POSITIVE HEALTH, DIGNITY, AND PREVENTION

Training Modules for Promoting Leadership Among Persons Living with HIV

Developed by PLHIV in Jamaica

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JN+
Jamaican Network of Seropositives

National HIV/STI Programme

HEALTH POLICY PROJECT

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CONTENTS

INTRODUCTION

The curriculum modules contained in this document are intended to enhance the understanding and skills of communities living with HIV in Positive Health, Dignity, and Prevention (PHDP) in Jamaica. These modules are part of a larger capacity-building curriculum developed and implemented by persons living with HIV through the Jamaican Network of Seropositives (JN+) under the guidance of the Greater Involvement of People Living with HIV (GIPA) Unit of the Government of Jamaica Ministry of Health's National HIV/STI Programme, with technical assistance from the USAID- and PEPFAR-funded Health Policy Project.

Building on the 2011 global policy framework of Positive Health, Dignity, and Prevention, the GIPA Unit will use this curriculum to strengthen the capacity of people living with HIV (PLHIV) leaders to advance the framework of PHDP in Jamaica's HIV response. The GIPA Unit and JN+ led a participatory assessment and curriculum development process to identify priority areas for Positive Health, Dignity, and Prevention in Jamaica. From the community, two cohorts of PLHIV leaders worked with partners to develop and pilot the curriculum in a participatory manner. *Positive Health, Dignity, and Prevention: Training Modules for Promoting Leadership Among Persons Living with HIV in Jamaica* is a result of these efforts.

Background: Why and How Were these Modules Developed?

The creation of this curriculum was initiated by PLHIV in Jamaica through the GIPA Unit, a sub-programme of the Ministry of Health's HIV and AIDS response.

JN+ is a network of self-support groups of PLHIV from across Jamaica. Formed in 1996, the network's vision is for PLHIV to be accepted as full members of society and to have a good quality of life. The network focuses on interventions in advocacy for access to high-quality care and treatment and in other areas such as counselling, training, and nutritional support. Additionally, the network aims to implement efforts to reduce stigma and discrimination against PLHIV by improving the public's perception of what it means to live with HIV.

Located in the Enabling Environment and Human Rights Component of the Ministry of Health's National STI/HIV Programme, the GIPA Unit aims to build the capacity of PLHIV in Jamaica. Its work includes a focus on building the literacy, communication, and leadership skills of community leaders living with HIV so they can recognise, advocate, and claim the rights of people living with HIV to advance their health and prevention priorities.

During the development of this curriculum, JN+ and the GIPA Unit decided to merge to better implement capacity building for community leaders and facilitate their active and more meaningful participation in the national response to HIV.

The Global Framework of Positive Health, Dignity, and Prevention

The 2011 global policy framework of Positive Health, Dignity, and Prevention, jointly authored by Global Network of People Living with HIV (GNP+) and UNAIDS, advances a holistic framework for responding to HIV. Moving beyond the focus on prevention by and for PLHIV, known as "positive prevention," Positive Health, Dignity, and Prevention "is built on a broader basis that includes enhancing and maintaining the dignity of individuals living with HIV, to support and enhance that individual's physical, mental, emotional and sexual health; in turn, among other benefits, [this] creates an enabling environment that will reduce the likelihood of new infections." It aims to provide a road map that can help to assess strengths, gaps, and needed adjustments in programme and policy responses to fully realise PHDP in the lives of PLHIV.

By and For Community Leaders Living with HIV

These modules were created by and for the persons in leadership positions at both JN+ and the GIPA Unit Programme. Through an ongoing process of workshops and a participant technical working group, more than 60 leaders living with HIV gained familiarity with the PHDP framework, identified priority gaps and additional areas for PLHIV capacity building needed to advance the PHDP framework in Jamaica, and participated in the pilot and revisions to these new modules. In the first phase, the process to identify these priorities and develop these modules spanned seven months, from October 2011 through May 2012; a second phase ran from April to December 2013.

The curriculum development process harmonises with broader efforts within the government of Jamaica/Ministry of Health's National STI/HIV Programme to advance the framework of Positive Health, Dignity, and Prevention. As such, these modules benefitted from review by and technical assistance from representatives of the Ministry of Health's National STI/HIV Programme and the USAID- and PEPFAR-funded Health Policy Project.

Who Should Use These Modules?

These modules should be used to build the capacity of communities living with HIV and other key affected communities, enabling them to help shape the HIV response in Jamaica. The primary audience for these modules is leaders from the communities of PLHIV in Jamaica.

PLHIV leaders will also likely use these modules in their work as part of the broader response—to share key concepts and, at times, to facilitate modules in the spaces where they lead. This leadership can range from serving as resource people in workplace settings to working and/or advocating with healthcare centers, community-level support groups, peers, and family members.

While the primary audience of these modules is PLHIV in Jamaica, they could be used by PLHIV to work with other stakeholders in the HIV response. Also, while the content of these modules reflects the Jamaican context, they may be adapted to other settings with additional work and consideration.

How to Use These Modules

As part of the larger GIPA capacity-building curriculum, these modules assume that participants have already undergone other basic capacity-building related to HIV. For instance, it is assumed that participants have knowledge of basic facts about HIV and have had a basic introduction to human rights and HIV. Both of these (basic facts on HIV and human rights) are the foundation of the GIPA Programme's overall capacity-building curriculum.

These modules can be used independently; however, if a full module is going to be used, individual activities are sequenced to build on each other. Each module concludes with time for reflection on the key messages that were communicated and a worksheet that helps participants think about and plan how they would put what they learned into action.

Module Sequencing

The table below outlines the flow or order in which the curriculum is delivered. However, if needed, each module can be used on its own.

MODULE NAME AND OBJECTIVES	ACTIVITY OVERVIEW
1. HIV AND AIDS BASICS By the end of this module, participants will be able to ▪ define the terms 'HIV' and 'AIDS' ▪ describe how HIV is transmitted ▪ discuss how to prevent HIV ▪ discuss the steps involved in and the key terms associated with testing for HIV ▪ demonstrate the use of a male condom ▪ demonstrate the use of a female condom (for vaginal sex) ▪ discuss the steps involved in the use of a female condom (for anal sex) ▪ discuss the facts and myths associated with HIV and AIDS	**1.** HIV and AIDS Pre-Test **2.** Introduction to HIV and AIDS **3.** Basic Facts about HIV and AIDS **4.** Risk Assessment and Condom-Use Skills **5.** Discrimination Reduction Conversation **6.** Post-Test **7.** Key Messages, How to Put This Module Into Action, and Wrap-Up
2. THE FRAMEWORK OF PHDP By the end of this module, participants will be able to ▪ describe the three key concepts of Positive Health, Positive Dignity, and Positive Prevention, and their relation to each other ▪ describe the global PHPD Framework ▪ name 8 core elements of PHDP, and link these to the overall PHDP framework ▪ discuss their vision of how to anchor PHDP in the context of the lives of PLHIV ▪ give examples of how to operationalise PHDP in Jamaica ▪ develop strategies on how to share the PHDP Framework with others	**1.** Module Introduction, Objectives **2.** Exploring Key Concepts and their relation to each other **3.** PPT: PHPD Framework: What is it and why was it developed? **4.** 8 Core Elements of PHDP **5.** Envisioning PHDP **6.** Priority Areas to Make PHPD a Reality **7.** Summary, How to Put This Module Into Action, and Wrap-Up
3. STIGMA AND DISCRIMINATION By the end of this module, participants will be able to ▪ identify different forms of stigma ▪ explain why stigma occurs ▪ identify some of the ways people have challenged stigma ▪ explain why internal stigma is a key component of the cycle of Stigma and Discrimination (S&D) ▪ challenge stigma and discrimination in an assertive way ▪ make a plan on how they will manage stigma and discrimination in their lives	**1.** Naming Stigma **2.** Experiences of Stigma **3.** Breaking the Cycle: Stigma, Internal Stigma, and Discrimination **4.** Building Self-Acceptance **5.** How to Challenge Stigma Assertively **6.** Key Messages: How to Put This Module Into Action and Wrap Up

MODULE NAME AND OBJECTIVES	ACTIVITY OVERVIEW
4. SEXUAL AND REPRODUCTIVE RIGHTS By the end of this module, participants will be able to ■ define the terms 'rights,' 'sexual rights,' and 'reproductive rights' ■ discuss how a person's sexual and reproductive rights can be abused ■ discuss ways a person can realise his/her sexual and reproductive rights	**1.** Rights from the Start **2.** Rights from the Start (Optional – Charades) **3.** What Does it Take to Realise Human and Sexual and Reproductive Rights? **4.** Key Messages, How to Put This Module Into Action, and Wrap-up
5. GENDER By the end of this module, participants will be able to ■ define and differentiate between the terms 'sex' and 'gender' ■ talk about their attitudes and values on gender ■ explain the social expectations for men and women ■ explain how social expectations may limit men's and women's ability to develop and maintain good health and well-being	**1.** Module Introduction, Objectives **2.** Exploring Key Concepts, and their relation to each other **3.** PPT: PHPD Framework: What is it and why was it developed? **4.** 8 Core Elements of PHDP **5.** Envisioning PHDP **6.** Priority Areas to Make PHPD a Reality **7.** Summary, How to Put This Module Into Action, and Wrap-Up
6. SEXUALITY By the end of this module, participants will be able to ■ speak honestly about how they feel about sex ■ list some common understandings of sexuality ■ explain the framework for sexuality ■ explain how the framework can enhance HIV prevention, treatment, care, and support responses, as well as positive health, dignity, and prevention	**1.** Talking about Sexuality **2.** Circles of Sexuality **3.** Key Messages, How to Put This Module Into Action, and Wrap-up
7. SEXUAL DIVERSITY By the end of this module, participants will be able to ■ define the core elements of healthy, satisfying relationships ■ describe a framework of sexual diversity ■ discuss how stigma and discrimination related to sexual diversity links to HIV vulnerability and access to care, treatment, and support ■ discuss how a better understanding of sexual diversity can help to promote positive health, dignity, and prevention ■ recognise and be able to de-mystify common misperceptions about sexual orientation, gender identity, and HIV	**1.** Healthy, Satisfying Relationships **2.** Sexual Diversity Continuum **3.** Myths and Realities in Our Communities **4.** Key Messages, How to Put This Module Into Action, and Wrap-up

MODULE NAME AND OBJECTIVES	ACTIVITY OVERVIEW
8. DISCLOSURE ISSUES By the end of this module, participants will be able to - define 'disclosure' - define voluntary and involuntary disclosure - describe the differences between non-disclosure, partial disclosure, and full disclosure - discuss the issues involved in disclosing one's HIV status - discuss some of the criteria needed to assess whether or not to disclose - list some tips on how to disclose in different contexts	**1.** Defining Disclosure **2.** Voluntary and Involuntary Disclosure **3.** Levels of Voluntary Disclosure **4.** Levels of Voluntary Disclosure: Benefits and Challenges **5.** Assessing Whether or Not to Disclose **6.** Reviewing 3 Tools for Disclosure **7.** Key Messages, How to Put This Module Into Action, and Wrap-up
9. POSITIVE HEALTH AND HEALTH PROMOTION By the end of this module, participants will be able to - advocate for a holistic definition of health - identify actions/resources that PLHIV/PLHIV leaders can take and use to promote positive health	**1.** Focusing on the 'PH' in PHDP **2.** The Recipe for Positive Living **3.** Defining Health (20 minutes) **4.** Healthy Mind, Body, Soul **5.** Promoting Positive Health and Access **6.** International and Regional Mandates **7.** Key Messages, How to Put This Module Into Action, and Wrap-up
10. LOSS AND GRIEF By the end of this module, participants will be able to - define 'grief' - name the Stages of Grief as outlined by the Kübler-Ross Grief Cycle - describe why, when, and how persons experience grief - describe the signs of grief and grieving styles - define coping - discuss some of most common losses that PLHIV experience and how to grieve healthily during the process - name at least three signs that indicate that they (or others) need to go to see a professional therapist	**1.** Identifying the Emotions, Thoughts, and Behaviours that Accompany Loss **2.** Loss and Grief Presentation **3.** Anticipating Losses **4.** Loss and Grief—When to Refer **5.** Key Messages, How to Put This Module Into Action, and Wrap-up
11. CONTINUUM OF CARE By the end of this module, participants will be able to - explain what the 'Continuum of Care' involves - discuss what Jamaica's 'minimum package of care' for PLHIV includes - discuss the gaps between their 'ideal' package of care and their current care	**1.** The Continuum of Care (CoC) **2.** The Ideal CoC **3.** PLHIV Package of Care **4.** Jamaica's Minimum Package of Care for PLHIV **5.** The Current and the Ideal—Jamaica's Package of Care for PLHIV **6.** Key Messages, How to Put This Module Into Action, and Wrap-up

MODULE NAME AND OBJECTIVES	ACTIVITY OVERVIEW
12. ADVOCACY By the end of this module, participants will be able to ▪ explain policy and advocacy and outline their relationship ▪ identify at least two key priority policy issues for PLHIV in relation to PHDP ▪ prepare the outline of an advocacy plan	*Note: This module is designed to be delivered over a three-day period. However, activities can be extracted and used on their own, depending on time and the purpose of the workshop.* **Day #1** **1.** Introduction **2.** Key Concepts: Advocacy and Policy **3.** The Ecological Model **4.** Other Advocacy-related Key Concepts **5.** Policy Issues Related to HIV in Jamaica **Day #2** **6.** Day #1 Recap **7.** Introduction to the Advocacy Process **8.** Steps 1–2: Issue Selection and Analysis **9.** Step 3: Identifying Goals and Objectives **10.** Steps 4–5: Identifying Targets, Allies, Resources **11.** Step 6: Creating an Action Plan **Day #3** **12.** Day #2 Recap **13.** Step 7: Creating Key Messages **14.** Step 8: Monitoring and Evaluation **15.** Being an Advocate: Refining and Implementing the Plan **16.** Next Steps: Refining and Implementing the Plan **17.** Evaluation and Key Messages
13. COMBINATION PREVENTION By the end of this module, participants will be able to ▪ describe steps to prevention using a Theory of Change model ▪ illustrate how the Ecological Model helps people to understand their relationship with other people in their community and society ▪ define structural, biomedical, and behavioural aspects of Combination Prevention using examples ▪ describe how a Cascade of Services is linked to prevention	**1.** Goal of Prevention **2.** The Ecological Model **3.** Combination Prevention **4.** Key Messages, How to Put This Module Into Action, and Wrap-up

MODULE NAME AND OBJECTIVES	ACTIVITY OVERVIEW
14. SELF-CARE By the end of this module, participants will be able to ■ explain key elements of self-care for PLHIV ■ assess current challenges and supports to self-care for PLHIV and PLHIV leaders ■ identify actions/resources that PLHIV/PLHIV leaders can take and use to promote positive health	**1.** Self-Care and Self-Management **2.** Self-Care among PLHIV Groups **3.** Taking Care of Ourselves: Self-Care as PLHIV Leaders **4.** Key Messages, How to Put This Module Into Action, and Wrap-up

INTRODUCTION

MODULE 1

HIV AND AIDS BASICS

1

What is in this Module?

This module starts with an overview of the terms 'HIV' and 'AIDS,' followed by activities aimed at teaching participants how HIV is transmitted and how it can be prevented. Practical skills that aid in prevention (such as how to put on condoms and dental dams) are also taught. Finally, a number of the myths and facts associated with HIV and AIDS are explored.

Adapted from: Module 1 – HIV and AIDS Basics of the Ministry of Health National HIV/STI Programme. 2010. HIV/AIDS Workplace Basics: Generic Syllabus, 3-hour Sensitisation Workshops for Trainers, Instructors, or Facilitators. Kingston, Jamaica: Ministry of Health, Jamaica.

OBJECTIVES	**By the end of this module, participants will be able to** ▪ Define the terms 'HIV' and 'AIDS' ▪ Describe how HIV is transmitted ▪ Discuss how to prevent HIV ▪ Discuss the steps involved in and the key terms associated with testing for HIV ▪ Demonstrate the use of a male condom ▪ Demonstrate the use of a female condom (for vaginal sex) ▪ Discuss the steps involved in the use of a female condom (for anal sex) ▪ Discuss the myths and facts associated with HIV and AIDS
TIME	4 hours
ACTIVITY OVERVIEW	**1.** HIV and AIDS Pre-test (15 minutes) **2.** Introduction to HIV and AIDS (30 minutes) **3.** Basic Facts About HIV and AIDS (45 minutes) **4.** Risk Assessment and Condom-use Skills (1 hour) **5.** Discrimination Reduction Conversation (30 minutes) **6.** HIV and AIDS Post-test (15 minutes) **7.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**Handouts** ▪ HIV and AIDS Basics (pre- or post-test questionnaire) ▪ Risk Assessment for Sexual Transmission instrument ▪ How to Use a Male Condom ▪ How to Use a Female Condom for Vaginal Sex ▪ How to Use a Female Condom for Anal Sex ▪ Discrimination Reduction Conversation Tool ▪ Key Messages—HIV and AIDS Basics ▪ Putting Learning into Action—How Can I Use What We've Done? HIV and AIDS Basics

MATERIALS

Facilitator Notes

- Instructions—How to Use a Male and Female Condom Properly
- Discrimination Reduction Conversation Tool—Answer Sheet
- HIV and AIDS (Pre or Post-test Questionnaire—Answer Sheet)
- Pinch, Leave an Inch, Roll Campaign
- Risk Assessment for Sexual Transmission—Answer Sheet

Stationery

- Pens or pencils

Prepared Flipcharts

- HIV
- AIDS
- Transmission
- How You CANNOT Get HIV
- Prevention
- Table

	GROUP #1		GROUP #2	
	YES	NO	YES	NO
Q1				
Q2				
Q3				
Q4				
Q5				
Q6				

Files

- File—HIV and AIDS Basics

Other

- Male condom(s)
- Female condom(s)
- Penis model
- Vagina model
- Lubricant

Activity 1. HIV and AIDS Pre-test

OBJECTIVE	By the end of this activity, participants will know how much they know about HIV and AIDS.
TIME	15 minutes
MATERIALS	■ HIV and AIDS Basics (pre-test questionnaire) ■ Pens or pencils
STEPS	**1.** Give the instrument to each participant. **2.** Instruct them to complete it by themselves (without consulting anyone else). **3.** Collect the instruments. **4.** Review the responses and record how many people answered each question correctly.

Facilitator Note

Do not tell participants what their scores were. Leave the results until the end and use them to compare with the post-test.

Activity 2. Introduction to HIV and AIDS

OBJECTIVE	**By the end of this activity, participants will be able to** ■ Define the terms 'HIV' and 'AIDS' ■ Explain what transmission involves ■ List three ways that HIV CANNOT be transmitted ■ Explain three methods of preventing transmission of HIV
TIME	30 minutes
MATERIALS	**Five (5) pre-prepared flipchart papers or cartridge papers with the following headings:** ■ HIV ■ AIDS ■ Transmission ■ How You CANNOT Get HIV ■ Prevention

STEPS

1. Invite all participants to write words and phrases under each heading—this should be what they think each word or phrase means.

Facilitator Note: Instruct participants not to repeat what is already written.

2. When everyone has written their words/phrases, ask volunteers to read what has been written.
3. Review all that has been written and comment by giving the facts about what each heading means or involves. This process will help to begin dispelling myths and reinforcing HIV facts.

Activity 3. Basic Facts about HIV and AIDS

OBJECTIVE

By the end of this activity, participants will be able to

- Give some basic facts about HIV and AIDS
- Express their concerns and questions about HIV and AIDS

TIME

45 minutes

MATERIALS

PowerPoint Presentation

- Laptop
- Projector
- Screen
- File—HIV and AIDS Basics
- Copies of the presentation

STEPS

1. Make the presentation.
2. Encourage participants to ask any questions they have during the presentation. Explain that there will also be time at the end of the presentation to ask questions or discuss it again.
3. Summarise the main points that emerged from the 'HIV and AIDS Basics' presentation.
4. Answer queries and talk about any concerns that were most challenging. Avoid the 'red herrings.' (These are issues that will sidetrack the discussion. For example, "Where did AIDS come from?" Answer the question this way: "We are still not certain, but HIV is here with us and can be prevented." Then go back to the lesson.)

Activity 4. Risk Assessment and Condom-use Skills

OBJECTIVE

By the end of this activity, participants should be able to demonstrate how to use male and female condoms properly.

TIME

1 hour

MATERIALS

For Risk Assessment

- Risk Assessment for Sexual Transmission instrument
- Pens or pencils

For Male Condom-use Skills

- Male condom(s)
- Penis model
- Handout—How to Use a Male Condom[1]

For Female Condom-use Skills (for vaginal sex)

- Female condom(s)
- Vagina model
- Handout—How to Use the FC2 Female Condom[2]
- For Female Condom-use Skills (for anal sex)
- Handout—How to Use a Female Condom for Anal Sex[3]

STEPS

Risk Assessment

1. Distribute the 'Risk Assessment for Sexual Transmission' instrument to each person.
2. Ask everyone to complete it by themselves.
3. When everyone is finished, read each of the six statements and say which of the answers means that the person is at risk.
4. End by reminding people that condom use is one of the ways to reduce transmission.

Male Condom-use Skills

1. Set up the model and condoms in a place where all can see.
2. Distribute the handout 'How to Use a Male Condom'.
3. Demonstrate how to put on a male condom correctly by following the steps outlined in the handout. Read each step and then do the corresponding action.
4. Ask people if they have any questions/comments.

Female Condom-use Skills (for vaginal sex)

1. Set up the model and condoms in a place where all can see.
2. Distribute the handout 'How to Use a Female Condom for Vaginal Sex'.
3. Demonstrate how to use a female condom correctly by following the steps outlined in the handout. Read each step and then do the corresponding action.
4. Ask people if they have any questions/comments.

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[1] Kirlees Young People Friendly. n.d. "How to Use a Condom: A Step-by-Step Guide to Male Condom Use." Retrieved from http://www.kypf.org.uk/contraception/condom/how-to-use-a-condom/.

[2] FC2 is one name brand for a female condom

[3] Makadon, H. J., K. H. Mayer, J. Potter, and H. Goldhammer (eds.). 2008. "Fenway Guide to Lesbian, Gay, Bisexual & Transgender Health." USA: American College of Physicians. Retrieved from http://www.acponline.org/acp_press/fenway/how-to-put-on-a-female-condom-for-anal-sex.pdf.

Female Condom-use Skills (for anal sex)

1. Review the steps outlined in the handout 'How to Use a Female Condom for Anal Sex.'
2. Ask people if they have any questions/comments.

Activity 5. Discrimination Reduction Conversation

Facilitator Note

Use someone from the people living with HIV (PLHIV) community to conduct discrimination reduction conversations when possible.

OBJECTIVE

By the end of this activity, participants should be able to discuss whether they have a tendency to discriminate against PLHIV.

TIME

30 minutes

MATERIALS

- Handout—Discrimination Reduction Conversation Tool
- Pen/pencil
- Prepared flipchart with the following table:

	GROUP #1		GROUP #2	
	YES	NO	YES	NO
Q1				
Q2				
Q3				
Q4				
Q5				
Q6				

STEPS

1. Divide the group into two smaller groups.
2. Instruct each group to discuss each of the six items in the 'Discrimination Reduction Conversation Tool' and answer the questions.
3. In the large group, ask each small group to present its answers.
4. Record the answers on the prepared flipchart.
5. Discuss the answers by reinforcing the facts on HIV and AIDS, and integrate the importance of overcoming discrimination against PLHIV.

Activity 6. HIV and AIDS Post-test

TIME	15 minutes
MATERIALS	■ HIV and AIDS Basics (post-test instrument) ■ Pens or pencils
STEPS	**1.** Give the instrument to each participant. **2.** Instruct them to complete it by themselves (without consulting anyone else). **3.** Collect the instruments. **4.** Review the responses and record how many people answered each question correctly. **5.** Calculate results from both tests. **6.** Present the comparison of the pre- and post-test results to the group and discuss.

Activity 7. Key Messages, How to Put this Module into Action, and Wrap Up

OBJECTIVES	By the end of this activity, participants should be able to ■ Recall the key issues and information learned about HIV and AIDS ■ Develop a plan of action regarding how they will use the information in their everyday lives
TIME	45 minutes
MATERIALS	**Handouts** ■ Key Messages—HIV and AIDS Basics ■ Putting Learning into Action: How Can I Use What We've Done? HIV and AIDS Basics
STEPS	**Review of Key Messages** **1.** Explain that the participants have finished the module 'HIV and AIDS Basics.' **2.** Invite participants to share any further comments or reflections that they have at this time. **3.** Explain that this module will conclude with a chance to reflect on key take-away messages. **4.** Ask participants to take three minutes to discuss the following question with a partner: "What are your key learnings on 'HIV and AIDS Basics'?" Ask participants to note their responses so they can share them out loud. **5.** After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.

6. Distribute the handout 'Key Messages—HIV and AIDS Basics.' Ask one person to read this out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the 'Key Messages' handout for their own future reference.

How to Put this Module into Action

1. Distribute the handout 'Putting Learning into Action: How Can I Use What We've Done?' HIV and AIDS Basics.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

FACILITATOR'S NOTES—HIV AND AIDS BASICS

Instructions—How to Properly Use a Male and Female Condom

Male (Latex) Condom

- The penis must be erect before putting on the male condom. Ensure that there are sufficient latex condoms within easy reach.
- Check the expiry date and the manufacturer's date on the package.
- Feel the package before opening. It should contain air. If there is no air present, the condom may be damaged. Exposure to sunlight or inappropriate storage can damage the condom.
- Open the package carefully to avoid damage to the condom. Avoid using anything sharp to open the package, such as teeth or nails. After removing the outer package, squeeze the tip of the condom to expel the air.
- Ensure that the condom is on the side that will roll out naturally. Pinch, Leave an Inch, and Roll! Roll down the condom one or two notches (the inch) to allow for sufficient space at the tip. While holding the tip of the condom, unroll the rest of the condom along the penis until your hand reaches the base of the penis.
- **ALWAYS use a water-based lubricant with the condom. This is extremely important for both vaginal and anal sexual intercourse. (Some condoms are already lubricated.)**
- After ejaculation (cum), withdraw the penis while it is still hard to prevent spillage of the semen. Hold the condom near the base of the penis as you withdraw. Remove the condom carefully, ensuring that your fingers do not come in contact with the semen or vaginal fluids. If this happens, just wash your hands.
- Take note of the colour of the semen in the condom or any discolouration on the outside from the vaginal fluids. Discoloured semen or vaginal fluids may indicate the presence of another sexually transmitted infection (STI).
- Once the condom is removed, tie the end and dispose of it in the garbage bin.
- Wash your hands.
- Each condom should be used one time only with each sex act. If the couple desires to continue having sex, wait until the penis gets hard again and put on a new condom.

Sources

MOH HIV/AIDS Workplace Basics Generic Syllabus

http://www.kypf.org.uk/contraception/condom/how-to-use-a-condom

Female Condom[1]

- The female condom can be inserted up to eight hours before sex. In practice, it is inserted between two and 20 minutes before sex. (Note that the FC2 has only been studied for insertion of up to two hours.)
- The female condom should be used one time only with each sex act.
- FC2 is latex-free and is made of nitrile, but is also protective against STI and HIV transmission if used correctly.
- Practise using the female condom without having sex.
- To insert the condom, find a comfortable position, such as standing with one leg up on a chair, sitting with knees apart, or lying and facing the ceiling.
- Ensure that the inner ring is at the bottom, closed end of the pouch. The condom is lubricated; however, extra lubricant may be added to the tip of the pouch and to the outer ring.
- Hold the pouch with the open end hanging down. While holding the outside of the pouch, form the number eight with the inner ring.
- Grasp the flexible inner ring and squeeze with the thumb and middle finger so it becomes long and narrow.
- If the female condom is slippery during insertion, let it go and start over.
- Use the index finger to push the inner ring and the rest of the pouch into the vagina. Keep inserting the pouch until your finger feels the pubic bone.
- Make sure that the female condom is not twisted when it enters the vagina.
- About one inch of the open end of the female condom will remain outside of the body. Once the penis enters, the vagina will expand and the slack will decrease. Use your hand to guide the penis into the female condom which has been inserted into the vagina.
- To remove the female condom, close off the area with the seminal fluids by twisting the condom in a circular motion. Pull out gently.
- Wrap the condom in its package or a tissue. Discard the used condom in the garbage bin.
- Wash your hands.

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[1] FC2 is one name brand for a female condom

Sources
MOH HIV/AIDS Workplace Basics Generic Syllabus
http://www.feroniaproject.org/a-condom-for-females/

Discrimination Reduction Conversation Tool—Answer Sheet

In groups of two, please answer YES or NO to each of the following six questions. After you answer to each question, I will tell you if you answered appropriately and thus scored a red ribbon.

One person will read all six questions while the other person answers. Then the person asking the questions will mention the discussion points below. Discuss these points with each other.

QUESTIONS	YES	NO
1. Would you buy fresh vegetables or food from a vendor whom you know is HIV positive?	🎗	
2. Do you think that a teacher who is HIV positive but is not sick should continue teaching students, including children?	🎗	
3. Should people be tested for HIV without their consent for them to continue working?		🎗
4. Should everyone be treated with respect, even if he or she is HIV positive?	🎗	
5. Should everyone with HIV be treated with respect, regardless of sexual orientation?	🎗	
6. If a co-worker told you his or her HIV-positive status, would you disclose it to someone in authority, such as the Human Resources Director, or to someone else, without your co-worker's consent?		🎗

If you scored fewer than six red ribbons, this means that you may be contributing to discrimination on the basis of HIV status. **HIV-related discrimination is treating someone unfairly based on his or her HIV status.**

Discussion Points

- There are four body fluids which are important to HIV transmission: semen, vaginal fluid, blood, and breast milk. If you do NOT come into contact with any of these four body fluids, then you will not be at risk for HIV.
- It is therefore okay for you to buy fresh vegetables or food from anyone, even if the person selling the vegetables or food is HIV positive.
- There is no need for workers to get tested for HIV for exclusion from employment. There is no reason for an HIV-positive person to lose his or her job unless he/she has been diagnosed as medically unfit to work.
- Remember that a person's HIV-positive status is a private matter. There is no need to tell anyone else if someone discloses his or her HIV status to you.
- If you witness any form of discrimination, or if someone has discriminated against you, you should report it to the Jamaican Network of Seropositives (JN+), 3 Trevennion Park Road, Kingston 5. Telephone: 929-7340 or email complaints@jnplus.org (National HIV-Related Discrimination Reporting and Redress System).
- Complaint forms are available at the JN+ Office, from Adherence Counsellors, or at the website www.jnplus.org.

Source
MOH HIV/AIDS Workplace Basics Generic Syllabus

Pre- or Post-Test Questionnaire Answer Sheet

Section 1. Please Answer All Questions by Ticking the Correct Response Box (True or False).

ITEM #	STATEMENTS/QUESTIONS	TRUE	FALSE
1	Undetectable viral load reduces the rate of transmission.	✓	
2	You can get HIV from the saliva of HIV+ people.		✓
3	There is no difference between HIV-related stigma and HIV-related discrimination.		✓
4	Only homosexuals can transmit HIV.		✓
5	Oral sex is considered to have a low risk of transmission of HIV but can transmit other infections.	✓	
6	Screening for HIV is not necessary for recruitment or continuation of employment.	✓	
7	Having an STI can increase the risk of transmitting or acquiring HIV.	✓	
8	It is risky for HIV+ persons to have unprotected sex with someone who is also HIV+.	✓	
9	Only the presence of the HIV antibody determines if someone is HIV+.	✓	
10	The window period is that phase of HIV infection when it is difficult to detect HIV infection with any test.	✓	

Section 2. Write the Answers to the Following Statements

11. Name the four body fluids essential for HIV transmission (in order of the most infectious).

1. Blood
2. Semen
3. Vaginal Fluid
4. Breast Milk

12. Write a verb (e.g., ‘buy’) in the blank space that best represents what a person needs to remember when using a condom.

1. Knowing how to properly STORE condoms
2. Knowing how to properly USE condoms
3. Knowing how to properly DISPOSE of used condoms

13. List the Important steps in using a condom.

1. Check the package for puffiness and expiry date.
2. Tear the package to remove the condom.
3. Place on an erect penis—Pinch, Leave an inch, and Roll the condom to the base of the penis.
4. After ejaculation, hold the tip of the condom to secure the discharge inside and to prevent spillage while you roll the condom from the erect penis.
5. Examine discharges inside and outside the condom, then tie and wrap the condom in tissue.

6. Dispose of the used condom properly. Wrap the condom in its package or a tissue and discard it in a secured garbage container.
7. Wash your hands.

Section 3: Circle the Correct Answer

14. GIPA is the principle that supports

1. Proper use of antiretroviral medication and condoms.
2. Keeping of proper medical appointments and records.
3. **The full participation of seropositive people in the response to HIV and AIDS (Greater Involvement of People Living with HIV and AIDS).**
4. Helping AIDS organisations to get more money for the fight against AIDS.

15. Presenting HIV and AIDS basic facts requires sound knowledge of the following:

1. The work of the National HIV/STI Programme only
2. Information about antiretrovirals only
3. **Information on HIV and AIDS (what they are), how to prevent HIV, transmission, and associated myths**
4. A session on human sexuality and its link to HIV transmission
5. All of the above

Pinch, Leave an Inch, Roll Campaign

Risk Assessment for Sexual Transmission

Answer YES or NO to each of the following:

	STATEMENTS	YES	NO
1	Abstinence is appropriate and easy for me to sustain.		▨
2	I use a condom CORRECTLY EVERY TIME I have sex.		▨
3	I have had or contracted a sexually transmitted infection.	▨	
4	I know my HIV status.		▨
5	I know my partner's HIV status.		▨
6	I have only one sexual partner.		▨
7	I am sure I have been his/her only sexual partner since my most recent test.		▨

If any of your YES or NO answers falls in a shaded area, you are at risk for HIV transmission. Use a condom correctly the next time you have sex.

Discrimination Reduction Conversation Tool

In groups of two, please answer YES or NO to each of the following six questions. After your answer to each question, I will tell you if you answered appropriately and thus scored a red ribbon.

One person will read all six questions while the other person answers. Then the person asking the questions will mention the discussion points below. Discuss these points with each other.

	STATEMENTS	YES	NO
1	Would you buy fresh vegetables or food from a vendor whom you know is HIV positive?		
2	Do you think that a teacher who is HIV positive but is not sick should continue teaching students, including children?		
3	Should people be tested for HIV without their consent for them to continue working?		
4	Should everyone be treated with respect, even if he or she is HIV positive?		
5	Should everyone with HIV be treated with respect, regardless of sexual orientation?		
6	If a co-worker told you his or her HIV-positive status, would you disclose it to someone in authority, such as the Human Resources Director, or to someone else, without your co-worker's consent?		

If you scored fewer than six red ribbons, this means that you may be contributing to discrimination on the basis of HIV status. **HIV-related discrimination is treating someone unfairly based on his or her HIV status.**

Discussion Points

- There are four body fluids which are important to HIV transmission: semen, vaginal fluid, blood, and breast milk. If you do NOT come into contact with any of these four body fluids, then you will not be at risk for HIV.
- It is therefore okay for you to buy fresh vegetables or food from anyone, even if the person selling the vegetables or food is HIV positive.
- There is no need for workers to get tested for HIV for exclusion from employment. There is no reason for an HIV-positive person to lose his or her job unless he/she has been diagnosed as medically unfit to work.
- Remember that a person's HIV-positive status is a private matter. There is no need to tell anyone else if someone discloses his or her HIV status to you.
- If you witness any form of discrimination, or if someone has discriminated against you, you should report it to the Jamaican Network of Seropositives (JN+), 3 Trevennion Park Road, Kingston 5. Telephone: 929-7340 or email complaints@jnplus.org (National HIV-Related Discrimination Reporting and Redress System).
- Complaint forms are available at the JN+ Office, from Adherence Counsellors, or at the website www.jnplus.org.

Source

MOH HIV/AIDS Workplace Basics Generic Syllabus

HIV and AIDS Basics (Pre- or Post-test Questionnaire)

Section 1. Please answer all questions by ticking the correct box (True or False).

ITEM #	STATEMENTS/QUESTIONS	TRUE	FALSE
1	Undetectable viral load reduces the rate of transmission.		
2	You can get HIV from the saliva of HIV+ people.		
3	There is no difference between HIV-related stigma and HIV-related discrimination.		
4	Only homosexuals can transmit HIV.		
5	Oral sex is considered to have a low risk of transmission of HIV but can transmit other infections.		
6	Screening for HIV is not necessary for recruitment or continuation of employment.		
7	Having an STI can increase the risk of transmitting or acquiring HIV infection.		
8	It is risky for HIV+ persons to have unprotected sex with someone who is also HIV+.		
9	Only the presence of the HIV antibody determines if someone is HIV+.		
10	The window period is that phase of HIV infection when it is difficult to detect HIV infection with any test.		

Section 2. Write the answers to the following statements:

11. Name the four body fluids essential for HIV transmission (in order of the most infectious).

____

____

____

____

12. Write a verb (e.g., 'buy') in the blank space that best represents what a person needs to remember when using a condom.

1. Knowing how to properly ____________________ condoms
2. Knowing how to properly ____________________ condoms
3. Knowing how to properly ____________________ of used condom

13. Write the steps involved in using a condom correctly.

____

____

____

____

Section 3. Circle the correct answer

14. GIPA is the principle that supports

a. Proper use of antiretroviral medication and condoms

b. Keeping of proper medical appointments and records

c. The full participation of seropositive people in the response to HIV and AIDS

d. Helping AIDS organisations to get more money for the fight against AIDS

15. Presenting HIV and AIDS basic facts requires sound knowledge of the following:

a. The work of the National HIV/STI Programme only

b. Information about antiretrovirals only

c. Information on HIV and AIDS (what they are), how to prevent HIV, transmission, and associated myths

d. A session on human sexuality and its link to HIV transmission

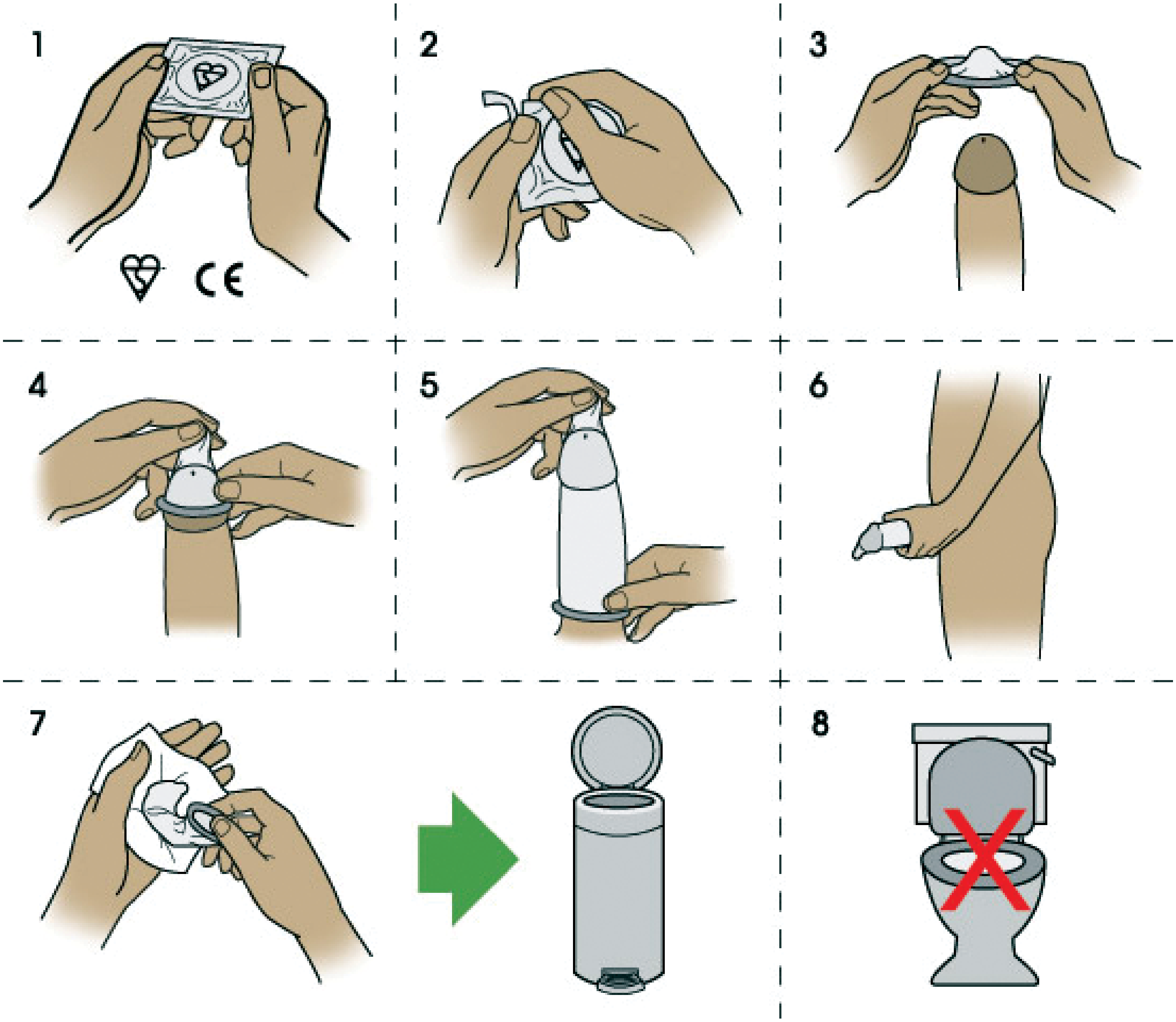
e. All of the above

Risk Assessment for Sexual Transmission

Answer YES or NO to each of the following:

	STATEMENTS	YES	NO
1	Abstinence is appropriate and easy for me to sustain.		
2	I use a condom CORRECTLY EVERY TIME I have sex.		
3	I have had or contracted a sexually transmitted infection.		
4	I know my HIV status.		
5	I know my partner's HIV status.		
6	I have only one sexual partner.		
7	I am sure I have been his/her only sexual partner since my most recent test.		

