thriving market town where local and foreign produce and products are bought and sold. Ngongi has one of the largest markets both in the country and in the region. More than a thousand trucks come and go each day. The roads are in need of repair and are often clogged with traffic.

Natural resources
The primary natural resource is timber in the surrounding forests. There are a few potash mines in the hills surrounding the city. Men come from all over the country to work in the forests and the mines.

Population
The population of Ngongi reflects the diversity of the entire country: three different tribal groups speaking three different languages are found in equal numbers. Half the population is under the age of 15.

Religion
The majority of the population is Christian, but 1 per cent is Muslim. Religion has a strong influence on the population in all areas of people's lives. The churches and mosques are relied on for social activities, information, education, health care etc. Religious organizations are very active in Ngongi, operating several health clinics. Several churches also require their parishioners to be tested for HIV before getting married.

History, politics and administration
The national government is in the process of decentralizing many government services, including those in the health sector. An electoral system was recently established and a charismatic mayor was elected in Ngongi.

Education
Progress has been made in raising literacy rates and providing access to school for girls; 67 per cent of males and 47 per cent of females are literate. Class sizes are much too large and family life education either does not exist or does not adequately cover reproductive health.
Status of women

One-fourth of the women have no formal education. Due to economic pressure, the amount of time that they work outside the house has increased. Most women work in the commercial sector selling goods. Many young girls work as ambulatory sellers of small goods. Less than 10 per cent of the women use modern contraceptives. As a result, each woman has an average of six live births in her lifetime.

Family structure

The character of the average family is changing rapidly. The average age at marriage is increasing. Many rural families have migrated to the cities, with most leaving their extended family support systems behind. The number of polygamous men has decreased, as young men seldom take more than one wife.

Occupations

Traditionally, lumber companies and commerce at the large central market provided urban employment. However, these traditional sources of employment do not generate enough work to support the rapidly growing population. A large military base on the outskirts of the city provides some civilian employment. Many women work in the large regional market. Some men from the city work in the mines in the hills around the city, but most of the miners come from other parts of the country and live in hostels at the mines. Half of the population is unemployed.

Health

A small regional hospital built during the colonial period is woefully inadequate and does not meet the needs of the population. A number of small, private clinics have been established, but their cost places them out of the reach of much of the population. The newly built shantytown area has no medical facilities at all. The hospital has a small laboratory, which can test for HIV. The hospital also has several nurses trained in counselling. One or two churches in the community have clinics that provide general health-care services.

Role of non-governmental organizations

Non-governmental organizations are relied on to fill many of the social services that the government cannot provide. There are non-governmental organizations that train health-care providers and peer educators in family planning and HIV/AIDS, build sanitation systems and latrines, fund small agricultural projects, build infrastructure, etc. However, the mayor is trying to persuade more non-governmental organizations to move to the area to meet the needs of the fast-growing population.

Media

There are two radio stations in Ngongi. The first is part of the government network of stations, although it is now expected to raise its own revenues locally. Another private station opened in 2004. It provides less news than the government station and plays mainly popular music, which attracts a large and youthful audience. There is a local weekly newspaper that covers local news; it also has a popular advice column and comics. Television is available only to those who have satellite dishes, which means that few people in this low-income community have access to television.
HIV situation

Since the first AIDS case was reported in 1986, various studies and reports have shown that there has been a continuous increase in the HIV prevalence rate in Ngongi. The national prevalence rate increased from 1.8 per cent in 1991 to 3.8 per cent in 1993, 4.5 per cent in 1995, and 5.4 per cent in 1999. The trend has been similar in Ngongi, with statistics showing a higher prevalence rate in 1999 (6.1 per cent) than the national rate (5.4 per cent).

Local studies also indicate that the prevalence rate near the market and lumber companies is relatively high (estimated to be about 10.1 per cent, based on 7,063 blood samples screened for HIV between July 1999 and June 2000). This relatively high prevalence rate is believed to be attributable to the special social characteristics of these settings. The big transportation business and educational opportunities in Ngongi are also factors favouring population movement to and from the area. This movement contributes to the spread of sexually transmitted infections.
Handout 29: Additional information about Ngongi, for day 4, session 2, step 3

- Some populations (such as sex workers, transport workers and in-school youth) in Ngongi are at increased risk of HIV infection.
- Among young people and sex workers, money, food, clothing or goods are exchanged for sex.
- People also engage in ‘aspirational sex’ (i.e., they have sex, hoping to get something out of it). Usually adolescent girls or young women will engage in aspirational sex with an older man who has, or appears to have, money in order to get a cell phone, be seen as ‘cool’, get rides in a car, or have pocket money.
- Transport workers often have multiple sexual partners.
- In the community, there is inadequate manpower for the provision of HIV/AIDS prevention, care and support.
- There is stigmatization against people living with HIV/AIDS.
- Some religious organizations (including the Catholic Church) and community leaders oppose condom use.
- Sex workers, travellers (e.g., truck drivers, commercial salespeople and migrant workers in mines, forests and the military), and sexually active youths are thought to be the groups most at risk.
- Since most people do not know of anyone who has died of AIDS, they deny that HIV is a problem in Ngongi and that high-risk behaviour needs to be reduced.
- The national condom social marketing project has an office in Ngongi and uses a local food distribution company to distribute its condoms. These condoms are available in small shops in most parts of the city.
- The Ministry of Health has established HIV counselling and testing centres at the regional hospital, but demand for testing has been low.
- One local agency has developed support groups for people living with HIV/AIDS, but it has had difficulty getting people who test positive to join the group.
- Another agency partnered with a secondary school to provide reproductive health education, but it was forced to stop its in-school education programme because of opposition from parents.
- Most behaviour change communication efforts have focused on knowledge diffusion and have met with success.
- Of the total population, 80 per cent has heard of HIV/AIDS, 75 per cent know what causes HIV, and 60 per cent know how to prevent infection.
- There is some misunderstanding about the risk of casual contact.
- Non-governmental organizations and the Ministry of Health have been using information, education and communication materials developed by the Ministry.
- These materials place a great deal of importance on the different modes of transmission, but they make only brief mention of methods of prevention, such as condom use and rapid treatment of sexually transmitted infections.
Handout 30: Ngongi report from studies conducted with the target population (transport workers), for day 4, session 2, step 3

Profile
The transport workers interviewed are males aged 20 to 48. More than 30 per cent are unmarried, and all are Christians.

Attitudes of target population towards HIV and other sexually transmitted infections
Transport workers believe that sexually transmitted infections are common, but that HIV is not as common. They believe HIV is deadly and that anyone who becomes infected with the virus is “as good as dead”. Because of the nature of their job, they believe that contracting a disease is inevitable.

All key informants believe that, “HIV/AIDS is God’s way of redirecting people towards Him because HIV is a venereal disease and it is deadly”.

Sex work within and around the target population
Sex work within and around the target population remains intense, especially when workers are out of their home areas. They begin sexual activity at an early age—15–18. Transport workers actively and indiscriminately engage in sex for the following reasons:
- High alcohol and cannabis consumption
- The availability of cheap sex away from ‘base’

They usually have several regular sexual partners in different towns or cities where they travel.

Availability of condoms and preferences for condom outlets
Condoms are very accessible. They are obtained from pharmacies, hawkers in the park and provision stores. Transport workers prefer to buy condoms from the park hawkers.

Health-seeking behaviour for sexually transmitted infections
Transport workers generally prefer to go to traditional doctors; very few go to the hospitals.

High-risk behaviour associated with HIV and other sexually transmitted infections and risk-reduction methods
Transport workers believe that high-risk behaviours include eating from the same bowl as a person infected with HIV, having sex without a condom, and using unsterilized instruments. To reduce their risk, they “use condoms or have sexual intercourse with the same partners”.