How to Use a Male Condom



- The penis must be erect before putting on the male condom. Ensure that there are sufficient latex condoms within easy reach.
- Check the expiry date and the manufacturer's date on the package.
- Feel the package before opening. It should contain air. If there is no air present, the condom may be damaged. Exposure to sunlight or inappropriate storage can damage the condom.
- Open the package carefully to avoid damage to the condom. Avoid using anything sharp to open the package, such as teeth or nails. After removing the outer package, squeeze the tip of the condom to expel the air.

- The penis must be erect before putting on the male condom. Ensure that there are sufficient latex condoms within easy reach.
- Check the expiry date and the manufacturer's date on the package.
- Feel the package before opening. It should contain air. If there is no air present, the condom may be damaged. Exposure to sunlight or inappropriate storage can damage the condom.
- Open the package carefully to avoid damage to the condom. Avoid using anything sharp to open the package, such as teeth or nails. After removing the outer package, squeeze the tip of the condom to expel the air.
- Ensure that the condom is on the side that will roll out naturally. Pinch, Leave an Inch, and Roll! Roll down the condom one or two notches (the inch) to allow for sufficient space at the tip. While holding the tip of the condom, unroll the rest of the condom along the penis until your hand reaches the base of the penis.
- ALWAYS use a water-based lubricant with the condom. This is extremely important for both vaginal and anal sexual intercourse. (Some condoms are already lubricated.)
- After ejaculation (cum), withdraw the penis while it is still hard to prevent spillage of the semen. Hold the condom near the base of the penis as you withdraw. Remove the condom carefully, ensuring that your fingers do not come in contact with semen or vaginal fluids. If this happens, just wash your hands.
- Take note of the colour of the semen in the condom or any discolouration on the outside from the vaginal fluids. Discoloured semen or vaginal fluids may indicate the presence of another sexually transmitted infection (STI).
- Once the condom is removed, tie the end of it and dispose of it in the garbage bin.
- Wash your hands.
- Each condom should be used one time only with each sex act. If the couple desires to continue having sex, wait until the penis gets hard again and put on a new condom.

Sources

MOH HIV/AIDS Workplace Basics Generic Syllabus

http://www.kypf.org.uk/contraception/condom/how-to-use-a-condom/

How to Use a Female Condom for Vaginal Sex

How to use FC2 Female Condom

These instructions show step by step how to insert the FC2 female condom in the vagina. FC2 can be inserted either a few hours or just before sex. When FC2 is used for the first time, people might need to practise insertion. FC2 can be inserted by women themselves but their partner can also do it for them.

1 Before opening your FC2:

- Check the expiry date which is stamped on the front or on the side of the FC2 packet.
- Spread the lubrication inside around by rubbing the packet with your hands.

2 To open the packet, tear straight down from the arrow at the top and remove the condom. Do not use scissors, a knife or your teeth to open the packet.

3 Hold the inner ring between your thumb and forefinger. Then squeeze the sides of the inner ring together to form a point.

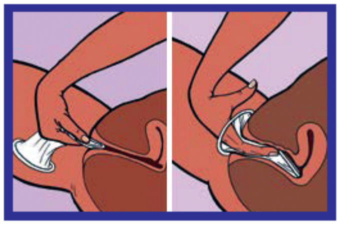
4 You can insert FC2 in lots of different ways. Find a position that is comfortable. This may be standing, sitting, squatting or lying down.

5 Feel for the outer lips of your vagina and spread them.

FC2 female condom is manufactured by The Female Health Company (FHC)
Chicago USA/London UK/Malaysia

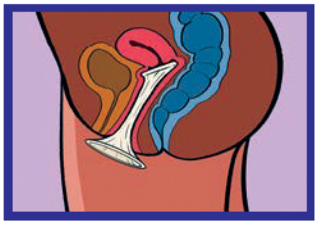
How to Use a Female Condom for Vaginal Sex

Support



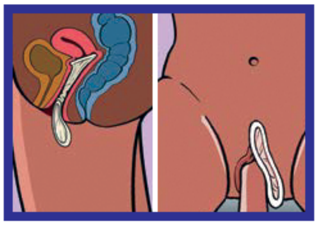
6 Use the squeezed inner ring to push FC2 into your vagina.
Slide your index finger or middle finger inside the condom and push it in your vagina as far as possible, using the inner ring. Make sure the condom is not twisted and lies smoothly against your vaginal wall.

7 A small part of the condom, including the outer ring, stays outside your body and lies over the lips of your vagina, partially protecting your external sex organs and covering the base of your partner's penis.



8 FC2 lines the inside of your vagina and covers your cervix. The opening of your cervix is so small that it is impossible for FC2 to pass through this space.

9 Hold the outer ring in place as your partner guides his penis inside the condom. Once his penis is inside the condom, you do not have to continue holding the outer ring.
For extra pleasure you may want to add more lubricant either on the inside or outside of FC2 or directly onto your partner's penis once the condom is inserted.



10 **Please notice!** Your partner needs to immediately withdraw his penis if:

- His penis enters between the condom and the vagina wall. In this case you should put the outer ring back in position before he slides his penis back inside the condom.
- The outer ring has been pushed into your vagina. In this case you should use a new FC2.

11 To take FC2 out, hold the outer ring and twist it to keep the semen inside.
It's best to do this before standing up. Gently pull the condom out, wrap it in a tissue or the empty packet, and throw it in a rubbish bin.

www.femalecondom.org | info@femalecondom.org
SUPPORT is a division of The Female Health Company

- The female condom can be inserted up to two hours before sex. In practice, it is inserted between two and 20 minutes before sex.
- The female condom should be used one time only with each sex act.
- Practise using the female condom without having sex.
- To insert the condom, find a comfortable position, such as standing with one leg up on a chair, sitting with knees apart, or lying and facing the ceiling.
- Ensure that the inner ring is at the bottom, closed end of the pouch. The condom is lubricated; however, extra lubricant may be added to the tip of the pouch and to the outer ring.
- Hold the pouch with the open end hanging down. While holding the outside of the pouch, form the number eight with the inner ring.
- While holding the "eight," use the other hand to spread the lips of the vagina and insert the squeezed female condom.
- If the female condom is slippery during insertion, let it go and start over.
- Use the index finger to push the inner ring and the rest of the pouch into the vagina. Keep inserting the pouch until your finger feels the pubic bone.
- Make sure that the female condom is not twisted when it enters the vagina.
- About one inch of the open end of the female condom will remain outside of the body. Once the penis enters, the vagina will expand and the slack will decrease. Use your hand to guide the penis into the female condom which has been inserted into the vagina.
- To remove the female condom, close off the area with the seminal fluids by twisting the condom in a circular motion. Pull out gently.
- Wrap the condom in its package or a tissue. Discard the used condom in the garbage bin.
- Wash your hands.

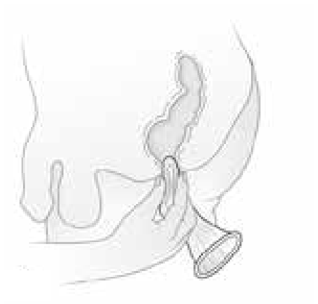
Sources
MOH HIV/AIDS Workplace Basics Generic Syllabus
http://www.femalecondom.org/materials

How to Use a Female Condom for Anal Sex

These are provisional guidelines for using the female condom for anal sex. The female condom was not originally designed for anal sex, and more research is needed to determine the safety, effectiveness, or acceptability of the female condom for anal sex.

1. Gently insert the inner ring into the anal opening.
2. With your index finger inside the condom, push the inner ring up the anal cavity (for maximum protection, the inner ring should be inserted past the sphincter muscle). Be sure the condom is not twisted. When inserted properly, about one inch of the outer ring of the condom will hang out of the anal opening.
3. Add more lubricant to the inside of the condom, penis, or sex toy. The female condom is made of polyurethane and therefore can be used with any kind of lubricant.
4. To remove the condom, squeeze and twist the outer ring and gently pull the condom out.
5. Wrap the condom in its package or a tissue and throw it in the garbage. Do not put it into the toilet.
6. To remove the condom, squeeze and twist the outer ring and gently pull the condom out.

1



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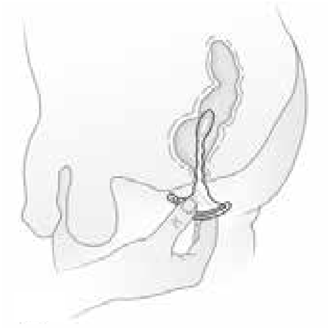

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1. FC2 has not been studied or approved for use for anal sex

Additional Notes

- It is recommended that you practice placing and removing the condom a few times before using it for the first time during sexual intercourse.
- Extra lubrication is strongly recommended.
- Make sure that the penis or sex toy enters inside the center of the condom and is not underneath or beside the condom.
- You may feel the condom slipping up and down in the anal cavity, riding on the penis. This is normal as long as the outer ring does not get pushed into the anal cavity. If this happens, stop immediately, remove and discard the condom, and insert a new one.
- Do not use male and female condoms at the same time.
- Another way to use the female condom for anal sex is for the insertive partner to wear it like a male condom. 1) Add extra lubricant inside the female condom. 2) Place the condom over the penis. 3) Add extra lubricant on the outside of the condom.

Source

Makadon, H. J., K. H. Mayer, J. Potter, and H. Goldhammer (eds.). 2008. *Fenway Guide to Lesbian, Gay, Bisexual & Transgender Health*. USA: American College of Physicians, pp. 507–508.

Key Messages—HIV and AIDS Basics

HIV is the virus that causes AIDS.

H—Human—Reminds us that HIV is transmitted only by an HIV-infected human being to another human being.

I—Immunodeficiency—HIV attacks the immune system of the infected human being and gradually destroys the body's natural defences against infection—thereby breaking down the immune system.

V—Virus—HIV is a virus that gets into the blood system. This is a microscopic or tiny germ which lives inside a human living cell. There may be no signs and symptoms of this virus attacking the immune system. However, HIV gradually destroys the cells which it attacks—mainly the T cells or fighter cells (also called the CD4 cells). HIV also replicates itself, increasing the infected person's viral load or the amount of HIV infection in the body.

AIDS

A—Acquired—The HIV-infected person developed AIDS because he or she acquired the AIDS-causing virus (HIV).

I—Immune—This refers to the immune system as described above.

D—Deficiency—Suggests that the immune system, the body's natural defence against infection, is deficient or compromised. The two words together mean the same thing as immunodeficiency, explained above.

S—Syndrome—A syndrome is a collection of symptoms and signs of disease. AIDS is a syndrome, rather than a single disease, because it is a complex illness with a wide range of complications and symptoms.

People living in Jamaica who are HIV positive have had access to antiretroviral (ARV) treatment free of cost since 2006. The ARV treatment delays the onset of AIDS by improving the body's immune system through increasing CD4 (fighter) cells and decreasing the viral load.

There are **four** body fluids important to HIV transmission.

1. Blood
2. Semen (including pre-cum)
3. Vaginal fluids
4. Breast milk

Prevention of Sexual Transmission (sexual activity is the primary infection route)

The ABCs of prevention

A—Abstain from sex until the 'right' or 'appropriate' time. This suggests delayed sex, not celibacy.

B—Being faithful to one equally faithful sexual partner, with both persons being uninfected, can prevent HIV transmission.

C—Used correctly and consistently, latex condoms are highly effective in preventing the sexual transmission of HIV (during vaginal, oral, or anal intercourse). HIV (Practical condom use session—see Guide, p. 7).

D—Do get tested—knowing your HIV status helps in decision making for a prevention option.

E—Exercise universal precautions when handling body fluids and skin-piercing or sharp instruments for protection from all blood-borne pathogens, including HIV.

Other Key Messages (that you have identified):

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Putting Learning Into Action: How Can I Use What We've Done?

HIV and AIDS Basics

1. How can I use what I've learned from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)

   a. With whom would I want to share? Please list.
   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

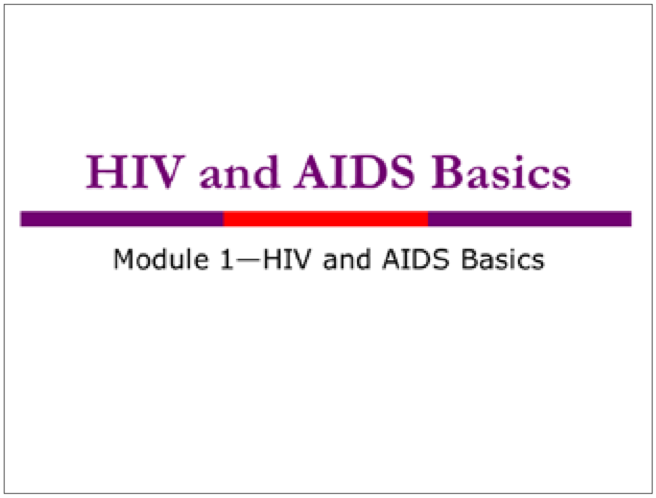
Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ______________________

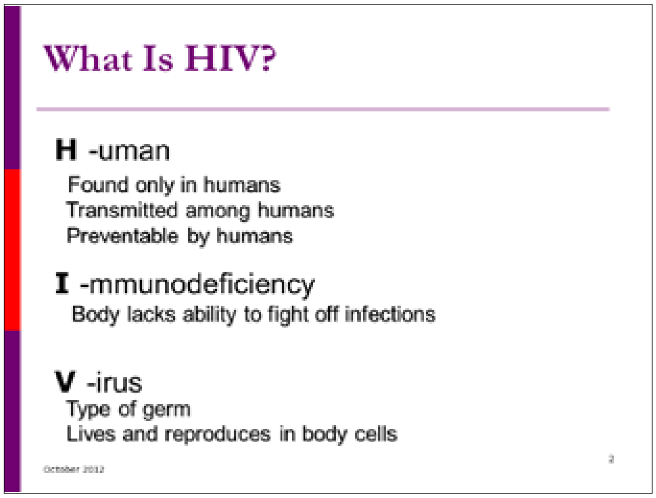
1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?



HIV and AIDS Basics

Module 1—HIV and AIDS Basics

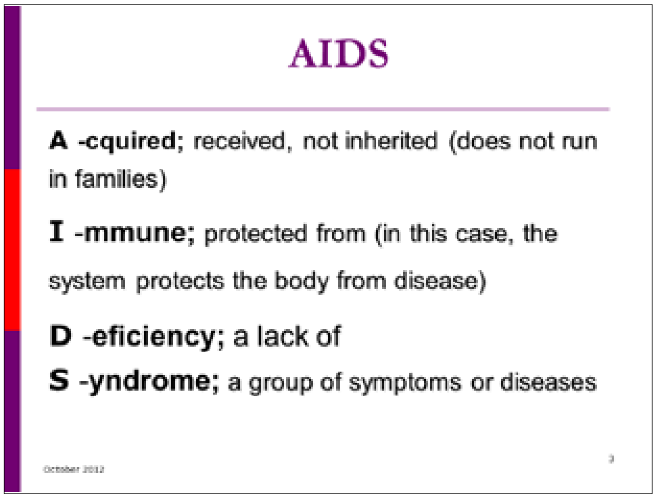


What Is HIV?

H -uman
Found only in humans
Transmitted among humans
Preventable by humans

I -mmunodeficiency
Body lacks ability to fight off infections

V -irus
Type of germ
Lives and reproduces in body cells



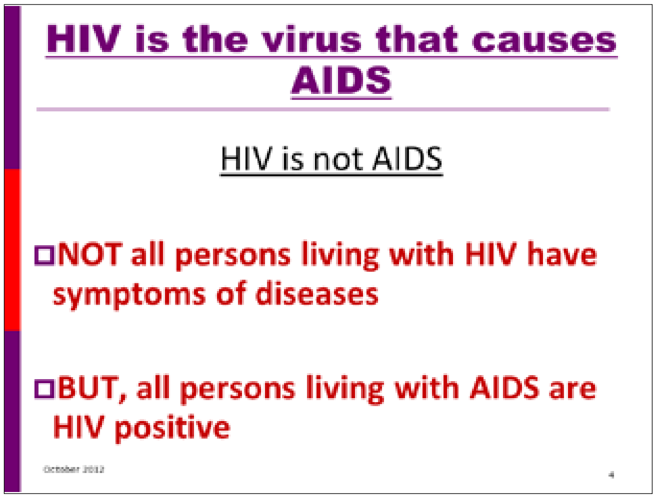
AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases



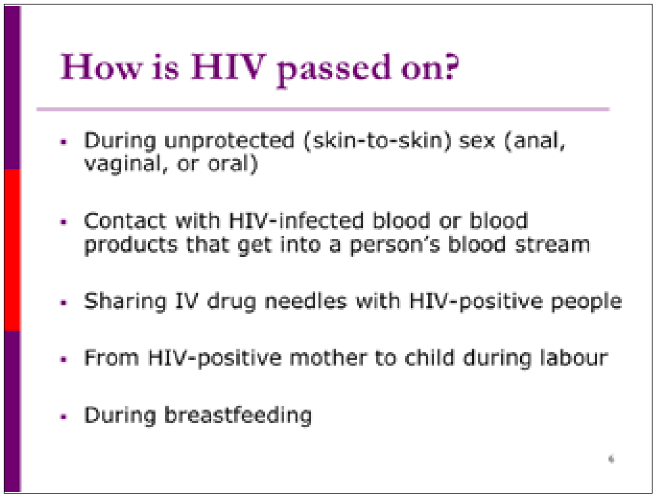
HIV is the virus that causes AIDS

HIV is not AIDS

- **NOT all persons living with HIV have symptoms of diseases**
- **BUT, all persons living with AIDS are HIV positive**

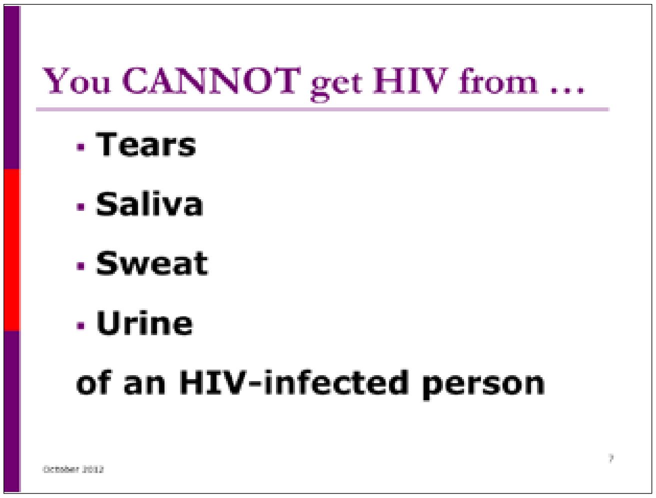
HIV IS FOUND IN THESE BODY FLUIDS

- **Blood**
- **Semen**
- **Vaginal fluid**
- **Breast milk**



How is HIV passed on?

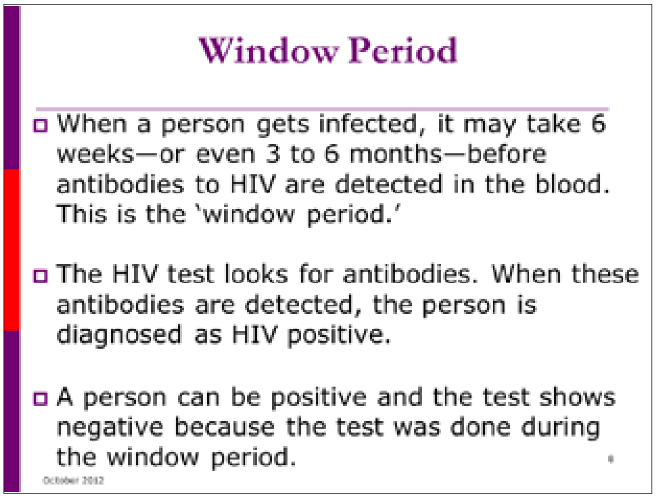
- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding



You CANNOT get HIV from …

- **Tears**
- **Saliva**
- **Sweat**
- **Urine**

of an HIV-infected person

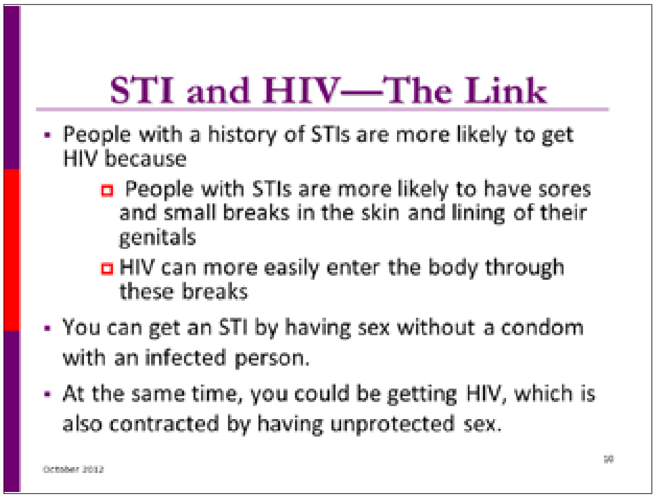


Window Period

- ☐ When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- ☐ The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- ☐ A person can be positive and the test shows negative because the test was done during the window period.

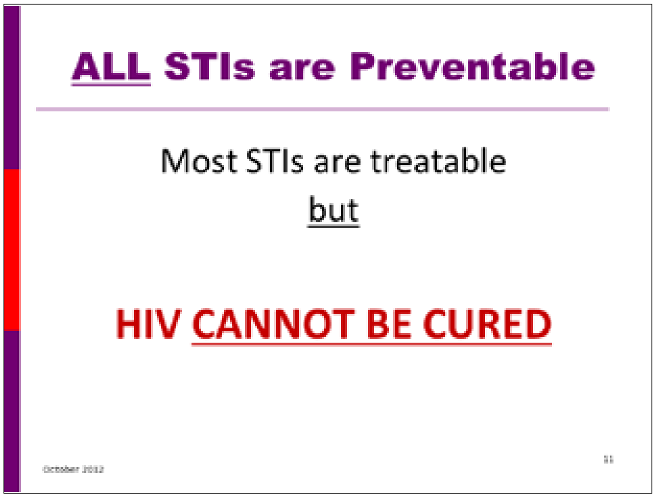
Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for .... things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles



STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
    - ☐ People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
    - ☐ HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.



ALL STIs are Preventable

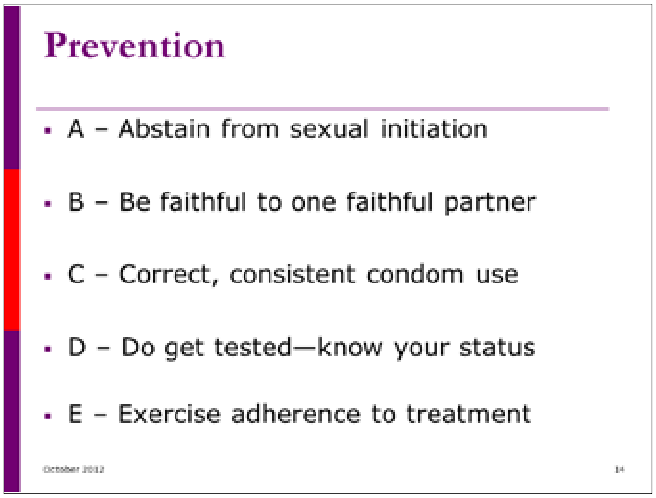
Most STIs are treatable
but

HIV CANNOT BE CURED

Prevention Treatment

Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.

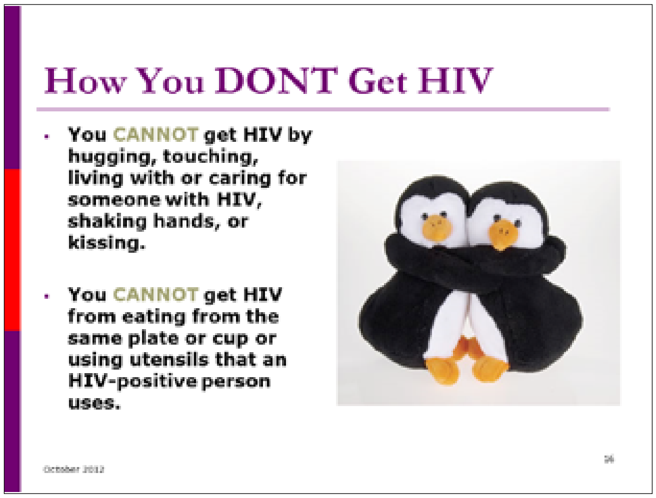


Prevention

- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment

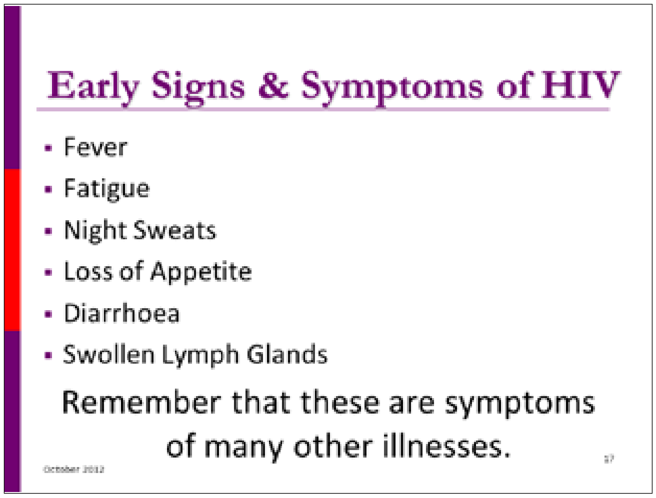
Who is most at risk for HIV?

- Anybody having sex without a condom
- People with more than one partner who don't use a condom during sex
- People whose sex partners have sex with other partners without using a condom



How You DONT Get HIV

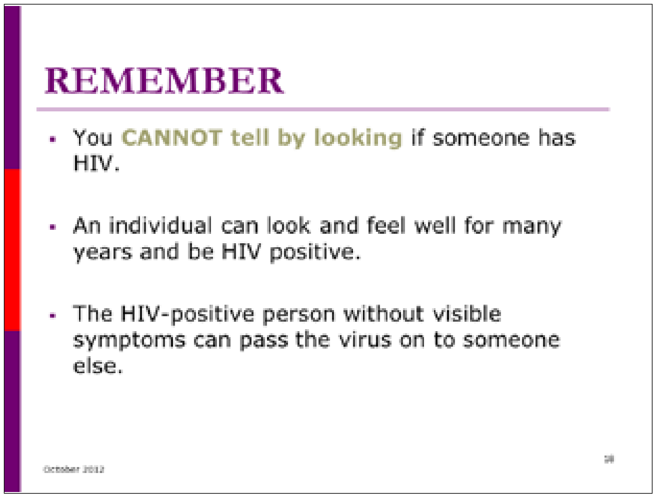
- **You CANNOT get HIV by hugging, touching, living with or caring for someone with HIV, shaking hands, or kissing.**
- **You CANNOT get HIV from eating from the same plate or cup or using utensils that an HIV-positive person uses.**



Early Signs & Symptoms of HIV

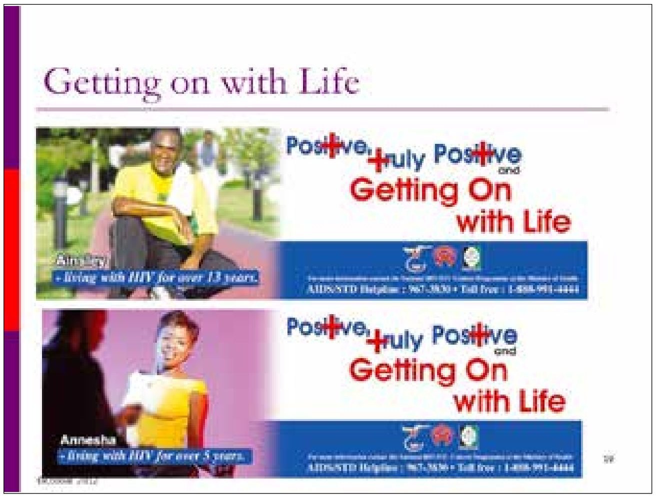
- Fever
- Fatigue
- Night Sweats
- Loss of Appetite
- Diarrhoea
- Swollen Lymph Glands

Remember that these are symptoms of many other illnesses.



REMEMBER

- You **CANNOT tell by looking** if someone has HIV.
- An individual can look and feel well for many years and be HIV positive.
- The HIV-positive person without visible symptoms can pass the virus on to someone else.



Getting on with Life

October 2012

Can YOU support someone living with HIV?

October 2012

What have we learnt?

October 2012

MODULE 2

THE FRAMEWORK OF POSITIVE HEALTH, DIGNITY, AND PREVENTION (PHDP)

What is in this Module?

This module provides an introduction to the Framework of Positive Health, Dignity, and Prevention (PHDP). The first two activities provide a basic overview of PHDP, including a holistic, participatory process to define PHDP and an overview of the PHDP Framework with a PowerPoint (PPT) presentation and discussion. The additional activities provide opportunities to consider the PHDP Framework in greater depth. These include an in-depth review of the eight elements of PHDP programming; an exercise during which people draw and write what they envision their individual lives and communities would be like in 20 years, with PHDP fully realised; and a process to begin prioritising gaps that need to be addressed to realise this vision. A final activity helps participants to reflect on key learnings from this module and identify how they might apply these in their own lives and their engagement in the HIV response.

OBJECTIVES	**By the end of this module, participants will be able to** ■ Describe the three key concepts of Positive Health, Positive Dignity, and Positive Prevention, and their relation to each other ■ Describe the global PHDP Framework ■ Name eight core elements of PHDP and link these to the overall PHDP framework ■ Discuss their vision of how to anchor PHDP in the context of the lives of people living with HIV (PLHIV) ■ Give examples of how to operationalise PHDP in Jamaica ■ Develop strategies on how to share the PHDP Framework with others
TIME	6–7 hours
ACTIVITY OVERVIEW	**1.** Introduction and Warm-up (10 minutes) **2.** What Is Positive Health, Dignity, and Prevention? (Exploring key concepts, and their relation to each other) (60–90 minutes) **3.** The Positive Health, Dignity, and Prevention Framework (PPT presentation and discussion: What is the PHDP Framework, and why was it developed?) (45 minutes) **4.** Envisioning PHDP: What Is PHDP in Our Lives and Communities? (60 minutes) **5.** Eight Core Elements of PHDP (60 minutes) **5.1.** Eight Key Programme Elements of PHDP: What Are These? (45 minutes) **5.2.** Linking Eight Key Programme Elements to PHDP (15 minutes) **6.** Priority Areas to Make PHDP a Reality in Our Lives (90 or 45 minutes; see options) **7.** Key Messages, How to Put this PHDP Module into Action, and Wrap-up (up to 60 minutes)
MATERIALS	**Handouts** ■ PPT presentation for participants ■ PHDP: Eight Programmatic Components, Elements, and Linkages ■ Positive Health, Dignity, and Prevention: One-Page Overview ■ Key Messages—Positive Health, Dignity, and Prevention ■ Putting Learning into Action: How Can I Use What We've Done? The Framework of Positive Health, Dignity, and Prevention

MATERIALS	**Prepared flipcharts** ■ Group work instructions ■ PHDP Programme Elements for prioritising **Materials for activities with visuals** ■ Coloured paper (ideally heavy paper—i.e., construction paper) ■ Scissors ■ Glue sticks ■ Glitter, or other art materials **Other Materials** ■ Coloured dot stickers (with at least three colours) to use in prioritisation ■ PPT presentation and computer ■ Prepared cards with the eight elements (three sets) ■ Flipchart paper ■ Colored markers/crayons ■ Masking tape or blue tack (to post flipcharts)

Activity 1. Introduction and Warm-up

OBJECTIVE	By the end of this activity, participants should be able to share openly about whether they know about PHDP.
TIME	10 minutes
MATERIALS	Flipchart paper/markers
STEPS	**1.** Explain that this module seeks to introduce a framework developed in the past year by the Global Network of People Living with HIV (GNP+), called Positive Health, Dignity, and Prevention (PHDP). Highlight that this framework was developed to provide a vision of health, dignity, and prevention from the point of view of people living with HIV—and to foster stronger, collective national responses to HIV. **2.** Ask participants, "How many people have heard of the PHDP Framework?" If anyone has, ask them: "What have you heard?" Take a couple of responses. **3.** Ask participants, "What would you like to know about this framework?" Take a couple of additional responses, and record them on the flipchart. **4.** Review the objectives of the session. Note how these objectives link to what participants said they would like to know.

Activity 2. What are "Positive," "Health," "Dignity," and "Prevention"?

OBJECTIVE

By the end of this activity, participants should be able to do the following:

- Define the words 'positive,' 'health,' 'dignity,' and 'prevention'
- Explain how the terms relate to each other in the context of HIV

TIME

60–90 minutes

Facilitator Note: Time table: 50 minutes for Activity 2, Part One; 40 minutes for Activity 2, Part Two. If you conduct Activity 2, Part One only, you should allow 60 minutes.

MATERIALS

- Prepared flipcharts with group instructions
- Flipchart paper for each table
- Markers for each table
- Masking tape or blue tack (to post flipcharts)
- Materials for art projects
  - Coloured paper (ideally heavier—i.e., construction paper)
  - Scissors
  - Glue sticks
- Glitter, or other art materials

STEPS

1. Transition to this activity, explaining that participants will explore the core concepts of 'Positive Health, Dignity, and Prevention' in depth. Explain that this activity will be carried out in small groups.

Key Concepts, Part One

2. Introduce Part One of the activity. Explain that in the first part of the activity, participants will explore what these terms mean to the people in the room. Referring to a prepared flipchart with instructions, explain that each small group will be assigned one of these key terms; within the group, participants are to do the following:

> **Prepared Flipchart**
>
> Small Group Work: Key Concepts—Part One
>
> Your group will be assigned a key concept: Health, Dignity, or Prevention
>
> First, for your key concept
>
> - Brainstorm what it means for you, in the context of your lives.
> - Record key words, ideas, phrases—whatever comes to mind.

Second, add the word 'Positive' to your concept:

- Brainstorm what Positive Health, Positive Dignity, or Positive Prevention means for you, in the context of your lives.
- Record any additional words, ideas, or phrases.

Be prepared to take five minutes to share your responses.

3. Explain that participants will have 20 minutes for their small group work. Divide participants into groups. Give each group one key concept.
4. After 20 minutes, ask the groups to reconvene.
5. Have each group present its key concept in five minutes (seven minutes maximum). Ask for any clarifying questions after each presentation. Then, after all groups have presented their concepts, facilitate a discussion, asking the following:
   a. What strikes you about these key concepts?
   b. Are there any surprises? What?
   c. How does adding 'positive' affect these core elements?
   d. Are there any additions you would like to make? (The facilitator should record these on the appropriate flipcharts.)

Facilitator Option

If you do not have time to complete Activity 2, Part Two, include discussion of the following questions here. Otherwise, proceed to Part Two and wait to discuss these questions as part of the processing questions for Activity 2, Part Two (see below).

   e. How do the individual components 'Positive Health,' 'Dignity,' and 'Prevention' relate to each other?

Possible prompts

- Is one more important than the other? Why or why not?
- Is one harder to achieve than the others? Why or why not?
- What does 'Positive Health, Dignity, and Prevention' add to 'Positive Prevention'?

6. How might the framework of 'Positive Health, Dignity, and Prevention' help you in your life? How might the framework help your activism for improving the quality of life for PLHIV?

Key Concepts, Part Two

7. Introduce Part Two of the activity. Explain that participants should now consider how these key concepts relate to each other. Say that to do so, participants will return to their small groups. Review the instructions for their small group work, posted on a flipchart:

Prepared Flipchart

Small Group Work – Key Concepts, Part Two

Create an image that shows how Positive Health, Dignity, and Prevention relate to each other.

STEPS

8. Clarify that the image can be drawn, made out of collage, sculpted, done as a cartoon or a diagram, etc. ... participants should use their imagination. Point out the materials available for their work (construction paper, coloured pens, crayons, scissors, glue stick, etc.). Tell the groups that they will have 20 minutes.
9. After 20 minutes, ask each group to display its image. Have each group briefly describe its image. Facilitate a discussion using the following questions:
   a. What strikes you about the images?
   b. Are there any surprises?
   c. What do the images tell us about how positive health, dignity, and prevention relate to each other?

Possible prompts

- Is one aspect more important than the other? Why or why not?
- Is one aspect harder to achieve than the others? Why or why not?

10. How might the framework of 'Positive Health, Dignity, and Prevention' help you in your life? How might the framework help in your activism for improving the quality of life for PLHIV?
11. You might end the discussion on concepts by asking the participants if they have other concepts related to PHDP that they would like to discuss.
   a. A list of other key concepts that have been used in terms of prevention and living with HIV might include terms such as the following:
      - Primary prevention: Activities with both infected and uninfected people to reduce primary (i.e., initial or new) HIV infections (Summerside and Davis, 2002)
      - Secondary prevention: Activities to maintain the well-being of people with HIV (including wider sexual health) and delay disease progression (Summerside and Davis, 2002)
      - Sero-discordant: Where one partner is HIV positive and the other is HIV negative
   b. There are many other terminologies that could come up in the discussion. Have a copy of the UNAIDS terminology guidelines at hand to help with definitions. Available at http://www.unaids.org/en/resources/documents/2011/name,63629,en.asp.

Activity 3. The Positive Health, Dignity, and Prevention Framework

OBJECTIVE

By the end of this activity, participants should be able to describe the PHDP Framework.

TIME

45 minutes

MATERIALS

For PowerPoint presentation

- File—PHDP Overview
- Laptop
- Projector
- Screen
- Copies of PPT presentation for participants

Handout: Positive Health, Dignity, and Prevention: One-Page Overview

STEPS

1. Transition to this activity by saying that the group will now take a moment to highlight some of the main components of the global Positive Health, Dignity, and Prevention (PHDP) Framework, noting that the framework reflects many of the ideas already identified by participants. Point out that the full PHDP prevention document is available on the GNP+ website.
2. Present the PPT presentation. Encourage participants to ask any questions they have during the course of the presentation. Explain that there will be time to discuss the presentation at the end, too.
3. After the presentation, facilitate a brief discussion asking the following:
   a. What do you think of the framework? What stands out for you?
   b. What questions do you have?
   c. How does the framework relate to your understanding of PHDP from the previous exercise?
      i. Were there any elements that surprised you?
      ii. Are there any additions you would want to make?
   d. Are there any parts that you want to particularly emphasise in the context of what's important in your life? How about in the context of priorities for action for PLHIV in Jamaica?
4. Summarise the main points shared by participants and share the handout PHDP: One-Page Overview as a reference. Ask if there are any final comments before concluding the activity.

Facilitator Option

The facilitator also has an option of conducting Activity 4 as an open discussion (see the question under the Prepared Flipchart, below), rather than using the small group work and prioritisation process. This also would shorten the time required.

Activity 4. Envisioning PHDP: What is PHDP in our Lives and Communities?

OBJECTIVE

By the end of this activity, participants should be able to explain how PHDP relates to their lives, using pictures.

TIME

60 minutes, plus 15 minutes for coffee break and gallery walk

STEPS

1. Initiate a brief discussion to recap and refresh, asking the following:

"Remembering our prior discussions, have you had any further thoughts or 'Aha!' moments related to PHDP?"

2. Introduce the exercise. Explain that to make the group's vision of PHDP even more concrete, participants will work in small groups to create this vision through drawing. To do this, ask participants to follow two steps:
   a. As individuals, think about and draw the following: "When you hear PHDP, what visuals come into your mind? Take five minutes to draw your own picture." Distribute blank computer paper and markers/crayons.
   b. As a group, think about and draw the following: "What does PHDP—fully realised—look and feel like in our lives (20 years down the road)?" Take 25 minutes to draw your collective vision. Distribute flipchart paper and markers/crayons. One flipchart should be given to each group.

STEPS	**3.** Divide participants into four groups. Allow 30 minutes for group work. Ask participants to post their drawings prior to taking a break—and to be sure to look at each other's drawings while on break. **4.** Reconvene the group. Have each group present its visions. Paste the drawings on the wall. **5.** Afterwards, facilitate a discussion asking the following: a. How was the process of drawing their vision of PHDP? Easy or hard? Any key debates? b. What strikes them about the visions? c. What (more) do the drawings tell about what PHDP is? d. Are there any new insights into what it takes to fully make PHDP a reality? e. How does having a collective vision help our work? **6.** Note that drawing the concept of PHDP can help to anchor this work by providing a vision of what participants should work for in their lives and communities. Encourage participants to remember their vision and use it as a resource as they identify priority actions to take in their lives and in their efforts to strengthen the HIV response in their communities.

Activity 5.1 Eight Key Programme Elements of PHDP: What are These?

OBJECTIVE	By the end of this activity, participants should be able to recite at least four of the eight programme elements of PHDP and explain what they mean.
TIME	45 minutes
MATERIALS	Pre-printed cards with the following: ■ The titles of the eight PHDP Elements (e.g., Gender Equality)—one title per card ■ The definitions and/or example(s) of each element—the example(s) or definition on each card must match one element *Example* **GENDER EQUALITY** | **Definition:** having equal rights, responsibilities and opportunities for women, men, girls, and boys **Example:** Legal advocacy and activism for women's rights *Facilitator Note: Print two sets of these cards*
STEPS	**1.** Transition from the previous exercise, noting that there are eight key elements of programming that the PHDP document identified as key to fully realising PHDP. **2.** Explain that this exercise is designed to familiarise everyone with these eight elements. **3.** Ask participants to work in their small groups. Hand each group a stack of cards. Explain that participants are to match each key element with its best definition; note that there are more definitions than terms.

4. Allow 15 minutes to carry out the exercise in small groups. When done, invite each group to arrange its matched responses on the floor in the front of the room.
5. Gather participants around one group's cards. Ask for a volunteer to point out each card and 'matched' definition; after each card, ask if there were any other (different) responses in other groups. Clarify any questions or confusion.
6. After all eight elements have been defined, facilitate a brief discussion of the following:
    a. What do you think about these eight programme elements?
    b. Are there any surprises? Any gaps? (Are there other elements needed?)
    c. Are there any additional questions or clarifications?
    d. How can knowing these eight specific programme elements help you to realise PHDP in your own life? What about in your work to improve the HIV response in your community?
7. Thank participants for their participation and transition to the next exercise.

Activity 5.2 Linking Eight Key Programme Elements to PHDP

OBJECTIVE

By the end of this activity, participants should be able to describe how the eight programme elements are linked/connected to the overall framework of PHDP.

TIME

15 minutes

MATERIALS

Prepared flipchart

- Three large circles (each one labeled Health, Dignity, or Prevention), posted on a wall in an overlapping Venn diagram

Other

- One set of the eight programme elements cards

STEPS

1. Explain the purpose of this short follow-up activity.
2. Refer to the circle diagram of the PHDP on the wall. Give each group two of the eight elements cards. Ask the group to take five minutes to discuss their two cards and to decide in which circle they fit best.
3. After five minutes, ask all groups to place their cards on the diagram on the wall. Then ask each group to explain why they placed their cards where they did. Take any clarifying questions after each group presents.
4. After all of the groups present, facilitate a discussion:
    a. Were there any surprises?
    b. What strikes you about where the eight elements were placed?
    c. What (new) insights does this provide about PHDP?
    d. What does this mean, in terms of our work as PLHIV to make PHDP a reality?
5. Thank everyone for the insights and transition to the next activity.

Activity 6. Priority Areas to Make PHDP a Reality in Our Lives

Option 1 (Longer)

OBJECTIVE

By the end of this activity, participants should be able to explain how PHDP is or isn't connected to their everyday lives.

TIME

90 minutes (30 minutes small group work, 60 minutes report out)

MATERIALS

Prepared flipchart

- Flipchart with group work instructions

Other:

- Flipchart paper
- Flipchart easel
- Markers

STEPS

1. Introduce this activity, explaining that participants will now take an initial look* at how PHDP relates to the current realities of their lives. In particular, for each of the eight programme elements, participants should begin to identify the following from the perspective of their own lives (and the lives of their peers): What are the priority issues/challenges that we face in each area?

   *Participants will then explore these issues in more depth over the next couple of days.

2. Ask participants to work in four small groups. Explain that each group will receive two of the eight PHDP elements. Review the group work instructions:

> **Small Group Work Instructions (on flipchart or PPT)**
>
> For each of your group's PHDP programme elements, please do the following:
>
> - Brainstorm the list of issues/challenges you face.
> - Prioritise the top three to four issues/challenges.
> - Write these on a flipchart.
>
> Be prepared to share your responses (five minutes for each element).

3. Allow 30 minutes for the small group work.
4. Reconvene the groups and have each group report out. Take clarifying questions after each group's report. Once all groups have reported, facilitate a discussion, asking the following:
   - a. How did it feel to work on this exercise?
   - b. Were there any surprises?
   - b. Do you have any additions to any of these areas?
   - c. Looking across all of the elements (and the issues)
     - i. Where are the strengths? Why are these strengths?
     - ii. Where are the biggest gaps/problems? Why?
     - iii. What does this mean in terms of our work as leaders to advance PHDP?
5. Thank everyone for their participation.

Activity 6. Priority Areas to Make PHDP a Reality in Our Lives

Option 2 (Shorter)

OBJECTIVE

By the end of this activity, participants should be able to explain which of the elements are most important to them as a focus for initial action, in order of priority.

TIME

45 minutes

MATERIALS

Prepared flipchart

- Flipchart prepared with the instructions for the small group activity

Handout:

- PHDP: Eight Programmatic Components, Elements, and Linkages

Other:

- Sticky dots (to vote with)—one colour per small group, three dots per table
- Flipchart paper
- Markers

Facilitator Option

The facilitator also has the option of conducting this activity as an open discussion (see the question under the prepared flipchart, below), rather than using the small group work and prioritisation process. This also would shorten the time required.

STEPS

1. Transition to this activity, noting that a main next step for the Positive Health, Dignity, and Prevention Framework is the 'now what'—that is, putting it into practice—which means building on successful efforts underway and identifying new areas and ways to move PHDP forward.
2. Acknowledge that there are different entry points for putting the framework into practice. Explain that for this activity, participants will focus on the eight PHDP Programme Elements to consider how to put the Positive Health, Dignity, and Prevention Framework into practice.
3. Re-orient participants to the eight elements, returning to that slide of the PPT presentation. Acknowledge that these elements are very interrelated, but ask participants to consider the following:

Prepared Flipchart

Small Group Work–Eight PHDP Programme Elements

Based on the current context of your communities, which of these eight programme elements would you prioritise for additional focus in Jamaica?

1. Discuss and identify your top three choices.
2. Be prepared to elaborate why these are priorities and give some ideas of what needs to happen in this area.
3. When asked, post your dots by your chosen programme elements.

4. Give participants the handout PHDP: Eight Programmatic Components, Elements, and Linkages for reference and further detail.

STEPS

5. Ask participants to return to their small groups. Allow 20 minutes for small group work. Distribute flipchart paper and markers. Ask groups to write the titles of each of the eight elements and post their dots by each of their three prioritised programme areas.
6. Briefly summarise the patterns of the 'priorities' (i.e., where groups placed their dots). Facilitate a discussion on the following questions, taking a few responses from different groups/participants:
   - How was the process within groups? Easy or hard?
   - For the areas that have the most dots, why are these areas prioritised? What within these areas needs to be addressed?
   - For some of the areas with fewer dots, what are the needs/concerns related these areas?
   - What patterns, if any, do we see among these priorities? What are some key areas on which to focus (in your communities and your country context)?
   - How can we move PHDP forward? That is, what next steps can be taken
     - In your lives?
     - In your support groups and programs?
     - In broader advocacy?

Activity 7. Key Messages, How to Put this PHDP Module into Action, and Wrap-up

TIME

45 minutes (if all parts completed)

MATERIALS

- Handout—Key Messages: PHDP
- Handout—Putting Learning into Action: How Can I Use What We've Done? (see Module 4 for Facilitator Notes and Handout)

STEPS

Part One—Review Key Messages

1. Explain that the group has finished the overview to the Positive Health, Dignity, and Prevention Framework.
2. Invite participants to share any further comments or reflections on the Positive Health, Dignity, and Prevention Framework that they have at this time.
3. Explain that the group should conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key learnings about Positive Health, Dignity, and Prevention?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Share the handout on Key Messages: PHDP, asking one person to read them out loud. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

Part Two—How to Use This Module

7. Carry out the activity steps, including completion of the workshop, outlined for this activity in Training Module 4—Putting PHDP into Action.

Part Three—Wrap-up

8. Highlight that this orientation is part of the larger effort to strengthen how Positive Health, Dignity, and Prevention is put into practice—and that the ongoing and future efforts of all the participants will continue to be vital to this process.

Thank participants for their active participation and contributions.

Positive Health, Dignity, and Prevention: Eight Programmatic Components, Elements, and Linkages

Excerpts from: *Positive Health, Dignity, and Prevention: A Policy Framework*. March 2011, pp. 19–25. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20110701_PHDP_0.pdf.

Operationalising Positive Health, Dignity, and Prevention is not necessarily about creating new programmes, except where basic programmes do not currently exist. Rather, it is about using this new framework to create linkages among existing programmes, as well as taking them to scale, so that they are more efficient and more responsive to the needs of people living with HIV.

Individual programmatic elements will inevitably differ from setting to setting, as local needs and resources dictate, but fall under eight major component headings.

1. Empowerment
2. Gender equality
3. Health promotion and access
4. Human rights
5. Preventing new infections
6. Sexual and reproductive health and rights
7. Social and economic support
8. Meaningful involvement of people living with HIV (PLHIV) in measuring impact

Empowerment

- Meaningful involvement of PLHIV
  - Positive leadership
  - Participation in policy dialogue and advocacy
  - Mentoring of future leaders, including women and young people living with HIV
  - Peer support groups

- Education and literacy, including
  - Treatment
  - Sexual health and comprehensive sexuality
  - Prevention of transmission
  - Reproductive health
  - Family planning
  - Legal and rights
  - Health education for living well (improving nutrition, ceasing smoking, limiting alcohol and drug use, increasing exercise), which helps provide information on health options
  - Building self-esteem and confidence

  - Age-appropriate and HIV-specific sex and relationships education for children and adolescents born with HIV
- Capacity building for organisations and networks of people living with HIV

Gender equality

- Gender-based violence prevention and management
  - Health provider training on sexuality, gender, stigma, discrimination, and gender-based violence
  - Legal reform and enforcement of laws and mechanisms protecting people from gender-based violence
- Constructive engagement of men in reproductive and sexual health
- Appropriate health services for women living with HIV, including, but not limited to, prevention of vertical transmission of HIV
- Legal advocacy and activism for women's rights
  - Networking opportunities
- Legal advocacy and activism for rights of men who have sex with men and lesbian, gay, bisexual, transgender, and intersex people
  - Networking opportunities
- Economic empowerment of women, education, support for caregiving, and social empowerment, including equality in decision making and negotiating skills

Health promotion and access

- Knowledge of HIV status under conditions of informed consent, confidentiality, and good counselling
  - Community-based voluntary counselling and testing
  - Provider-initiated counselling and testing
- Treatment and care access, availability, sustainability, and quality assurance
- Psychosocial well-being services access, availability, sustainability, and quality assurance
  - Mental and emotional health services
  - Counselling services and support groups

Human rights

- Confidentiality of HIV-positive status, including conditions for safe, voluntary, and beneficial disclosure
- Respect for individual autonomy
  - Choosing when and if to test, disclose, and/or initiate antiretroviral therapy
- Establishment of an enabling environment, including protective laws
  - Stigma and discrimination reduction
  - Support for advocacy and activism, leading to legal and policy reform and implementation of a non-punitive approach to health

  - A focus on shared responsibility for preventing new HIV infections, including removal of punitive, HIV-specific criminal laws

The UNAIDS Secretariat promotes seven key programmes to reduce stigma and discrimination and increase access to justice. These programmes should be integral to every national AIDS response. These are programmes to

- Provide legal literacy or 'know your rights and laws'
- Train healthcare workers in nondiscrimination, informed consent, confidentiality, duty to treat, and universal precautions
- Train police in nondiscrimination and providing space for HIV outreach interventions
- Provide legal services
- Reduce stigma and discrimination
- Reform laws
- Achieve gender equality, transform harmful gender norms, and eliminate violence against women

All of these, in varying ways, protect and empower people living with HIV, enabling them to be full citizens with equal rights and dignity, and have access to justice as well as health services.

Preventing new infections

- Accessibility and availability of tools and technologies that help prevent sexual HIV transmission
  - Male and female condoms and water-based lubricants
  - Male circumcision
  - Antiretroviral therapy
  - Post-exposure prophylaxis
  - New prevention technologies, such as pre-exposure prophylaxis and microbicides, as and when they become available
- Access to and availability of services that help prevent vertical transmission
  - Providing appropriate treatment, care, and support to mothers living with HIV and their children and families
- Access to evidence-informed harm reduction for people who use drugs, including opiate substitution therapy
- Serodiscordant couples counselling (including partner and couples testing)
- Prevention, screening, and treatment of sexually transmitted infections, including viral hepatitis
  - Human papillomavirus vaccination
  - Hepatitis A and Hepatitis B vaccination

Sexual and reproductive health and rights

- Sexual health and well-being
- Age-appropriate, comprehensive sexuality education, including a focus on the specific needs of adolescents born with HIV
- Prevention and treatment of sexually transmitted infections, including viral hepatitis
- Counselling and support for a satisfying sex life, including, but not limited to, improving libido and treating sexual dysfunction

- Reproductive health
  - Maternal health
  - Family planning, including infertility and contraceptive services
  - Cervical, breast, and other related cancer screening and management
  - Access to appropriate, safe, and non-coerced termination services
- Sexual and reproductive health and rights advocacy and funding

Social and economic support

- Food and water security
- Social and economic support for caregivers
- Access to financial services
  - Support of productive linkages, including cooperatives
- Employment of people living with HIV
  - Further education and retraining opportunities for adults with HIV
  - Access to full education and employment opportunities for young people living with HIV
  - Health and social protection for children and adolescents living with HIV

Meaningful involvement of PLHIV in measuring impact

Meaningfully engaging and supporting people living with HIV to develop data collection tools, conduct evaluations, and review and analyse data can result in more relevant and nuanced understandings. This helps to ensure that programmes are grounded in the reality of those hoping to benefit from these programmes.

Positive Health, Dignity, and Prevention: One-Page Overview

The primary goals of Positive Health, Dignity, and Prevention (PHDP) are to improve the dignity, quality, and length of life of people living with HIV (PLHIV); if achieved, this will in turn have a beneficial impact on their partners, families, and communities, including reducing the likelihood of new infections.

PHDP is not just a new name for the concept of HIV prevention for and by PLHIV, formerly known as 'positive prevention.' Rather, PHDP is built on a broader basis that includes improving and maintaining the dignity of the individual living with HIV to support and enhance that individual's physical, mental, emotional, and sexual health, which, in turn (among other benefits), creates an enabling environment that will reduce the likelihood of new HIV infections.

PHDP encompasses the full range of health and social justice issues for PLHIV. It espouses the fundamental principles that responsibility for HIV prevention should be shared, and that policies and programmes for people living with HIV should be designed and implemented with the meaningful involvement of PLHIV.

By linking together the social, health, and prevention needs of the individual living with HIV within a human rights framework, PHDP results in a more efficient use of resources, with outcomes more responsive to the needs of PLHIV and more beneficial for their partners, families, and communities.

Programmatic Components of PHDP

Operationalising PHDP is not about creating new programmes, except where basic programmes currently do not exist. Rather, it is about using this new framework to create linkages among existing programmes and taking them to scale, so that they are more efficient and more responsive to the needs of PLHIV. Furthermore, as mentioned above, individual programmatic elements inevitably will differ from setting to setting according to local contexts.

Programmatic components of PHDP fall under the following eight thematic areas:

- Empowerment of PLHIV and PLHIV networks
- Gender equality
- Health promotion and access
- Human rights
- Preventing new infections
- Sexual and reproductive health and rights
- Social and economic support
- Measuring impact

The meaningful involvement and engagement of PLHIV and networks of people living with HIV throughout all levels and stages of design, implementation, monitoring, and evaluation is a common thread of all actions in all eight component areas.

Key Messages—Positive Health, Dignity, and Prevention

Key messages related to PHDP include the following:

- PHDP is a global framework for strengthening program and policy responses to HIV.
- PLHIV led the development of the PHDP Framework, along with other stakeholders. It is a positive framework that seeks to enable prevention, as well as a response wherein all people can live together with health and dignity.
- Health, dignity, and prevention all are linked together. This framework emphasises that if the dignity, quality, and length of life of PLHIV are improved, prevention for all will also be improved.
- There are eight key programme areas of PHDP:
  - Empowerment
  - Gender equality
  - Health promotion and access
  - Human rights
  - Preventing new infections
  - Sexual and reproductive health and rights
  - Social and economic support
  - Measuring impact

However, PHDP is not about creating new programmes, except where basic programmes do not exist currently. Rather, it is about using this new framework to create linkages and respond to gaps in existing programmes so that they are more efficient and responsive to the needs of PLHIV.

Additional key messages or learnings include the following (please fill in, based on your own reflections and those of others):

Putting Learning into Action: How Can I Use What We've Done?

The Framework of Positive Health, Dignity, and Prevention

1. How can I use information from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

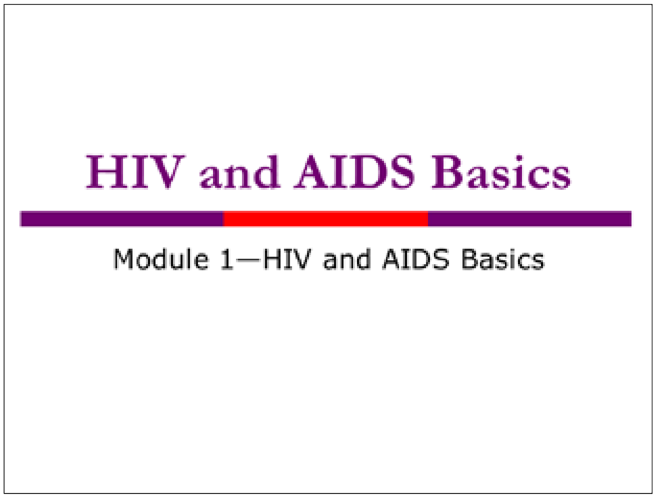
Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

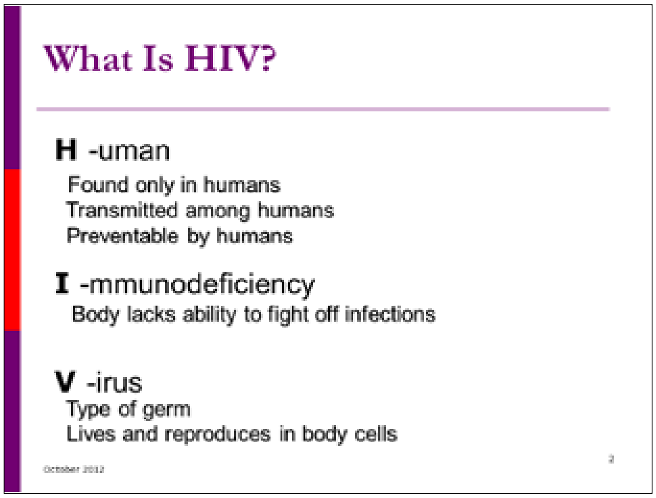
1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or …)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?



HIV and AIDS Basics

Module 1—HIV and AIDS Basics



What Is HIV?

H -uman

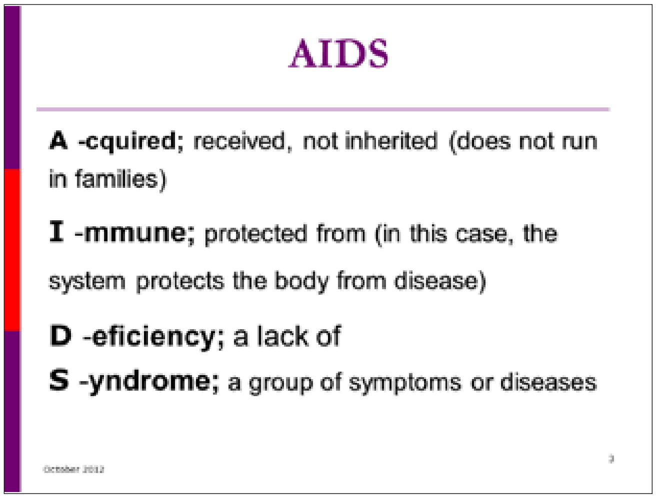
Found only in humans
Transmitted among humans
Preventable by humans

I -mmunodeficiency

Body lacks ability to fight off infections

V -irus

Type of germ
Lives and reproduces in body cells



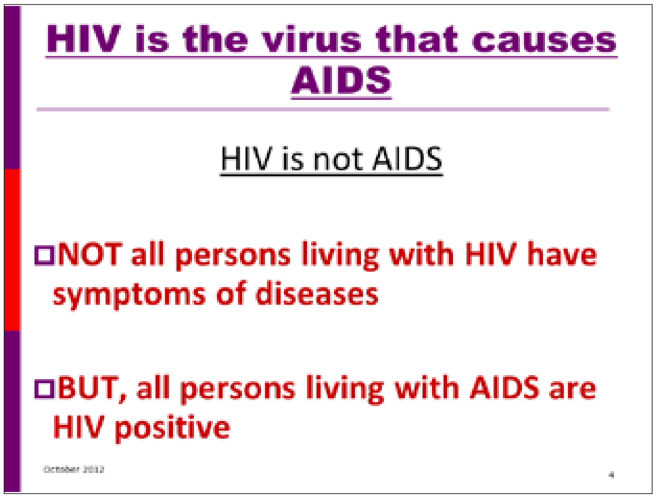
AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases



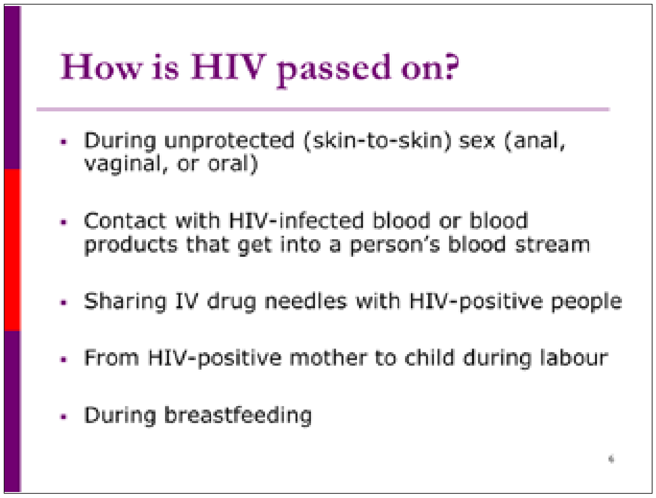
HIV is the virus that causes AIDS

HIV is not AIDS

- **NOT all persons living with HIV have symptoms of diseases**
- **BUT, all persons living with AIDS are HIV positive**

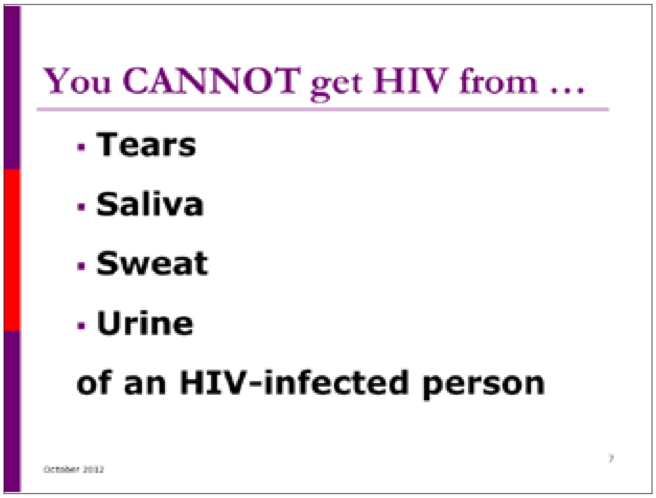
HIV IS FOUND IN THESE BODY FLUIDS

- **Blood**
- **Semen**
- **Vaginal fluid**
- **Breast milk**



How is HIV passed on?

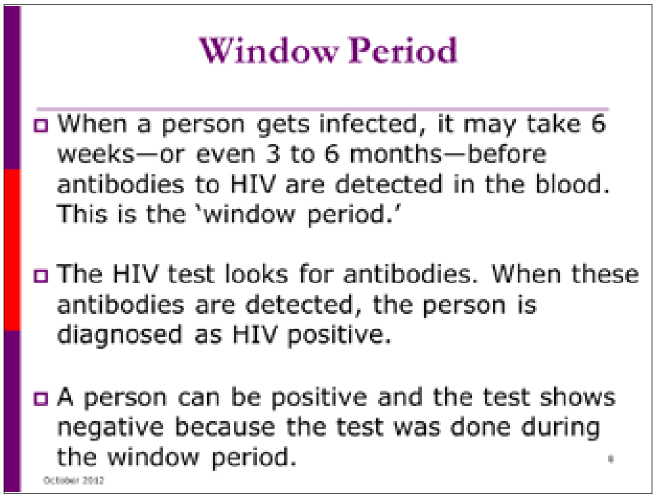
- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding



You CANNOT get HIV from …

- **Tears**
- **Saliva**
- **Sweat**
- **Urine**

of an HIV-infected person

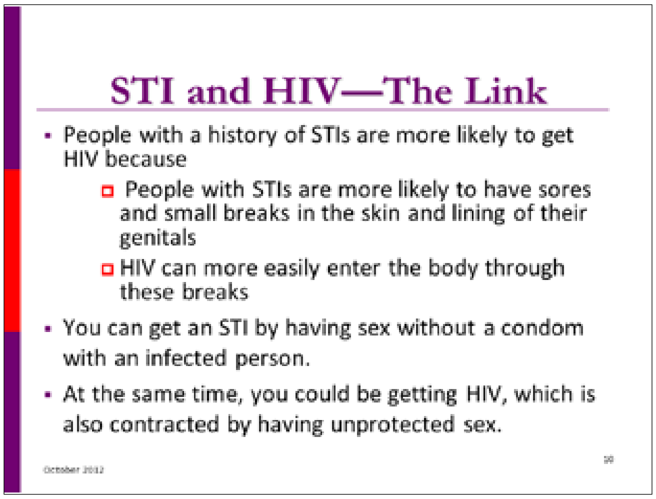


Window Period

- ☐ When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- ☐ The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- ☐ A person can be positive and the test shows negative because the test was done during the window period.

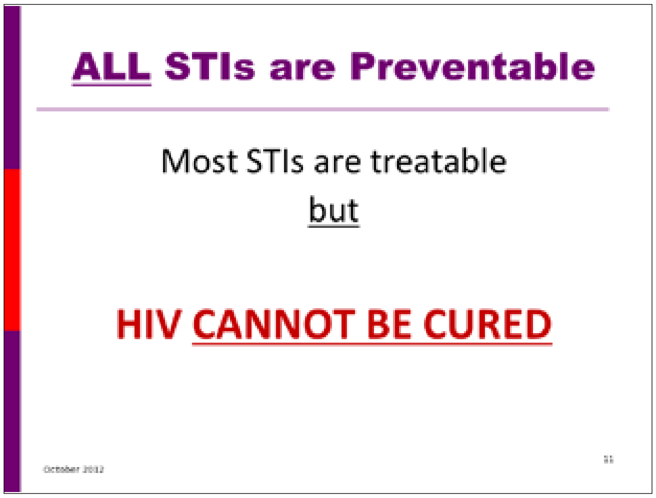
Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for …. things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles



STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
  - ☐ People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
  - ☐ HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.



ALL STIs are Preventable

Most STIs are treatable

but

HIV CANNOT BE CURED

Prevention Treatment

Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.

October 2012

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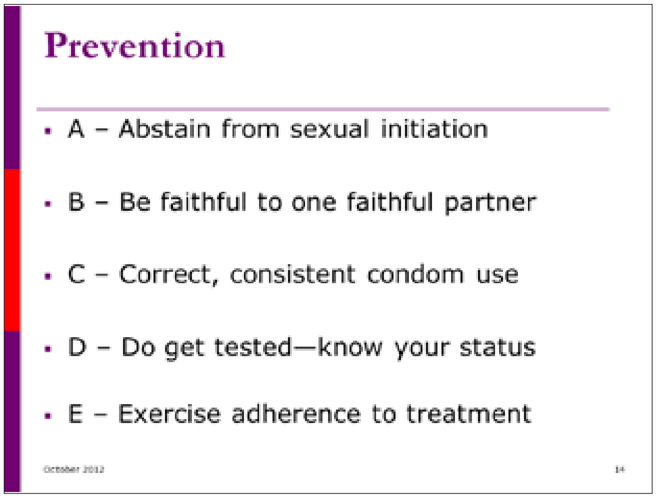

Prevention

- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment

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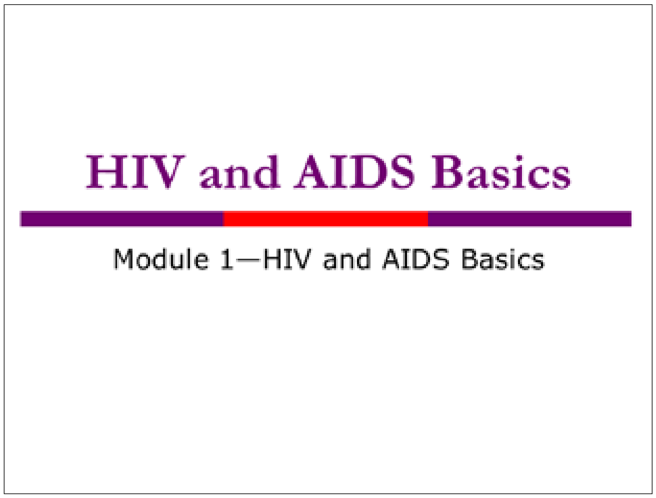
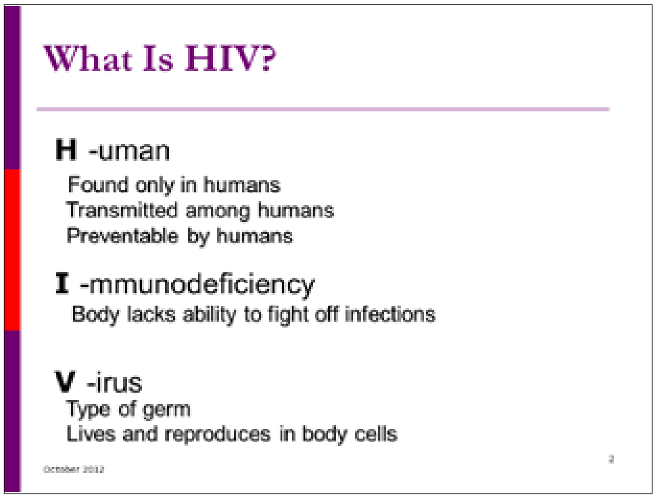


HIV and AIDS Basics

Module 1—HIV and AIDS Basics



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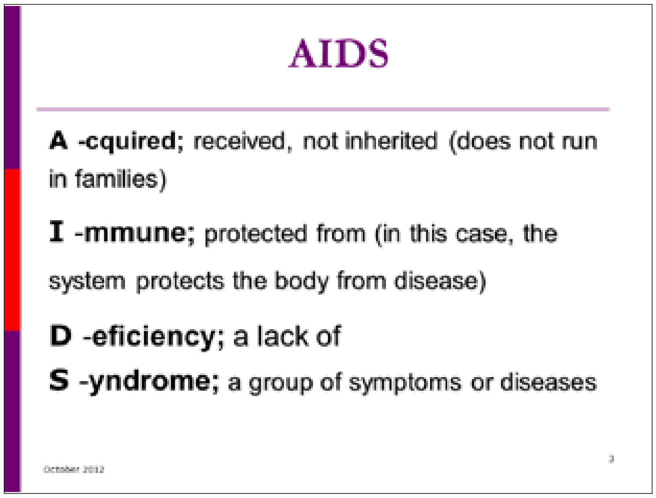

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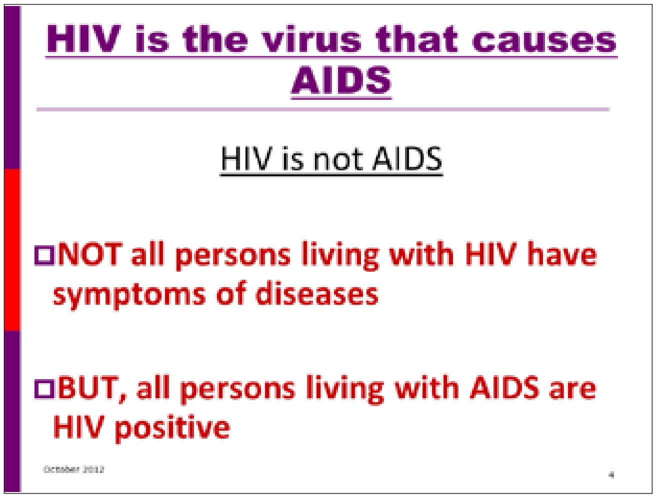

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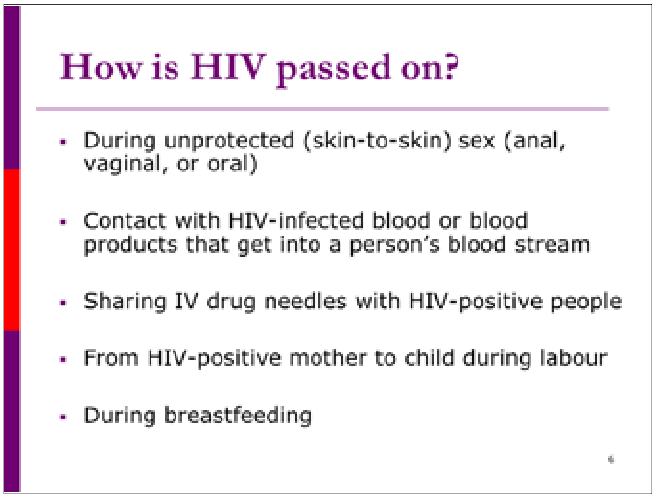

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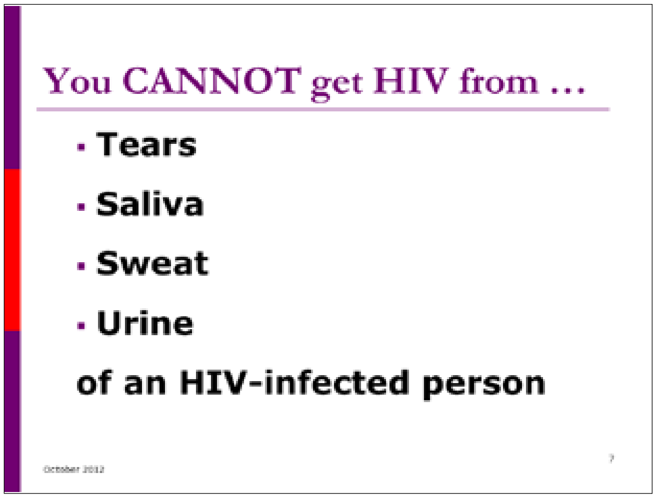

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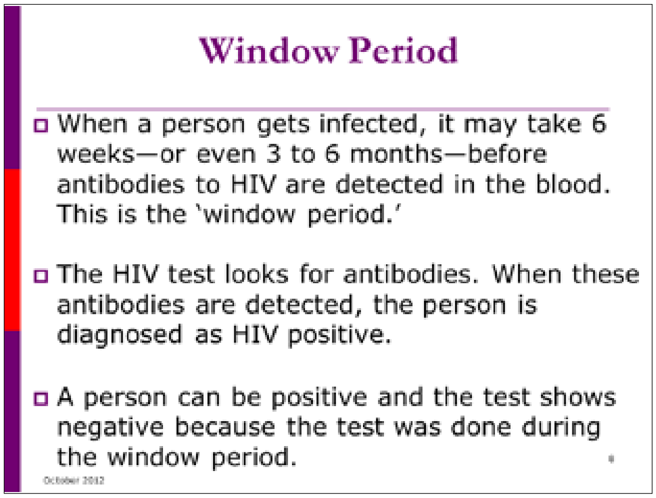

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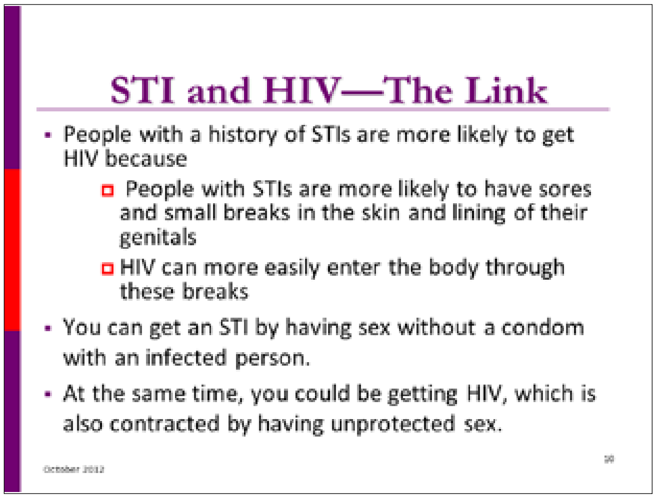

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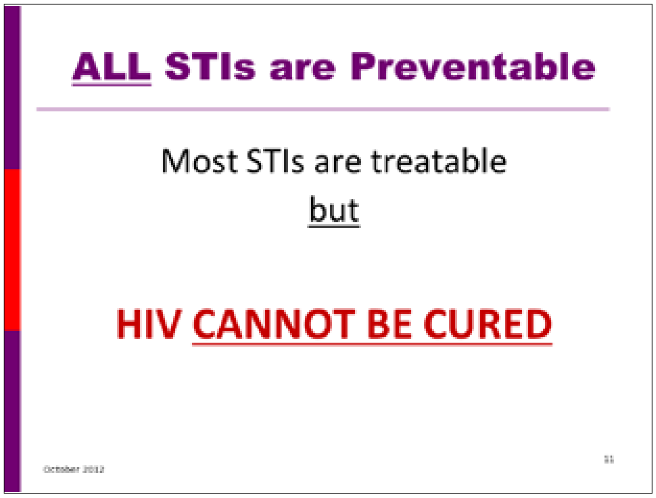

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Most STIs are treatable

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Prevention Treatment

Prevention

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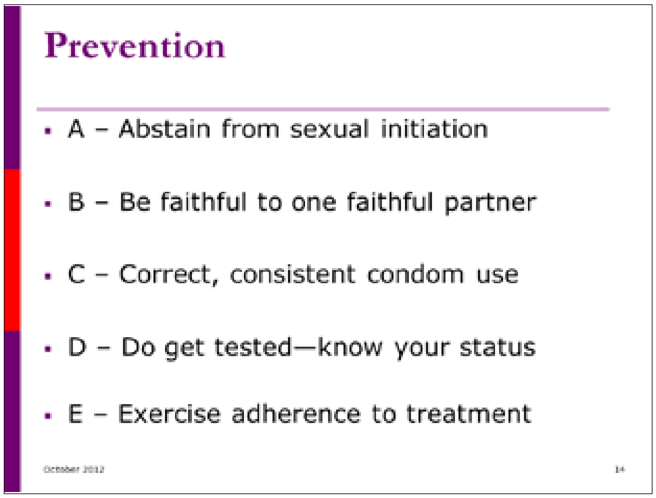

Prevention

- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment

MODULE 3

Stigma & Discrimination

What is in This Module?