Target population’s attitudes towards free condoms, purchase of condoms and condom use
This target group endorses the distribution of free condoms. They believe that giving free condoms to them and others should be highly encouraged. They know that condom use helps prevent sexually transmitted infections.
Communication about HIV and other sexually transmitted infections among peers and associates

Sex and related issues are freely discussed among peers and close friends.

Appropriate channels of communication favoured by target population

They prefer radio programmes in the local language.
Handout 31: Activity worksheet for communication channels, for day 4, session 2, step 3

Instructions: Using the case study of Ngongi and the information on the target population of truck drivers, please respond to the questions below.

1. Which communication channels would you prioritize and why?

2. Which communication products would you like to develop?

3. Are there any areas (channels, products or materials) about which you would have liked to have further information?
Day 4, Session 3: Designing a Strategy—Analysis of materials

**Preparation**

The facilitator will need to prepare sets of communication materials used in other behaviour change communication programmes (which may or may not be focused on HIV/AIDS). Choose between enough sets of the same materials for each group or different materials for each group. These materials might include such things as posters, brochures, transcripts of radio and TV spots, etc.

**Process**

**Step 1:** Small group work (40 minutes)
- Have participants re-form their small groups.
- Provide each group with sample communication materials and handout 32 (see page 144).
- Instruct the groups to answer the questions on the handout about the material. Based on their answers, the groups should then decide if the material was effective or ineffective, and why.

**Step 2:** Group presentations and discussion (20 minutes)
- Have each group present its findings.

**Objectives**

By the end of this session, participants will have learned to build capacity to effectively analyse materials in preparation for the development of communication materials.
Handout 32: Questions for analysing sample communications materials, for day 4, session 3, step 1

Instructions: Examine the sample communications materials and answer the following questions about them.

- Who is the intended audience? How clearly can you tell who the intended audience is?
- How clearly is the message stated? How well is the message integrated into the material? (Does the message seem to belong in the material or does it seem out of place?)
- How attractive is the design of the material?
- How memorably is the message presented?
- Is the material an appropriate choice for the intended audience?
- What is the likely key benefit to the audience of adopting the promoted behaviour? Is the key benefit clearly presented? Is it presented visually (or orally) as well as through the text?
- What does each item tell the audience to do? Do visual or other elements in the material promote or reinforce the suggested action?
- Was this material effective or ineffective? Why? What would you change or improve in it?
Day 4, session 4: Developing Materials

1 hour

Flipchart, markers (enough for each participant), blank paper (A4 or 8½” x11” format) for developing communication materials, handout 33, ‘Advantages and disadvantages of different communication channels’ (see page 149)

Objectives

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

- Identify key elements of effective design of communication products, and
- Review and identify key elements of effective message/theme development and ensure that those elements are included in communication products.

Process

Step 1: Presentation and discussion (20 minutes)

- Tell participants the following: “Remember that the design of your materials, just like your messages, should come out of your knowledge about the target population. Therefore, your design team should be familiar with the results of the formative assessment.
- Explain the process of designing effective communication products.

[Note: As you mention the following, list the main points on a flipchart.]

- Materials should capture the viewer’s attention.

- Materials should feature a credible source. In your drawings, illustrations, photos or film, use a credible source (person) to relay the information – someone who is believable and reliable, and who will win the confidence of the target population.

- Effective materials should touch the hearts and minds of the audience.
- Effective materials should be relevant and related to real life.

- Messages may be more effective if they surprise the audience. These materials and their messages have to find a way to distinguish themselves from the many messages that most people are exposed to every day.

- Materials should be tailored to the geographical region of the country they are used in. For example, the visuals on a poster for an urban population should differ from those used on a poster for a rural population.
Effective messages use the ‘active’ rather than the ‘passive’ voice. With the active voice, the subject performs the action expressed by the verb—for example, ‘The counselling and testing centre will start providing services on the first day of the month’. With the passive voice, the subject receives the action expressed by the verb—for example, ‘Services will start to be provided by the counselling and testing centre on the first day of the month’, or ‘Services will begin being provided on the first day of the month’ (which is ambiguous, as we have no idea who will provide the services). The active voice presents a much more convincing argument than the passive voice, which often leaves people uncertain as to exactly who will carry out the action under discussion.

Materials should restate and review information repeatedly, when possible. A poster may say, ‘Come in for testing – we are there for you,’ then explain how the test can help and how safe and confidential it is, and then finish with a statement such as, ‘We care for you and are here to support you – come in for testing’.
Step 2: Small group work (40 minutes)

- Tell participants that they will use the guidelines you noted on the flipchart to develop sample communication material.
- Divide participants into three groups. Tell them that group 1 will design a poster, group 2 will create a flyer or brochure, and group 3 will create a brief script for a radio ad. The materials should be related to HIV/AIDS behaviour change communication (e.g., condom use, HIV counselling and testing, treatment for HIV or other sexually transmitted infections, etc.).
- Distribute handout 33 on the advantages/disadvantages of different communication channels to each group (see page 149).
- Tell participants that, in this case, the concept is more important than the artwork.

Step 3: Presentation of materials (15 minutes)

- Have the groups present their materials.
- When all the groups have finished, discuss their presentations and provide feedback.
### Handout 33: Advantages and disadvantages of different communication channels, for day 4, session 4, step 2

<table>
<thead>
<tr>
<th>Channel</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio</td>
<td>- Wide reach, even in rural areas of less developed countries&lt;br&gt;- Inexpensive&lt;br&gt;- Can reach illiterate audiences&lt;br&gt;- Good for mobilizing community to attend public events, etc.&lt;br&gt;- Flexible in formatting&lt;br&gt;- Good for regular tune-ins&lt;br&gt;- Good for creating awareness and agenda-setting</td>
<td>- One-way&lt;br&gt;- Ill-suited for complex content&lt;br&gt;- Difficult to assess degree of audience interest&lt;br&gt;- Needs to be tied in with other approaches in order to be effective</td>
</tr>
<tr>
<td>Radio</td>
<td>- Popular&lt;br&gt;- Combination of sound and picture allows for complicated messages to be conveyed&lt;br&gt;- Good for regular tune-ins&lt;br&gt;- Flexible formatting&lt;br&gt;- Good for illiterate audiences&lt;br&gt;- Good for creating awareness and agenda-setting</td>
<td>- Expensive&lt;br&gt;- Receivers not always available in remote rural areas&lt;br&gt;- No audience participation&lt;br&gt;- More customary for political and entertainment content than education/development&lt;br&gt;- Technology not advanced enough in many countries</td>
</tr>
<tr>
<td>Print</td>
<td>- Can be detailed&lt;br&gt;- Good for clear explanation of technical issues&lt;br&gt;- Good for creating awareness and mobilizing public opinion&lt;br&gt;- Can be shared and referenced&lt;br&gt;- Good for development topics</td>
<td>- Literates only&lt;br&gt;- Difficult to reach remote areas&lt;br&gt;- Expensive&lt;br&gt;- One-way&lt;br&gt;- Feedback is difficult</td>
</tr>
<tr>
<td>Cinema/film</td>
<td>- Captures attention&lt;br&gt;- Very wide reach (with travelling cinemas)</td>
<td>- Distribution can be difficult&lt;br&gt;- May not be the best setting for educational messages&lt;br&gt;- Good films are hard to make&lt;br&gt;- One-way: needs to be combined with discussion groups for maximum effectiveness&lt;br&gt;- Requires costly equipment</td>
</tr>
<tr>
<td>Theatre</td>
<td>- Culturally relevant&lt;br&gt;- Easy and inexpensive&lt;br&gt;- Credible</td>
<td>- Incomplete control over message&lt;br&gt;- Format can distract</td>
</tr>
<tr>
<td>Billboards</td>
<td>- Wide reach - Inexpensive, if well located</td>
<td>- Easy to ignore&lt;br&gt;- Difficult to convey complex messages</td>
</tr>
<tr>
<td>Leaflets, brochures, etc.</td>
<td>- Good for in-depth presentation of technical issues&lt;br&gt;- Easy to reference and personalize&lt;br&gt;- Use of graphics improves presentation&lt;br&gt;- Easy to distribute</td>
<td>- Expensive&lt;br&gt;- Needs to be well-written and produced to be effective</td>
</tr>
<tr>
<td>Video</td>
<td>- Good for teaching small groups&lt;br&gt;- Good for explaining complicated and technical issues&lt;br&gt;- Immediate feedback</td>
<td>- Expensive; requires costly equipment&lt;br&gt;- Needs professional organizer for sessions&lt;br&gt;- Needs to be combined with booklets and leaflets for maximum effectiveness</td>
</tr>
<tr>
<td>Flipcharts</td>
<td>Models and displays</td>
<td>Maps, charts, diagrams</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>- Cheap and simple</td>
<td>- Good for detailed illustrations of ideas</td>
<td>- Visual appeal</td>
</tr>
<tr>
<td>- Can be stopped at any point</td>
<td>- Suitable for different occasions</td>
<td>- Simplified</td>
</tr>
<tr>
<td>- Easy to make</td>
<td></td>
<td>- Allows for study at one’s own pace</td>
</tr>
<tr>
<td>- Good for explaining ideas in a sequence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Can be seen only by a few people at a time</td>
<td>- Requires skill in building</td>
<td>- Can oversimplify</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Difficult to explain complex ideas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Wears out soon</td>
</tr>
</tbody>
</table>