This module builds a deeper understanding of stigma and discrimination (S&D). It particularly focuses on internal stigma and the process of self-acceptance.

The module includes activities with three distinct, although related, areas of focus:

- It first offers two experiential exercises to name stigma and the experiences of stigma in the context of Jamaica: 1. Naming Stigma, and 2. Experiences of Stigma.
- It then provides a more in-depth look at internal stigma within a broader framework of stigma, internal stigma, and discrimination, using a PowerPoint presentation and discussion. An accompanying activity on self-acceptance offers an opportunity to identify and reflect on processes that can help a person to overcome self-stigma.
- Finally, the module includes three activities to translate greater understanding of stigma and discrimination into action.

The activities are: *Experiences of Stigma*, *Self-Acceptance*, and *How to Challenge Stigma Assertively*; they are designed to be used specifically with people living with HIV (PLHIV) and other key populations. When sequencing activities, it is recommended to move from exploring experiences to identifying processes and skills that support self-acceptance and claiming rights.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Identify different forms of stigma ▪ Explain why stigma occurs ▪ Identify some of the ways people have challenged stigma ▪ Explain why internal stigma is a key component of the cycle of S&D ▪ Challenge S&D in an assertive way ▪ Make a plan about how they will manage S&D in their lives
TIME	3 hours 30 minutes (core), plus 2 hours (recommended)
ACTIVITY OVERVIEW	**1.** Naming Stigma (45 minutes) **2.** Experiences of Stigma (1 hour) **3.** Breaking the Cycle: Stigma, Internal Stigma, and Discrimination (30 minutes) **4.** Building Self-Acceptance (1 hour 15 minutes) **5.** How to Challenge Stigma Assertively (1 hour) **6.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**For PowerPoint presentation** ▪ Laptop ▪ Projector ▪ Screen

MATERIALS

PowerPoint files

- File—Breaking the Cycle: Stigma, Discrimination, and Internal Stigma
- File—Self-Acceptance Exercise
- File—About Self-Acceptance

Background Reading

- Policy Briefing Note on Stigma: Breaking the Cycle

Handouts

- Picture Walk—Questions for Discussion
- Copies of Stigma and Discrimination PowerPoint presentation
- Popular Self-Acceptance Quotations
- Key Messages—Stigma and Discrimination
- Putting Learning into Action: How Can I Use What We've Done? Stigma and Discrimination
- 'Just the Way You Are' or 'Video'

Other

- Flipchart paper
- Flipchart easel
- Markers
- Masking tape
- S&D pictures posted on the wall, far enough apart to allow people to move around
  - Picture 1—Man sitting alone on a bus
  - Picture 2—Man living with HIV fired
  - Picture 3—Man sitting alone on a bed
  - Picture 4—Doctor talking to nurse beside a patient's bed
  - Picture 5—Father kicking his son out of the house
  - Picture 6—Pastor preaching about sinners
  - Picture 7—Nurse refusing to provide services to sex worker

Activity 1. Naming Stigma[1]

OBJECTIVES

By the end of this activity, participants should be able to

- Identify different forms of stigma in different contexts in Jamaica
- Identify how stigma affects individuals, families, and communities
- Explain why stigma occurs
- Discuss examples of stigma from their own communities, work contexts, and personal experiences
- Identify how people have challenged stigma

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1. This activity is drawn from: Health Policy Project. 2013. "Naming HIV and Key Population Stigma and Discrimination through Pictures," in *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project.

TIME

45 minutes

OBJECTIVES

Handout

- Picture Walk—Questions for Discussion

Other

- S&D pictures posted on the wall far enough apart so people can move around
  - Picture 1—Man sitting alone on a bus
  - Picture 2—Man living with HIV fired
  - Picture 3—Man sitting alone on a bed
  - Picture 4—Doctor talking to nurse beside a patient's bed
  - Picture 5—Father kicking his son out of the house
  - Picture 6—Pastor preaching about sinners
  - Picture 7—Nurse refusing to provide services to sex worker
- Facilitator's Guide—Stigma and Discrimination

STEPS

1. Explain that this is a warm-up activity. Point out the posted pictures.
2. Ask participants to go around in pairs and look at as many pictures as possible. After five minutes, ask participants to choose and discuss one of the pictures, using the handout questions to guide their discussion.
   - What do you think is happening in the picture in relation to stigma?
   - Why do you think it is happening?
   - Does this happen in your community/work setting? If so, discuss some examples.
3. With participants still standing by their chosen picture, have each picture group share its responses to the questions.

Sample Responses

Picture 1–Man sitting alone on a bus

The man looks very isolated. Other passengers seem to be talking about him and making fun of him. They think he has HIV or that he is gay.

Picture 2–Man living with HIV fired

The man is leaving the office, having been fired for having HIV. He looks very depressed and is asking himself, "What am I going to do?"

Picture 3–Man sitting alone on a bed

This man has been isolated—put into a room on his own and forced to stay there all alone. He has no visitors. No one is there to comfort or help him. He looks abandoned.

Picture 4–Doctor talking to nurse beside a patient's bed

The doctor and nurse are keeping a distance from the patient and gossiping about him. Excessive use of gloves and masks makes the patient feel rejected.

Picture 5—Father kicking his son out of the house

The father is pointing at his son and telling him to leave the house. The son (who may be a man who has sex with men) is upset and feels rejected. This is stigma based on fear and shame.

Picture 6—A pastor preaching about sinners

A preacher in church is telling his congregation that people living with HIV are 'sinners.' This creates stigma based on shame and blame, as well as a quickness to judge other people.

Picture 7—Nurse refusing to provide services to sex worker

The nurse looks very angry and refuses to help the sex worker. The sex worker looks shocked and upset. She may be telling herself, "This woman is judging me. I will have to go to a private doctor."

4. Facilitate a large group discussion, asking the following processing questions:
   a. What are the major forms of stigma?
   b. Why do people stigmatise others who are known or suspected to be HIV positive?
   c. Why do people stigmatise other key populations (e.g., men who have sex with men [MSM], sex workers, migrants, etc.)?
   d. What are some of the effects of stigma?

5. Summarise and elaborate: Draw out the main points from the discussion using the Facilitator Notes on Stigma and Discrimination.

Activity 2. Experiences of Stigma (Reflection)[2]

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Describe how participants have been stigmatised as PLHIV and/or other key populations ■ Recognise some of their feelings of being stigmatised and how they have been affected ■ Identify some of the ways people have challenged stigma
TIME	1 hour
MATERIALS	None
STEPS	*Facilitator Note: This exercise requires a lot of* **trust, mutual support, and openness** *within the group, so it should not be used as the first exercise. It works better if it is used after two or three exercises selected from the Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide, in which participants identify stigma faced by key populations in different contexts. These exercises promote a personalised understanding of stigma. By this point, participants are beginning to open up with each other and are now ready to share some of their own experiences of being stigmatised as a PLHIV and/or other key population.*

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[2] This activity is excerpted from Health Policy Project. 2013. "Personal Experiences of Stigma (Reflection)," in *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project.

STEPS

This exercise needs a **good introduction** *to help participants break out of their initial discomfort about reflecting on and sharing their own experiences with others.*

Emphasise that **sharing is entirely voluntary** *and that confidentiality—that what is shared should stay in the room—is of great importance.*

This exercise can trigger painful memories or experiences for some participants. As the facilitator, you should be ready to deal with the emotions raised.

1. Ask participants to sit by themselves. Then say, "Think about a time in your life when you felt stigmatised for being seen as PLHIV, MSM, or another identity." Give them a few examples—being teased at school for being seen as different, or being poorly treated in a clinic once staff found out that you were MSM or a sex worker. Ask them to consider: "What happened? How did it feel? What impact did it have on you?"
2. Say: "Share with someone with whom you feel comfortable." Then give the pairs a few minutes to share their stories with each other.
3. Invite participants to share their stories in the large group. This is voluntary—no one should be forced to give his/her story. People will share if they feel comfortable. If it helps, give your own story to get things started. As the stories are presented, ask, "How did you feel? How have you reacted to or coped with stigma?"
4. Ask: "What did you learn from this exercise?"
5. Summarise the main points made by participants. You might include some of the following points:

- The feelings of being stigmatised—of being mocked, despised, and rejected—are very painful, and they last a long time. Everybody has felt stigmatised at different times in their lives. It is okay to have these feelings of shame and isolation; you are not alone.

Example Responses

How did you feel when you were stigmatised?

Angry. Ashamed. Worthless. Misunderstood. Depressed. Rejected. Judged. Nothing. Powerless. Second-class citizen. Pushed down. Useless. Failure. Hated. Despised.

How have you reacted to or coped with stigma?

I talk to other MSM and tell them how I am feeling. I no longer use the public clinic—I now go to a private doctor. I keep things hidden—I don't tell anyone I am a sex worker. I ignore their insults and shut my ears. I disguise my behaviour so I don't get harassed.

- The hardest stigma we face is the blaming and shaming from our families. We are forced to change our behaviour in order to be accepted. Once we lose the love of our families, we feel very alone.
- Stigma destroys our self-esteem—we begin to doubt and hate ourselves. We feel very alone at a time when we really need the support and company of other people.
- PLHIV, MSM, and other key populations have rights like all other people. These populations are human beings and deserve to be treated like anyone else.

Activity 3. Breaking the Cycle: Stigma, Internal Stigma, and Discrimination

OBJECTIVES	By the end of this activity, participants should be able to explain why internal stigma is a key component of the cycle of S&D.
TIME	30 minutes
MATERIALS	**For PowerPoint presentation** ■ Laptop ■ Projector ■ Screen ■ File—Stigma & Discrimination **Handout** ■ Copies of PowerPoint presentation **Background Reading** ■ Policy Briefing Note on Stigma: Breaking the Cycle
MATERIALS	**1.** Introduce the PowerPoint presentation, noting that this presentation recaps much of the previous activity's discussion. **2.** Share the presentation, asking participants to give any clarifying comments as the presentation progresses. **3.** After the presentation, facilitate a brief discussion that asks the following: a. What did you think of the presentation? b. Were there any surprises? c. To what extent have you had a chance to focus on internal stigma before? What might a focus on internal stigma add to our understanding of stigma and discrimination?

Activity 4. Building Self-Acceptance

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Recite at least one quotation on self-acceptance ■ Share about their journey of self-acceptance
TIME	1 hour 15 minutes

MATERIALS

For PowerPoint presentation

- Laptop
- Projector
- Screen
- PowerPoint File—Self-Acceptance Exercise
- PowerPoint File—About Self-Acceptance

Handouts

Popular Self-Acceptance Quotations

- Just the Way You Are[3]
- Video[4]

STEPS

Quotations

1. Pass five quotations around the room on flipchart paper. (See handout Popular Self-Acceptance Quotations for examples.)

> **Sample Quotations to Post (one per flipchart around room)**
>
> "The fundamental problem most patients have is an inability to love themselves, having been unloved by others during some crucial part of their lives." (Bernie S. Siegel)
>
> "Friendship with oneself is all-important, because without it one cannot be friends with anyone else." (Eleanor Roosevelt)
>
> "We can never obtain peace in the outer world until we make peace with ourselves." (Dalai Lama XIV)
>
> "I don't know if I continue even today, always liking myself. But what I learned to do many years ago was to forgive myself. It is very important for every human being to forgive herself or himself because if you live, you will make mistakes—it is inevitable. But once you do and you see the mistake, then you forgive yourself." (Maya Angelou)
>
> "The real difficulty is to overcome how you think about yourself. If we don't have that we never grow, we never learn, and sure as hell we should never teach." (Maya Angelou)

2. Ask participants to stand under the quotation that best speaks to them about what 'self -acceptance' is.
3. Once each group is under the quotation, go around the room and ask a volunteer from each group to read the groups quotation. Then get one or two people from the group to explain why they chose it.
4. Bring participants back.

Facilitator Note: Leave a large flipchart up in the room so that people can write other inspiring quotations, if they have them, as the workshop progresses.

Process of Self-Acceptance in Testimonials

5. Explain that participants should be able to more precisely identify what helps to build self-acceptance—identifying key steps and supports. To do so, they should draw from their own and others' experiences.

---

[3] Mars, B. 2010. "Just The Way You Are." Retrieved from http://www.brunomars.com/audio.

[4] Arie, I. 2001. Video. Retrieved from http://www.azlyrics.com/lyrics/indiaarie/video.html.

Facilitator Note

There are two options for how to facilitate this activity.

Option 1: With a group that has had more opportunities to learn about themselves and living with HIV, this step may work best with people using their own personal experiences.

Option 2: With participants newer to reflecting on their lives and living positively, it may be helpful to include short testimonials (written or video) of PLHIV who reflect on their processes of learning to live positively with HIV; ideally, testimonials should be short–i.e., one page or two to three minutes maximum.

Option 1 (building on own experience)

6. Divide participants into four or five groups.

7. Project the PowerPoint slide titled 'Self-Acceptance Exercise #1'

Facilitator Note: The content on the slide can also be written on flipchart paper.

8. Ask participants to first respond to the following questions individually:

a. What does self-acceptance mean to you?

b. What have been some of the key steps in your/a person's journey towards greater self-acceptance?

c. What have been some of the key sources of support?

d. (As a group): What similarities and differences do you see in your processes?

9. After five minutes, ask the group to come together and develop a visual that synthesises their responses.

10. Reconvene the large group and ask each group to present its artwork.

Option 2 (building on testimonials and own experience)

6. Divide participants into four or five groups.

7. Give each group a 'testimonial' and ask participants to read it individually or have someone in the group read it aloud.

8. Project the PowerPoint slide titled 'Self-Acceptance Exercise #2' and instruct the group to discuss the questions projected/written.

Facilitator Note: The content of the slide can also be written on flipchart paper.

9. After five minutes, ask the group to come together and develop a visual that synthesises their responses.

Examples of reflections shared by participants

- Self-acceptance is an ongoing process.
- Self-acceptance varies for each person.
- The self-acceptance process can have forward and backward movement. It is important to remember this dynamic and to use the experience of previous successes in one's self-acceptance to help overcome new challenges (and steps 'backwards') when they happen.
- Support is vital. It takes a balance of external and self-support.
- What self-acceptance looks like is different in different people's lives. For some people, an indicator of self-acceptance can be the ability to have fun—living normally within reason and being at peace with oneself—yet for others, self-acceptance and being at peace with oneself may not focus on 'fun' in this sense.

STEPS

- Motivation is a key step in moving towards self-acceptance. Motivation is linked to a balance of one's own internal resources and external support.
- External sources of support can include the following:
  - Faith
  - Testimonials by others
  - Support groups
  - Mentoring
  - Supportive services
- Counselling is also an important intervention, but it can be very limited in its availability. Also, there is a societal stigma attached to counselling.

11. Facilitate a large group discussion, asking the following:

a. What stood out for you? What surprised you?

b. Is there any particular theme, step, or support that seems to be especially key, across different experiences?

c. Which of these strategies seems easier to realise in our lives? Which seem harder to realise in our own lives? Why?

12. Make a brief presentation using the PowerPoint file 'About Self-Acceptance.' Then ask, "How do the stages of self-acceptance theory relate to the discussions you had before?"

13. Move to close the processing of this exercise, asking: "Considering all we have discussed today ... "

a. How can we use these reflections in our own lives?

b. How can we use these reflections to support each other in coping with internal stigma?

14. Thank everyone for their sharing and insights, and encourage people to continue to reflect on—and learn from—their own and others' processes.

Activity 5. How to Challenge Stigma Assertively[5]

OBJECTIVES

By the end of the session, participants from key affected populations and PLHIV will be able to challenge stigma and discrimination in an assertive way.

TIME

1 hour

MATERIALS

- Flipchart paper
- Flipchart easel
- Markers

STEPS

1. Introduce the objectives. Explain that this session is aimed at practising how to challenge stigma in an assertive way.
2. Open a brief discussion:
   a. Ask, "What does it mean to 'challenge' something? And to do so 'assertively'?"
   b. Write the main responses to each.
   c. Share that challenging stigma in an assertive way means looking the stigmatiser in the eye and saying what we think, feel, and want in a clear, forceful, and confident manner—without being aggressive or showing anger.
   d. Ask, "Does it always make sense to confront stigma? When and why, or when and why not?"
3. Ask participants in the large group to brainstorm a list of specific situations in which key populations or PLHIV are stigmatised.
4. Record the list of stigmatising situations on the flipchart.
5. Explain that participants will carry out role playing in pairs. Give everyone the following instructions:

Everyone stand up and find a partner. Face your partner. A is the father and B is the gay son. In each pair, agree who is A and who is B (wait until they decide). The situation is this: The father tells his son that he should be a 'real man.' The son should respond in a strong and confident way. Act out the situation—PLAY! (Ask pairs to start their role plays.)

Example of a Role Play

Father: You should change—I want you to be a real man!

Son: I am a real man. I'm just attracted to other men. This is who I am. I cannot change.

Father: Don't you care about your future?

Son: I do care. You want me to get married to a woman—and that's impossible. I don't have feelings for women. I want a future where I can be with a person I have feelings for.

Examples of Responses

- Family tells you that you have to be a 'real man'
- Healthcare workers tell a woman living with HIV that she is irresponsible to want to have a baby
- Healthcare workers make fun of a MSM or sex worker at a clinic
- Teachers are overly protective of a student living with HIV, telling her that she must 'rest' and 'not play' in any strenuous activities, or keep the student in isolation from other students

6. After two minutes, ask a few pairs to show their role plays (one at a time) in the center of the circle.
7. After each role play, ask the following:
   a. How did the gay boy do? Was he convincing and effective?
   b. What made a difference in the way he challenged his father?

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5. This activity is drawn from Health Policy Project. 2013.. "How to Challenge Stigma Assertively," in *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC: Futures Group, Health Policy Project.

STEPS

8. After a few pairs perform, ask other participants if they have a better way of challenging the stigmatiser and let them step into the role play; they can take over the role play of the gay boy and show their approaches. After each new play, ask, “What made a difference?”
9. Repeat the process for other stigmatising situations brainstormed in Step 3, as time allows.
10. At the end of all the role plays, ask the following processing questions:
    a. What have you learned from the practice role plays?
    b. How can you use this in your own lives?
11. Summarise and discuss the following list of assertiveness techniques:
    - Tell people what you think, feel, and want clearly and forcefully.
    - Say “I feel,” “I think,” or “I would like.”
    - Don’t apologise for saying what you think or put yourself down.
    - Stand and sit straight in a relaxed way.
    - Hold your head up and look the other person in the eye.
    - Speak so that people can hear you clearly.
    - Stick with your own ideas and stand up for yourself.
    - Don’t be afraid to disagree with people.
    - Name and claim your human rights.
12. Ask if there are any final questions or comments.

Activity 5. Key Messages, How to Put This Module into Action, and Wrap-up

OBJECTIVES

By the end of this activity, participants should be able to

- Recall the key issues and learnings on stigma and discrimination
- Develop a plan of action regarding how they will use the information learned in their everyday lives

TIME

45 minutes

MATERIALS

Handouts

- Key Messages—Stigma and Discrimination
- Putting Learning into Action: How Can I Use What We’ve Done? Stigma and Discrimination

STEPS

Review of Key Messages

1. Explain that we have finished the Stigma and Discrimination module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group should conclude this module by reflecting on key take-away messages.

STEPS	**4.** Ask participants to take three minutes to discuss with a partner, "What are your key learnings about stigma and discrimination?" Ask participants to note their responses so they can share them out loud. **5.** After three minutes, ask for responses to people's discussions. Record responses on a large flipchart. **6.** Distribute the handout 'Key Messages—Stigma and Discrimination.' Ask one person to read them out loud. **7.** Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include additional responses on the Key Messages handout for their own future reference. **How to Put this Module into Action** **1.** Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Stigma and Discrimination. **2.** Ask people to complete it individually. **3.** Ask a few people to volunteer to share what they wrote. **Wrap-up** Thank participants for their participation.

Facilitator Notes—Stigma & Discrimination

Sometimes we treat people badly. We isolate or reject them—for example, refusing to sit beside someone who is assumed to have HIV—or we gossip about them and call them names. When we isolate or make fun of other people, it is referred to as '**stigma**,' commonly called 'prejudice' in our culture.

Stigma is a process where we (society) create a '**spoiled identity**' for an individual or a group of individuals. We identify a difference in a person or group—for example, a behavioural difference (e.g., men who have sex with men [MSM]) or physical difference (e.g., physical disfiguration)—and then mark that difference as something negative, as a sign of disgrace. In identifying and marking differences as 'bad,' it justifies us in stigmatising the person or group. Stigmatised people lose status because of these assigned 'signs of shame,' which other people view as showing they have done something wrong (sinful or immoral behaviour).

When we stigmatise people, we **isolate** them, saying they are a danger or threat to us (because we think they might infect us with HIV or we might be negatively affected by their behaviour); or we **judge** them, saying they have broken social norms and should be shamed or condemned.

Stigma is a belief or attitude. The action resulting from stigma is '**discrimination**,' or unfair treatment. For example, people living with HIV (PLHIV) or MSM are not hired, are kicked out of their houses, are refused treatment at the clinic, or have their HIV status or sexual identity publicly revealed.

Stigma hurts people. When we stigmatise, it makes people feel bad, lonely, ashamed, and rejected. They feel unwanted and lose confidence and, as a result, they may take less care in protecting their health (e.g., stop using health facilities and condoms).

People living with HIV and other key populations are often **stigmatised by their own families and the community**. They have to change their behaviour to be accepted, or they are forced to leave home. They are forced to lead a hidden, underground existence and, as a result, find it difficult to get work, secure housing, and access health services that could save their lives.

There are different forms of stigma. Refer to the selected visual aids below. The full set can be found on pages 275–296 of *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide* (Health Policy Project, 2013):

- **Isolation and rejection**—Based on ignorance and fear about HIV transmission, or about the behaviours of a marginalised group. The person stigmatised is forced to sit alone, eat alone, and/or live alone.
- **Shaming and blaming**—Can include gossip, name calling, insulting, judging, and/or shaming. Stigmatised people are 'blamed and shamed' for assumed 'bad behaviour' or for breaking social norms.
- **Discrimination (enacted stigma)**—Unfair treatment such as refusing to provide services, firing someone who is found to be HIV positive or MSM, or kicking someone out of housing.
- **Self-stigma** (also referred to as **internal stigma** or **internalised stigma**)—PLHIV or other key populations stigmatise themselves in reaction to stigmatisation from society. They accept the blame and rejection of society and withdraw from social contact or exclude themselves from accessing health and other services out of fear of having their status revealed.
- **Stigma by association**—People associated with stigmatised groups often face stigma themselves. The family of a person living with HIV or a person from another key population may be stigmatised because of the stigma faced by their family member—the reputation of the family is affected.
- **Layered stigma**—Marginalised groups (e.g., MSM, sex workers, migrants) are already stigmatised. If they get HIV, they are doubly stigmatised—taking on another layer of stigma.

Some of the **effects** of stigma include

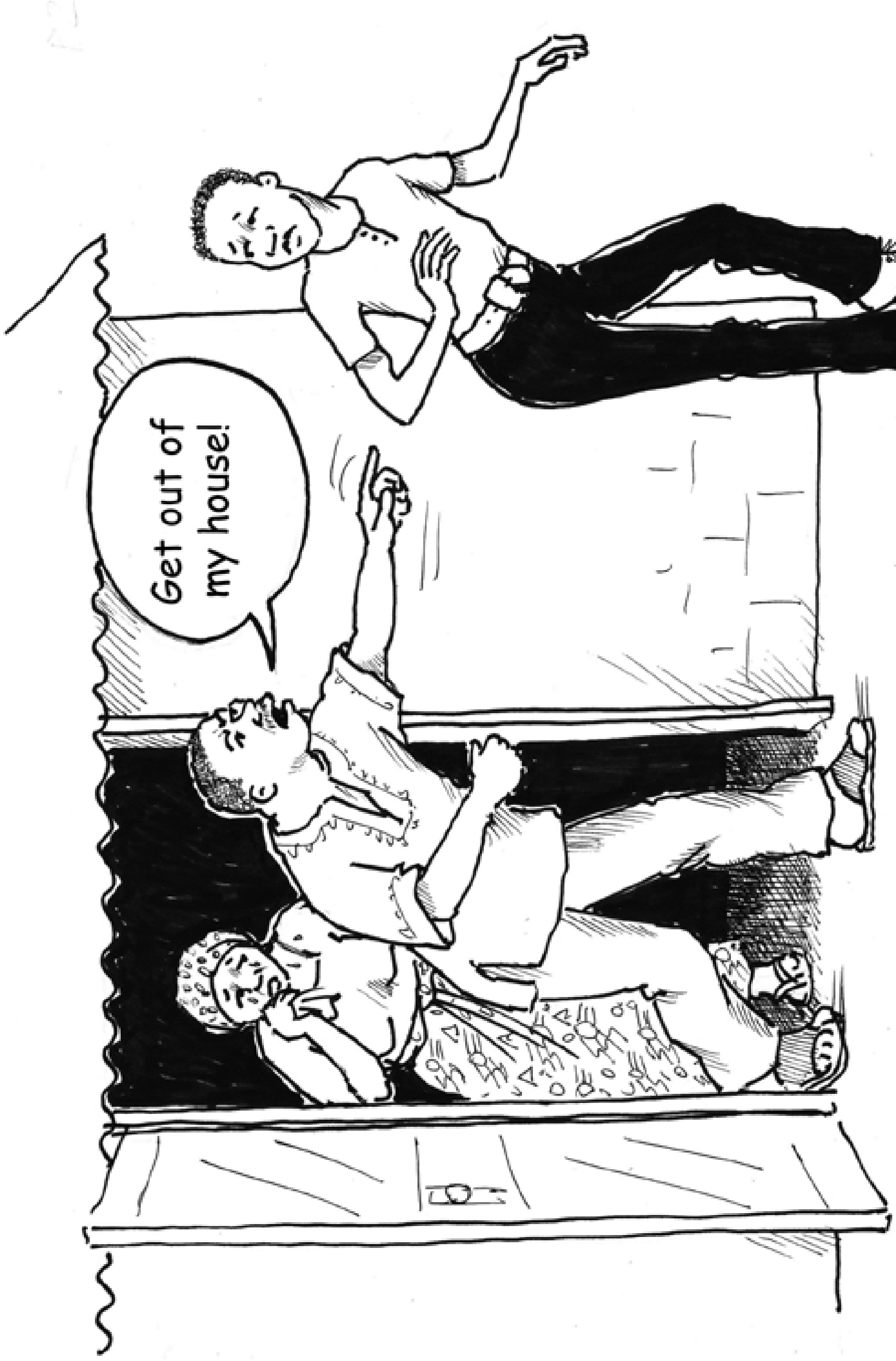
- Feelings of sadness, loneliness, rejection, hopelessness, and self-doubt
- Shame and loss of confidence—people feel they are no longer accepted by others
- Discrimination—people are kicked out of their family, community, job, or organisations
- Denial—stops people from disclosing their status and getting help

HIV stigma hurts PLHIV and drives the HIV epidemic underground. Those stigmatised become silent and don't disclose their status to their partners—as a result, they pass HIV on to others.


DAILY NEWS


OFFICE
Dismissed

3




Sinners!


CLINIC

Popular Self-Acceptance Quotations

“No one can make you feel inferior without your consent.” – Eleanor Roosevelt

“Do not wish to be anything but what you are.” – Saint Francis de Sales

“Our entire life … consists ultimately in accepting ourselves as we are.” – Jean Anouilh

“Friendship with oneself is all-important, because without it one cannot be friends with anyone else.” – Eleanor Roosevelt

“To love others, we must first learn to love ourselves.” – Anonymous

“My recipe for life is not being afraid of myself, afraid of what I think or of my opinions.” – Eartha Kitt

“You yourself, as much as anybody in the entire universe, deserve your love and affection.” – Siddhārtha Gautama

“We can never obtain peace in the outer world until we make peace with ourselves.” – Dalai Lama XIV

“Commandment #1: Believe in yourself. Commandment #2: Get over yourself.” – Kristan Higgins

“No amount of self-improvement can make up for any lack of self-acceptance.” – Robert Holden

“When you stop living your life based on what others think of you real life begins. At that moment, you will finally see the door of self acceptance opened.” – Shannon L. Alder

“Someone’s opinion of you does not have to become your reality.” – Les Brown

Picture Walk—Questions for Discussion

For each picture, stop and discuss the following:

1. What do you think is happening in the picture in relation to stigma?

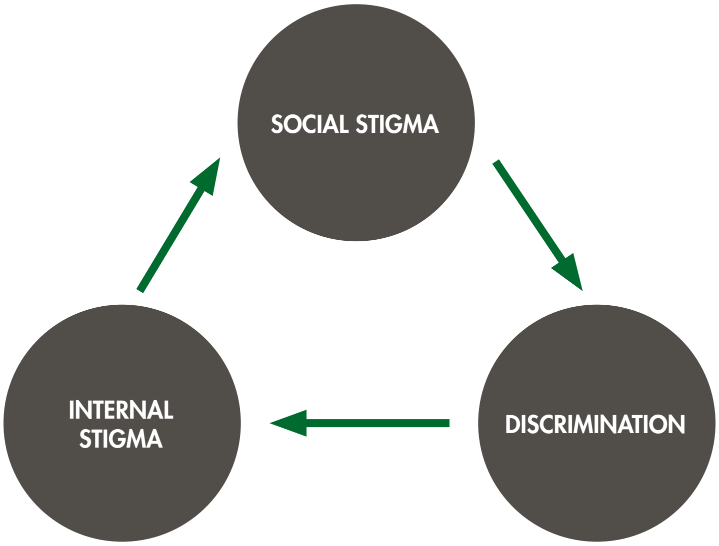
2. Why do you think it is happening?

3. Does this happen in your community/work setting? If so, discuss some examples.

Key Messages—Stigma and Discrimination

Some key messages include the following:

- Stigma and discrimination exist in a cycle



- The feelings of being stigmatised—of being mocked, despised, and rejected—are very painful, and they last a long time. Everybody has felt stigmatised at different times in their lives.
- Stigma can destroy our self-esteem—we can begin to doubt and hate ourselves, and to stigmatise ourselves. We feel very alone at a time when we really need the support and company of other people.
- People can be stigmatised for any number of reasons. Sometimes it is for a combination of reasons, such as living with HIV and belonging to a group (such as men who have sex with men or sex workers) or for being poor. This is sometimes called layered stigma.
- Stigma and the fear of being stigmatised results in PLHIV and key populations not getting full access to HIV-related health services and other forms of support. It limits our ability to achieve Positive Health, Dignity, and Prevention—in our lives, and in our communities.
- PLHIV, MSM, and other key populations have rights like other people. We are human beings and deserve to be treated like anyone else.
- As we work to reduce stigma and promote human rights, we need to be sure to support ourselves to believe in our own self-worth and self-acceptance, as part of the process of overcoming self-stigma. At the same time, our process of self-acceptance is much easier as broader stigma and discrimination are eliminated.

Additional key messages or learnings include the following (please fill in, based on your own reflections and those of others):

Putting Learning into Action: How Can I Use What We've Done?

Stigma and Discrimination

1. How can I use learnings from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
    a. With whom would I want to share? Please list.

    b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

   1. What do I want to share?

   2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

   3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 4

Sexual and Reproductive Rights

What Is in this Module?

The contents of this module offer an introductory warm-up for discussion of sexual and reproductive rights (SRR), and include an optional charades game to strengthen participants' familiarity with key rights. It assumes that participants will have already completed a basic introduction to human rights, although it does include reference material on human rights in case this module is presented as a stand-alone session.

A third activity—What Does It Take to Realise Human and Sexual & Reproductive Rights—is also included here. This would be best sequenced after activities on other barriers to realising rights (i.e., stigma and discrimination; and gender inequality and intolerance of sexual diversity).

OBJECTIVES	**By the end of this module, participants should be able to** ■ Define the terms 'rights,' 'sexual rights,' and 'reproductive rights' ■ Discuss how a person's sexual and reproductive rights can be abused ■ Discuss ways a person can realise his/her sexual and reproductive rights
TIME	3 hours
ACTIVITY OVERVIEW	**1.** Rights from the Start (45 minutes) **2.** Rights from the Start (Optional Charades) (30 minutes) **3.** What Does It Take to Realise Human and Sexual & Reproductive Rights? (1 hour) **4.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**Handouts** ■ Human Rights ■ Sexual and Reproductive Rights ■ Key Messages—Sexual and Reproductive Rights ■ Putting Learning into Action: How Can I Use What We've Done? Stigma & Discrimination, Sexual and Reproductive Rights **Other** ■ Flipchart paper ■ Flipchart easel ■ Markers

Activity 1. Rights from the Start[1]

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Define the terms 'rights,' 'sexual rights,' and 'reproductive rights' ■ Discuss how a person's sexual and reproductive rights can be abused ■ Explain that people living with HIV (PLHIV) have the same sexual and reproductive rights as others

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[1] This activity is excerpted from SAfAIDS and Seke Rural Home Based Care. n.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide*. South Africa: Oxfam Canada, pp. 16–19.

TIME

45 minutes

MATERIALS

- Flipchart paper
- Flipchart easel
- Markers

STEPS

What Is a Right?

1. Ask participants to assemble in groups of three.
2. Instruct them to discuss and then write down what they understand by the terms 'rights' or 'personal rights.' What do they think these mean, and can they give any examples?

Facilitator Notes

Personal rights are rights that people have over their own bodies—i.e., rights to protect and safeguard themselves from physical harm and abuse. These rights also protect aspects of their personalities, such as their reputations or privacy.

In short, a right is something to which a person is entitled. These rights may be enshrined in law or may be understood as being part of the law of nature, such as the right to breathe, think, or move about. Many 'natural' laws are enshrined as human rights under the United Nations Universal Declaration of Human Rights; they include the rights to life, liberty, freedom of expression, equality before the law, and education.

3. Once participants have had a chance to write down some ideas, ask them to share their definitions.
4. Write some of these on the flipchart. (You are not looking for a dictionary definition from participants, but rather responses that convey ideas of respect, law, and fair and reasonable treatment of self and others.)

Some Definitions of Rights

Rights are "entitlements to certain kinds of treatment, based on one's status. The modern tradition is one of natural rights, in which each person is born with certain rights as a human being. Other rights are acquired by virtue of contract or ownership."[2]

"A **Right** is: the legal or moral entitlement to do or refrain from doing something, or to obtain or to refrain from obtaining an action, thing or recognition in civil society. Rights serve as rules of interaction between people, and as such, they place constraints and obligations upon the actions of individuals or groups. (For example, if one has a right to life this means that others do not have the liberty to kill him.) Modern concepts of rights are universalist (applying to everyone) and egalitarian (the same for everyone)."[3]

What Are 'Sexual Rights' and 'Reproductive Rights'?

5. Divide the large group into two groups. Name one group 'sexual rights' and the other 'reproductive rights.'
6. Instruct the groups to do the following, based on their assigned name:

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[2] SAfAIDS and Seke Rural Home Based Care. n.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide.* South Africa: Oxfam Canada, p. 17.

[3] SAfAIDS and Seke Rural Home Based Care. n.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide.* South Africa: Oxfam Canada, p. 17.

STEPS

b. Discuss and write down the following:
  i. What are some of the ways that sexual or reproductive rights can be violated? Give examples of behaviours, practices, or beliefs which breach a person's sexual or reproductive rights.
  ii. What are some of the consequences of sexual or reproductive rights being abused (health, social, or psychological)?

Facilitator Note: Participants are not expected to come up with a highly technical definition. However, it is important that the main concepts are captured (i.e., the rights of individuals to control their own bodies, enjoy safe and satisfying sex, say 'no' to sex, and enjoy sex that is free from violence and force).

7. Call participants back into an open session to share their findings.
8. Write their responses on two flipcharts labeled 'Abuse of Sexual Rights' and 'Abuse of Reproductive Rights.'
9. Lead a discussion on how breaches of rights impact people's positive health, dignity, and prevention.

The Rights of People Living with HIV

10. Ask participants the following:
  a. Do you think that PLHIV have a different set of sexual and reproductive rights?
  b. What do you think your rights are?

Facilitator Notes

People living with HIV are entitled to the same sexual and reproductive rights as anyone else. They have the right to • Protect themselves from harm and abuse • Protect their reputations • Enjoy safe and satisfying sex • Have access to reproductive healthcare services • Plan to have a family.

Some particular concerns of PLHIV which can impinge on their rights include • Stigma and discrimination • Failure of individuals, groups, and institutions to respect their dignity • Failure of individuals, groups, and institutions to respect their right to disclose their HIV status or not • Failure to be able to access high-quality, supportive information and counselling or health services related to sexuality and reproductive desires.

11. Ask participants to brainstorm some of the ways in which the treatment of PLHIV by individuals, groups, institutions, and society impinges upon their sexual and reproductive rights.
12. Write their responses on flipchart paper.
13. Affirm that PLHIV have the same sexual and reproductive rights as all other human beings. Explain that

Activity 2. Rights From the Start (Optional Charades)

OBJECTIVES

By the end of this activity, participants should be able to

- Name at least one sexual right
- Name at least one reproductive right
- Explain that human rights are indivisible (that is, everyone is entitled to them)

TIME

30 minutes

MATERIALS

Handouts

- Human Rights
- Sexual and Reproductive Rights

STEPS

1. Explain that the group should now take the opportunity to become familiar with specific rights—human and sexual and reproductive rights—using their creativity to do so.
2. Divide participants into five to six groups (groups of three to four people).
3. Give half of the groups (two or three) the handout with human rights. Give the other half (two or three) the handout with sexual and reproductive rights.
4. Introduce the assignment, explaining that each group is to choose one right it finds especially important. For that right, one of their team members will act it out silently. The rest of the audience will have to guess what right it is.
5. Give each group five minutes to prepare. After five minutes, have the first group act out its 'right.' Once another guesses it correctly, record the right on a flipchart. Ask the group why they chose that right. Continue with the rest of the groups.
6. Once all groups have done a charade, thank everyone for their efforts. Briefly reflect on the process, asking
   a. How was the process—easy or hard?
   b. Why was it easy or hard?
   c. What did they notice?
7. Move towards a brief summary of specific human and sexual and reproductive rights. Observe that while the portrayals of the charades were humorous, the reasons why the rights were selected are quite serious. Explain that the list of rights on the handouts shows rights that are 'universal' and 'indivisible'—meaning that **everyone** is entitled to **all** of these rights, and that these rights also depend on each other.
8. Ask participants if they have any final questions or comments about this activity. Explain that there will be other opportunities in further activities to explore, in more depth, some of the types of stigma and discrimination that are among the root causes of barriers to realising sexual and reproductive rights. These include stigma and discrimination related to gender, sexuality, and gender identity and sexual orientation.

Activity 3. What Does it Take to Realise Human and Sexual and Reproductive Rights?

OBJECTIVES

By the end of this activity, participants should be able to

- Discuss at least one way that PLHIV can realise their sexual and reproductive rights
- Name at least one reproductive right
- Explain that human rights are universal and indivisible (that is, **everyone** is entitled to **all** of them)

TIME

1 hour

MATERIALS

Handouts

- Human Rights
- Sexual and Reproductive Rights

STEPS

Realise a Right—Creatively

1. Introduce the session. Note that participants have explored the importance of human rights to achieving Positive Health, Dignity, and Prevention (PHDP). Note that participants have also explored a number of barriers to realising these rights.
2. Highlight that participants should now focus on putting together a complete picture of human rights—and what it takes to realise them.
3. Explain that for this exercise, participants will work in three small groups and explain that each group will construct a scenario for a character that will be assigned to them.

Facilitator Note: The assigned characters should link to prior discussions about barriers to realising rights. For instance, if this activity follows the module on gender equality, sexuality, and sexual diversity, the three assigned characters could be a woman, a transgender woman, and a man who has sex with men.

4. Describe the group instructions:
    a. For each group's assigned person, identify one key human right—or specific sexual and reproductive right—as the focus (such as the right to health or to found a family).
    b. Discuss and identify what has to be in place to realise that right fully.
    c. Figure out how, as a group, to show a 'statue' (portraying a situation that is 'frozen') in two parts: part one, with the right unrealised; and part two, with the right fully realised.

    Be sure that you start with an image of what the right—fully realised—looks like. Try to include reference to as many specific elements as you need to realise this right.

Facilitator Note: Participants can use a role play instead of a statue.

5. Give the groups 15 minutes to develop their statue or role play.
6. After 15 minutes, ask a group to come to the front of the room and depict their statue (or other creative presentation).
7. After each group performs, facilitate a brief discussion:
    a. What did you see (or hear)? What was happening?
    b. What specific elements were highlighted?
8. Are there any new insights about what it takes to move from a right being unrealised to realised?
9. Write their responses on flipchart paper.

What it takes to realise rights—Concretely

10. After all the groups have performed, facilitate a large discussion:
    a. How was the process? Easy or hard?
    b. Were there any new elements/ideas that surprised group members?
    c. What did the exercise highlight about realising human rights?
    d. Based on what participants have just seen, as well as their work in the workshop, what are key actions that PLHIV leaders can take to support realising human rights?

What it takes to realise rights—A Commitment

11. Thank participants for their participation. Explain that before the group concludes the session, participants should take a moment to reflect on what they've learned personally. Ask them to take 10 minutes to think about and write their own responses to the following prompts:
    a. For me, I've learned that in order for PLHIV to fully enjoy their human rights, including their sexual

   a. In the next two years, one change I would like to see related to sexual and reproductive rights in my community is …
   b. In the next three months, one thing that I can and will do to help promote this change is …

12. Allow participants an opportunity to share in pairs of their choosing. Take a few responses from the larger group.
13. Summarise the activity and participants' insights. Thank everyone for their contribution and transition to the closing.

Activity 4. Key Messages, How to Put This Module into Action, and Wrap-up

OBJECTIVES

By the end of this activity, participants should be able to

- Recall the key issues and lessons about sexual and reproductive rights
- Develop a plan of action regarding how they will use the information they have learned in their everyday lives

TIME

45 minutes

MATERIALS

Handouts

- Key Messages—Sexual and Reproductive Rights
- Putting Learning into Action: How Can I Use What We've Done? Stigma & Discrimination, Sexual and Reproductive Rights

STEPS

Review of Key Messages

1. Explain that the group has finished the Sexual and Reproductive Rights module.
2. Invite participants to share any further comments or reflections they have at this time.
3. Explain that the group should conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about Sexual and Reproductive Rights?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages—Sexual and Reproductive Rights. Ask one person to read it out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout, for their own future reference.

How to Put this Module into Action

1. Distribute the handout Putting Learning into Action: How Can I Use What We've Done?
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Human Rights

What are human rights?

Rights are "entitlements to certain kinds of treatment, based on one's status. The modern tradition is one of natural rights, in which each person is born with certain rights as a human being. Other rights are acquired by virtue of contract or ownership."[1]

"A **Right** is the legal or moral entitlement to do or refrain from doing something, or to obtain or to refrain from obtaining an action, thing or recognition in civil society. Rights serve as rules of interaction between people, and as such, they place constraints and obligations upon the actions of individuals or groups. (For example, if one has a right to life this means that others do not have the liberty to kill him.) Modern concepts of rights are universalist (applying to everyone) and egalitarian (the same for everyone)."[2]

Human rights include rights to the following:

- The highest attainable standard of physical and mental health, including sexual and reproductive health
- Equal access to adequate healthcare and health-related services, regardless of sex, race, and other status
- Access to safe drinking water and sanitation
- An adequate standard of living and housing
- A safe and healthy workplace
- Education and access to information relating to health
- The human rights of a child to an environment appropriate for physical and mental health

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[1] SAfAIDS and Seke Rural Home Based Care. n.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide*. South Africa: Oxfam Canada, p. 17.

[2] SAfAIDS and Seke Rural Home Based Care. n.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide*. South Africa: Oxfam Canada, p. 17.

Sexual and Reproductive Rights[1]

Sexual and reproductive health include the following:

- Women's and men's ability to enjoy and express their sexuality free of the risk of sexually transmitted diseases, unwanted pregnancy, violence, and discrimination
- A state of complete physical, mental, and social well-being in relation to sexual and reproductive matters; it does not merely signify the absence of disease or infirmity

Sexual and reproductive rights include the following:

- The right of all individuals to control their own bodies
- The right to enjoy safe and satisfying sex
- The right to enjoy sex while using protection against unwanted pregnancy and sexually transmitted infections, including HIV
- The right to choose when, with whom, and how to have sex between consenting adults
- The right to have sex upon mutual consent
- The right to say 'no' to sex
- The right to have sex that is free from violence and force
- The right to enter marriage with the full and free will of both parties
- The right to decide freely and responsibly
  - The number of children one would like
  - The spacing of children
  - With whom one would like to have children
  - To have children without the use of force or violence
- The right to information and services on sexual and reproductive matters

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[1] Excerpted from SAfAIDS and Seke Rural Home Based Care. N.d. *Sex, Sexuality and HIV Prevention for Women, Men and Couples: Addressing the Challenges of HIV Prevention in Southern Africa – A Trainer's Guide*. South Africa: Oxfam Canada, p. 114.

Key Messages—Sexual and Reproductive Rights

- As human beings, we are all entitled to fundamental rights called our human rights.
- Sexual and reproductive rights are human rights. We all have the right to make choices about our bodies, our sexual relations, and our reproductive and sexual health. This includes the right to pleasure as well as the right to say 'no' to unwanted sexual relations.
- Many cultures are uncomfortable with sexuality. This discomfort, plus the layered stigma and discrimination faced by men and women living with HIV and other key populations, means we sometimes face serious barriers to realising our sexual and reproductive rights.
- When we can realise our sexual and reproductive rights, we are better able to promote our health; to live with dignity; and to prevent new infections for ourselves, our partners, and communities.

Additional key messages or lessons include the following (please fill in, based on your own reflections and those of others):

Putting Learning into Action: How Can I Use What We've Done?

Sexual and Reproductive Rights

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider

   Person 1 or group 1: ________________________
      1. What do I want to share?
      2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
      3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

   Person 2 or group 2: ________________________
      1. What do I want to share?
      2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
      3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 5

Gender

What Is in this Module?

This module opens with an icebreaker that helps participants explore personal values related to gender norms and inequalities. The module then examines, through an initial participatory activity, the gender norms and inequalities faced by women and men, and follows this up with a review of key concepts. It includes a structured discussion to directly identify the links between gender norms and inequalities and HIV. The module concludes with a brief reflection on how to put this module into action.

This module assumes that participants have already completed a basic introduction to HIV and human rights. Although it can stand alone, it would ideally be followed by the modules on sexuality and sexual diversity.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Define and differentiate between the terms 'sex' and 'gender' ▪ Talk about their attitudes and values related to gender ▪ Explain the social expectations for men and women ▪ Explain how social expectations may limit men's and women's ability to develop and maintain good health and well-being
TIME	3 hours 45 minutes
ACTIVITY OVERVIEW	**1.** Vote with Your Feet (Values Clarification and Energiser) (20 minutes) **2.** Act like a Man/Act Like a Woman (1 hour 15 minutes) **3.** What Are Gender and Sex? (25 minutes) **4.** Structured Discussion: Links between Gender Norms and Inequalities and Positive Health, Dignity, and Prevention (PHDP) (1 hour) **5.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	▪ Signs: one with 'agree' written on it and the other with 'disagree' ▪ Flipchart paper ▪ Markers ▪ Handouts ▪ Sex and Gender Definitions ▪ Key Messages—Gender ▪ Putting Learning into Action—How Can I Use What We've Done? Gender

Activity 1. Vote With Your Feet (Values Clarification and Energiser[1]

OBJECTIVES	By the end of this activity, participants should be able to talk about their attitudes and values related to gender.
TIME	30 minutes

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[1] This activity is from the USAID InterAgency Gender Working Group; it can be accessed at http://www.igwg.org/training/SettingTheStage/VoteWithYourFeet.aspx.

MATERIALS

- Posted signs with agree/disagree (on either side of the room)
- Vote with Feet Statements (two to three)

STEPS

1. Ask the group to stand in the center of the room. Explain that you are going to call out a statement. Tell the participants to go to the side of the room which says 'agree' if they agree with the statement or step to the other side if they disagree.
2. Call out the first statement. Repeat it to ensure that everyone heard it. After everyone indicates whether they agree or not, ask two or three participants from each side to explain why they voted the way they did.

   Possible statements (choose two to three)

   - "Women are naturally better parents than men."
   - "Sex is more important to men than to women."
   - "It is easier to be a man than a woman."
   - "People who go against expectations for being a man or a woman experience more internal stigma."
   - "Women's socialisation makes them more likely to engage in self-care than men."
   - "HIV-positive women are more accepted and supported than HIV-positive men."
   - "The freedom to express one's sexuality openly is key to contributing fully to society."
3. Facilitate a brief discussion about their reasons. Read up to three statements.
4. Debrief the activity by asking the following:
   - How did it feel to do this exercise?
   - What struck you?
   - What did you learn?
   - How does what you learned apply to working as leaders in our communities?
5. If not mentioned, offer the following additional points for consideration:
   - Even though we may be familiar with the different expectations and opportunities for men and women, we likely all have deeply ingrained (and varying) assumptions.
   - Being able to reflect on our assumptions critically is important for our own health and relationships, and for our ability to work with/for our peers.
   - Also, as we will discuss in more depth later, being able to help participants listen to each other and to different opinions is an important skill for facilitating discussions about gender and sexuality.

Activity 2. Act Like a Man/Act Like a Woman[2]

OBJECTIVES

By the end of this activity, participants should be able to

- Explain the social expectations for men and women
- Explain how social expectations may limit men's and women's ability to develop and maintain good health and well-being

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[2] This activity is from the USAID InterAgency Gender Working Group; it can be accessed at http://www.igwg.org/training/ExpositoryActivities/ActLikeAManActLikeAWoman.aspx

TIME

1 hour 15 minutes

MATERIALS

- Flipchart paper
- Markers

STEPS

1. Ask the participants if they have ever been told to 'act like a man' or 'act like a woman' based on their gender. Ask them to share some experiences in which someone has said this or something similar to them. Why did the individual say this? How did it make the participant feel?
2. Tell the participants that the group is going to look more closely at these two phrases. Explain that by examining them, participants can begin to see how society can make it very difficult to be either male or female.
3. In large letters, print on a piece of flipchart paper the phrase 'Act Like a Man.' Ask the participants to share their ideas about what this means. These are society's expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper and write the meanings of 'act like a man' inside this box. Some responses might include the following:
    - Be tough.
    - Do not cry.
    - Shout at people.
    - Show no emotions.
    - Have sex with many women.

Facilitator Note: If it is not mentioned, prompt participants to think about expectations regarding who men are supposed to be attracted to sexually and romantically.

4. Then ask, "What are behaviours that are outside of the box? And what names are men called if they act outside the box?" Take a few responses and record them.
5. Once you have brainstormed your list, initiate a discussion by asking the following questions:
    a. Can it be limiting for a man to be expected to behave 'inside the box'? Why?
    b. Which emotions are men not allowed to express?
    c. How can 'acting like a man' affect a man's relationship with his partner(s)? How about his children?
    d. How can social norms and expectations to 'act like a man' have a negative impact on men's health? How about on dignity and prevention?
    e. How do these expectations link to stigma and discrimination?
    f. Can men actually live outside the box? Is it possible for men to challenge and change existing gender roles?
    g. What are the consequences of acting outside the box?
    h. Is it different for men in rural versus urban areas?
    i. When is it OK for a man to live outside the box?
6. Now, in large letters, print on a piece of flipchart paper the phrase 'Act Like a Woman.' Ask the participants to share their ideas about what this means. These are society's expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper and write the meanings of 'act like a woman' inside this box. Some responses may include the following:

- Be passive.
- Be the caretaker.
- Act sexy, but not too sexy.
- Be smart, but not too smart.
- Be quiet.

Facilitator Note: If it is not mentioned, prompt participants to think about expectations regarding who women are supposed to be attracted to sexually and romantically.

7. Then ask, "What are behaviours that are outside of the box? And what names are women called if they act outside the box?" Take a few responses and record them.

8. Once you have brainstormed your list, initiate a discussion by asking the following questions:
   a. Can it be limiting for a woman to be expected to behave 'inside the box'? Why?
   b. What emotions are women not allowed to express?
   c. How can 'acting like a woman' affect a woman's relationship with her partner(s)? How about her children?
   d. How can social norms and expectations to 'act like a woman' have a negative impact on a woman's health? How about on dignity and prevention?
   e. How do these expectations link to stigma and discrimination? How do they link to sexual and reproductive health?
   f. Can women actually live outside the box? Is it possible for women to challenge and change existing gender roles?
   g. What are the consequences of acting outside the box?
   h. Is it different for women in rural versus urban areas?
   i. When is it OK for a woman to live outside the box?

Activity 2. What Are Gender and Sex?

OBJECTIVES	By the end of this activity, participants should be able to explain the difference between gender and sex.
TIME	25 minutes
MATERIALS	■ Handout—Sex and Gender Definitions ■ Flipchart paper ■ Markers
STEPS	**1.** Explain the objective of the activity. **2.** Ask participants what they have heard about the terms 'gender' and 'gender equality.' Take a few responses. **3.** Review the terms 'sex' versus 'gender'. Put both words on a piece of flipchart paper and ask participants to list ideas associated with each.

STEPS

4. When this is done, share the definitions of sex and gender on the handout. Ask for questions and clarify, building on examples already shared in the analysis of the links between gender expectations and PHDP.
5. Then introduce other key terms on the handout Sex and Gender Definitions. Be sure to clarify that gender norms and expectations affect anyone who lives outside the 'box' of gender expectations, including transgender persons and people in same-sex relations. Also be sure to examine the definition of gender equality and how it applies to people of all gender identities and sexual orientations.
6. Ask for any questions or comments.

   (Optional): Ask participants to take two to three minutes to complete one of the following sentences:
   - Gender equality is important to positive health, dignity, and prevention in my community because …
   - Greater gender equality in my life would mean that ...
7. Invite a few participants to share their responses. Recap major points shared by participants and transition to the next activity.

Activity 4. Links Between Gender Norms and Inequalities and PHDP

OBJECTIVES

By the end of this activity, participants should be able to

- Explain the key gender norms that may limit PHDP in our lives
- Talk about actions to help change these

TIME

1 hour

MATERIALS

- Prepared flipcharts
- Flipchart paper
- Markers

STEPS

1. Explain that the group should now focus on how specific expectations of men and women—those expectations that define a 'box' and whether a person is inside or outside of it—relate to positive health, dignity, and prevention. In particular, we want to consider what *harmful expectations* of men and women can limit their respective abilities to realise PHDP, and what helpful expectations of women and men can lead to greater PHDP.
2. Tell participants that they will work in four small groups (depending on the number of participants) to explore these links. Explain that two groups will focus on women and two groups will focus on men. Review the group work assignment, pointing to the flipchart that each group will receive.

Prepared flipcharts (for each group)

In your small group

1. Please identify two to three key expectations that limit positive health, positive dignity, and positive prevention.
2. Please discuss and fill out the following grid with your results.

Expectations of Being a Man (or Being a Woman)

CURRENT HARMFUL EXPECTATIONS	HOW THESE EXPECTATIONS LIMIT POSITIVE HEALTH, DIGNITY, AND PREVENTION	ALTERNATIVE EXPECTATIONS AND MESSAGES

Allow 15 minutes for group work. Explain that the groups should be looking for highlights. Some examples from previous workshops include the following:

CURRENT HARMFUL EXPECTATIONS	HOW THESE EXPECTATIONS LIMIT POSITIVE HEALTH, DIGNITY, AND PREVENTION	ALTERNATIVE EXPECTATIONS AND MESSAGES
For Women Women have to be 'less than' men	Limit women's ability to develop their full potential	Women have the same human rights as anyone—and should be able to develop their full potential.
For Men Men cannot show emotions Men must always be in control and not be 'weak' Assumed to be gay if outside of the box	Psychological challenges Men do not seek healthcare Hard to adopt healthier, alternative ways of behaving for all men	It is important for men to express emotions. Seeking healthcare and taking care of oneself are parts of being a healthy man. The 'box' limits all men. All men will be healthier and stronger if we let men express the full range of who they are.

3. Have each group present their results. When all groups have finished, facilitate a discussion asking the following:
    a. What stands out?
    b. What are the similarities and differences between women and men?
    c. Are there particular types of norms or expectations that appear to be most important to challenge? Which ones? Why?
    d. What are the key messages related to these expectations that we think will help promote greater positive heath, dignity, and prevention?
    e. How can we put these into practice in our own lives? In our communities? In our advocacy for PLHIV?

STEPS

4. Close the activity by summarising some of the discussion and sharing any final thoughts. A final comment and question could be as follows:

   The roles of men and women are changing in our society. It has slowly become less difficult to step outside of the box. Still, it is hard for men and women to live outside of these boxes—and some aspects of 'living inside the box' can profoundly limit options for positive health, dignity, and prevention.

   - What would make it easier for men and women to live outside of the boxes?
   - What can we do to try to make it easier for men and women to live outside of boxes?
5. Close the activity, thanking participants for their participation. Transition to the next activity.

Activity 4. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVES

By the end of this activity, participants should be able to

- Recall the key issues and lessons on gender
- Develop a plan of action regarding how they will use the information they have learned in their everyday lives

TIME

45 minutes

MATERIALS

Handouts

- Key Messages—Gender
- Putting Learning into Action: How Can I Use What We've Done? Gender

STEPS

Review of Key Messages

1. Explain that we have finished the Gender module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group will conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about gender?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages—Gender. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put This Module Into Action

1. Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Gender.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Sex and Gender Definitions

Sex: Biology, anatomy, and physiology associated with being male or female.

Gender: Refers to the economic, social, political, and cultural attributes, opportunities, and constraints associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time.

Society's expectations regarding what activities you should do and how you should act as a woman or as a man are sometimes called **gender roles** and **gender norms**.

Sexual Orientation: The overall term used to describe people's emotional, physical, or romantic attraction to other people. The most common labels are **heterosexual** (attracted to the opposite sex), **homosexual** (attracted to the same sex), or **bisexual** (attracted to both sexes).

Gender Identity: A person's internal, deeply felt sense of being a man or woman, something else, or in between. This may or may not match the sex a person was assigned at birth.

Transgender: When a person's gender identity does not match their biological sex or when they feel their identity is neither male nor female, or a combination of being male and female.

Gender Equality: Refers to the state or condition that affords women and men equal enjoyment of human rights, socially valued goods, opportunities, and resources.

Key Messages—Gender

1. In every society, gender expectations and gender roles influence aspects of both men's and women's lives, including our health and sexual lives.
2. Gender expectations and roles shape the lives of all men and women, including men and women of all gender identities and sexual orientations.
3. Gender expectations that uphold rigid ideas of what it means to be a man or a woman can
   a. Increase vulnerability to HIV
   b. Limit access to healthcare and prevention options
   c. Fuel stigma and discrimination against those who live outside of these norms
   d. Undermine our ability to live with dignity and realise our human rights
4. Although there are variations, most gender expectations give more power and rights to men compared to women, and to men and women who are in heterosexual relationships rather than those in same-sex relationships. In other words, many gender expectations maintain inequalities.
5. **Gender** expectations and roles are learned. They change and vary across different cultures and over time. We can take action to change harmful expectations and to promote alternative, more positive norms.
6. Gender equality is fundamental to achieving positive health, dignity, and prevention for everyone.

Additional key messages or lessons include the following (please fill in, based on your own reflections and those of others):

Putting Learning Into Action: How Can I Use What We've Done?

Gender

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)

    a. With whom would I want to share? Please list.

    b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 6

Sexuality

What Is in this Module?

This module offers the opportunity to increase participants' comfort in talking about sexuality and expand how people understand sexuality in their own lives and communities. The module starts with a fun warm-up to get people talking about sexuality. It then focuses on an activity that presents a framework for exploring sexuality by building on participants' own ideas and terms; this framework is broader than most people's thoughts about sexuality and offers participants an opportunity to consider and reflect on its multiple dimensions.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Speak honestly about how they feel about sex ▪ List some common understandings of sexuality ▪ Explain the framework for sexuality ▪ Explain how the framework can enhance HIV prevention, treatment, care, and support responses, as well as positive health, dignity, and prevention
TIME	2 hours
ACTIVITY OVERVIEW	**1.** Let's Talk about Sex (20 minutes) **2.** Circles of Sexuality (1 hour 10 minutes) **3.** Key Messages, How to Put This Module Into Action, and Wrap-up (30 minutes)
MATERIALS	**Handouts** ▪ Circles of Sexuality ▪ Putting Learning into Action: How Can I Use What We've Done? Sexuality Prepared flipchart at the front of the room with the Circles of Sexuality diagram, with envelope attached (in which to place cards) **Other** ▪ Flipchart paper ▪ Markers ▪ Cards of one color: one prepared word written per card ▪ Cards of a second color to write participants' brainstormed words ▪ CD player or laptop ▪ CD or MP3s containing music

Activity 1. Let's Talk About Sex[1]

OBJECTIVES	By the end of this activity, participants should be able to speak honestly about how they feel about sex.
TIME	20 minutes

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[1] This activity is excerpted and adapted from Government of Jamaica Ministry of Health. 2010. *National HIV/STI Programme Generic Syllabus: 3-hr Sensitization Workshops for Trainers, Instructors or Facilitators – HIV/AIDS Workplace Basics*, pp. 46–47.

STEPS

1. Play the music and ask all participants to move to the music in a wide space. Stop the music at intervals and ask participants to group themselves, as instructed, in groups of two, three, etc. to talk about the question posed. Allow two to three minutes per question.

Questions

   a. In groups of two: What do your friends say about sex?
   b. In groups of four: What does the church say about sex?
   c. In groups of five: How do men ask for sex?
   d. In (different) groups of five: How do women ask for sex?
   e. In groups of seven: What do you like about sex?

2. With the group still standing, facilitate a brief discussion, asking the following:
   a. How did you feel doing this exercise?
   b. Which topics were easier to talk about? Which topics were difficult to discuss? (Be sure to get a few different reactions.) Why?
3. Thank everyone for their participation. Acknowledge that talking about sexuality can be challenging and can prompt a range of responses and experiences, both positive and negative. It takes practice and respect. This module and the next will attempt to foster both as the group moves forward.

Activity 2. Circles of Sexuality[2]

OBJECTIVES

By the end of this activity, participants should be able to

- List some common understandings of sexuality
- Explain the framework for sexuality
- Explain how the framework can enhance HIV prevention, treatment, care, and support responses—and positive health, dignity, and prevention

TIME

1 hour 10 minutes

MATERIALS

Handout

- Circles of Sexuality

Prepared Flipchart

- Flipchart at the front of the room prepared with the Circles of Sexuality diagram, with envelope attached (in which to place cards)

Other

- Flipchart paper

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[2] This activity is from the *IGWG Training Module on Gender, Sexuality and HIV*, which drew from two key resources: Advocates for Youth. "Circles of Sexuality." Retrieved July 24, 2010, from http://www.advocatesforyouth.org/index.php?option=com_content&task=view&id=198&Itemid=129; and "Inner Spaces, Outer Faces ISOFI Toolkit: Tools for Learning and Action on Gender and Sexuality." Copyright © 2007, Cooperative for Assistance and Relief Everywhere, Inc. (CARE and International Center for Research on Women (ICRW. Used by permission. Retrieved from http://www.icrw.org/files/publications/ISOFI-Toolkit-Tools-for-learning-and-action-on-gender-and-sexuality.pdf.

MATERIALS

- Markers
- Cards of one color: one prepared word written per card
- Cards of a second color to write participants' brainstormed words

STEPS

Brainstorming 'Sexuality'—First Words

Ask the group to brainstorm the first words or phrases they can think of that are associated with sexuality. Be sure to give each person two cards to write down the two terms that come to mind—one per card. This should be done quickly.

Facilitator Note: The facilitator should also have prepared the following cards, one term per card, in a different color than that of the participants' cards.

Kissing
Massage
Caring
Infertility
HIV
Touching
Fantasy
Sharing
Child spacing
Communication
Unwanted pregnancy
Rape
Hugging
Sexual harassment
Loving/liking
Abortion
Date agression
Masturbation
Passion
Impotence
Emotional vulnerability
STIs
Ovaries
Contraception
Vasectomy
Need to be touched
Pornography
Sperm
Bisexual
Flirtation
Self-esteem
Orgasm
Sexual attraction
Withdrawal method
Getting pregnant
Lesbian
Gay
Body image
Petting
Anal sex
Incest

Circles of Sexuality (small group matching)

1. Show participants the Circles of Sexuality diagram at the front of the room, which represents one way of exploring sexuality. Explain that most aspects of human sexuality can fit into one or more of these circles.
2. Briefly read out loud the name of each circle.
3. Explain that each group will now be given a stack of cards—the ones they brainstormed plus some others. Their job within groups will be to decide to which circle they think the word best applies.
4. Ask each group to make stacks according to the different circles. When they are done, ask the group to tape their cards to the circle. Allow 10 minutes for this process.

Circles of Sexuality (large group interactive discussion)

5. Reconvene participants as a large group.
6. Review each circle one by one. First, read the taped cards in the circle. Then ask the group, based on their understanding of the definition of that circle: "Do all the cards belong?" If there are any cards that do not, identify where they should go instead, and place them there; or, if the group is not sure, place the cards to the side of the circle for the moment. Repeat this process for each circle.
7. Once all of the circles have been reviewed, use the handout Circles of Sexuality and read the definitions for each circle. After reading the definition for each circle, ask participants whether they would change any of their cards. After reading all of the definitions, seek to place any remaining cards that still provoke questions.

Facilitator Note: Participants may decide some cards fit in more than one circle. That is all right; some of the concepts overlap with each other.

Circles of Sexuality (large group reflection)

8. When the groups are finished, facilitate a discussion with the larger group, asking the following:
    a. Which of the six sexuality circles feels most familiar? Which the least familiar? Why do you think that is the case?
    b. Which circles do you think provoke the heaviest silence and are hardest to talk about? Why is that?
    c. Ask about differences in silences: What are they for women? For men? For people in same-sex relationships? For people living with HIV? For HIV programming?
    d. Which circles receive the most focus in HIV programs? Where are the gaps?
    e. How can you apply these six circles in your own lives—to enhance positive health, dignity, and prevention? How can you apply these circles in your advocacy for PLHIV in the broader HIV response?
9. Summarise the group's main conclusions and thank everyone for their participation.

Activity 3. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVES

By the end of this activity, participants should be able to

- Summarise key messages from the module
- Develop a plan of action regarding how they will use the information they have learned in their everyday lives

TIME

45 minutes

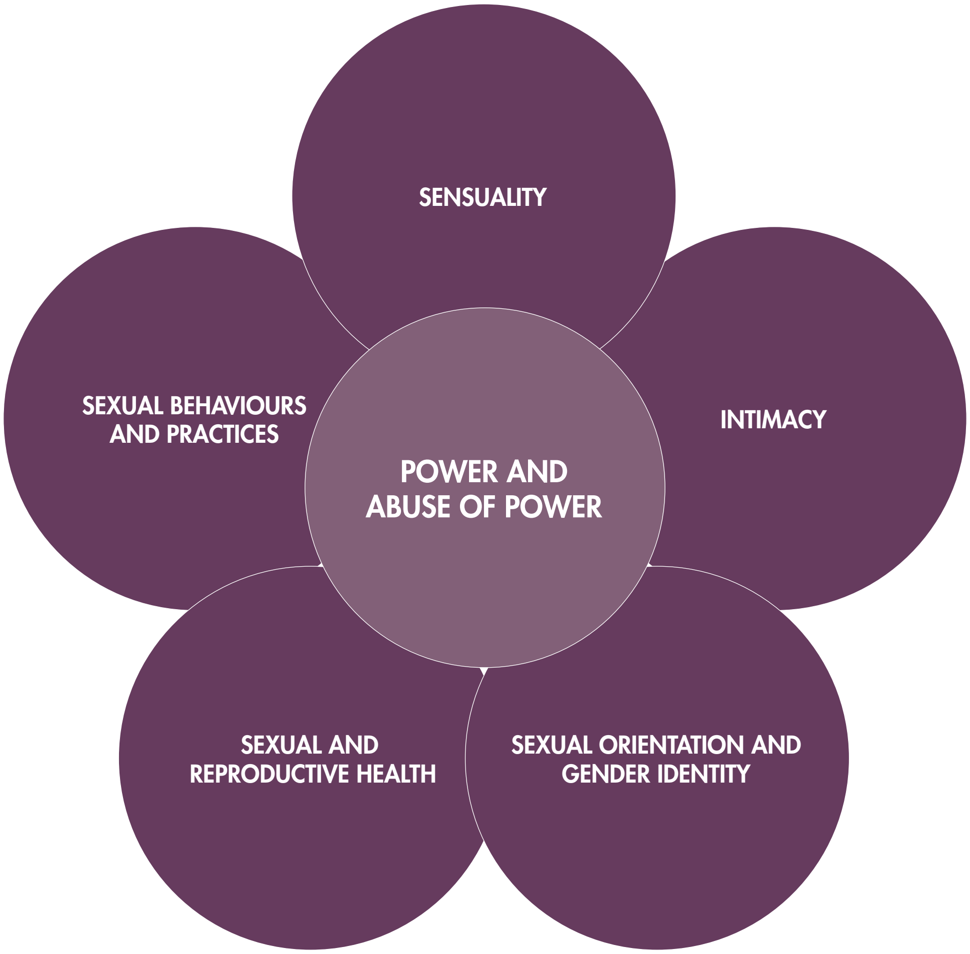
STEPS

Review of Key Messages

1. Explain that the group has finished the Sexuality module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group will conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about sexuality?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages—Sexuality. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

STEPS	**How to Put this Module into Action** **1.** Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Sexuality. **2.** Ask people to complete it individually. **3.** Ask select people to volunteer to share what they wrote. **Wrap-up** Thank participants for their participation.

Circles of Sexuality



Sensuality: Awareness and feeling with one's own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel, and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give ourselves and others.

Intimacy: The ability and need to be close to another human being and accept closeness in return. Aspects of intimacy can include sharing, caring, emotional risk-taking, and vulnerability.

Sexual orientation and gender identity: A person's understanding of who he or she is sexually, including the following:

- **Gender identity:** a person's internal sense of being a man or a woman, which may or may not correspond with the sex assigned at birth
- **Gender expression:** how one's characteristics and behaviours conform to or transgress gender norms and roles of femininity and masculinity
- **Sexual orientation:** whether a person's primary attraction is to the opposite sex (heterosexuality), the same sex (homosexuality), or both sexes (bisexuality)

Sexual health and reproduction: One's capacity to reproduce and the behaviours and attitudes that support sexual health and enjoyment. This includes factual information about sexual anatomy, sexual intercourse and different sex acts, reproduction, contraception, STI prevention, and self-care.

Sexual behaviours and practices: Who does what with which body parts, items, and/or partners.

Sexual power and agency: Power within sexual relations. This includes the following:

- Power within, derived from a sense of self-worth and understanding of one's preferences and values, which enable a person to realise sexual well-being and health
- Power to influence, consent, and/or decline
- Power with others to negotiate and decide
- Power over others; using sex to manipulate, control, or harm other people

Key Messages—Sexuality

Some key messages include the following:

- Sexuality begins at birth and ends at death. It is central to our existence.
- How we regard sexuality is important for our sexual behaviour, our relationships, and our well-being.
- Sexuality includes at least six different aspects: sensuality, intimacy, sexual orientation and gender identity, sexual and reproductive health, sexual behaviours and practices, and power and abuse of power.
- Some aspects of sexuality carry silences and are stigmatised.
- By creating more open discussions of sexuality in our own lives and in our communities, we can help to reduce stigma and discrimination—and to promote positive health, dignity, and well-being.

Additional key messages or lessons include (please fill in, based on your own reflections and those of others) the following:

____

____

____

____

____

Putting Learning Into Action: How Can I Use What We've Done?

Sexuality

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or …)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or …)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or …)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ______________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 7

Sexual Diversity

What Is in This Module?

This module is intended to increase participants' awareness and understanding of sexual diversity. Overall, it seeks to better enable participants to dispel myths about sexual diversity; understand links between stigma and discrimination related to sexual diversity and HIV vulnerability; and advocate for HIV responses that promote positive health, dignity, and prevention (PHDP).

The module starts by helping participants reflect on their own priorities in safe, healthy relationships. Using a set of brief character stories grounded in the Jamaican context, the module's second activity introduces participants to a framework of sexual diversity. It then asks them to apply this framework to the diversity within the character stories and consider the links between stigma and discrimination and vulnerability to HIV in the context of these stories. The module then guides participants in naming and reflecting on what they hear in their communities about persons in heterosexual, homosexual, and bisexual relationships—and in identifying myths and explaining realities.[1]

The module concludes with an exercise to build participants' understanding and skills in what it means to be an 'ally' to a group experiencing stigma and discrimination. This is a particularly important exercise to include, especially for providing a sense of empowerment and solidarity after the activity about 'Myths and Realities,' which surfaces strong, deeply stigmatising statements. The module also includes a summary exercise that asks participants to consider how they can apply their new knowledge.

This module assumes that participants have completed prior modules on Gender Norms and Equality, and Sexuality.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Define the core elements of a healthy, satisfying relationship ▪ Describe a framework of sexual diversity ▪ Discuss how stigma and discrimination related to sexual diversity link to HIV vulnerability and access to care, treatment, and support ▪ Discuss how a better understanding of sexual diversity can help to promote PHDP ▪ Recognise and be able to demystify common misperceptions about sexual orientation, gender identity, and HIV
TIME	3 hours 45 minutes
ACTIVITY OVERVIEW	**1.** Healthy, Satisfying Relationships (45 minutes) **2.** Sexual Diversity Continuum (1 hour) **3.** Myths and Realities in Our Communities (1 hour 15 minutes) **4.** Key Messages, How to Put This Module Into Action, and Wrap-up (45 minutes)
MATERIALS	Facilitator Notes—Myths and Realities in the Community **Handouts** ▪ Sexual Diversity Continuum ▪ Sexual Diversity Terms and Concepts

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[1] See annex handout on page 300: 'Criminalisation and HIV in Jamaica.'

- Sexual Diversity in People's Lives
- Key Messages—Sexual Diversity and Positive Health, Dignity, and Prevention
- Putting Learning into Action: How Can I Use What We've Done? Sexual Diversity

Other

- Laptop
- Projector
- Screen
- Flipchart easel
- Flipchart paper
- Markers

Activity 1. Healthy, Satisfying Relationships

OBJECTIVES

By the end of this activity, participants should be able to

- Define the core elements of healthy, satisfying relationships
- Reflect on barriers and supports to healthy, satisfying relationships

TIME

45 minutes

MATERIALS

- Prepared flipchart for each group: "A healthy, satisfying relationship is ... "
- Flipchart and paper

STEPS

1. Transition from the previous activity on Circles of Sexuality (in Module 6). Note that sexuality is a core aspect of our selves, whether or not we are in sexual or intimate relationships with another person. Sexual and intimate relationships are often an important part of our lives and sexuality. Thus, in this activity, we want to take the opportunity to think about relationships, and what makes for healthy, satisfying relationships.
2. Introduce the objectives of this activity.
3. Split into small groups of no more than 5–6 people to take five minutes to discuss and write their responses to the following statement:

   "The Top 10: A healthy, satisfying sexual relationship includes … "
4. In the larger group, post all groups' lists. Ask one person from each group to read their group's definition.
5. Take about seven minutes to facilitate a discussion to identify common elements among the lists, underlining common elements with the same colour. Also identify and discuss differences among the definitions, flagging these with a different colour. Seek to identify a set of shared, core elements, and to understand when/why there are differences in ideas.
6. Ask participants the following:
   a. What strikes you about the list of core elements?
   b. How might lessons from previous activities (on gender norms and sexuality) relate to achieving these core elements?

STEPS

   c. Do you think the list would be different if just men or just women were asked? Why or why not?
   d. Do you think this list would be different for people in relationships with the opposite sex than for people in relationships with the same sex? Why or why not?
   e. What (new information) have we learned about our sexual relationships?
   f. How can we use this information in our work to promote PHDP?

7. Take two to three minutes to summarise the main points, including the following, if they have not already been covered:
   a. Core elements include … (likely to be: respect, shared power, and ability to make decisions important to each person; sexual pleasure; being with someone one is attracted to); these are elements that we learn by X, and see opportunities to strengthen by Y.
   b. Although people may be in different types of relationships, and may engage in a range of different sexual behaviours with different sexual partners, there is a largely shared set of core elements of safe, satisfying sexual relationships.
   c. While many people share similar elements, individual prioritisation of these elements differs. It is important to know your priorities, and the priorities of those with whom you have a relationship.

8. Thank everyone for their contributions and explain that the group will now move on to the next activity.

Activity 2. Sexual Diversity Continuum

OBJECTIVES

By the end of this activity, participants should be able to

- Recite the key terms and concepts related to sexual diversity
- Describe a framework of sexual diversity
- Discuss how stigma and discrimination related to sexual diversity link to HIV vulnerability and access to care, treatment, and support
- Discuss how a better understanding of sexual diversity can help to promote PHDP

TIME

1 hour

MATERIALS

Handouts

- Sexual Diversity in People's Lives
- Sexual Diversity Continuum
- Sexual Diversity: Key Terms and Concepts
- Prepared flipchart (or PPT): Sexual Diversity Continuum

Other

- Laptop
- Projector
- Screen
- Flipchart paper
- Markers

STEPS

Lecture—Sexual Diversity Basics and Continuum (10 minutes)

1. Introduce the term 'sexual diversity.' Ask people: "What are a couple of ideas that come to mind when you hear the term?" Building on participants' responses, explain that in addition to sexual orientation—to whom one is attracted sexually—there are other aspects of sexual diversity.