- Flipcharts:
  - Cheap and simple
  - Can be stopped at any point
  - Easy to make
  - Good for explaining ideas in a sequence
  - Can be seen only by a few people at a time
  - Difficult to explain complex ideas
  - Wears out soon

- Models and displays:
  - Good for detailed illustrations of ideas
  - Suitable for different occasions
  - Requires skill in building
  - Can be difficult to store or move

- Maps, charts, diagrams
  - Visual appeal
  - Simplified
  - Allows for study at one’s own pace
  - Can oversimplify
  - Symbols and layout need to be chosen carefully

- Slides
  - Easy to make with local photos
  - Flexible and topical
  - Good for illustrating a concept
  - Could be expensive
  - Needs good commentary
Day 4, session 5: Developing Materials—Pre-testing

Optional: Sample educational materials that are not very well done (e.g., where pictures, words, messages or layout are unclear). Get sufficient copies for all participants or enough to facilitate sharing in pairs.

Objectives
By the end of this session, participants will understand the importance of pre-testing messages and materials.

Process

Presentation and discussion

- Tell participants the following: “Now that you have developed your prototype materials, it is time to pre-test them.”
  Note: As you mention the following, list the main points on a flipchart.

- Pre-testing is not research about a target audience. It is a process of determining an audience’s reaction to, and understanding of, messages or behaviour change products and materials. Pre-testing takes place before materials are produced in final form. Regardless of the channels chosen, pre-testing confirms the effectiveness of the materials you develop.

- What exactly should you pre-test?

- Materials to pre-test include drawings, storyboards, themes, ideas, messages, draft text and visual concepts. A good graphic artist should be able to produce inexpensive, initial copies of materials for pre-testing, called ‘mock-ups’ or ‘prototypes’.

- You do not need to pre-test every type of item that you plan to produce, assuming that various items will utilize the same basic design concept. For example, if you are producing billboards, banners and posters, all targeting the same audience, you can pre-test just one image for all three. But a brochure is a different type of material and it should be pre-tested separately.
Training on Use of the HIV/AIDS Behaviour Change Communication Toolkit for the Workplace

- Why should you pre-test?

  Pre-testing increases the likelihood that messages and materials will have the intended effect. It is an inexpensive way to reduce errors, increase ownership through participation of target audience members, and enhance the creative process. In short, pre-testing helps determine whether your materials will have the desired effect on the target audience.

- When should you pre-test?

  Always pre-test before it is too late to change your materials. Pre-test early on and at as many stages in the development process as possible. This will help you fine-tune your materials – to find out what works and what does not. For example, you might pre-test an early design concept or image and text for a poster, then pre-test a prototype poster, then pre-test the modified second prototype of that poster before producing the final product. If programme staff members disagree about certain aspects of a product, then that is a good time to pre-test. Always get feedback on drafts of ideas, messages and materials from representatives of the target population.

- What do you want to learn through pre-testing?

  You want to know if your material or product is:
  - understandable;
  - culturally appropriate;
  - believable;
  - relevant to the real world;
- acceptable;
- visually appealing;
- informative; and
- capable of motivating people to take action.

- How should you pre-test?

<table>
<thead>
<tr>
<th>Pre-testing</th>
<th>What?</th>
<th>Why?</th>
<th>When?</th>
<th>What to learn?</th>
<th>How?</th>
</tr>
</thead>
</table>

- Pre-testing is usually carried out through focus group discussions or interviews with target audience members. Always include people living with HIV/AIDS in your review groups. They have insights into messages and images that non-infected people simply do not have. They can be especially helpful in identifying language or images that promote stigma and discrimination.
- You should pre-test with 10–50 target audience members. A good basic rule is to first test visuals alone, then test text alone, then test visuals and text together.
- Who should conduct the pre-testing?

<table>
<thead>
<tr>
<th>Pre-testing</th>
<th>What?</th>
<th>Why?</th>
<th>When?</th>
<th>What to learn?</th>
<th>How?</th>
<th>Who should conduct?</th>
</tr>
</thead>
</table>

- Anyone can conduct pre-testing. With practice, people's pre-testing skills increase. Use a third party for pre-testing—that is, someone not intimately involved in the production process. Consider using the researcher who carried out your formative assessment for pre-testing. Do not let the graphic designer or advertising agency responsible for production do the pre-testing – they cannot be entirely objective and their priority is most likely to get your job done quickly, since they are a business and will need to be available for other work as soon as possible.
What questions should you ask?

Pre-testing
What?
Why?
When?
What to learn?
How?
Who should conduct?
What to ask?

Note to facilitator: (Optional) This exercise will be more interesting if you review these questions while referring to sample educational materials that are not very well done (e.g., where pictures, words, messages or layout are unclear). As you review the categories below, ask participants to look at the sample material and identify problems that may have been avoided by pre-testing. For example, in the first category below, participants will focus on the graphics in the sample material.

About a picture or image:
- What do you see in the picture?
- What does this image say or convey to you?
- Do you think the picture is appropriate to illustrate the intended message?
- Do you like this picture?
- What kind of person do you think would like this picture?
- Is this picture believable?

About the words:
- Do you understand this text?
- If there is something you do not understand, how would you rephrase it to better convey the message?
- Do you think this text can potentially disturb someone? If so, how would you rework it?
- Do you like the sound of this message?
- Does reading this encourage you to do something? If so, what?
- Can you suggest something to improve this text?
If you are pre-testing visuals and text together:

- Do you think these pictures are appropriate for the text? Do they go well together? If not, how would you improve them?
- Do you feel comfortable reading letters of this size?
- What kind of person do you think this material would appeal to?
- Is there anything you would like to add or take away?
- Is this image/text believable?
- Does seeing and reading this item encourage you to do anything? If so, what?