   Sexual diversity: The diversity of people's sexual desires, identities, and behaviours.

2. Explain that this activity provides an opportunity to understand sexual diversity in greater depth—with a focus on diversity related to sexual orientation and gender identity, as well as sexual behaviours.

3. Briefly explain that there are a number of different theories and research findings about sexual orientation and diversity. Some of the key, largely agreed-upon points include the following:

   a. People may experience feelings of love, attraction, and sexual desire for the other sex, the same sex, or both. This variation has always been true throughout history. It is true in all societies, whether or not a society accepts same-sex attraction.

   b. A range of sexual orientations is part of healthy, human development.

   c. People do not 'choose' those to whom they are attracted. Also, people cannot be (and do not need to be) 'cured' if they are attracted to people of the same sex.

   d. Researchers such as Kinsey and Kinsey (North American researchers who did some of the first contemporary studies on sexuality in the 1940s and 1950s) emphasise that most people exist somewhere on a continuum of desire for people of the same or opposite sex.

4. Introduce the Sexual Diversity Continuum.[2] Explain that many people think that men who have sex with men (MSM) all look, dress, and behave in the same way. This is not true. MSM have many different identities and we need to be able to understand these to respond to their needs effectively.

   In addition, recap that many people also think that all people in heterosexual relationships engage in similar sexual practices and desires. This is also not the case.

   Put up the flipchart on the Sexual Diversity Continuum (see handout for diagram).

   As you review each of these categories, use a concrete example (of a fictional person) and ask for any clarifying questions. Explain that there will be an opportunity to understand what these categories mean more concretely in the context of the characters' lives, which they will review. Refer participants to a handout with definitions.

   Take a moment to remind people that these terms are concepts to help understand key aspects of diversity. Emphasise that people may or may not accept these terms to describe their own lives and may prefer other terms; also emphasise that people's sexuality and sexual lives are far more diverse and complex than these categories suggest. It is important to understand and respect the terms people prefer when describing themselves.

Activity—Sexual Diversity and People's Lives (50 minutes)

5. **Group work.** Divide into small groups (of three to four participants in each group) and give each group the handout 'Sexual Diversity in People's Lives.' Instruct each group to think about and discuss two stories—especially how the individual in each description is related to each of the elements of the sexual diversity framework—and decide where that character falls along each of the lines/continuums. Give each group 10 minutes.

6. **Report back.** Ask each group to report on one of the stories. In giving its report, the group should show or plot on the diagram the position of each character for each of the dimensions (sex, gender identity, gender expression, and sexual orientation).

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[2] The instructions for steps 4–6 and step 9 are drawn from Sakara, P. Y., S. Eng, P. P. Barmey, M. Reeves, L. Nyblade, et al. 2010. *Understanding and Challenging Stigma Toward Men Who Have Sex with Men: Toolkit for Action.* Washington, DC and Phnom Penh: Pact Inc. and the International Center for Research on Women.

STEPS

7. After all of the stories have been presented, discuss them to build understanding of sexual diversity:

   a. What strikes you? What patterns do you notice?

   b. Which of these characters is most likely to be stigmatised, and why? How does this relate to living inside or outside of the box of gender and sexual norms?

   c. Which of these characters could face more challenges in protecting their health, especially related to HIV? Why? Which of these characters would face fewer challenges? Why?

Recap (10 minutes)

8. Facilitate a discussion to synthesise key points, asking participants the following:

   a. What new ideas stand out for you?

   b. How can these lessons help you to reduce stigma and discrimination? How can you use this knowledge to help make PHDP a reality for everyone?

9. Bring the session to a close by summarising the main points participants have made during the exercise. You may wish to make some of the following points if they have not already been mentioned by participants.

- Society often tells us that the diagram should be one straight line; that is, a man has a male gender identity and a masculine gender expression, and is totally heterosexual (i.e., sex with women only). The reality is totally different. The examples given in the exercise show this diversity:

   a. The term ‘MSM’ includes a wide variety of sexual desires, identities, and practices. So do the terms ‘heterosexual,’ ‘homosexual,’ or ‘bisexual.’ Sexual diversity—and these categories—also help us to think about the diverse ways in which men and women of all sexual and gender identities live their lives.

   b. There are often social expectations that ‘real men’ should behave in ‘masculine’ ways, and ‘proper women’ should behave in ‘feminine’ ways. Related to this, there are stereotypes that people living ‘outside of the gender box’ by having a same-sex partner will show less ‘masculinity’ as a man and less ‘femininity’ as a woman. Yet people of various sexual orientations and gender identities can and do express a range of ‘masculine’ or ‘feminine’ behaviours.

   c. People may also experience and enjoy a range of sexual behaviours within a range of relationships with different people. Although there may be social norms that assume men and women have only penile-vaginal sex or that men in same-sex relations have anal sex only, these assumptions do not match the reality. People engage in a range of types of sexual activities with each other.

   d. Most labels, even thoughtful, non-stigmatising ones, do not begin to capture the complexity of people’s lives and lived experiences.

   e. This exercise shows us that people are sometimes stigmatised and harassed for having a gender identity, gender expression, and sexual orientation outside of the social norms of ‘proper’ behaviour for men or for women. This is true for anyone who lives outside of what is expected, but stigma and discrimination intensify for people who live outside the box on multiple fronts.

   f. It is important to understand these diversities if participants are going to promote universally accessible health, dignity, and prevention. It is also important to ensure that everyone is able to exercise their human rights. This is why key components in promoting PHDP are gender equality and sexual diversity.

10. Transition to the next activity, explaining that participants will now have the opportunity to think about common attitudes in their communities related to sexual diversity.

Activity 3. Myths and Realities in Our Communities

OBJECTIVES

By the end of this activity, participants should be able to

- Identify common myths about sexual diversity in the community
- Recognise and be able to de-mystify common misperceptions about sexual orientation, gender identity, and HIV

TIME

1 hour 15 minutes

MATERIALS

- Blank cards (three different colours)
- Prepared cards, with statements from facilitators to mix with other statements (to use if key statements for discussion do not surface from within the group)
- Facilitator resource: possible responses to myths (placed at the end of this activity)

STEPS

Identifying Community Statements (15 minutes)

1. Introduce the activity, explaining that the module has helped to clarify core elements of healthy, satisfying sexual relationships. The group will now examine a number of questions and myths—along with a few truths—about sexual diversity.
2. Review the objectives. Explain that the group should focus on sexual diversity, especially aspects related to sexual orientation and gender identity, given the gaps in information and range of questions and myths in many communities. In addition, explain that sexual diversity also includes sexual relations and practices that may be perceived to be outside of what are assumed to be a community's norms.
3. Explain that each group will be given four colours of cards. The group is to identify two to three main 'things they hear' in the community about each of the following groups:
    - People in same-sex relationships
    - People in bisexual relationships
    - People in opposite-sex relationships
    - People who are transgender
4. Ask participants to write one statement on each card and to put a (*) on their priority statement for discussion (in case there is not enough time to cover all of them).
5. Give participants 15 minutes and then ask them to post their statements on the wall—by colour—for each group considered.

Facilitator Note: Depending on the time, you may be able to review only 10–12 statements. This means it is important to be able to choose three to four from each group of statements and then move on. Depending on the time, you then can go back to any other 'burning' statements that the group needs to discuss.

Discussing and Clarifying Statements (40 minutes)

6. Ask the participants to stand and join you next to the first column. Ask a participant to read the first statement aloud. Then ask whether people hear this in their communities. Clarify whether the statement is true or false, facilitating a brief discussion asking participants to explain 'the reality.'
7. Continue to other statements. Discuss three to four statements per colour/type of diversity considered

STEPS

8. After all the statements have been discussed, offer the option to return to any other 'burning' statements for discussion. Also offer the option for participants to identify other common 'things that they hear' in their communities about sexual diversity. Record each on a flipchart. As time permits, review these additional statements from their communities.

Reflection and Summary (15 minutes)

9. Facilitate a discussion to synthesise what people have learned, including the following:
   a. How did it feel to hear these statements?
   b. What stands out for you about the exercise and our discussion?
   c. What do you think are some of the causes of these myths?
   d. What are the consequences of the myths, especially for PHDP?
   e. What can we do to help support positive change?

10. Take five minutes to summarise the points that participants have made, including the following, if not already mentioned:[3]
   a. First and foremost, we are all people. We all have similarities and differences compared to other people in our families, schools, workplaces, and communities. A diversity of human experience exists everywhere.
   b. Dominant social expectations of sexual and gendered behaviours—especially to whom one 'should be' attracted, or how one 'should' express being 'masculine' or 'feminine'—can result in stigma, discrimination, and violence.
      i. All of the myths use judgment and fear to maintain rigid ideas about men, women, and proper sexual desire and behaviour.
      ii. These myths reinforce the perception that same-sex intimacy is rare, exceptional, and/or harmful. They also reinforce the ideas that behaviours thought to be 'outside' of the box/ norms of what men and women should do should be sanctioned—even punished.
      iii. The roots of these myths, like those of much stigma and discrimination, include a combination of lack of knowledge and fear about what is different and unknown—and are deeply rooted value judgements about what is perceived to be outside of social norms.
      iv. These myths are used to justify stigma, discrimination, and violence, all of which increase HIV vulnerability. This is true for people who are lesbian, gay, bisexual, or transgender (LGBT) people, as well as those who live outside of the box in other ways.
   c. Stigma can also lead to the following:
      i. Invisibility, exclusion, or discrimination against those who are perceived to be outside of the box—in HIV testing, counselling, treatment, and care programs.
      ii. Barriers to getting the needed information, support, and skills to be able to live and enjoy healthy, satisfying sexual relationships.
   d. In spite of such obstacles, individuals, families, and communities can take steps to build respect for everyone's human rights—and promote PHDP.

3. Conclude the exercise by thanking everyone for their engagement and sensitivity, acknowledging that even in a supportive environment like the workshop, it can be challenging to hear the intensity of stigma and discrimination to which these statements point. Encourage participants to be alert to identifying myths and to continue working to identify strategies to dispel these myths.

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[3] A number of these speaking points are adapted from International Sexuality and HIV Curriculum Working Group. 2011. *It's All One: Curriculum. Volume 1: Guidelines for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education*. New York: Population Council.

Activity 4. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Summarise key messages from the module ■ Develop a plan of action regarding how they will use the information learnt in their everyday lives
TIME	45 minutes
MATERIALS	**Handouts** ■ Key Messages—Sexual Diversity and Positive Health, Dignity, and Prevention ■ Putting Learning into Action: How Can I Use What We've Done? Sexual Diversity
STEPS	**Review of Key Messages** **1.** Explain that the group has finished the Sexual Diversity module. **2.** Invite participants to share any further comments or reflections that they have at this time. **3.** Explain that the module will conclude with a chance to reflect on key take-away messages. **4.** Ask participants to take three minutes to discuss with a partner, "What are your key lessons about sexual diversity?" Ask participants to note their responses so they can share them out loud. **5.** After three minutes, ask for responses to people's discussions. Record responses on a large flipchart. **6.** Distribute the handout Key Messages—Sexual Diversity and Positive Health, Dignity, and Prevention. Ask one person to read the messages out loud. **7.** Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference. **How to Put this Module into Action** **1.** Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Sexual Diversity. **2.** Ask people to complete it individually. **3.** Ask select people to volunteer to share what they wrote **Wrap-up** Thank participants for their participation.

Handout: Sexual Diversity Continuum[1]

BIOLOGICAL SEX

Male	Intersex	Female

GENDER IDENTITY

Man	Transgender	Woman

GENDER ROLES/EXPRESSION

Masculine	Transgender	Feminine

SEXUAL ORIENTATION

Heterosexual	Bisexual	Homosexual

SEX OF SEXUAL PARTNER

Opposite sex	Both sexes	Same sex

SEXUAL PRACTICES

Penile-Vaginal	Oral sex	Anal sex

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1. Excerpted and adapted from: *Training of Facilitators for Stigma and Discrimination*. (Working draft, April 2012). Washington, DC: Futures Group/Health Policy Project; and PACT/ICRW. Curriculum on MSM, Stigma, and Discrimination.

Handout: Sexual Diversity Terms and Concepts[2]

Sexual orientation: The overall term used to describe people's emotional, physical, or romantic attraction to other people. The most common labels are **heterosexual** (attracted to the opposite sex), **homosexual** (attracted to the same sex), or **bisexual** (attracted to both sexes).

Sexual identity: How one perceives one's identity as a sexual being. Men, for instance, may have sex with other men but not identify themselves as homosexual or 'gay'; they may instead identify as heterosexual.

Gender identity: A person's internal feeling about whether they are male or female. A person's gender identity usually matches his or her biological sex; for example, a person feels internally that she is a female and was born biologically female. Sometimes a person's gender identity does not match her or his biological sex; for example, a person may feel that she is female, although she was born biologically male.

Transgender: When a person's gender identity does not match that person's biological sex; or when a person has a perceived identity that is neither male nor female or is a combination of male and female.

Gender roles/expression: A person's outward expression of who he or she is, related to whether the person's behaviour would be considered **'feminine'** or **'masculine.'**

Sexual behaviours: The sexual acts that people engage in with themselves or others.

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[2] These terms are adopted from The Jamaican Task Force Committee for Comprehensive Sexuality Education. 2008. *Jamaican Guidelines for Comprehensive Sexuality Education. Pre-School through Age 24.* First Edition. St. Ann's Bay, Jamaica: FAMPLAN.

Handout: Sexual Diversity in People's Lives

Oliver is 22 years old. When he was young, he liked to dress in girls' clothing. In his teens, he began to think of himself as a female. His schoolmates used to tease him, saying that he looked more beautiful than a woman. After trying to change him, his parents gave up and kicked him out of the house. He moved to the city, where he can live more comfortably much of the time as a woman named Olivia. Olivia has met a 28-year-old more traditionally masculine-looking man named **Peter**, who is a taxi driver. They fell in love, developed a strong sexual relationship, and moved in together. Olivia found it difficult to get work and is sometimes forced to earn money as a sex worker.

Carl is a 40-year-old married businessman. He makes a few effeminate gestures, but everyone sees him as a happily married man. He also loves to have sex with men on the side—and sends his assistant out to arrange such activities with male sex workers. One of the male sex workers is **Rick**, a young man who has few financial resources and makes his living as a sex worker. Rick has sex with men only for money. He is sexually attracted to women and in the future hopes to marry his girlfriend.

Sam is a 35-year-old policeman. He has always been a fairly large man, and has worked out to be muscular and because he enjoys sports. He has a male lover but also has a girlfriend to maintain the appearance of not being a man who has sex with men. As a younger man, he always had several girlfriends and fathered children by two women. Sam also has joined other policemen in forcing female sex workers to provide them with free sex.

George is a self-identified, openly gay man in his 50s who has lived through the HIV epidemic from its start. Although he is aware of potential threats to his safety, he nevertheless feels comfortable spending time at social clubs and restaurants that make a point of welcoming gay, bisexual, transgender people, and other MSM.

Karen is a woman in her early 30s who has a 14-year-old daughter and an eight-year-old son. Her children's father left the island for a job in England several years ago, and they have since broken up. She works as a receptionist at a local hotel. Over the years, Karen has had several female friends with whom she's been romantically and sexually involved. Currently, she is in a close relationship with **Amanda**, a confident woman with a job in sales who takes great pride in maintaining her ultra-feminine appearance. They have talked about having Amanda move in as a 'roommate,' although they would like to be able to live openly as partners.

Regina met **Barry** in their hometown. They married 15 years ago, shortly after graduating, and have since had a male child together. They have stayed romantically and physically attracted and faithful to each other since they've been together. Neither wanted more children, so Barry had a vasectomy. Barry still gets teased by his male friends for being 'less than a man,' and is perceived to have 'given in' to Regina's controlling ways. Regina's mother and sisters believe Regina would be a happier woman if she had more children.

Christian will be 65 years old tomorrow. He now believes that he made the right decision 15 years ago, when he turned 50, to tell his wife that he thought their marriage was over, even though she was and would always be the great love of his life.

> He has now come to think of himself as a homosexual man. After turning 50, Christian felt tired of the deception. He had formed a strong bond with **Ryan**, a man who lives overseas, on one of his trips as an engineer. He could see the pain he was causing his family because of his frequent trips and their not knowing about his sexual orientation. The freedom to be himself with Ryan was such a priceless gift that he could not return to his former self.
>
> He knew it would be difficult to have an open discussion with his wife and two children. What he was not prepared for were the reactions of some of his closest friends. They thought that he was selfish and thoughtless. They even encouraged his wife to be as tough as she could be on Christian, both financially and emotionally.
>
> Fortunately for Christian, his wife did not take their advice, and they went to a psychologist for counselling and

advice. They first attended these sessions separately and then did a few together. There were many repercussions and changes in the trajectory of Christian's life. However, he reflects that, as he nears 70, what has not changed is that he is a family man, devoted to his children and to his former wife, while also embracing a full relationship with Ryan.

Handout: Key Messages—Sexual Diversity and Positive Health, Dignity, and Prevention

Key messages include the following:

- First and foremost, we are all people. We all have similarities and differences compared with other people in our families, schools, workplaces, and communities. The diversity of human experience exists everywhere.
- Most of us do not recognise the diversity in how people identify as human beings and the diversity of sexual experiences that individuals have in their relationships—whether they are in relationships with the same or the opposite sex.
- Dominant expectations of how people should behave as men and women—especially to whom one 'should be' attracted, and how one 'should' express being 'masculine' or 'feminine'—can result in stigma, discrimination, and violence.
- Our communities perpetuate many myths that keep misunderstanding, stigma, and discrimination alive. Some of these myths are based on lack of knowledge and understanding; some are based on judgments.
- These myths place everyone's health at risk and limit the ability of all people to claim the rights to which they are entitled as human beings.
- In spite of such obstacles, individuals, families, and communities can take steps to build respect for everyone's human rights and promote positive health, dignity, and prevention.

Additional key messages or lessons include the following (please fill in based on your own reflections and those of others):

Putting Learning Into Action: How Can I Use What We've Done?

Sexual Diversity

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 8

Disclosure Issues

8

What Is in this Module?

This module opens with a brief introduction of what disclosure means, followed by a discussion on voluntary and involuntary disclosure. The session then segues into a more in-depth exploration of voluntary disclosure. It offers an overview of the levels of voluntary disclosure and the benefits and challenges of each. After this, participants are encouraged to think through the factors that affect whether or not they will choose to disclose. They are asked to reflect on a past experience of disclosure and develop some criteria that will help them to decide whether or not they will disclose again. Before concluding the module, participants will review four tools that can help them to manage disclosure in the media, in the community, and to family members and partners. Finally, participants will reflect on what they've learned and write about how they will apply the information to their lives.

This module assumes that participants have already completed a basic introduction to HIV.

OBJECTIVES	**By the end of this module, participants should be able to** ■ Define 'disclosure' ■ Define 'voluntary' and 'involuntary' disclosure ■ Describe the differences between nondisclosure, partial disclosure, and full disclosure ■ Discuss the issues involved in disclosing one's HIV status ■ Discuss the issues involved in serodiscordant (mixed-status) relationships ■ Discuss some of the criteria needed to assess whether or not to disclose ■ List some tips on how to disclose in different contexts
TIME	3 hours 30 minutes
ACTIVITY OVERVIEW	**1.** Defining Disclosure (10 minutes) **2.** Voluntary and Involuntary Disclosure (30 minutes) **3.** Levels of Voluntary Disclosure (45 minutes) **4.** Levels of Voluntary Disclosure: Benefits and Challenges (45 minutes) **5.** Assessing Whether or Not to Disclose (30 minutes) **6.** Reviewing Four Tools for Disclosure (20 minutes) **7.** Key Messages, How to Put This Module into Action, and Wrap-up (30 minutes)
MATERIALS	**Handouts** ■ Assessing Whether or Not to Disclose: Guiding Questions Worksheet ■ Tools for Disclosure a. Disclosure considerations when interviewed by the media b. Disclosure considerations when dealing with the community c. Disclosure considerations when disclosing to family members d. Disclosure considerations when disclosing to partners (including serodiscordant couples, or when the status of the other is unknown)

MATERIALS	■ Key Messages—Disclosure ■ Putting Learning into Action: How Can I Use What We've Done? Disclosure **Other** ■ Flipchart easel ■ Flipchart paper ■ Markers ■ Pens/pencils

Activity 1. Voluntary and Involuntary Disclosure

OBJECTIVES	By the end of this activity, participants should be able to explain what disclosure means.
TIME	10 minutes
MATERIALS	Flipchart paper, markers
STEPS	**1.** Ask: "When you hear the word 'disclosure,' what are the first things that come to mind?" **2.** Write the group's responses on the flipchart. **3.** Review the responses by reading them aloud. **4.** Ask: "How would you define disclosure?" or "What is disclosure?" **5.** Ask for a few people to volunteer to share. **6.** Share the formal, dictionary-listed meaning of disclosure. Disclosure: "The action of making new or secret information known."[1]

Activity 2. Defining Disclosure

OBJECTIVES	By the end of this activity, participants should be able to ■ Define 'voluntary' and 'involuntary' disclosure ■ Discuss the issues involved in the two types of disclosure
TIME	30 minutes

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[1] Oxford Dictionaries, s.v. 'http://oxforddictionaries.com/definition/english/disclosure,' accessed September 25, 2014

MATERIALS

Prepared flipcharts with the following information:

Flipchart #1

Voluntary Disclosure

Provision of sensitive information by an individual about him/herself and group. Such information, when given, is given by the choice of the person, without coercion or pressure. It may or may not be useful to the decision making of the user or hearer.

Flipchart #2

Your understanding of:

Voluntary Disclosure

CONTROL

Involuntary Disclosure

NO CONTROL

STEPS

1. Discuss the following questions:
    a. When you first learned about your HIV status, could that be considered disclosure?
    b. Disclosure is normally considered to be something that you say to somebody. What if somebody says something about you? Would you also consider that to be disclosure?
2. Ask: "What is voluntary disclosure?"
3. Listen to the group's responses.
4. Show the prepared flipchart with the definition of voluntary disclosure.
5. Instruct the group to read the definition aloud together.
6. Ask the following:
    a. "How do you feel about the definition?"
    b. "Are there any key words that stand out to you?"
    If there are, underline the words as the participants share.
7. Ask: "What is involuntary disclosure?"
8. Listen to the group's responses.
9. Show the prepared flipchart with 'Control vs. No Control.'
10. Ask: "Would you say that the difference between voluntary and involuntary disclosure is based on how much control a person feels about who, when, where, what, and why s/he discloses?"
11. Listen to the responses.

Activity 3. Levels of Voluntary Disclosure

OBJECTIVES

By the end of this activity, participants should be able to

- Describe the three levels of voluntary disclosure: non-, partial, and full
- Give examples of non-, partial, and full disclosure

TIME

45 minutes

MATERIALS

Prepared cartridge paper strips with examples of scenarios that involve disclosure

1. Disclosing on the radio about one's HIV+ status
2. Disclosing at an international conference
3. Disclosing that one is HIV+ in a sensitisation session
4. Telling one's boss that one is HIV+
5. Telling one's new doctor that one is HIV+
6. Telling one's wife that one is HIV+
7. Telling one's best friend that one is HIV+
8. Writing letters, disclosing to one's partners
9. Appearing in a TV programme discussing HIV
10. Marching in a campaign to advocate for treatment
11. Appearing on a poster with a person who is known publicly as being HIV+ (e.g., Ainsley Reid, Rosie Stone)

Flipchart paper and markers

Tape

STEPS

Talking about the Levels of Voluntary Disclosure

1. Ask: "Have you ever disclosed? Why? To whom?"
2. Write the responses on the flipchart.
3. After all comments have been taken, review them by reading them aloud.
4. Ask: "Based on what you just shared, could we describe voluntary disclosure as being on 'levels'? If so, what are these levels?"
5. Write down the responses.

Facilitator Note: It is assumed that persons would have had some exposure to the levels of voluntary disclosure before.

Levels of Voluntary Disclosure: Scenarios

1. Label three flipchart papers with the following titles (one per paper):
    a. Examples of Nondisclosure
    b. Examples of Partial Disclosure
    c. Examples of Full Disclosure

STEPS	**2.** Divide the group into smaller groups of four to six people. **3.** Give each group three or four strips of paper with the scenarios. **4.** Instruct groups to discuss among themselves whether the scenarios are examples of non-, partial, or full disclosure. **5.** After five minutes, instruct each group to paste its scenarios onto the relevant flipchart. **6.** Read aloud all the responses on each flipchart paper. **7.** Ask the large group, "Do you agree with the placement of these scenarios? Why or why not?" **8.** Listen to the responses.

Activity 4. Levels of Voluntary Disclosure: Benefits and Challenges

OBJECTIVES	By the end of this activity, participants should be able to discuss the benefits and challenges of each level of disclosure.
TIME	45 minutes
MATERIALS	Flipchart papers and markers
STEPS	**1.** Divide the group into smaller groups of four to five people. **2.** Give each group one flipchart paper and markers. **3.** Assign each group one level of voluntary disclosure to discuss: non-, partial, or full. ***Facilitator Note: You must have at least three small groups. If the number of participants is small, reduce the number of people per group so that you still end up with three groups. If the number of people is large, then you can assign multiple groups to the same level.*** **4.** Instruct each group to discuss and write down the benefits and challenges associated with the level of disclosure they've been assigned. **5.** After 15 minutes, bring together the large group and ask each small group to present what it wrote. **6.** Listen to the presentations and encourage the group to discuss the findings. Mention, as part of the discussion, the following facts: a. Disclosure doesn't necessarily progress from non- to full. b. Disclosure varies based on factors related to age, gender, etc. c. The reasons for disclosure are context-specific regarding the relative benefits and risks of disclosing to certain people at a certain time and place.

Activity 5. Assessing Whether or Not to Disclose

OBJECTIVES	By the end of this activity, participants should be able to discuss the issues involved in disclosing one's HIV status.
TIME	30 minutes

STEPS

Prepared flipcharts labelled

- Question 1
- Question 2
- Question 3
- Question 4

Handout—Assessing Whether or Not to Disclose: Guiding Questions Worksheet

MATERIALS

1. Explain that the group will explore the different issues that should be considered when deciding to disclose.
2. Introduce the small group exercise with the following instructions:
   a. In your group, please ask one person to share his/her experience with deciding whether or not to disclose to someone (or in some setting).
   b. After s/he shares the experience, record her/his responses to the questions on the Assessing Whether or Not to Disclose: Guiding Questions Worksheet handout.
   c. Please remember that sharing your experience is completely voluntary!
3. Distribute the Assessing Whether or Not to Disclose: Guiding Questions Worksheet handout to each small group.
4. After 20 minutes, bring the larger group back together.
5. Ask one person from each small group (it doesn't have to be the person who shared his/her experience of disclosure) to present the scenario that was shared.
6. Write down the answers to each of the questions on the relevant flipchart paper.
7. Discuss the findings by asking the following questions:
   a. What strikes you about these responses? Are there any surprises or concerns?
   b. What patterns do you see?
   c. Are there considerations specific to different groups within PLHIV communities? What are these considerations?
   d. Are there any other ideas to add?
8. Ask: "Based on what we have discussed, what would you say are the three to five key issues, questions, or concerns that PLHIV need to be aware of as they assess whether or not to disclose?"
9. Write their responses.
10. Thank everyone for their hard work. Wrap up the activity by asking participants for any final reflections or questions. Encourage participants to keep thinking about what is most important to them in making decisions about disclosure.

Activity 6. Reviewing Four Tools for Disclosure

OBJECTIVES

By the end of this activity, participants should be able to

- Recall some of the key considerations when (1) being interviewed by the media, (2) dealing with the community, and (3) disclosing to family members.
- Critique the considerations listed in the handout and determine whether others need to be added or taken away.

Activity 6. Reviewing Four Tools for Disclosure

TIME	20 minutes
MATERIAL	Handout—Tools for Disclosure
STEPS	**1.** Distribute the Tools for Disclosure handout. *Facilitator Note: Make enough copies so that each person gets one copy of each of the four tools.* **2.** Ask for four volunteers. Each volunteer will read aloud one of the four tools described here: a. Disclosure considerations when interviewed by the media b. Disclosure considerations when dealing with the community c. Disclosure considerations when disclosing to family members d. Disclosure considerations when disclosing to an intimate partner, including issues for serodiscordant couples (or when the status of the other is unknown) **3.** Instruct participants to get together in pairs and discuss briefly which of the tips stood out to them in any or all of the tools. **4.** Gather together the large group and ask if there are any questions/concerns or additions they would make to any of the suggestions presented in the tools.

Activity 7. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVES	**By the end of this activity, participants should be able to** ▪ Recall the key issues and lessons on disclosure ▪ Develop a plan of action regarding how they will use the information they have learned in their everyday lives ▪ Determine whether their knowledge on disclosure has improved
TIME	30 minutes
MATERIALS	▪ Key Messages—Disclosure ▪ Putting Learning into Action—Disclosure Issues
STEPS	**Review of Key Messages** **1.** Explain that the group has finished the Disclosure Issues module. **2.** Invite participants to share any further comments or reflections that they have at this time. **3.** Explain that the group will conclude this module reflecting on key take-away messages.

MATERIALS

4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about disclosure?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record the responses on a large flipchart.
6. Distribute the handout Key Messages: How Can I Use What We've Done? Disclosure. Ask one person to read the messages out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put This Module into Action

1. Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Disclosure.
2. Ask people to complete it individually.
3. Ask a few people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Assessing Whether or Not to Disclose: Guiding Questions Worksheet

Think about a person or group to whom you have disclosed and answer the following questions. Please note that you do not have to provide five answers. You can give as many or as few answers as you choose.

1. What were the main issues that you considered when you thought about whether or not to disclose?

Issue #1

Issue #2

Issue #3

Issue #4

Issue #5

2. Disclosure often involves risks. For each of the issues identified in Question 1, what were some of the things you did or actions you took to manage and minimise the risk of disclosure?

Action #1

Action #2

Action #3

Action #4

Action #5

3. What support did you need to take these actions? Is the support available now?

SUPPORT RECEIVED	AVAILABILITY		
	YES	PARTIALLY	NO

4. We identified the benefits of disclosure in a previous activity. What would you need to do, or what would need to happen in your life, for you to benefit from disclosure?

Tool A—Disclosure Considerations When Interviewed by the Media

- Have a good understanding before the interview begins as to what the reporter generally plans to cover. You should be able to get that information from the person arranging the interview.
- If you are nervous or anxious, ask to do role-playing ahead of time. Ask someone (perhaps the person arranging the interview) to play the role of the reporter. It is a good way to settle your nerves and consider how best to answer some questions you expect to be asked.
- Be clear in your mind about what you are comfortable disclosing regarding your personal life, so that if a question is asked that you do not want to answer you will not go beyond your boundaries. Do not make these decisions during the course of the interview. Have your own internal ground rules set ahead of time.
- You have agreed to be interviewed and identified by the media. That does not mean anyone else in your life has agreed. The confidentiality of others must be respected.
- If there are people in your life whom you believe would not object to being identified and discussed, clarify this with them up front and before the interview.
- A reporter may ask you the same question in several different ways in an effort to elicit more information than you are willing to provide. Do not let him or her badger you. If you do not want to answer the question—no matter how it is asked—do not give in.
- If you are confused about what the reporter is asking in a particular question, ask the reporter to rephrase the question. Do not try to guess. This is your life and your story; you have every right to be certain what is being asked of you!
- You may know more about HIV than the reporter to whom you are talking. If the reporter says something that is factually incorrect, do not let it stand. Correct the record. It will not be helpful to you or the reporter to be associated with a factually flawed story.
- At the end of the interview, if you feel the reporter has missed some key points, say so. A reporter usually will be grateful for that kind of help because the information will make for a stronger story.
- Do not be fooled. A reporter is not your friend. The story is a reporter's friend, so he or she will do what is best for the story. Do not get lulled into a comfort zone where you may say something you will later regret. Remember that journalists tend to cut things into pieces to get their point across. Make your points clear and simple and understand that you can answer a question with a question.
- Once you have told a reporter something, there is no taking it back. That is why this kind of preparation is necessary. Think about the key points you wish to get across and make up some short catchy expressions—"sound bites"—that you might repeat in the interview that express those key points.

Tool B—Disclosure Considerations When Dealing with the Community

Establish the five "W's" of disclosure—Who, What, When, Where, and Why.

- Who: Who invited you? To whom will you be talking?
- What: What is your message? What do you want to tell people about your HIV infection, and what are you expecting from the people to whom you are disclosing your HIV status?
- When: When will you be presenting? For how long will you present?
- Where: Where will this activity be taking place (venue)?
- Why: Why did they select you?

Consider the following:

- Are you ready for this?
- Equip yourself to use different methods to communicate your message.
- What amount of time will you need to deliver your information and accomplish your task?
- Enquire about an institutional confidentiality policy and how it applies to you, especially if you have not shared your HIV status with your family, friends, or other loved ones.
- Who may be linked to the information you are about to disclose? Will you be involuntarily disclosing anything (relative to a spouse, partner(s), children, parents, and significant others)?

Remember the following:

- Be clear about the content of your presentation.
- Always bear in mind that you need to protect your emotional well-being.
- You don't have to discuss the circumstances surrounding your sexual history.
- Highlight care issues (diet, hygiene, treatment, and adherence) and how you address them.
- Highlight the social support needs of people living with HIV.
- Highlight the risk of sharing, and that it can affect your life in ways that you haven't considered or prepared for.
- If you have feelings of uncertainty about disclosing, it is ok—these are normal reactions in this situation.
- You have a virus; it does not mean that you have done something wrong. You do not have to apologise to anyone for being HIV positive.
- Be selective! You don't have to tell everything. Keep it simple. Support a few key points with some personal anecdotes to illustrate them.
- Know your audience. Determine who makes up the audience.
- Summarise.
- Express your appreciation.
- Evaluate by soliciting feedback on your presentation.

Tool C—Disclosure Considerations When Disclosing to Family Members

Establish the five "W's" of disclosure—Who, What, When, Where, and Why.

- Who: Who do you need to tell?
- What: What do you want to tell people about your HIV infection, and what are you expecting from the person(s) to whom you are disclosing your HIV status?
- When: When should you tell them?
- Where: Where is the best place to have this conversation?
- Why: Why are you telling them?

Remember the following:

- The choice is yours to tell or not to tell. Sometimes, however, difficult situations can put you into uncomfortable positions where you feel forced to disclose.
- You don't have to reveal every detail of your life story.
- Avoid being hard on yourself as a result of your HIV status and the challenges you experience when thinking about disclosure.
- Draw on the support and experience available through local organisations (e.g., websites, newsletters, and books about personal experiences).
- Seek support on the matter of disclosure from local resources (e.g., social workers, PLHIV, competent counsellors).
- There is no perfect way to disclose.
- Remain optimistic! Fearing a bad reaction is not unusual. Be patient and remember that you will get through it, no matter how difficult it may seem to be.
- Be selective! You don't have to tell everyone. Telling people without full consideration may affect your life in ways that you have not considered or prepared for.
- If you aren't sure about disclosing, remember that this is a common feeling for many individuals in similar situations.
- You have a virus; it does not mean that you have done something wrong and should apologise to anyone for being HIV positive.
- If you feel compelled to give details, do it incrementally. Keep it simple.

Tool D—Disclosure Considerations When Disclosing to Partners

(including serodiscordant couples, or when the status of the other is unknown)

Disclosure to an intimate partner brings its own set of considerations.

Apply the five "W's" of disclosure—Who, What, When, Where, and Why.

- Who: Who do you need to tell?
- What: What do you want to tell people about your HIV infection, and what are you expecting from the person(s) to whom you are disclosing your HIV status?
- When: When should you tell them?
- Where: Where is the best place to have this conversation?
- Why: Why are you telling them?

In some cases, the partner may not know his or her own HIV status, or may have a different HIV status than you. When an intimate partner or spouse has a different HIV status (one person is HIV positive and the other negative), the couple may be referred to as having a 'mixed-status' (also called a 'serodiscordant') relationship.

Individuals may worry that they will lose an important support system when they disclose to an intimate partner.

It is important to consider the following:

- Disclosure is a process, and your spouse or partner's reaction may change over time.
- Consider where to disclose. Identify a secure and private place that is safe, familiar, and comfortable.
- Consider disclosing to your partner when you can discuss your diagnosis in a clear way and have basic information. Do you prefer to have a third party present who is neutral and well informed about HIV?
- It is better to discuss your diagnosis when you feel you have a clear sense about what it means. It is best for individuals to know their status. Should you consider testing and counselling together?
- Treatment advances now mean that if you are HIV positive and on antiretroviral therapy, it can reduce the risk of transmitting HIV to your HIV-negative partner.
- Although antiretroviral treatment can lower viral load, it may still be possible to transmit HIV to your partner, so it is important to use a condom and practice safer sex.

Key Messages—Disclosure

Key messages include the following:

- HIV infection is still considered highly stigmatised; for that reason, many PLHIV have specific challenges around who knows or has access to personal information relating to their HIV status.
- Disclosure may be voluntary or involuntary. Sometimes a person can be put into situations of forced disclosure; forced disclosure is often a human rights violation.
- Voluntary disclosure is the provision of sensitive information by an individual about him/herself and group. Such information, when given, is given by the choice of the person, without coercion or pressure. It may or may not be useful to the decision making of the users/hearer.
- People are at varying levels of disclosure: nondisclosure, partial disclosure, or full disclosure. Each has its benefits and implications. It is important to recognise where you are. It is also important to continue to assess situations and yourself to establish if you want to disclose your HIV status and, if so, to whom, what, when, where, and why.
- Not disclosing one's health status can be held as a traditional value in the Caribbean. Traditionally, family members find it problematic to speak openly about chronic illnesses in the family, especially when the illness opens the possibility of shame and disgrace.
- Obstacles to disclosure include the following:
  - Fear of loss, rejection, humiliation, or retaliation
  - Gender dynamics and inequalities, including gender-based violence
  - Lack of a mechanism for redress when confidentiality is breached
  - Lack of social support
  - Concerns about confidentiality
- It is sometimes good to have other people with whom to discuss issues and the decision-making process around disclosure. Sometimes talking to a person or sharing with a support group, peer, or counsellor helps to clarify one's situation and options so he or she can move forward.

Additional key messages or lessons include the following (please fill in, based on your own reflections and those of others; feel free to use the back of the paper):

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1. Adapted from UNESCO. 2010. *Positive Partnerships: A Toolkit for the Greater Involvement of People Living with or Affected by HIV and AIDS in the Caribbean Education Sector*, p. 119.

Putting Learning Into Action: How Can I Use What We've Done?

Disclosure Issues

1. How can I use information from this module in my own personal life? Please list.

2. How might I want to share lessons from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
    a. With whom would I want to share? Please list.

    b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 9

Positive Health and Health Promotion

9

What Is in this Module?

This module explores the relationships among Positive Health, Health Promotion, and Self-care. It begins by putting exploration in context through an overview of Positive Health, Dignity, and Prevention (PHDP); the Recipe for Positive Living; and a definition of health. Before explaining health promotion and access, the associated international and regional mandates, and what all of this means for the lives of PLHIV, an activity titled 'Healthy Mind, Body, and Soul' helps people begin personalising what they've learned up to this point in the module and sets the stage for the remaining activities.

OBJECTIVES	**By the end of this module, participants should be able to** ■ Advocate for a holistic definition of health ■ Identify actions/resources that PLHIV/PLHIV leaders can take to promote positive health
TIME	4 hours 30 minutes
ACTIVITY OVERVIEW	**1.** Focusing on the 'PH' in PHDP (10 minutes) **2.** The Recipe for Positive Living (20 minutes) **3.** Defining Health (20 minutes) **4.** Healthy Mind, Body, Soul (1 hour, 45 minutes) **5.** Promoting Positive Health and Access (1 hour) **6.** International and Regional Mandates (10 minutes) **7.** Key Messages, How to Put This Module into Action, and Wrap-up (45 minutes)
MATERIALS	**For PowerPoint presentation** ■ Laptop ■ Projector ■ Screen ■ Files **Handouts** ■ Definitions of Health and Related Concepts ■ About Health Promotion ■ Levels of Key Resources and Actions for Health Promotion (and Access) ■ International and Regional Health Promotion Mandates ■ Key Messages—Positive Health, Health Promotion, and Self-care ■ Putting Learning into Action: How Can I Use What We've Done? Positive Health and Health Promotion **Other** ■ Flipchart paper ■ Flipchart easel ■ Markers ■ Crayons

	■ Small post-it notes ■ Masking tape

Activity 1. Focusing on the ‘PH’ in PHDP

OBJECTIVES	By the end of this activity, participants should be familiar with the broad objectives to be met by this module.
TIME	10 minutes
MATERIALS	■ Prepared flipchart paper or PPT with module objectives ■ Prepared flipchart paper or PPT with three overlapping circles of PHDP (Activity 1 in ‘Resources’)
STEPS	**1.** Introduce the module’s title. **2.** Refer to the diagram of the three overlapping circles of PHDP. Ask participants to recap what this diagram means to them. Remind participants of other modules they may have covered related to other aspects of PHDP. **3.** Highlight that this module will focus on key elements of positive health, while not losing sight of its relation to dignity and prevention. **4.** Review the module’s objectives and planned activities. **5.** Ask if there are any questions.

Activity 2. The Recipe for Positive Living[1]

OBJECTIVES	By the end of this activity, participants should be able to recite the recipe for positive living.
TIME	20 minutes
MATERIALS	■ Prepared flipchart or PPT slide with Recipe for Positive Living (Activity 2 in ‘Resources’) ■ Flipchart paper, easel, markers ■ Masking tape
STEPS	**1.** Tape many pieces of flipchart paper along one wall of the training room to form one continuous sheet of paper. Write at the top of the wall, “Positive living is …” Tell participants that this is an open ‘graffiti wall.’ **2.** Ask participants to take one minute to close their eyes and think about how they or people they know live positively with HIV.

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1. Pathfinder International. 2006. *Community and Home-based Care for People and Communities Affected by HIV/AIDS – A Trainer’s Guide – Unit 7, Promoting Positive Living and Emotional Well-being*. Watertown, MA: Pathfinder International. Retrieved from http://www.pathfinder.org/publications-tools/Unit-7-Promoting-Positive-Living-and-Emotional-Wellbeing-Trainers-Guide.html

STEPS

3. At the end of the minute, give each participant a marker and ask everyone to get up and write one word on the graffiti wall that represents what it means to live positively with HIV. Encourage participants to be creative—use words, drawings, songs, etc., to express what it means to live positively with HIV.
4. After about 10 minutes, review what has been written on the graffiti wall as a large group.
5. Write the following 'recipe for positive living' on the flipchart.

KNOWLEDGE + DETERMINATION TO LIVE
with actions for a
HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL
= A LONG, HEALTHY LIFE

6. Ask participants to discuss what the different 'ingredients' in the 'recipe' mean, drawing from examples on their graffiti wall. Ask if there are any elements missing from the recipe that they would like to add, record these on additional cards, and tape them to the flipchart.
7. When done, facilitate a brief discussion asking the following:
   - What do you think of the recipe?
   - How do you feel after reading it?
   - How might you use it?
   - When you think of yourself as a PLHIV leader, how does this definition of positive living impact your work as an advocate?

Activity 3. Defining Health

OBJECTIVES

By the end of this activity, participants should be able to define health.

TIME

20 minutes

MATERIALS

- Prepared flipchart (or PPT slide) with the WHO definition of health
- Laptop, projector, screen (if PPT is used)
- Flipchart paper, easel, markers
- Tape

STEPS

1. Share the flipchart with the World Health Organization (WHO) definition of health, explaining that this is an official definition of health for global health policies.

   WHO Definition of Health:[2] "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

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1. Pathfinder International. 2006. *Community and Home-based Care for People and Communities Affected by HIV/AIDS – A Trainer's Guide – Module 7, Promoting Positive Living and Emotional Well-being*. Watertown, MA: Pathfinder International.
2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April, 1948.

2. Ask a participant to read it. Facilitate a brief discussion, asking:
    - What strikes you about this definition?
    - Is there anything that you disagree with? That should be changed? That needs to be added?
    - Is this true for you? Is this the way that you have always viewed/thought about health?
    - Has your HIV status affected how you thought about health before and after being diagnosed?

Activity 4. Healthy Mind, Body, Soul

OBJECTIVES

By the end of this activity, participants should be able to

- Explain their personal definition of well-being regarding its impact on their physical, social, mental, and spiritual selves
- Discuss the challenges associated with achieving mental, physical, social, and spiritual well-being as PLHIV
- List some of the actions and resources needed to address the challenges (described above)

TIME

1 hour 45 minutes

MATERIALS

- Prepared flipchart paper or PPT slide with questions on well-being for group work
- Flipchart paper, easel, markers
- Tape
- Handout—Definitions of Health and Related Concepts

STEPS

Visualising Well-being

1. Conduct the following visualisation exercise.

    Close your eyes. Think about the following:

    - What does physical well-being look and feel like? What is its shape? How about its size? What would put a smile on your face regarding your physical well-being?
    - What does mental well-being feel like? What would make you smile?
    - What does social well-being look like? What are the spaces you would like to feel accepted in or be a part of? What are the spaces that make you feel that you are well?

    Share, as your feelings lead you.

Facilitator Note: Tell people that what they visualised shows what is important to keep them in good health. When they find that they are losing these things, they should get help!

Achieving Well-being, Part 1

1. Explain that participants will work in small groups to consider specific elements of health in more detail: physical health, mental health, social health, and spiritual health.
2. Divide the group into four subgroups of five to six people.
3. Write the following questions on flipchart paper:
    - How does our group define well-being?

STEPS

  - What challenges do we as PLHIV face in realising this?
  - What key actions or resources do we as PLHIV need to achieve this?

4. Instruct each group to write the questions on the blank flipchart paper they will be given, leaving some space to write the answers.
5. Assign one aspect of health to each group: mental, physical, social, and spiritual. Instruct them to answer the questions.
6. Give them 15 minutes to discuss the questions and write their answers.
7. After 15 minutes, reconvene the large group and instruct each small group to present its questions and answers.
8. After all groups have presented, facilitate a discussion, including the following questions:
   - What were the common themes/patterns across each group for these questions?
     - Question 1—Defining well-being
     - Question 2—Challenges in realising well-being
     - Question 3—Key actions/resources needed
   - Is there anything missing from the basic definitions? (*Facilitator Note: If they are not included, ask about reproductive health, sexual health, and sexuality; also about links to other health concerns and chronic conditions.*)
   - Is any one of these areas more important than another?
   - Are there any specific differences in needed resources or challenges faced pertaining to men? What about for women, LGBTI people, or sex workers?
   - Is any one of these areas more or less recognised as 'health' by community members in Jamaica? What about by PLHIV networks, community organisations, providers, or policies? How does this affect the health of PLHIV?
   - How did it feel to do this exercise? Was it easy or hard?
9. Distribute the handout Definitions of Health and Related Concepts. Instruct participants to read it during their free time and reflect on how it relates to the activity.

Activity 5. Promoting Positive Health and Access

OBJECTIVES

By the end of this activity, participants should be able to

- Define and understand health promotion
- Be aware of global and regional definitions of health promotion and how they can support PLHIV efforts to advance health promotion
- Be familiar with the framework of health promotion and name its four strategies/levels
- Explain why each level is important to the positive health of PLHIV

TIME

1 hour

MATERIALS

- Prepared flipchart or PPT slide with Levels of Action/Resources to Promote Health
- Sticky notes or pieces of coloured paper

MATERIALS

- Tape

Handouts

- About Health Promotion
- Levels of Key Resources and Actions for Health Promotion (and Access)

STEPS

About Health Promotion (30 minutes)

1. Explain that participants should develop a shared understanding of health promotion.
2. Ask participants to work in pairs or at their tables for two minutes and brainstorm what 'health promotion' means to them.
3. Take a few responses and record them on a flipchart.
4. Distribute the handout About Health Promotion.
5. Ask a participant to volunteer to read the WHO definition of health promotion.
6. Ask participants to identify any similarities and differences between their definitions and that of the WHO.
7. Ask a participant to volunteer to read about health promotion in the Caribbean context.
8. Say that health promotion relies on supportive actions at multiple levels.
9. Refer to the diagram of the different levels of health and explain that key levels include the following:

   Levels of Key Resources and Actions for Health Promotion (and Access)

   - Individual—Knowledge; Beliefs and Attitudes; Skills
   - Relationships—Positive/Psychosocial and Spiritual Support
   - Community-level organisations (responsive, accessible); healthcare services (available, accessible, high-quality, and holistic)
   - Enabling Environment
     - Supportive laws and policies
     - Helpful social and cultural beliefs
     - Open environment in the media and communications
     - Economic opportunities

Optional Activity—Achieving Well-being, Part 2

1. Instruct each group to review the list of supports and challenges for their assigned area (physical, social, mental, and spiritual health) from the activity Achieving Well-being, Part 1.
2. Distribute pre-cut slips of paper.

Facilitator Note: One colour should be assigned to each group–the Mental Health group would have one colour, the Physical Health group would have another colour, etc.

3. Ask the groups to choose one example from the list for each level of key resources and actions for health promotion, and write it on their slips of paper.
4. After 10 minutes, have a representative from each group post its examples on the diagram on the level where they belong.
   - What do you think about this framework?
   - Was it easy or hard to apply these different levels to a specific health issue?

STEPS	■ Are certain levels easier to think about than others? Why or why not? ■ What, if anything, does this framework add to how we think about health promotion? ■ Why does this matter to promoting the health of PLHIV? ■ Thinking of PLHIV leaders, what are some types of action and advocacy that PLHIV leaders can take to promote positive health at these different levels?

Activity 6. International and Regional Mandates

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Explain at least one international or regional health promotion mandate ■ Discuss the relevance to PLHIV of at least one mandate
TIME	10 minutes
MATERIALS	Handout—International and Regional Health Promotion Mandates
STEPS	**1.** Distribute the handout International and Regional Health Promotion Mandates. **2.** Ask participants to work in pairs for five minutes to read one of the mandates and consider the following questions: a. What is the mandate? (Instruct pairs to answer in one to two sentences.) b. How might it be useful for PLHIV leaders in promoting positive health? **3.** After five minutes, discuss the mandates in a large group, including the following: a. What did each mandate say? How might it be useful? b. What experiences do people have in using such mandates? c. When and where are these mandates useful, or not useful? d. Are there other mandates that people have found useful?

Activity 7. Key Messages, How to Put This Module into Action, and Wrap-up

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Recall the key issues and lessons on positive health ■ Develop a plan of action regarding how they will use the information they have learned in their everyday lives
TIME	45 minutes

MATERIALS

- Flipchart paper
- Flipchart easel
- Markers
- Masking tape

Handouts

- Key Messages—Positive Health, Health Promotion, and Self-care
- Putting Learning into Action: How Can I Use What We've Done? Positive Health, Health Promotion, and Self-care

STEPS

Review of Key Messages

1. Explain that the group has finished the Positive Health and Health Promotion module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group should conclude this module by to reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about Positive Health and Health Promotion?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages: How Can I Use What We've Done? Positive Health and Health Promotion. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put This Module into Action

1. Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Positive Health and Health Promotion.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote. For actions that would involve any organised action among PLHIV leaders (such as support group materials or advocacy items for the PLHIV networks), ask what some of the next steps might be for participants to move their ideas forward.

Wrap-up

Thank participants for their participation.

Definitions of Health and Related Concepts

Health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

—World Health Organization, 1948 (the definition has not changed since)

Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

—World Health Organization, October 2011

Psychosocial well-being and support[1]

- 'Psycho-' refers to the mind and soul of a person (involving internal aspects, such as feelings, thoughts, beliefs, attitudes, and values).
- 'Social' refers to a person's external relationships and environment. This includes interactions with others, social attitudes, values (culture), and the influence exerted by one's family, peers, school, and community.
- Psychosocial well-being refers to the state of being when a person's internal and external needs are met and he or she is physically, mentally, and socially healthy.
- Psychosocial support addresses the ongoing emotional, social, and spiritual concerns and needs of people living with HIV, their partners, and their caregivers.
- Psychosocial support can come from a range of sources—from supportive relationships with family, friends, and community members; to peer support and support groups; to more specialised, professional services, including counselling, psychological, and psychiatric care.[2]

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[1] Drawn from ICAP. 2012. *Adolescent HIV Care and Treatment, A Training Curriculum for Health Workers: Module 5–4*. New York: Columbia University Mailman School of Public Health.

[2] IASC (Inter-Agency Standing Committee). 2007. *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC.

International and Regional Health Promotion Mandates (1)

Health Promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to well-being.

—Ottawa Charter for Health Promotion, 1986, from the First International Conference on Health Promotion[1]

Health promotion … in the Caribbean context will strengthen the capacity of individuals and communities to control, improve, and maintain physical, mental, social, and spiritual well-being … The strategies that will ensure … health promotion that adheres to the principle of equity in matters of health include the following:

1. Reformulating public health policy (across multiple sectors and actors)
2. Reorienting health services (to make them more responsive to communities and involving members of the community)
3. Empowering communities to achieve well-being (embracing community action and involvement and the tradition of the extended family)
4. Creating supportive environments (healthy physical, social, economic, and political environments)
5. Developing/increasing personal skills (education for personal health … is a continuous process and must be facilitated at all stages of life)
6. Building alliances with special emphasis on the media (across traditional and non-traditional sectors that impact health)

—Caribbean Charter for Health Promotion, 1993[2]

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[1] Retrieved from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/

[2] Retrieved from http://www.healthycaribbean.org/publications/documents/cchp.pdf.

International and Regional Health Promotion Mandates (2)

Excerpts from A Policy Framework—Eight Elements[3]

Operationalising Positive Health, Dignity, and Prevention is not necessarily about creating new programmes, except where basic programmes currently do not exist. Rather, it is about using this new framework to create linkages among existing programmes, as well as taking them to scale, so that they are more efficient and responsive to the needs of people living with HIV.

Individual programmatic elements will inevitably differ from setting to setting, as local needs and resources dictate, but fall under eight major component headings:

1. Empowerment
2. Gender equality
3. Health promotion and access
4. Human rights
5. Preventing new infections
6. Sexual and reproductive health and rights
7. Social and economic support
8. Measuring impact

Health Promotion and Access

- Knowledge of HIV status under conditions of informed consent, confidentiality, and good counselling
    - Community-based voluntary counselling and testing
    - Provider-initiated counselling and testing
- Treatment and care access, availability, sustainability, and quality assurance
- Psychosocial well-being services access, availability, sustainability, and quality assurance
    - Mental and emotional health services
    - Counselling services and support groups

Preventing New Infections

- Access and availability of tools and technologies that help prevent sexual HIV transmission
    - Male and female condoms and water-based lubricants
    - Male circumcision
    - Antiretroviral therapy (ART)
    - Post-exposure prophylaxis
    - New prevention technologies, such as pre-exposure prophylaxis and microbicides, as and when they become available

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[3] Excerpted from GNP+ and UNAIDS. 2011. *Positive Health, Dignity and Prevention: A Policy Framework*, pp. 19–25. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20110701_PHDP_0.pdf.

- Accessibility and availability of services that help prevent vertical transmission
    - Providing appropriate treatment, care, and support to mothers living with HIV and their children and families
- Access to evidence-informed harm reduction for people who use drugs, including opiate substitution therapy
- Serodiscordant couples counselling (including partner and couples testing)
- Prevention, screening, and treatment of sexually transmitted infections (STIs), including viral hepatitis
    - Human papillomavirus vaccination
    - Hepatitis A and Hepatitis B vaccination

Sexual and Reproductive Health and Rights

- Sexual health and well-being
    - Age-appropriate, comprehensive sexuality education, including a focus on the specific needs of adolescents born with HIV
    - Prevention and treatment of STIs, including viral hepatitis
    - Counselling and support for a satisfying sex life, including but not limited to improving libido and treating sexual dysfunction
- Reproductive health
    - Maternal health
    - Family planning, including infertility and contraceptive services
    - Cervical, breast, and other related cancer screening and management
    - Access to appropriate, safe, and non-coerced termination services
- Sexual and reproductive health and rights advocacy and funding

International and Regional Health Promotion Mandates (3)

Excerpts from DRAFT (December 2011) PHDP Operational Guidelines[4]

Health Promotion and Access

Health Promotion and Access for Positive Health, Dignity, and Prevention aims to improve the health outcomes of PLHIV through a combination of actions at the service, systemic, and policy levels that address both scaling up the number of people who access health services as well as the quality of services provided and the outcomes.

As mentioned earlier, and in other parts of this document, the actions articulated in Health Promotion and Access are not 'new,' but rather articulate a rationale for why providing not only treatment services but a 'comprehensive set of health services' will have effective outcomes, and moreover will meet the health needs of PLHIV, which go beyond providing only the medication for ART.

Goal of Health Promotion and Access for Positive Health, Dignity, and Prevention

Improved health outcomes of PLHIV through the provision of appropriate, inclusive, quality, and sustainable treatment, care, and support.

The programmes and actions under the component on Health Promotion and Access fall under the following four areas:

1. Treatment access for PLHIV
2. Care and support of PLHIV
3. Prevention, diagnosis, and treatment of other infections and illnesses for PLHIV
4. Quality assurance of health services for PLHIV

Expected Outcomes

- Improved health outcomes of PLHIV through early diagnosis, adherence to effective and appropriate treatment regimes, and treatment of opportunistic and co-infections
- Improved cost-effectiveness through efficient procurement and delivery treatment systems

Under 'treatment access' (within Health Promotion and Access for Positive Health, Dignity, and Prevention), services and programmes that provide ART must be accompanied by quality and regular clinical monitoring and adherence support. ART access should also be complemented with treatment literacy that empowers PLHIV to know when and how to access treatment and how to manage side effects. ART regimes provided should be according to WHO guidelines; moreover, they must be accessible to PLHIV through overcoming the barriers of direct and indirect costs to the provider and end user.

Care and support for PLHIV must combine physical, emotional, and mental support. PLHIV must be supported in overcoming self-stigma and stigma and discrimination faced in their communities, dealing with their HIV infection, and managing their relationships with their families and loved ones. Effective referral systems between health and social sectors can result in efficiencies, but they must be functional and the end support must be nonjudgemental, relevant, and rights based.

Access to ART is not the only treatment needed by PLHIV. Tuberculosis (TB), for example, remains one of the highest causes of mortality for PLHIV, and diagnosis and treatment must be provided. Hepatitis C co-infections for PLHIV

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[4] GNP+ and UNAIDS. 2011. DRAFT *Positive Health, Dignity and Prevention Operational Guidelines.* Geneva and Amsterdam: GNP+ and UNAIDS.

who use drugs must also be diagnosed and treated, and legal barriers to providing opiate substitution therapy must be overcome. Last, ART comes with side effects that need management and treatment.

Moreover, health promotion and access for PLHIV must be sustained and of quality. In the absence of a cure to HIV, ART is a lifelong treatment. At the system level, actions must be taken to ensure that procurement of ART is sustainable, stockouts are managed and eliminated, and the antiretrovirals (ARVs) procured are of quality. Cost efficiency and effectiveness of systems must be addressed in procurement, distribution, and end-user access. Systemic provision of treatment, care, and support must be linked with Health Systems Strengthening. Also, continuous training opportunities for healthcare providers must be based on the most recent national guidelines as well as on stigma reduction and addressing human rights violations in service access and delivery.

The following pages in this section articulate the expected elements and actions under each area of Health Promotion and Access and offer an example of steps to improve the level and quality of health promotion and access for PLHIV. Different national contexts may require different sets of steps; thus, it is not expected that every country will follow the same path.

Key populations living with HIV

Throughout all actions to improve the health of PLHIV and health promotion access, the particular needs of key populations living with HIV must be addressed. Testing and counselling services for sex workers, for example, must be delivered in a way that does not endanger the lives and livelihoods of those who may be diagnosed as HIV positive. Treatment for men who have sex with men (MSM) living with HIV in the context of laws criminalising same-sex sexual relationships must be delivered in a way that does not put such persons at risk of persecution and further marginalisation from their communities. PLHIV who use drugs and access ART and opiate substitution therapy (OST) will require adapted treatment that considers the physical impact of both OST and ART on their health. Young people living with HIV who are accessing treatment, care, and support will have different needs because of legal restrictions due to their age (e.g., age of consent for testing) and managing their health while seeking or maintaining employment. Women living with HIV in a context of gender inequality will require gender-sensitive treatment, care, and support services that do not heighten their vulnerability.

About Health Promotion

Comprehensive health access and promotion for PLHIV means …

Treatment Access For PLHIV

Includes …

Testing and counselling
Timely and appropriate ART access
Clinical monitoring
Adherence support
Treatment literacy
Access to healthcare and insurance

Care and Support for PLHIV

Includes …

Palliative care
Facilitated referral systems
Mental and emotional health services
Psychosocial services
Counselling services and support groups
Social protection (see also the component on social protection)
Family planning and support (see also the sexual health and reproductive rights [SRHR] component)

Prevention, Diagnosis, and Treatment of other Infections and Illnesses for PLHIV

Includes …

Testing and counselling
Timely and appropriate ART access
Clinical monitoring
Adherence support
Treatment literacy
Access to healthcare and insurance

Quality Assurance of Health Services for PLHIV

Includes …

Age, gender, culturally sensitive specific services
Monitoring of service quality and availability
ART systems (procurement, delivery)
Insurance schemes
Monitoring compliance with WHO guidelines

At the international level, it also includes …

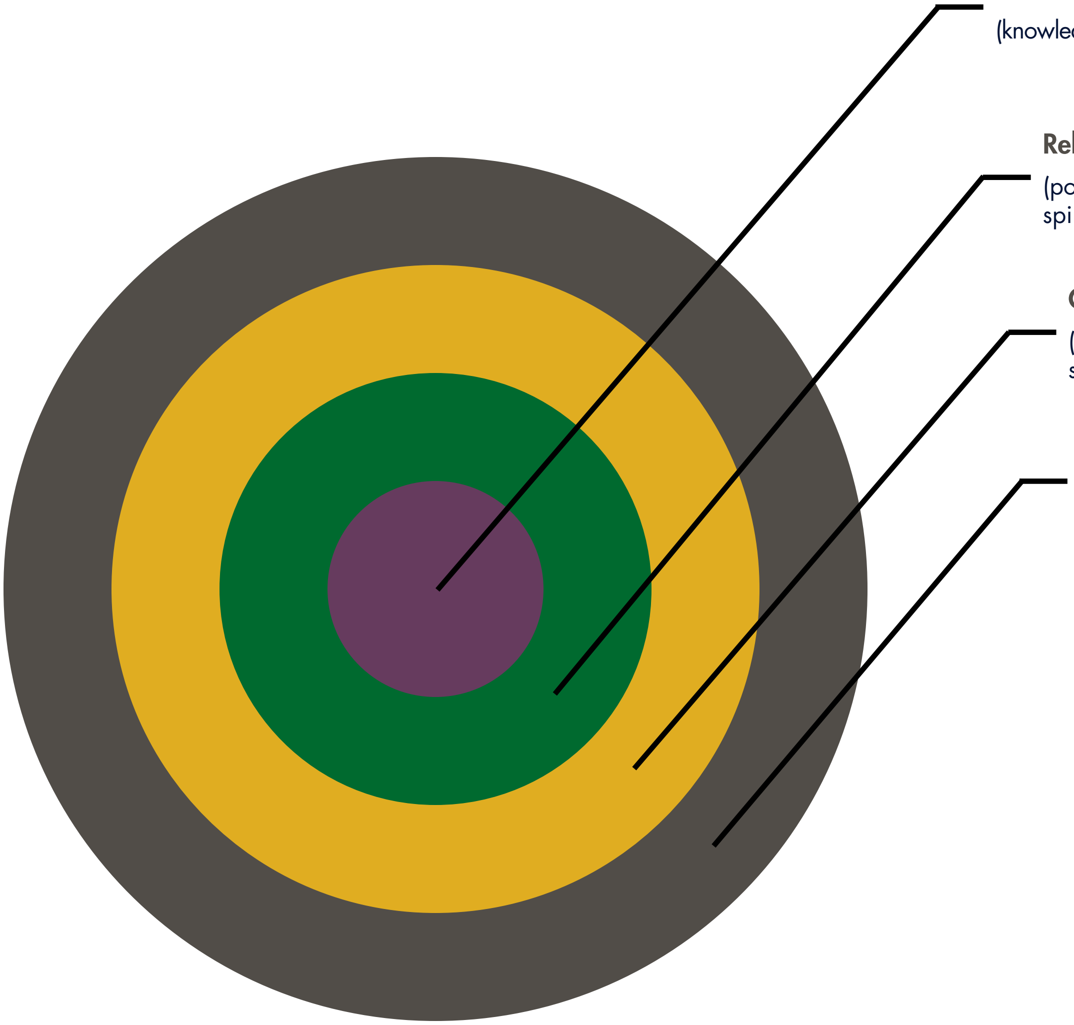
Research on long-term effects of ART
Research on paediatric dosages

To achieve the outcomes …

Improved health outcomes of PLHIV through early diagnosis, adherence to effective and appropriate treatment regimes, and treatment of opportunistic and co-infections

Improved cost-effectiveness through efficient procurement and delivery treatment systems

Levels of Key Resources and Actions for Health Promotion (and Access)



Individual

(knowledge, attitudes, beliefs, skills)

Relationships

(positive psychosocial and spiritual support)

Community

(health services and other supportive organisations)

Environment

(supportive laws/policies, helpful social and cultural beliefs, open media and communication, economic opportunities)

Self-care among PLHIV Groups

Part 1—Personal Experience

Based on your own experiences

1. How do you know when you need support?
2. How do you find out/specify what you need?
3. Where do you go and what do you do?
4. What challenges and gaps do you face?

Part 2—Case Study

1. What might this person's care and support needs include?
2. How would this person know what support they might need?
3. What challenges and gaps might they face …
    a. In knowing what they need?
    b. In whether these supports are available and/or accessible?

Sarah is a 17-year-old woman who lives at home with her mother and three younger siblings. She recently agreed to an HIV test at the family planning clinic and received the news that she is living with HIV. She has a number of friends and has been working at a local Juici Patties, so she has some income. Things at home are rough.

Donavan is an older man who has known that he is living with HIV for the past 15 years. His physical health has been good and he's been able to take good care of himself through nutrition, exercise, and a supportive relationship with his spouse. He sees his HIV doctor regularly and has been taking ART for the past three years; his viral load has been close to undetectable. Recently, he's been losing weight and he has chest pains every once in a while. The changes have left him feeling blue and he missed his most recent appointment with his HIV doctor.

Marie lives in a rural part of St Anne's Parish. At 35, she has been living with HIV for the past 10 years (she learned her status during her pregnancy with her second child). She has a good relationship with her social worker and HIV doctor at the clinic, but it's tough for her to get there. She's not been to a gynaecologist since her last daughter was born four years ago. There's a local support group she tries to attend, but that's also tough to reach with the children. At home, her days never end—she has four children to feed, a father who is not well and for whom she is the caretaker, and a brother who recently moved in, as he did not have any other place to go. Money and food are always short. Her faith and local church have always been a source of support for her and help to keep her spirits up in spite of her daily challenges.

Thomas is a man in his late 20s who has been living with HIV for the past five years. He lives in Montego Bay, where he moved in his late teens to be able to find work—and also to find male partners. His health has been good; he takes pride in taking care of his body and regularly lifts weights, runs, and eats healthily. He rarely goes to the doctor, feeling that he stays healthier and feels better when he avoids the clinic. A recent boyfriend was abusive and kicked Thomas out of their shared apartment. Even though his friends say Thomas has been better off without him, he has been having nightmares and difficulty in sleeping. Thomas has been partying more to cope.

Putting Learning Into Action: How Can I Use What We've Done?

Positive Health and Health Promotion

1. How can I use information from this module in my own personal life? Please list.

2. How might I want to share learnings from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

3. What do I want to share?

4. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

5. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ______________________

   1. What do I want to share?

   2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

   3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

Content for Prepared Flipchart/PowerPoint Slides

Activity 1—Focusing on the 'PH' in PHDP

By the end of the module, participants should be able to

- Advocate for a holistic definition of health
- Explain key elements of self-care for PLHIV
- Assess current challenges and supports to self-care for PLHIV and PLHIV leaders
- Identify actions/resources that PLHIV/PLHIV leaders can take to promote positive health

Activity 2—The Recipe for Positive Living

KNOWLEDGE + DETERMINATION TO LIVE
with actions for a
HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL
= A LONG, HEALTHY LIFE

Activity 3—Defining Health

WHO Definition of Health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1]

Activity 4—Healthy Mind, Body, Soul

Re: Achieving Well-Being, Part 1

- How does our group define this?
- What challenges do we as PLHIV face in realising this?
- What key actions or resources do we as PLHIV need to achieve this?

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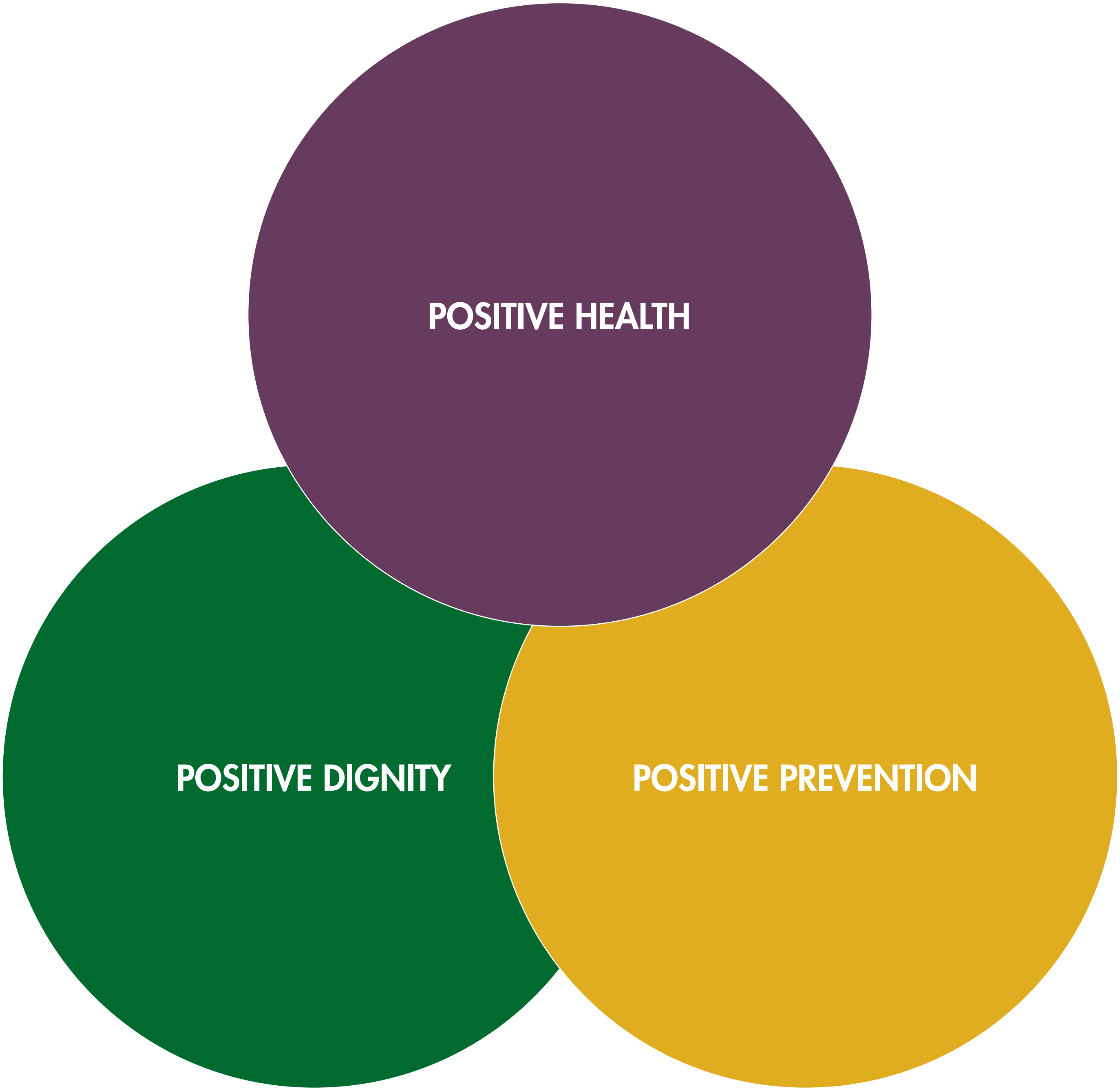
1. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July, 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April, 1948.

Activity 1—Focusing on the 'PH' in PHDP

PHDP Overarching Principles



Positive Health, Dignity, and Prevention

Excerpts from a Policy Framework—Eight Elements[2]

Operationalising Positive Health, Dignity, and Prevention is not necessarily about creating new programmes, except where basic programmes currently do not exist. Rather, it is about using this new framework to create linkages among existing programmes, as well as taking them to scale, so that they are more efficient and responsive to the needs of people living with HIV.

Individual programmatic elements will inevitably differ from setting to setting, as local needs and resources dictate, but fall under eight major component headings.

1. Empowerment
2. Gender equality
3. **Health promotion and access**
4. Human rights
5. **Preventing new infections**
6. **Sexual and reproductive health and rights**
7. Social and economic support
8. Measuring impact

Health Promotion and Access

- Knowledge of HIV status under conditions of informed consent, confidentiality, and good counselling
  - Community-based voluntary counselling and testing
  - Provider-initiated counselling and testing
- Treatment and care accessibility, availability, sustainability, and quality assurance
- Psychosocial well-being services accessibility, availability, sustainability, and quality assurance
  - Mental and emotional health services
  - Counselling services and support groups

Preventing New Infections

- Accessibility and availability of tools and technologies that help prevent sexual HIV transmission
  - Male and female condoms and water-based lubricants
  - Male circumcision
  - Antiretroviral therapy
  - Post-exposure prophylaxis
- New prevention technologies, such as pre-exposure prophylaxis and microbicides, as and when they become available

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[2] Excerpted from GNP+ and UNAIDS. 2011. *Positive Health, Dignity and Prevention: A Policy Framework*, pp. 19–25. Retrieved from http://www.gnpplus.net/en/resources/positive-health-digity-and-prevention/item/109-positive-health-dignity-and-prevention-a-policy-framework.

- Accessibility and availability of services that help prevent vertical transmission
    - Providing appropriate treatment, care, and support to mothers living with HIV and their children and families
- Access to evidence-informed harm reduction for people who use drugs, including opiate substitution therapy
- Serodiscordant couples counselling (including partner and couples testing)
- Prevention, screening, and treatment of sexually transmitted infections, including viral hepatitis
    - Human papillomavirus vaccination
    - Hepatitis A and Hepatitis B vaccination

Sexual and reproductive health and rights

- Sexual health and well-being
    - Age-appropriate, comprehensive sexuality education, including a focus on the specific needs of adolescents born with HIV
    - Prevention and treatment of sexually transmitted infections, including viral hepatitis
    - Counselling and support for a satisfying sex life, including but not limited to improving libido and treating sexual dysfunction
- Reproductive health
    - Maternal health
    - Family planning, including infertility and contraceptive services
    - Cervical, breast, and other related cancer screening and management
    - Access to appropriate, safe, and non-coerced termination services
- Sexual and reproductive health, and rights advocacy and funding

Health Promotion and Access

Goal: Improved health outcomes for PLHIV through the provision of appropriate, inclusive, high-quality, and sustainable treatment, care, and support.

Subcomponents

- Treatment access for PLHIV
- Care and support of PLHIV
- Prevention, diagnosis, and treatment of other infections and illnesses for PLHIV
- Quality assurance and improvement of health services for PLHIV

Expected Outcomes

- Improved health outcomes among PLHIV through early diagnosis, adherence to effective and appropriate treatment regimes, and treatment of opportunistic and co-infections
- Improved cost-effectiveness through efficient procurement and delivery treatment systems

Positive Health, Dignity, and Prevention aims to improve the health outcomes of PLHIV through a combination of actions at the service, systemic, and policy levels that accelerate scaling up the number of people who access health services, and also improve service quality and outcomes.

As with other components of Positive Health, Dignity, and Prevention, the actions falling under the heading of health promotion and access are not 'new,' but rather articulate a rationale for why providing not only HIV treatment services but a 'comprehensive set of health services' will improve outcomes. Moreover, health promotion and access will meet the comprehensive health needs of PLHIV, including but not limited to ART.

ART delivery must be accompanied by high-quality and regular clinical monitoring and adherence support services, as well as treatment literacy initiatives that empower PLHIV to know when and how to access treatment and how to manage side effects. ART regimes should be in accordance with WHO guidelines. ART regimes must be accessible to PLHIV, which may require overcoming barriers related to direct and indirect costs to the provider or the HIV-positive individual.

Care and support for PLHIV must combine physical, social, emotional, and mental support. PLHIV must be supported in overcoming self-stigma and stigma and discrimination faced at home, in their communities, and in health services; dealing with their HIV infection; and managing relationships with their families and loved ones. Effective bidirectional referral systems between health and social service sectors may result in efficiencies, but they must be functional, and the resulting services and support must be nonjudgmental, relevant, and rights-based.

Access to ART is not the only treatment needed by PLHIV. Tuberculosis (TB), for example, remains one of the most significant causes of mortality amongst PLHIV, demanding prompt diagnosis and treatment. Diagnostic and treatment services are similarly imperative for Hepatitis C co-infections for PLHIV who use drugs, and legal barriers to providing opiate substitution therapy must be overcome. In addition, ART is accompanied by side effects and can sometimes fail, underscoring the need for ongoing medical monitoring. Likewise, treatment services related to non-communicable diseases are also necessary for PLHIV and must not be neglected.

Moreover, the quality and sustainability of health promotion and access for PLHIV are critical priorities. In the absence of a cure for HIV, ART is a lifelong commitment. At the systemic level, actions must be taken to ensure seamless, uninterrupted procurement of ART, elimination of stockouts, and quality assurance for ARVs. Systemic actions are required to ensure cost-efficiency and effectiveness of mechanisms for procurement, distribution, and delivery of drugs to the end user. Ongoing health systems strengthening is vital to effective provision of treatment, care, and support. Furthermore, updated national guidelines must ensure continuous training opportunities for healthcare providers and include measures to reduce stigma, discrimination, lack of confidentiality, and informed consent in clinical settings, as well as the means of addressing such human rights violations related to access to and delivery of services.

This section pinpoints what the expected elements and actions are under each area of health promotion and access, and offers examples of steps that may be taken to improve the level and quality of health promotion and access for PLHIV. National contexts may require different sets of steps, and not every country will follow the same path.