Remember:

- Do not ask leading questions.
- Do not ask closed questions.
- Let people talk.
- Your own opinions do not matter.
- Take good notes, using a matrix or chart.
- Repeat pre-tests with members of the same target population, but not with the same people.
- A 75 per cent consensus within a focus group is an acceptable level of agreement.
- Pre-testing improves the chances of the target audience better receiving and understanding your material, but there are no guarantees.

With a television or radio product, it is necessary to test how the target population feels about the characters, the music and the ideas. For this reason, it is best to create a few different versions or to have actors perform the spot for an audience.

What should you do with the results of pre-testing? A summary of the results goes into a report that you can share with your designers, stakeholders and the other partners on your material development team.

Look for major points that are made repeatedly – points that show patterns across each of the focus groups with which you are pre-testing a product. These patterns should be clear when you have finished conducting your interviews. Some comments may appear as patterns that do not make sense when you apply them to a particular material. While you should get a diversity of views and your report should reflect the major views, it is not necessary to take advice that does not make sense. You should emerge with helpful suggestions.

Perhaps most importantly, keep in mind that it is normal to make changes based on pre-test results. You can always make changes, and then pre-test the new version to see if it is more successful in reaching and motivating the target population.

Refer participants to the ILO/FHI Booklet 4: Developing Communication Materials for a Behaviour Change Communication Programme for the Workplace for more information on the development and pre-testing of communication materials.
Day 5: Monitoring and Evaluation & Closing

<table>
<thead>
<tr>
<th>DAY 5</th>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of day 4</td>
<td>8:30 – 8:45</td>
<td>Review of the previous day’s activities and conclusions</td>
</tr>
<tr>
<td>Session 1</td>
<td>8:45 – 10:45</td>
<td>Booklet 5: Peer Education</td>
</tr>
<tr>
<td>Break</td>
<td>10:45 – 11:00</td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>11:00 – 12:00</td>
<td>Booklet 6: Monitoring and Evaluation: Monitoring, part 1</td>
</tr>
<tr>
<td>Lunch</td>
<td>12:00 – 1:00</td>
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</tr>
<tr>
<td>Session 3</td>
<td>1:00 – 2:00</td>
<td>Booklet 6: Monitoring and Evaluation: Monitoring, part 2</td>
</tr>
<tr>
<td>Session 4</td>
<td>2:00 – 3:00</td>
<td>Booklet 6: Monitoring and Evaluation: Evaluation</td>
</tr>
<tr>
<td>Break</td>
<td>3:00 – 3:15</td>
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</tr>
<tr>
<td>Session 5</td>
<td>3:15 – 4:00</td>
<td>Action planning</td>
</tr>
<tr>
<td>Session 6</td>
<td>4:00 – 5:15</td>
<td>Next steps</td>
</tr>
<tr>
<td>Session 7</td>
<td>5:15 – 5:30</td>
<td>Final evaluation and closing</td>
</tr>
</tbody>
</table>
Day 5, session 1: Peer Education

**Objectives**

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

- understand the advantages of developing a peer-education programme;
- determine when a peer-education programme is appropriate and how to select effective peer educators; and
- form an overview of the issues surrounding peer education.

**Process**

**Step 1: Discussion (15 minutes)**

- Tell participants that this session will give them a brief introduction to the material covered in Booklet 5 of the ILO/FHI toolkit, Guide to Conducting Peer Education at the Workplace.
- Lead a discussion on peer education at the workplace and how it should be organized, by asking the following questions:

  What is a peer educator?

  In the context of HIV/AIDS workplace programmes, peer educators are male and female workers who are trained to facilitate discussions with their co-workers, with the goal of encouraging them to examine and change their high-risk behaviour.

  What are the advantages of a peer-education programme?

  Peer education is a cost-effective option for employers. Compared to the cost of lost productivity, absenteeism, retraining and payment of health benefits due to HIV/AIDS, establishing a peer-education programme as part of an HIV/AIDS workplace programme can save money by helping to reduce new infections. It capitalizes on volunteer workers who can encourage their fellow colleagues to consider changing their current high-risk behaviour. A peer-education programme can be initiated rapidly and can reach a large number of workers.

At the workplace, HIV/AIDS programmes, including peer education, have proven to be very effective. Workplaces have organizational structures, hierarchies and policies. It is relatively easy to establish peer-education programmes in an environment where people with common socio-cultural, economic and educational characteristics can be easily identified and organized. Employees are generally easy to reach and participation can be high, especially if sessions occur during working hours.
The development of a peer-education programme improves the morale of workers, who see their employers and workers’ representatives contributing to the protection of their rights, health and well-being.

What steps do you need to take to establish a peer-education programme?
Nominate a peer-education coordinator for the workplace, select and train peer educators, support and supervise peer educators, monitor and evaluate their work (both the quality and quantity of their efforts and the success in achieving the objectives of the HIV/AIDS workplace programme (e.g., generating positive changes in specific knowledge, attitudes and behaviours among the workforce).

**Step 2: Small group work (15 minutes)**
- Divide participants into four or five small groups.
- Instruct participants to take a moment to think of five people in their organization who would make good peer educators. Each person should explain why the people they are thinking about would make good peer educators. Write the reasons on a flipchart. After each member of the group has finished, the group should look at the reasons given and come up with a list of 10–15 qualities that a good peer educator should have.

**Step 3: Group presentations and discussion (15 minutes)**
- Have a presenter from one group report that group’s list of qualities.
- Ask the other groups to add any qualities not already on the list.
- Come to a consensus on the top ten qualities that an effective peer educator should have. Answers should include the following:
  - Have good communication skills
  - Have a similar socio-economic status or background to that of the target population
  - Be respected and accepted by peers
  - Be non-judgemental
  - Be motivated
  - Have compassion for others
  - Have self-confidence
  - Be a good role model.

**Step 4: Discussion (15 minutes)**
- Ask participants to come up with some activities that peer educators might conduct and reach a consensus on ten activities that a peer educator might carry out.
Examples of peer-education activities might include:

<table>
<thead>
<tr>
<th>Activities to increase awareness of HIV and STIs among peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Conduct informal small group discussions about HIV/AIDS</td>
</tr>
<tr>
<td>- Organize and conduct formal group discussions about HIV/AIDS</td>
</tr>
<tr>
<td>- Teach peers about reproduction health and STI detection and treatment</td>
</tr>
<tr>
<td>- Organize meetings and educational sessions (to be taught by someone else)</td>
</tr>
<tr>
<td>- Participate in World AIDS Day and other public events</td>
</tr>
<tr>
<td>- Hold regular meetings</td>
</tr>
<tr>
<td>- Distribute educational materials</td>
</tr>
<tr>
<td>- Display posters and other educational materials</td>
</tr>
<tr>
<td>- Present video screenings</td>
</tr>
<tr>
<td>- Design/develop educational materials</td>
</tr>
<tr>
<td>- Perform dramas</td>
</tr>
<tr>
<td>- Organize sports events</td>
</tr>
</tbody>
</table>

**Step 5: Discussion (15 minutes)**

- Discuss with participants the kind of preparation, equipment and support that peer educators might need in order to carry out these activities.
- Examples might include the following:
  - Initial training
  - Refresher training
  - Educational materials
  - Condoms
  - Penis model for condom demonstrations
  - Supervision
  - Meeting space.

**Step 6: Small group work (30 minutes)**

- Have participants work in small groups to brainstorm about peer education as part of a BCC programme for the workplace, then create a peer-education programme for the Mumias Sugar Company.
- Distribute copies of handout 34, ‘Planning a peer-education programme’ (see page XX) for participants to use as a guide.

**Step 7: Small group presentations (15 minutes)**

- Have one group present its peer-education programme to all participants. Ask if other groups have points to add.
- Refer the participants to booklet 5 of the ILO/FHI toolkit.

Part 1 is designed to help workplace coordinators and other planners understand what peer education is and why it is important.

Part 2 focuses on preparation and supervision of peer educators.

Part 3 provides information on how to organize and conduct peer education.
Part 4 provides a generic peer-education guide. The topics to be covered during the peer-education session should be in line with the BC and BCC objectives of the BCC programme of the enterprise.
Handout 34: Worksheet for planning a peer-education programme,
for day 5, session 1, step 5

1. Selecting peer educators

2. Training peer educators

3. Activities of peer educators

4. Links to community resources and services

5. Supervision: who and how
6. Support for peer educators

7. Incentives

8. Anticipated problems and how you might resolve them
Day 5, session 2: Monitoring and Evaluation—Monitoring, part 1

Objectives
By the end of this session participants will have gained an initial understanding of how monitoring works.

Preparation
Pre-label flipchart stands or sets of flipchart pages. For each group, write ‘Implementation’, ‘Coverage’, ‘Quality’ and ‘Process’ on four separate pages, and post them on the wall by each table, with a few markers beside them.

Process
Step 1: Tell participants the following: “The goal of this exercise is to help you understand how ongoing monitoring can be designed to fit into your programme, giving you information to help you adjust your programme, as needed, while also gathering data with which to chart the programme’s progress and impact.”

Step 2: Presentation 1 (15 minutes)
Cover the following points:

- After you have developed a behaviour change communication strategy and designed activities, the next thing to do is to establish a monitoring plan.
- Monitoring is a continual process of systematically and regularly tracking and checking your programme activities to see if things are working as planned. Good monitoring can also help you adjust your communication strategies and programmes if your monitoring indicates any changes in your target population’s situation and needs.
- A monitoring plan should cover the process of how the information is to be collected, how it will be sent to the appropriate staff members, who will review the information, how it will be reviewed, and how the information and findings will be fed back to staff and back into the programme.
- Some people may think of monitoring as a burdensome task because it requires that you and your staff, volunteers and partners fill out extra forms, count people and collect data. Sometimes data are collected and submitted to managers or coordinators, and those who collect them never learn how the information will be used or why it is important.
Ideally, however, monitoring can demonstrate to staff, volunteers and partners how their hard work makes a difference in the programme. Monitoring can ensure that the plan and tools are working for the implementation activity. It can also be designed in accordance with the needs of those who will be collecting data, and it can allow for the collection of data in a way that easily fits into staff members’ work. Good monitoring design also ensures that only the right data are collected, avoiding the collection of a large amount of unnecessary information.

Giving staff and partners a sense of the larger picture of the programme and sharing the results of the data collection with those who collect them can be a motivating factor for all concerned.

The amount of monitoring needed varies, depending on the behaviour change communication activities. A programme should do as much monitoring as its staff can analyse and apply in a timely fashion. It can be helpful to conduct several small studies. Monitoring should continue throughout the life of the programme. Remember that even a small amount of monitoring is better than none.

For every item of information that you are planning to collect, you should ask, “How will this be used to ensure the process and quality of the programme?” Some additional data collection may be necessary to meet a donor’s requirement.

You should develop your programme monitoring plan and tools based on your behaviour change communication objectives, the type of intervention and the literacy level of the staff and volunteers involved in collecting data.

In order to design a monitoring plan, you and your staff must have a good understanding of the larger programme goals and then break those goals down into achievable objectives.

Clearly defining behaviour change and behaviour change communication objectives is an essential step in identifying what to monitor, what methods to use and what the monitoring plan will be.

Ask participants to take a look at the behaviour change and behaviour change communication objectives that they came up with earlier in the week.

[Note: Post the BCC objectives that participants generated on day 3.]

Step 2: Presentation 2 (15 minutes)

Cover the following points:

- Monitoring should answer the following questions: Are we doing what we planned to do? Is our work good enough?
- The monitoring methods you choose will depend on the objective of the monitoring. In other words, what is it that you will be monitoring – coverage, timely implementation, quality or the process of behaviour change communication?
- Like the information collected for a formative assessment, monitoring may be quantitative or qualitative.

[Note: Write the following concepts on a flipchart page as you discuss them.]

Quantitative monitoring (measuring quantity) tends to document numbers associated with the programme and answers questions beginning with, “How many?”
For example:

- How many of our target population were reached?
- How many materials (by type) were distributed?
- How many counselling sessions were held?
- How many training sessions were conducted?
- How many workers attended each session?
- How many condoms were distributed?
- How many workers prepared a will?

Quantitative monitoring focuses on which programme elements are being carried out and how often. Quantitative monitoring tends to involve record-keeping and numerical counts.

Look closely at your programme timeline of activities to see what kinds of monitoring activities might be used to assess their progress. Do not forget to integrate the monitoring plan itself and the associated activities into your overall programme timeline.

[Note: Write ‘Qualitative’ at the top of a new sheet of flipchart paper.]

Qualitative monitoring (measuring quality) will ask questions about how well the elements are being carried out. It is designed to determine whether your work is good enough.
For example:

- How are peoples’ attitudes changing towards abstinence, fidelity or condoms?
- What is the effect or impact of our activities on target populations?

To get at this type of information and feedback, qualitative methods, such as in-depth interviews and focus group discussions, are often used.

Within the behaviour change communication activities that you have designed, programme staff should define which components of the programme to monitor. Key areas could be implementation, coverage, quality and process.

**Step 3: Small group work (30 minutes)**

- Have participants re-form the groups that developed behaviour change and behaviour change communication objectives.
- Ask for a volunteer from each group to be an ‘ambassador of knowledge’ and ask those individuals to be responsible for collecting the group’s knowledge about how to monitor four programming aspects of one programme activity. They should record the groups’ ideas on a flipchart. An example of a programme activity might be condom distribution.
- Tell the groups that they will be monitoring the following aspects of the programme activity that they select:
  - Implementation
  - Coverage
  - Quality
  - Process
- The groups should come up with questions for monitoring each aspect of the activity.
- When time is up, invite participants to return to their seats, and distribute handout 35, ‘Examples of what to monitor in a behaviour change communication programme’ (see page 169).
Handout 35: Examples of what to monitor in a behaviour change communication programme, for day 5, session 2, step 3

Monitoring implementation of activities

Sample monitoring questions:

- Are activities taking place on schedule, at the planned frequency?
- Are training sessions being conducted as planned?
- Are peer educators being identified and recruited as planned?
- Are the supplies that are needed for safe behaviour (condoms, HIV counselling and testing services) available to, and affordable for, audience members?

Monitoring the coverage of the programme

Sample monitoring question:

- Are planned numbers of the audience being reached over time?

Monitoring quality of behaviour change communication and behaviour change communication products

Sample monitoring questions:

- Is the right target audience being addressed?
- Are the messages appropriate, considering the stage of the epidemic in the country and the changing attitudes in the community (e.g., messages focus on prevention but ignore care and support, or messages aim to increase awareness but ignore stigma)?
- Are messages taking into consideration the changing national policies on HIV/AIDS treatment, care and support? For example, are messages raising knowledge about viral load as a criterion of eligibility for antiretroviral treatment?
- Are the changing needs of the audience being captured?
- Do the messages appeal to the target audience's perceived needs, beliefs, concerns, attitudes, current practices and readiness to change?
- Do messages model the skills needed to change behaviours?

Monitoring the process of behaviour change communication

Sample monitoring questions:

- Are programme goals stated and well defined?
- Are relevant stakeholders involved in behaviour change communication development, implementation and monitoring?
- Does the intervention include follow-up mechanisms to reinforce and encourage the maintenance of newly acquired attitudes and behaviours?
Day 5, session 3: Monitoring and evaluation—Monitoring, part 2

Flipchart, markers, flipchart information generated in the previous session, handout 36, ‘Chart for monitoring behaviour change programmes’

Objectives

By the end of this session participants will have gained a more detailed understanding of how monitoring works.

Process

Step 1: Presentation and discussion (25 minutes)

Outline the monitoring process for participants, as follows.

- At this point, you have decided what to monitor. Now you will need to identify certain indicators (pointers, markers or signals) to help you answer the questions you have identified. These indicators must be reliable, direct, objective and practical.
- For example, let’s say you have a peer-education programme at your workplace and you want to measure how effective peer educators are in communicating with workers and discussing concepts. Which indicators would you use to help answer this question? In other words, what could you count or observe that would help measure peer educators’ effectiveness in communicating and discussing concepts?

[Answers may include, but are not limited to, the following:]

- How many peers attended each session?
- What kinds of questions did the peers ask?
- Did the questions asked by peers change over time?

- Next, you will need to identify appropriate monitoring methods and tools. If you use the quantitative monitoring method of reviewing materials distribution, for example, what would be a good tool to use?

[Answers might include, but are not limited to, the use of a distribution logbook.]

- Here are some additional quantitative monitoring methods, with their corresponding tools:
### Method Tool

<table>
<thead>
<tr>
<th>Method</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing BCC materials distribution</td>
<td>Distribution logbook</td>
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<tr>
<td>Periodic site visits</td>
<td>Check-list or questionnaire</td>
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<tr>
<td>Periodic review of implementation reports, e.g., peer-educator reports, supervisor reports, training reports</td>
<td>Checklist, questionnaire</td>
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<tr>
<td>Periodic compilation of service statistics</td>
<td>Tally sheet</td>
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- You might also use a qualitative monitoring method (such as focus group discussions) to assess target population satisfaction with the peer-education programme. What would be a good tool to use for this monitoring method?
  [Answers might include, but are not limited to, the use of a focus group discussion guide.]

- Here are some additional qualitative monitoring methods, with their corresponding tools:

<table>
<thead>
<tr>
<th>Method</th>
<th>Tool</th>
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<tr>
<td>Focus group discussions</td>
<td>Focus group discussion guide</td>
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<tr>
<td>Direct observation</td>
<td>Observation checklist</td>
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<tr>
<td>In-depth interviews (e.g., to monitor and track changes in questions emanating from target groups and audiences during the course of project implementation)</td>
<td>Content analysis checklist</td>
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<tr>
<td>Pre-testing of materials with target population</td>
<td>Pre-test checklist</td>
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<tr>
<td>Working with 'mystery clients' (e.g., testing the performance of peer educators by presenting them with the problems of hypothetical clients, such as, “My partner doesn’t want to use a condom. How can I encourage him to use one?” There are key points that should be covered in a response to each ‘mystery client’.)</td>
<td>Checklist</td>
</tr>
</tbody>
</table>

- Monitoring tools need to be appropriate to both the activity being monitored and the person who will be using the tool. For example, how would a peer educator's monitoring form differ from that of a theatre group?
  [Answers might include, but are not limited to, what material is presented and how, which questions are asked, how often the group meets, how many people participate, etc.]

- In some cases, tools should be designed for audiences with low levels of literacy. For example, a monitoring tool for a health-care provider may be more complex than a peer educator's if the health-care provider has a higher level of literacy. In addition, if some of the staff or volunteers are illiterate, alternative systems should be designed to meet their needs.

- What tools could be used for staff and volunteers with lower literacy levels, so as to include them in the data-collection process?
  [Answers may include, but are not limited to, symbols, hash marks, boxes to check.]

- Finally, your monitoring plan should include a plan for how the data will be used, once they have been collected. This will influence your data collection and analysis.
Step 2: Small group work and presentations (25 minutes)

- Have participants re-form their small groups.
- Distribute handout 36, ‘Chart for monitoring behaviour change programmes’ (see page 74).
- Ask each group to select three things they chose to monitor in the first exercise, and have them fill out the chart (element to monitor, indicator, method, tool).
- Tell participants they will have 15 minutes to fill out their charts and copy them onto a flipchart, and ten minutes to present them.

After 15 minutes, have participants reconvene. A representative from each group should present its chart.

Step 3: Presentation and discussion (10 minutes)

- Ask participants what use can be made of all the information (data) they collect.

[Answers may include the following points. Be sure to bring them up if participants do not mention them. Encourage participants to discuss how these points might work and provide examples, time permitting.]

- Improving performance

[Ask participants how this might be achieved. Answers might include hiring more staff, training staff, buying more supplies.]

- Feedback to programme staff

[Ask participants how this might work. Answers might include holding regular staff meetings, including field staff.]

Feedback is important to ensure that a programme is on track and achieving its objectives. Feedback allows programme designers to modify and adapt their programme so that it is more likely to achieve its objectives.

Your behaviour change communication strategy should be designed to ensure that there is feedback about the effectiveness of the elements of the strategy – particularly programme activities and messages. The feedback system should be designed to continually ‘take the pulse’ of the workplace so that the programme can provide flexible responses to evolving needs. Feedback activities can be integrated into an implementation plan.

- Decision-making about the future direction of the programme, (e.g., scaling up services, expanding coverage)
- Reporting to donors and policy-makers
- Communicating a programme’s success and challenges to the community (newspaper articles, press conference, town hall meeting, etc.)
- Fundraising (proposal writing).

Step 4: Summary statement

- Tell participants the following: “Ongoing monitoring can be designed to fit into your programme in a way that can support your staff and volunteers and not burden them – especially if you include them in both the reasons and overview of why you are collecting this information and also share the data summaries with them to show them how their hard work makes a difference. The information you gather on an ongoing basis can help you adjust your programme to best serve your target population.”
Handout 36: Chart for monitoring behaviour change programmes, for day 5, session 3

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Day 5, session 4: Monitoring and Evaluation—Evaluation

**Process**

**Step 1:** Presentation and discussion (15 minutes)

- Explain to participants that behaviour change communication programme evaluation is part of an overall HIV/AIDS prevention, care and support programme.
- Tell participants that it is important to include the questions that were used to evaluate the BCC programme in the general programme evaluation plan. Explain that the questions asked should be based on, and refer to, BCC objectives.
- Encourage participants to consider the following BCC objectives:
  - Increase demand for services
  - Position HIV/AIDS in a positive light to reduce stigma
  - Increase demand for condoms
  - Stimulate community dialogue about HIV/AIDS
  - Increase demand for information
  - Target and reach audiences effectively.
- Remind participants that these BCC objectives are different from behaviour change objectives, although they support and are linked to them.
- Explain to participants that indicators are criteria for assessing how, or to what extent, objectives are being achieved. Then ask the participants which indicators could be developed for the above-mentioned objectives. Brainstorm with the participants to come up with a series of BCC evaluation indicators linked to the BCC objectives.
- Examples of quantitative indicators for the six BCC objectives listed above follow.
### BCC objective | Example of indicator
--- | ---
Increase demand for services | Number of persons presenting for a given service
Position HIV/AIDS in a positive light to reduce stigma | Number of persons able to state correctly how HIV is, and is not, spread
Increase demand for condoms | Number of condoms distributed
Stimulate community dialogue about HIV/AIDS | Number of times HIV/AIDS is mentioned in certain types of gatherings
Target and reach audiences effectively | Number of persons aware of certain messages

### Step 2: Small group work (30 minutes)
- Instruct participants to re-form their target groups.
- Ask them to use flipcharts to list indicators for the BCC objectives that they developed for their workplace programme, to show that the programme is meeting its BCC objectives.

### Step 3: Group presentations and discussion (15 minutes)
- Have a representative of each group read the group’s BCC objectives and corresponding indicators aloud, referring to flipcharts, as necessary.
- Distribute handout 37, ‘Steps for developing a monitoring and evaluation workplan’ (see page 177).
- Refer participants to Booklet 6 of the ILO/FHI Toolkit, Tools for Monitoring and Evaluation of the Behaviour Change Communication Programme for the Workplace
Handout 37: Steps for developing a monitoring and evaluation workplan, for day 5, session 4

1) **Identify programme goals and objectives**
   - Write a clear statement that identifies programme goals and objectives (and sometimes sub-objectives) and describes how the programme expects to achieve them. This makes it easy to develop an evaluation plan framework.
   - State objectives and sub-objectives for each component of the programme and list the indicators that will be measured to determine progress.

2) **Determine monitoring and evaluation questions, indicators and feasibility**
   - Identify the most important evaluation questions, which should link directly to the stated goals and objectives. Questions should come from all stakeholders, including programme managers, donors and members of the target audiences. The questions should address each group's concerns, focusing on the following areas:
     - What do we want to know at the end of this programme?
     - What do we expect to have changed by the end of this programme?
   - Be prepared to revise the evaluation questions as the workplan is implemented.
   - Determine which indicators you will use, keeping in mind that you will need two sets of indicators—one to measure outcome (immediate or short-term change) and another to measure impact (long-term change).

3) **Develop data-collection tools**
   - Outline the data-collection methods and plan to analyse the data in addition to developing an overall timeline. It is crucial to clearly spell out how data will be collected to answer the evaluation questions. Here the planning team determines the appropriate evaluation designs, outcome measures or indicators, information needs, and the methods by which the data will be gathered and analysed. A plan must be developed to collect and process data and to maintain an accessible data system.
   - Include the following data-collection questions in the plan:
     - What information is to be monitored?
     - How will the information be collected?
     - How will it be recorded?
     - How will it be reported to the central office?
     - Which forms will be needed?
   - For issues that require more sophisticated data collection, the following questions should be included:
     - Which study design will be used?
     - Will the data be qualitative, quantitative, or a combination of the two?
     - Which outcomes will be measured?
     - How will the data be analysed and disseminated?
4) **Identify implementers and state how current and earlier evaluation data will be used.**
   - State clearly who will be responsible for each activity and for collecting and analysing the data.
   - Identify evaluation experts from planning and evaluation units of the Ministry of Health, academic institutions, non-governmental organizations, and private consulting firms to assist with the plan and the final evaluation.
   - Identify existing data sources and other evaluation activities, and determine if they have been done in the past, are ongoing, or have been sponsored by other donors.
   - Evaluators should determine whether other groups are planning similar evaluations and, if so, invite them to collaborate.

5) **Develop the monitoring and evaluation workplan matrix and timeline**
   - Develop a matrix to present the inputs, outputs, outcomes and impacts—and their corresponding activities—for each programme objective. This matrix summarizes the overall evaluation plan by including a list of methods to be used for collecting the data.
   - Include a timeline that shows when each activity in the monitoring and evaluation workplan will occur.

6) **Develop plan to disseminate and use evaluation findings**
   - Develop a plan for using the results of the evaluation and for translating the results into viable programmes.
   - Develop a plan for sharing the results with stakeholders, decision-makers, programme planners, and others involved in programme implementation.
   - Ask how the evaluation plan has been implemented and how the results have been used to improve HIV/AIDS workplace policies and programmes.
Day 5, session 5: Action planning

**Flipchart, markers, presentation on behaviour change communication strategy and the eight steps for developing and implementing a BCC programme, including actions to be taken by the BCC staff member/coordinator (prepared ahead of time on PowerPoint, overhead or flipchart – see page 180), and handout 38 of the presentation given in step 1.**

**Objectives**

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

- name and explain the eight steps involved in developing and implementing a BCC programme; and
- describe the actions needed for each step.

**Process**

**Step 1: Presentation (30 minutes)**

- Give the PowerPoint, overhead or flipchart presentation on the behaviour change communication strategy, outlining the eight steps for developing and implementing a BCC programme, including actions to be taken by ILO/AIDS national project coordinators. As you present each step, ask participants if they have comments or additions.

**Step 2: Discussion (15 minutes)**

- Invite participants to ask questions and make comments about the applicability of the eight-step process to the programmes they plan to initiate.
Handout 38: Presentation on Developing a BCC Strategy for the Workplace and Role of BCC Staff/Programme Coordinator

Slide 1

Elements of a comprehensive programme
- Behaviour change communication
- Target populations and communities
- Workplace policy
- STI services
- VCT
- Commodities (e.g., condoms)
- MTCT
- STI-treatment services
- Community mobilization
- Support to families and children
- Clinical services
- Links to other services
- Homecare
- PLWHA (people living with HIV/AIDS) networks

Slide 2

How to develop an effective BCC strategy for the workplace
1. Advocacy and stakeholder involvement.
2. Identify and segment target population
3. Conduct a formative BCC assessment
4. Design a BCC strategy and monitoring and evaluation plan
5. Develop support communication materials
6. Implement the strategy
7. Undertake monitoring and evaluation
8. Obtain feedback and make any necessary revisions

Slide 3a

Who will implement and oversee the BCC process?
The ILO national project coordinator (NPC) will provide technical support to a team of consultants (or national NGOs):
- to conduct the formative assessment in selected sectors
- to organize BCC strategy development workshop
- to support the training of peer educators
- to support the development of a few supporting communication materials.

Slide 3b

The NPC will also collect data from the coordinators (HIV/AIDS focal points) to monitor BCC programme implementation in targeted enterprises.
Each target workplace should have a BCC coordinator, who will coordinate and report on
the implementation of the BCC programme.

Slide 4

What follows is a review of each step in the BCC planning process and
the action required by the BCC coordinator.

Slide 5

Step 1: Advocacy and stakeholder involvement
- Avoids future backlash
- Forges links for coordination and collaboration

Slide 6

Step 1. Action by BCC coordinator (or HIV/AIDS focal-points)
- Identify and reach out to stakeholders and other key people
- Form an HIV/AIDS committee (see Annex III of the ILO Code of Practice on HIV/
AIDS and the world of work)
- Present BCC formative assessment summary to stakeholders and other key people

Slide 7

Step 1. Action by BCC coordinator (2)
- Seek stakeholder participation in events, training, etc.
- Present messages and materials to stakeholders
- Promote stakeholder appearances before the press, where appropriate
- Present monitoring data to stakeholders

Slide 8

Step 2: Identify and segment target populations by:
- high-risk behaviours
- gender
- age
- location
- ethnicity
- language
- religion
and as:
- primary/secondary
Slide 9

**Segment target populations**

- Primary populations
  - Those at high risk or vulnerable
  - Those providing services
  - Policy-makers

- Secondary populations are those that influence the primary population's ability to adopt or maintain safe behaviours

Slide 10

**Step 2. Actions by ILO/AIDS NPC and the team of consultants in country where there is an ILO project**

- Locate quantitative data/criteria to support selection of target audiences
- Identify priority target populations in working meetings or in a training setting
- Build support for selected target audiences among stakeholders, donors, etc.

Slide 11

**Step 3: Conduct formative BCC assessments**

Assess the following:

- Perceptions of risk
- High-risk environments
- Opinion leaders/change agents
- Services
- Barriers to behaviour change
- Motivating factors for behaviour change
- Media habits
- Entertainment habits
- Health-care-seeking behaviours
- Hopes and fears for the future
- Communication resources and infrastructure

Slide 12

**Step 3. Actions by ILO/AIDS NPC and the team of consultants in country where there is an ILO project**

- Collect and analyse existing quantitative assessments
- Oversee development/pre-testing of qualitative-assessment instrument
- Oversee implementation and analysis of qualitative assessment
- Oversee development of summary report
Slide 13

Step 4: Develop a BCC strategy and monitoring and evaluation plan

Elements:
- Target population profiles
- BCC objectives
- Key benefit statements
- Messages
- Theme
- Channels

Slide 14

Step 4. Actions by target population with the technical assistance of the ILO/AIDS NPC and the team of consultants in country where there is an ILO project

- Develop BCC strategy through a participatory workshop
- Establish BCC objectives:
  - Promote increased use of condoms
  - Encourage reduced number of sexual partners
- Develop a BCC programme of activities for the workplace including a timeline for the implementation of activities
- Identify partners in implementation
- Identify potential donors

Slide 15

Step 5: Develop support communication materials

To disseminate messages, use:
- printed materials
- peer-education materials
- TV/radio public service announcements
- Advocacy materials

Slide 16

Step 5. Actions by BCC coordinator with the support of the ILO/AIDS NPC and team of consultants in country where there is an ILO project

- Select graphic designer
- Select script writer
- Select peer-education trainer
- Select production agencies for graphics/radio/TV
Slide 17

**Step 5. Actions (continued)**
- Ensure that the appropriate messages are in the peer-education materials
- Oversee development of prototype materials
- Involve stakeholders where necessary/appropriate

Slide 18

**Pre-testing materials**
Test materials to see if they are:
- comprehensive
- attractive
- persuasive
- acceptable
- clear to the target audience
- likely to motivate people to take action

Slide 19

**Pre-testing materials**
Actions by BCC coordinator with the support of the ILO/AIDS NPC and team of consultants in country where there is an ILO project
- Coordinate focus group discussions/in-depth interviews
- Coordinate analysis of results
- Disseminate results to appropriate individual/groups
- Coordinate feedback/revisions of materials

Slide 20

**Step 6: Implement the strategy**
Implementation involves:
- sequencing of activities
- forward planning
- correct timing
- coordination
- linkages
- interactivity
- creating synergy between media used
- flexibility

Slide 21

**Preparation for campaign launch**
**Actions by BCC coordinator (in collaboration with the ILO/AIDS NPC)**
- Play TV/radio spots during launch event
- Prepare press kits
- Seek agreement on press release with stakeholders
- Remember logos
Give stakeholders and VIPs advance notice
Avoid scheduling around conflicting events (e.g., elections, carnivals)
Make sure to account for media attendance and follow-up
Check on distribution of materials (insist on records being kept)

Remember: The coordinator is responsible for all of the above

Slide 22
Step 7: Undertake monitoring and evaluation
Monitoring reminders
- Ensure that some programme monitoring takes place, even if resources are limited
- Remember that small studies work well
- Monitor throughout the entire project
Consider:
- Interviews about message reception
- Focus group discussions looking at message perceptions
- Observation and discussions at events

Slide 23
Step 7: Actions by BCC coordinator
Evaluation:
- Conduct BCC programme evaluation
- Ensure that BCC questions are integrated into overall programme evaluation
- Use evaluation results in planning

Slide 24
Step 8: Obtain feedback and make any necessary revisions
- BCC changes in response to changes in workplace target audience(s)
- Feedback provides information about changes in target audience(s)
- Information about changes in target audience is used to redirect BCC
- Feedback improves the future quality of programmes

Slide 25
Step 8. Actions by BCC coordinator
- Look for opportunities to use monitoring results to improve programme
- Inform relevant bodies/individuals about changes in programmes resulting from feedback
- Provide monitoring data to the ILO/AIDS NPC
- Analyse effects of programme changes over the long term
Day 5, session 6: Next steps

1 hour 15 minutes

Flipcharts, markers, ‘Next steps’ worksheet, handout 39 (see page 188)

Objectives

By the end of this session, participants will have:

- listed the next steps to take to initiate their workplace BCC HIV/AIDS programme; and
- shared their next steps with the large groups and received feedback on their strategies.

Note to facilitator: In workshops attended by national consultants and NGOs only, modify this exercise to give participants an opportunity to identify next steps in applying what they have learned in the workshop to their work. How will they use the workshop to strengthen workplace BCC HIV/AIDS programmes in the workplace in their country?

For example, an NGO can think about:

- preparing to provide technical assistance to companies for the design and implementation of BCC programmes in companies; and
- training its (the NGO’s) workers.

The NPC will list the next steps he or she will take to implement the ILO technical cooperation project.

Process

Step 1: Small group work (30 minutes)

- Have participants re-form their target groups, and distribute worksheet (see page 188) and flipcharts.
- Instruct participants to brainstorm about the first three steps that they need to take right away to promote their programme on HIV/AIDS behaviour change communication at the workplace, using the worksheet. They should also indicate who is responsible for each step, and by when it should take place.
- When they have reached a consensus, they should transfer their information on next steps to flipchart paper, using one page for each step.

Step 2: Group presentations and discussion (45 minutes)

- Have a representative from each group report to participants on the next steps they have identified for a workplace BCC programme, based on their target population.
- After each presentation, encourage participants to provide feedback on their colleagues’ strategies for launching a workplace HIV/AIDS BCC programme.
- Encourage participants to form a BCC working group charged with specific responsibilities and composed of key stakeholders in, and representatives of, the target population.
### Handout 39: Next steps, for day 5, session 7

**Worksheet: Next steps in planning for workplace BCC HIV/AIDS programmes**

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Day 5, session 7: Evaluation of the workshop and closing

**Objectives**

By the end of this session, participants will have submitted their evaluation of the usefulness of the workshop and of particular sessions or activities that they felt did, or did not, work.

---

**Process**

**Step 1:** Final evaluation (10 minutes)

- Tell participants that you would appreciate them taking a few minutes to fill out an evaluation form about the workshop.
- Distribute a copy of the evaluation form to each participant.

**Step 2:** Closing (5 minutes)

- Thank participants for their attention and hard work.
- Ask if they have any final comments they would like to share.
- Closure.

---

15 minutes

Final evaluation forms, handout 40 (see page 190)
1. I have a better understanding of the BCC strategy development process.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

2. The facilitators were well prepared and assisted the participants at every stage.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

3. Hotel, food and transport arrangements were satisfactory.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

4. The workshop was well organized.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

5. I was able to participate as much as I wanted to.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

6. There was a good balance between presentations and participatory exercises.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5

7. I was able to benefit from the experience of my colleagues during the workshop.

   DO NOT AGREE AT ALL  VERY MUCH AGREE
   1 2 3 4 5
SECTION B
Please indicate on a scale of 1 to 5 your response to the following statements about the small groups sessions (1 = NOT AT ALL, 5 = VERY MUCH SO).

8. The activities were useful in increasing my knowledge and skills for developing and implementing BCC programmes.

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<thead>
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<th>DO NOT AGREE AT ALL</th>
<th>VERY MUCH AGREE</th>
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<td>1</td>
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9. I will be able to develop and implement BCC strategies and programmes after this workshop.

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<th>DO NOT AGREE AT ALL</th>
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SECTION C

10. If you were to ADD something to this workshop, what would it be?

11. If you were to REMOVE something from this workshop, what would it be?

12. What else would you do to improve the workshop?
SECTION D

13. What do YOU plan to do as a follow-up to this workshop?

14. What follow-up ON THE PART OF the ILO would you like after this workshop?

SECTION E

15. What other comments do you have about the workshop?