Key Populations Living with HIV

With respect to health promotion and access, the particular needs of key populations living with HIV must be effectively addressed, and treatment and care should be tailored to their specific needs. For example, testing and counselling services for sex workers should be delivered in a manner that does not endanger the lives and livelihoods of workers who may be diagnosed as HIV positive. Treatment for men who have sex with men (MSM) living with HIV in settings where laws criminalise same-sex sexual relationships must be delivered in a way that does not place individuals at risk of prosecution or promote further social marginalisation. For PLHIV who use drugs, services for ART and OST should be tailored to each individual's specific needs, taking into consideration the impact of both OST and ART on their health. Young people living with HIV who access treatment, care, and support often have needs that differ from adults because of age-of-consent restrictions on health services or as a result of challenges they face in managing their health while seeking or maintaining employment. Moreover, adolescents living with HIV transitioning into adulthood have specific medical, sexual and reproductive health and rights (SRHR), and psychosocial needs. Transgender people living with HIV require treatment and care that consider living with HIV in conjunction with hormonal therapies as well as gender-related social drivers. In a broader context of gender inequality, women living with HIV require gender-responsive treatment services, antiretrovirals for themselves as well as their babies, and care and support services that do not heighten their vulnerability.

Last but not least, children living with HIV require access to health services that address both HIV-related issues and other development and health-related issues. Without treatment, about half of the children will not live to see their second birthday. In addition, paediatric ARV formulations are not available in most areas of the world, few ARVs have been tested in children, and generic paediatric ARVs are not based on the latest WHO guidelines. Moreover, parents and/or caretakers will require support related to when and how to disclose their HIV status to the children.

Comprehensive Health Access and Promotion for PLHIV Means …

Treatment Access for PLHIV

- Testing and counselling with informed consent and confidentiality
- Timely and appropriate access to ART (including paediatric ARV formulations)
- Clinical monitoring
- Adherence support
- Treatment literacy
- Access to healthcare and insurance

Care and Support for PLHIV

- Palliative care
- Facilitated referral systems

- Facility-and community-based interventions
- Mental and emotional health services
- Psychosocial services
- Counselling services and support groups
- Social protection (see also the component on social protection)
- Family planning and support (see also the SRHR component)

Prevention, Diagnosis, and Treatment of Other Infections and Illnesses for PLHIV

- Prevention of disease progression and further infections
- Prevention and treatment of side effects (e.g., heart diseases due to ART)
- Diagnosis, prevention, and treatment of co-infections (TB, Hepatitis C)
- Diagnosis and treatment of sexually transmitted infections (STIs)
- OST for PLHIV who use drugs
- Prevention and treatment of non-communicable illnesses (e.g., cardiovascular illnesses, lipodystrophy, cancers, etc.)
- Treatment of opportunistic infections
- Useful essential vaccines (e.g., Hepatitis B, pneumococcal, influenza vaccines, human papillomavirus, etc.)

Quality Assurance and Improvement of Health Services for PLHIV

- Age-, gender-, and culturally sensitive specific services
- Monitoring of the quality and availability of services, including by PLHIV and community-based organisations
- Training and support of healthcare workers, including on infection control, nondiscrimination, informed consent, and confidentiality
- ART systems (procurement, delivery)
- Insurance schemes
- Monitoring compliance with WHO guidelines
- For marginalised populations, services provided that integrate treatment, health, legal, and social support

At the international level, this also includes ...

- Research on long-term effects of ART
- Research on paediatric dosages

To achieve outcomes

- Improved health outcomes of PLHIV through early diagnosis, adherence to effective and appropriate treatment regimes, and treatment of opportunistic and co-infections
- Improved cost-effectiveness through efficient procurement and delivery treatment systems

Suggested Steps

- Map programmes and services
- Map coverage and determine gaps
- Assess costs and resources available
- Map and assess existing guidelines
- Gather other evidence
- Assess the success and challenges
  - Take follow-up steps
  - Share your work
  - Advocate
  - Meaningfully involve PLHIV and networks of PLHIV
  - Integrate
  - Mobilise political and organisational leadership
  - Demonstrate the impact of health access and promotion for PLHIV
  - Adapt current policies and remove legal barriers
  - Address stigmatising attitudes amongst healthcare workers, police, and other service providers
  - Address gaps in coverage
  - Review organisational and coordination management
  - Determine resources
  - Monitor and evaluate

MODULE 10

Loss and Grief

What Is in this Module?

The module opens with an activity designed to help participants think about different losses in their lives and the accompanying thoughts and feelings they experienced. After listening to the presentation 'Loss and Grief,' which includes information on the Kübler-Ross Grief Cycle, the participants have another discussion in small groups about the types of experiences of loss that occur frequently in the lives of PLHIV and how they can cope. The module ends with an inspirational quote and a review of the signs of unhealthy grieving that warrant professional intervention.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Define 'grief' ▪ Name the stages of grief as outlined by the Kübler-Ross Grief Cycle ▪ Describe why, when, and how people experience grief ▪ Describe the signs of grief and grieving styles ▪ Define 'coping' ▪ Discuss some of the most common losses that PLHIV experience and how to grieve healthily during the process ▪ Name at least three signs that indicate that they (or others) need to go see a professional therapist
TIME	2 hours 40 minutes
ACTIVITY OVERVIEW	**1.** Identifying the Emotions, Thoughts, and Behaviours that Accompany Loss (45 minutes) **2.** Loss and Grief Presentation (45 minutes) **3.** Anticipating Losses (30 minutes) **4.** Loss and Grief—When to Refer (10 minutes) **5.** Key Messages, How to Put This Module into Action, and Wrap-up (30 minutes)
MATERIALS	**Handouts** ▪ Discussion Questions about Loss ▪ Grief and Loss Presentation (created from the PowerPoint file) ▪ Anticipating Losses ▪ Key Messages—Loss and Grief ▪ Putting Learning into Action: How Can I Use What We've Done? Loss and Grief **Equipment** ▪ Laptop ▪ Projector ▪ Screen ▪ File—Loss and Grief **Other** ▪ Flipchart easel ▪ Flipchart paper

	■ Markers ■ Pens/pencils
PREPARATION	**Facilitator Notes: How to manage the emotions that emerge in the session** ■ Allow people to express how they have felt about the situation. ■ Talk about the importance of managing one's issues as part of leading and facilitating a group. ■ Talk about ways that you as a facilitator cope with issues that trigger strong emotions in you as you facilitate/advise—e.g., talking to someone who can give you perspective. ■ Talk about the fact that some things cannot be addressed in this group process. ■ Ensure that a therapist/counsellor is on hand to do one-on-one follow-up/referral. ■ Explain the difference between expressing empathy and advising. Talk about the importance of doing the former rather than the latter.

Activity 1. Identifying the Emotions, Thoughts, and Behaviours that Accompany Loss

OBJECTIVES	**By the end of the activity, participants should be able to** ■ Describe their thoughts and feelings about a loss they've experienced ■ Describe some of the ways they cope with loss ■ Discuss that there are different types of losses and that their reactions to each may vary
TIME	45 minutes
MATERIALS	■ Prepared flipcharts with the following titles: *Receiving an HIV-positive diagnosis* *Experiencing the death of a loved one* *End of an important relationship* *Having to leave a safe space, a home, or a community that you didn't want to leave* ■ Handout—Discussion Questions About Loss ■ Flipchart paper ■ Markers ■ Cartridge paper cut up into strips (large enough to write a sentence) ■ Tape

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Source: Dr. Sharlene Jarrett. 2013. "Loss and Grief." Presented at the Positive Health, Dignity, and Prevention (PHDP) Curriculum: Participatory Curriculum Development Workshop.

STEPS	**1.** Divide the large group into smaller groups of five to six people. **2.** Assign each group one type of loss: a. Receiving an HIV-positive diagnosis b. Experiencing the death of a loved one c. End of an important relationship d. Having to leave a safe space, a home, or a community that you didn't want to leave **3.** Distribute the handout Discussion Questions About Loss. **4.** Distribute pre-cut strips of cartridge paper to each group. Each strip represents one response. Tell the groups that they are to write their responses to each question on the strips provided. **5.** Instruct people to discuss their assigned loss for 20 minutes, using the discussion questions. **6.** Reconvene the large group. **7.** Ask for one person from each small group to place their responses on the corresponding flipchart paper. (Each flipchart paper should be taped to the wall beforehand.) **8.** Ask the following questions: a. What were some of the reactions you had as you watched each group present and heard the discussion around the responses that emerged? b. How do you cope with loss and grief? **9.** Write the responses on flipchart. **10.** End the activity by making the following points: a. Many events can be experienced as losses. b. Grief is unique and individual, but there are some aspects that are common to everyone. c. Knowing what to expect makes it easier to accept the accompanying feelings and thoughts, and helps you feel less like you're 'going crazy.' d. The only way to get past it is to feel it; set aside a time for grief and accept your emotions without judgement.

Activity 2. Loss and Grief Presentation

OBJECTIVES	**By the end of the activity, participants should be able to** ■ Define 'grief' ■ Name the stages of grief as outlined by the Kübler-Ross Grief Cycle ■ Describe why, when, and how people experience grief ■ Describe the signs of grief and grieving styles ■ Define 'coping' ■ List examples of emotional and problem-focused coping ■ Name at least three signs that indicate that they (or others) need to go see a professional therapist
TIME	45 minutes

MATERIALS	■ Handout—Loss and Grief Presentation (created from the PowerPoint file) ■ File—Loss and Grief Presentation ■ Multimedia projector, screen, laptop ■ Alternative: Prepared flipcharts with the information for the presentation written on them
STEPS	**1.** Make a presentation on Loss and Grief *Facilitator Note: At the point of the presentation where the slide shows 'Activity–Anticipating Losses,' stop and complete the following activity below.*

Activity 3. Anticipating Losses

OBJECTIVES	**By the end of the activity, participants should be able to** ■ Identify the types of losses that PLHIV are more likely to experience ■ Describe some coping skills that will help PLHIV to grieve healthily
TIME	30 minutes
MATERIALS	■ Handout—Anticipating Losses ■ Flipchart paper, markers
STEPS	**1.** Divide the group into smaller groups of four to five people. **2.** Distribute the handout Anticipating Losses. **3.** Read the instructions on the handout aloud and give each group 15 minutes to complete it. **4.** Reconvene the large group and ask the small groups to present what they discussed. **5.** Write the responses on flipchart paper, grouping together those that are the same. **6.** End by doing the following: a. Looking at the findings and talking about similarities and differences b. Encouraging people to remember at least three ways of coping they could use when they next grieve

Activity 4. Loss and Grief—When to Refer

OBJECTIVES	By the end of this activity, participants should be able to name at least three signs of unhealthy grieving that suggest that they (or others) need to be referred for professional help.
TIME	10 minutes

MATERIALS	■ File—Loss and Grief Presentation ■ Multimedia projector, screen, laptop ■ Alternative: Prepared flipcharts with the information for the presentation written on them
STEPS	***Facilitator Note: Refer back to the final two slides of the PowerPoint presentation made earlier to complete this activity.*** **1.** Show the final two slides of the Loss and Grief presentation. a. Slide 1—Quote on gratitude b. Slide 2—Contact a grief counsellor or professional therapist if … **2.** Read each slide aloud. **3.** Answer any questions/comments.

Activity 5. Key Messages, How to Put This Module into Action, and Wrap-up

OBJECTIVES	**By the end of this activity, participants should be able to** ■ Recall the key issues and lessons on loss and grief ■ Develop a plan of action regarding how they will use the information learnt in their everyday lives
TIME	30 minutes
MATERIALS	**Handouts** ■ Key Messages—Loss and Grief ■ Putting Learning into Action: How Can I Use What We've Done? Loss and Grief
STEPS	**Review of Key Messages** **1.** Explain that the group has finished the Loss and Grief module. **2.** Invite participants to share any further comments or reflections that they have at this time. **3.** Explain that the group should conclude this module by reflecting on key take-away messages. **4.** Ask participants to take three minutes to discuss with a partner, "What are your key lessons about loss and grief?" Ask participants to note their responses so they can share them out loud. **5.** After three minutes, ask for responses to people's discussions. Record responses on a large flipchart. **6.** Distribute the handout Key Messages—Loss and Grief. Ask one person to read them out loud. **7.** Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put This Module into Action

1. Distribute the handout Putting Learning Into Action: How Can I Use What We've Done? Loss and Grief.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Discussion Questions About Loss

1. What were the feelings you had (a) immediately, (b) a week later, (c) a month later, and (d) a year later in relation to the loss? How long did the feelings last?

2. What were some of the things you did to express these feelings?

3. What were some of the thoughts you had?

4. What did you do to feel better (both good and not-so-good things)?

5. How did the loss change you?

Anticipating Losses

Select two losses that PLHIV are likely to experience by putting a tick in the relevant box. Then list three healthy coping skills that can be used to manage each loss.

	Death of a loved one
	Divorce or relationship breakup
	Loss of health
	Losing a job
	Loss of financial stability
	A miscarriage
	Retirement
	Death of a pet
	Loss of a cherished dream
	A loved one's serious illness
	Loss of a friendship
	Loss of safety after a trauma
	Selling the family home
	(Other, please write)
	(Other, please write)
	(Other, please write)

Anticipating Losses

For Loss #1

Coping Skill #1

Coping Skill #2

Coping Skill #3

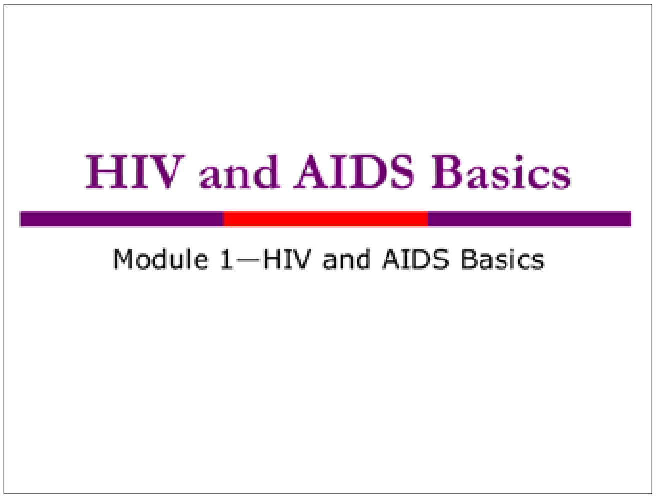
For Loss #2

Coping Skill #1

Coping Skill #2

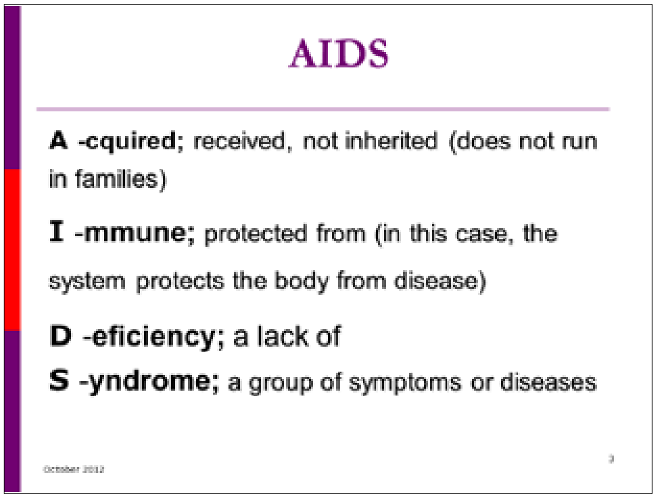
Coping Skill #3

Loss and Grief Presentation



HIV and AIDS Basics

Module 1—HIV and AIDS Basics



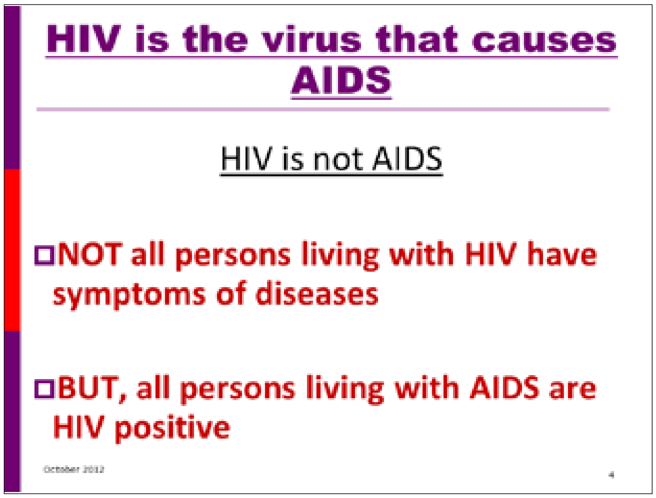
AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases



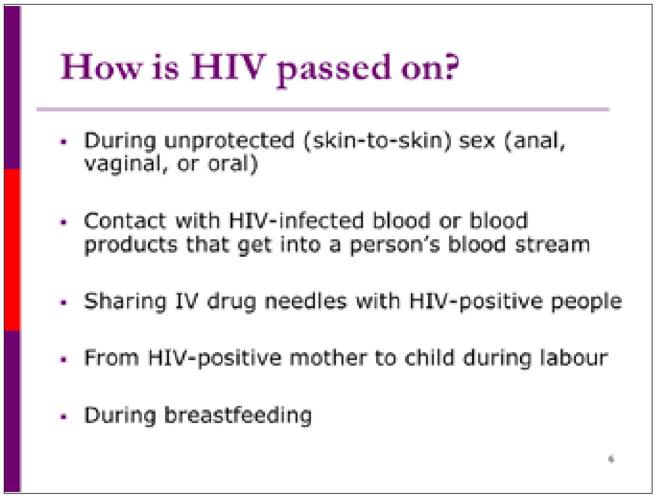
HIV is the virus that causes AIDS

HIV is not AIDS

- ☐ **NOT all persons living with HIV have symptoms of diseases**
- ☐ **BUT, all persons living with AIDS are HIV positive**

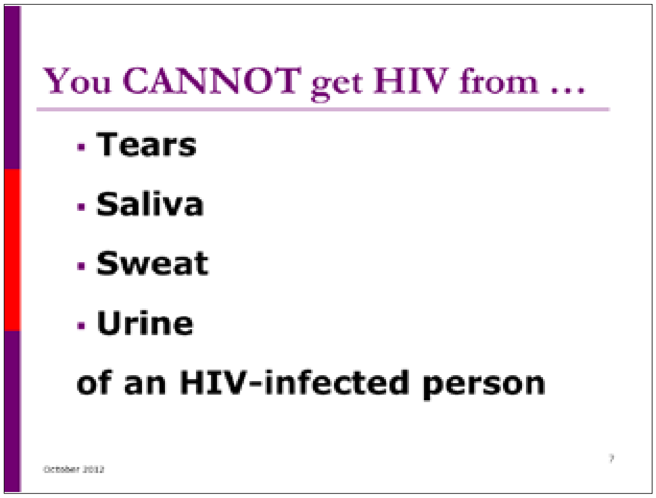
HIV IS FOUND IN THESE BODY FLUIDS

- ☐ **Blood**
- ☐ **Semen**
- ☐ **Vaginal fluid**
- ☐ **Breast milk**



How is HIV passed on?

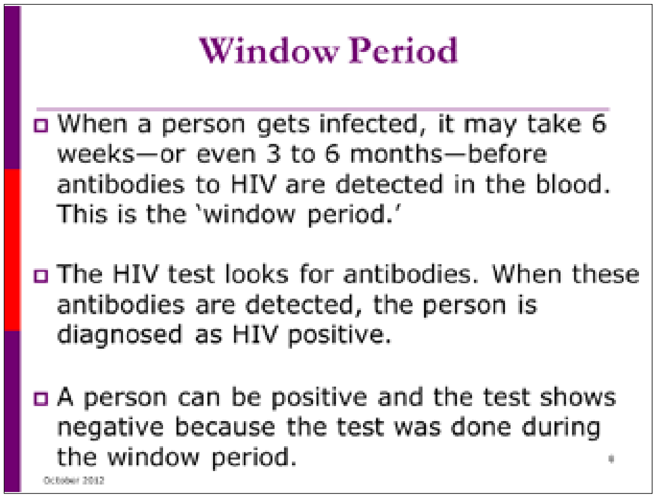
- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding



You CANNOT get HIV from …

- **Tears**
- **Saliva**
- **Sweat**
- **Urine**

of an HIV-infected person

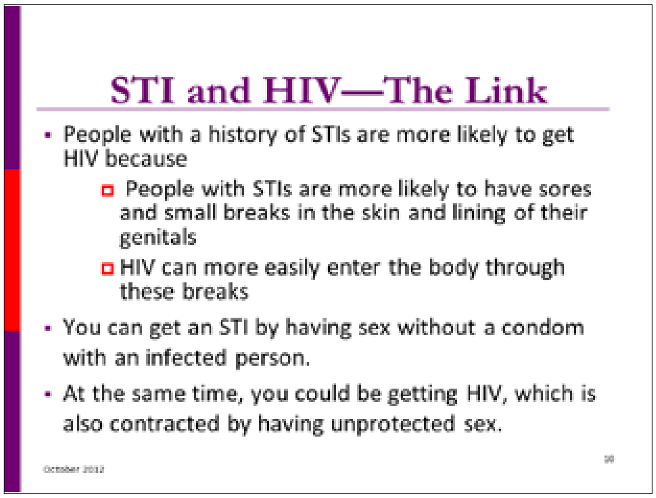


Window Period

- When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- A person can be positive and the test shows negative because the test was done during the window period.

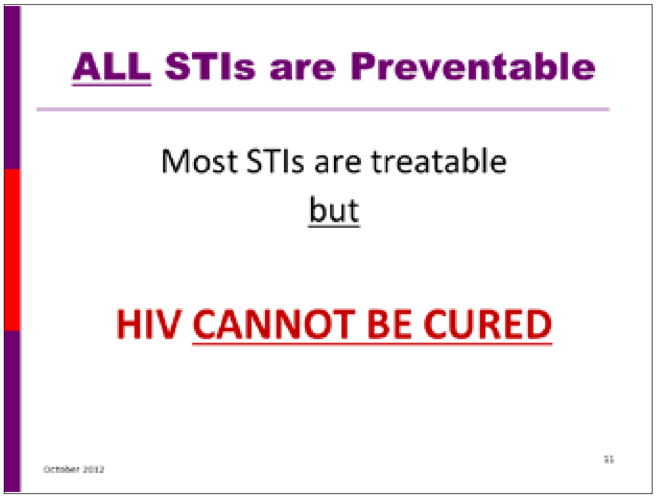
Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for .... things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles



STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
  - People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
  - HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.



<u>ALL</u> STIs are Preventable

Most STIs are treatable

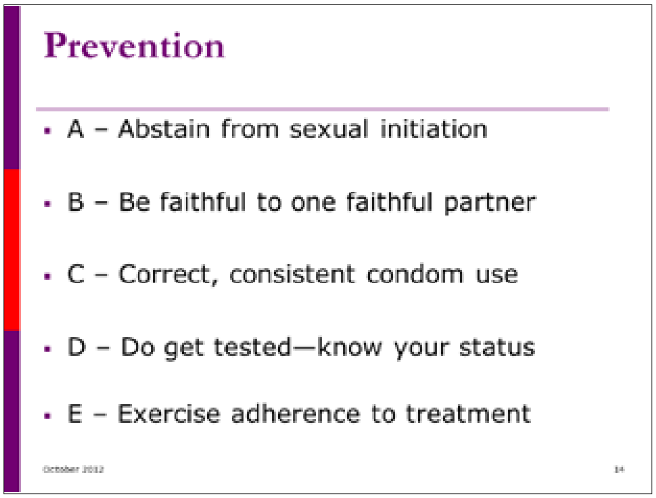
<u>but</u>

HIV <u>CANNOT BE CURED</u>

Prevention Treatment

Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.

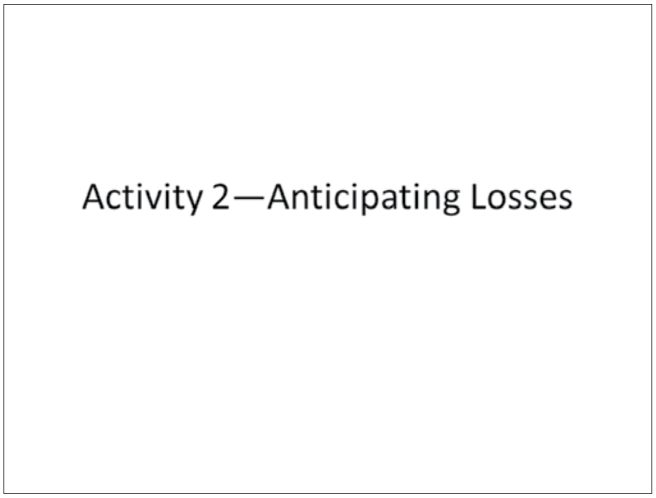


Prevention

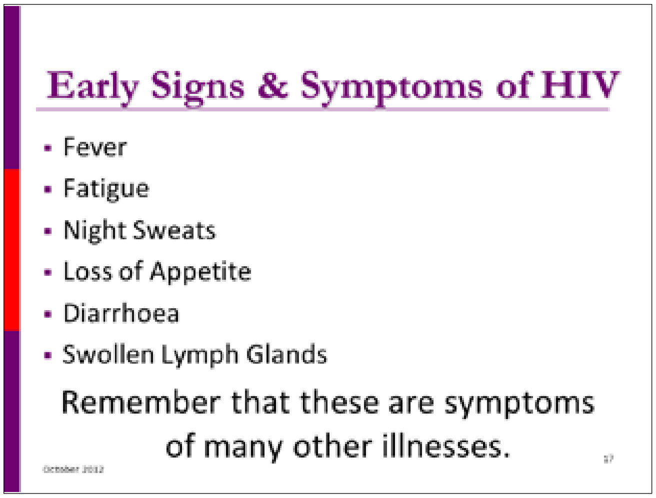
- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment

Who is most at risk for HIV?

- Anybody having sex without a condom
- People with more than one partner who don't use a condom during sex
- People whose sex partners have sex with other partners without using a condom



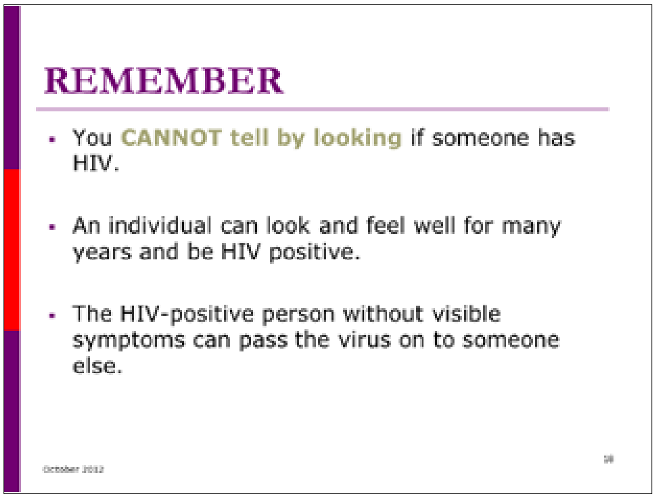
Activity 2—Anticipating Losses



Early Signs & Symptoms of HIV

- Fever
- Fatigue
- Night Sweats
- Loss of Appetite
- Diarrhoea
- Swollen Lymph Glands

Remember that these are symptoms of many other illnesses.



REMEMBER

- You **CANNOT tell by looking** if someone has HIV.
- An individual can look and feel well for many years and be HIV positive.
- The HIV-positive person without visible symptoms can pass the virus on to someone else.

Key Messages—Loss and Grief

Some key messages include the following:

- Many events can be experienced as losses.
- Grief is unique and individual, but some aspects of it are common to everyone.
- While grief stages models, such as the Kübler-Ross Grief Cycle, are good guides to show us what to expect during the process of grieving, in reality there is much looping back; stages can hit at the same time, or they can occur out of order.
- Knowing what to expect makes it easier to accept the accompanying feelings and thoughts, and helps you feel less like you're 'going crazy.'
- The only way to get past it is to feel it; set aside a time for grief and accept your emotions without judgement.

Additional key messages or lessons include the following (Please fill in, based on your own reflections and those of others; feel free to use the back):

Putting Learning Into Action: How Can I Use What We’ve Done?

Loss and Grief

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
    a. With whom would I want to share? Please list.

    b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

3. What do I want to share?

4. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

5. If I am going to use methods or materials from the activities I’ve just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?

2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)

3. If I am going to use methods or materials from the activities I’ve just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 11

Continuum of Care

11

What Is in this Module?

This module is aimed at helping participants begin to engage with their wider network of family, friends, and community as part of their care. It begins with an introduction to the concept of the 'Continuum of Care' and includes a diagram that illustrates how it operates. This is followed by a series of exercises that encourage participants to explore the services they received when they were first diagnosed, ask what their ideal 'package of care' would include, and detail the current 'package of care' being offered and implemented in Jamaica. The module ends with a discussion of the gaps between participants' ideals and the reality, and an initial consideration of which gaps need to be prioritised for urgent attention.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Explain what the 'Continuum of Care' involves ▪ Discuss what Jamaica's 'minimum package of care' for PLHIV includes ▪ Discuss the gaps between their 'ideal' package of care and their current care
TIME	3 hours 40 minutes
ACTIVITY OVERVIEW	**1.** The Continuum of Care (CoC) (30 minutes) **2.** The Ideal CoC (40 minutes) **3.** PLHIV Package of Care (45 minutes) **4.** Jamaica's Minimum Package of Care for PLHIV (30 minutes) **5.** The Current and the Ideal—Jamaica's Package of Care for PLHIV (30 minutes) **6.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**For PowerPoint presentation** ▪ Laptop ▪ Projector ▪ Screen ▪ File—The Continuum of Care ▪ File—Actively Participating in Self-Care **Handouts** ▪ Service Referral for PLHIV ▪ Key Messages—Continuum of Care ▪ Putting Learning into Action: How Can I Use What We've Done? Continuum of Care **Other** ▪ Flipchart paper ▪ Flipchart easel ▪ Markers ▪ Masking tape

Activity 1. The Continuum of Care (CoC)[1]

OBJECTIVES	**By the end of the activity, participants should be able to** ■ Define the CoC ■ Explain why a CoC is important ■ List at least three core services of the CoC ■ List at least two strategies used to create a CoC
TIME	30 minutes
MATERIALS	**For PowerPoint presentation** ■ Laptop ■ Projector ■ Screen ■ File—The Continuum of Care **For paper-based presentation** ■ Prepared flipcharts on the CoC
STEPS	**1.** Make a presentation (using PowerPoint or prepared flipcharts) on the CoC. **2.** Answer questions and comments.

Activity 2. The Ideal CoC

OBJECTIVE	By the end of this activity, participants should be able to describe how they envision the ideal CoC.
TIME	40 minutes
MATERIALS	Flipchart paper, easel, markers
STEPS	**1.** Divide the group into smaller groups of five to six people. **2.** Distribute flipchart paper and markers to each group. The flipcharts should display the following questions: ■ Ideally, what services should be in place for a CoC that functions well? ■ What other recommendations do you have re: network and PLHIV involvement? **3.** Ask participants to talk about the ideal, or their dream, as to what the CoC should look like, using the prompts on the flipcharts. **4.** After 15 minutes, ask each group to present its ideas.

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[1] *Continuum of Care for HIV.* http://www.aids.gov/federal-resources/policies/care-continuum/

STEPS

Alternate Method

1. Create a large diagram of the CoC on the wall (see PPT with the CoC diagram).
2. Divide the group into smaller groups of five to six people.
3. Instruct the small groups to discuss the specific services that they need to create the ideal CoC, based on the circles within the CoC, and write them on strips of paper.
4. In the large group, ask people to place the strips on the diagram in the place where it best fits.
5. Discuss the findings.

Activity 3. PLHIV Package of Care

OBJECTIVE

By the end of this activity, participants should be able to list the first five services they received from the point at which they were diagnosed.

TIME

45 minutes

MATERIALS

- Prepared flipchart with the list of services on the handout
- Handout—Service Referral for PLHIV

Other

- Flipchart paper
- Flipchart easel
- Markers

STEPS

1. Divide the large group into smaller groups of four to five people.
2. Distribute the handout 'Service Referral for PLHIV.'
3. Instruct participants to look at the list and complete the following:
    a. Identify the first four services they received after they did voluntary counselling and testing (VCT).
    b. Rate the order in which these services were received, with 1 being the first (VCT) and 5 being the last.

Facilitator Note: Five services will be ranked in total. The assumption is that VCT will be ranked number 1. Participants will then identify four other services, which will be assigned numbers 2 through 5.

4. After five minutes, ask each person to give his or her response and write it on the prepared flipchart with the list of services.
5. Discuss the following:
    a. What does this show?
    b. What services are most utilised?
    c. Are there other services not on the flipchart list that need to be included, based on your knowledge of the needs of other groups of PLHIV?
    d. How does the package of services offered (and needed) differ, depending on the stage of the

Activity 4. Jamaica's Minimum Package of Care for PLHIV

OBJECTIVE	By the end of this activity, participants should be able to describe what the 'package of care' for PLHIV in Jamaica includes.
TIME	30 minutes
MATERIALS	**For PowerPoint presentation** ▪ Laptop ▪ Projector ▪ Screen ▪ File—Minimum Package of Care for PLHIV in Jamaica **For paper-based presentation** ▪ Prepared flipcharts with the information **Other** ▪ Flipchart paper ▪ Flipchart easel ▪ Markers
STEPS	**1.** Make a presentation (using PowerPoint or prepared flipcharts) on the Minimum Package of Care for PLHIV in Jamaica. **2.** Answer questions and comments.

Activity 5. The Current and the Ideal—Jamaica's Package of Care for PLHIV

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Identify the gaps that exist between their ideal 'package of care' and the current 'package' offered in Jamaica, being sure to do the following: ▪ Specify which of the gaps are related to what the package does (not) include 'on paper' and which of the gaps are related to failures to translate what's on paper 'into practice' ▪ Consider any gaps specific to different groups ▪ Begin to prioritise which of the gaps need the most urgent attention for advocacy
TIME	30 minutes
MATERIALS	Flipchart paper, easel, markers

STEPS

1. Review the outputs from the previous activities, in which people identified (1) their ideal situation regarding a CoC, (2) the minimum package of care in Jamaica, and (3) the gaps that exist.
2. Ask (the large group), "Of the gaps spoken about before, can you think of three that are very important and need to be fixed?"
3. Write the responses.
4. Instruct the group to brainstorm and then rank the three most important gaps that need to be addressed.

Activity 6. Key Messages, How to Put this Module into Action, and Wrap-up

OBJECTIVE

By the end of this activity, participants should be able to

- Recall the key issues and lessons on the CoC
- Develop a plan of action regarding how they will use the information learnt in their everyday lives

TIME

45 minutes

MATERIALS

Handouts

- Key Messages—Continuum of Care
- Putting Learning into Action: How Can I Use What We've Done? Continuum of Care

STEPS

Review of Key Messages

1. Explain that the group has finished the Continum of Care module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group should conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key learnings about the Continuum of Care?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses from people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages—Continuum of Care. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put this Module into Action

- Distribute the handout Putting Learning into Action: How Can I Use What We've Done? Continuum of Care.
- Ask people to complete it individually.
- Ask a few people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Service Referral for PLHIV

SERVICE	PRIORITY RATING
1. VCT and referral	
2. Peer education/peer support	
3. Treatment and adherence counselling	
4. Employment support	
5. Testing (e.g., viral load, CD4, liver function)	
6. Home-based care	
7. Spiritual support/bereavement counselling	
8. Family acceptance and support from family	
9. Health and family planning education	
10. Nutritional support	
11. Financial counselling	
12. Education and counselling for family/community	
13. Support groups (including peer groups)	
14. Exercise	
15. Funeral support	
16. Medical follow-up	
17. Income generation	
18. Legal advice (HIV-related discrimination)	
19. End-of-life care	
20. Transportation support	

Key Messages—Continuum of Care

The Continuum of Care (CoC) is

- A network that links, coordinates, and consolidates care, treatment, and support services for HIV-positive people
  - These services are provided in their homes, communities, and health service sites
  - This is usually supported by a local coordinating body/committee that is responsible for facilitating referral linkages and planning
- A group of services that together provide comprehensive support to HIV-positive people and their families

CoC networks include the following services:

- HIV prevention and reproductive health services for PLHIV and discordant couples
- Prevention of mother-to-child-transmission (PMTCT) and health services for HIV-positive mothers and infants
- PLHIV support groups

The following are guiding principles of a CoC:

- Needs-based and client-focused
- Rights-based orientation
- Meaningful involvement of PLHIV
- Links a diverse set of services across different service delivery sites
- Locally defined design strategy

Jamaica's Minimum Package of Care is treatment-based and includes the following:

- Screening and diagnostic services
- Nutritional interventions
- ARV therapy
- Management of sexual complaints and dysfunctions
- Palliative care

Other Messages

Putting Learning Into Action: How Can I Use What We've Done?

Continuum of Care

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)

   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: _______________________

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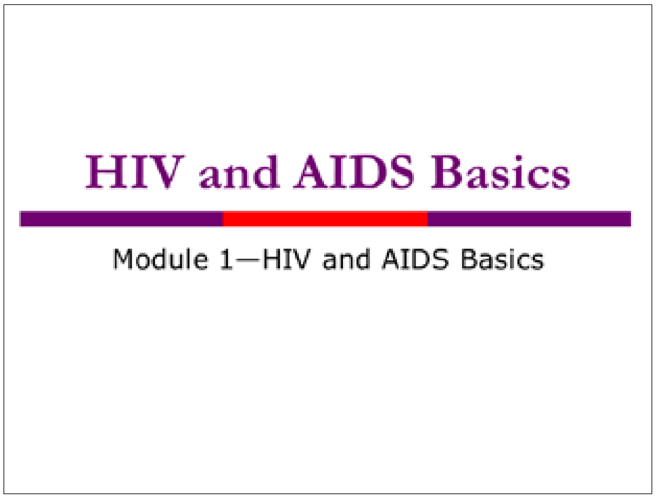
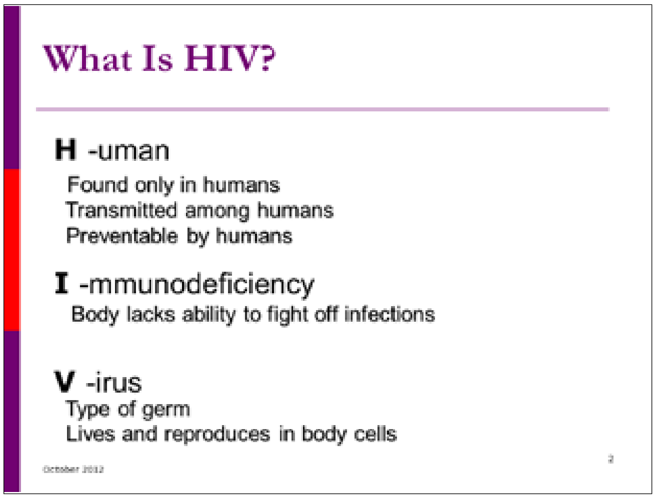


HIV and AIDS Basics

Module 1—HIV and AIDS Basics

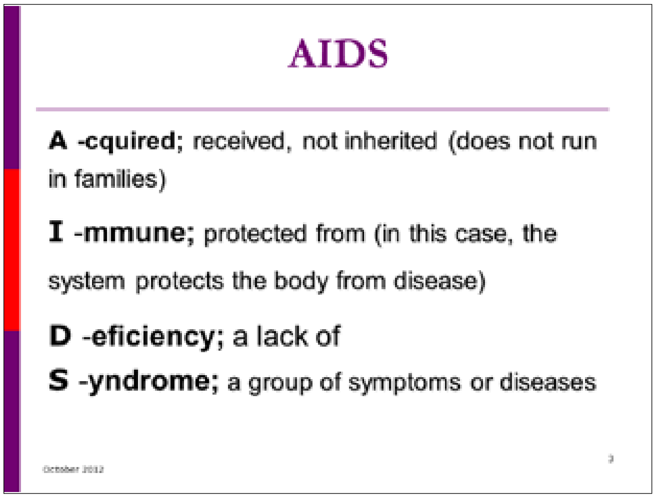


What Is HIV?

H -uman
Found only in humans
Transmitted among humans
Preventable by humans

I -mmunodeficiency
Body lacks ability to fight off infections

V -irus
Type of germ
Lives and reproduces in body cells



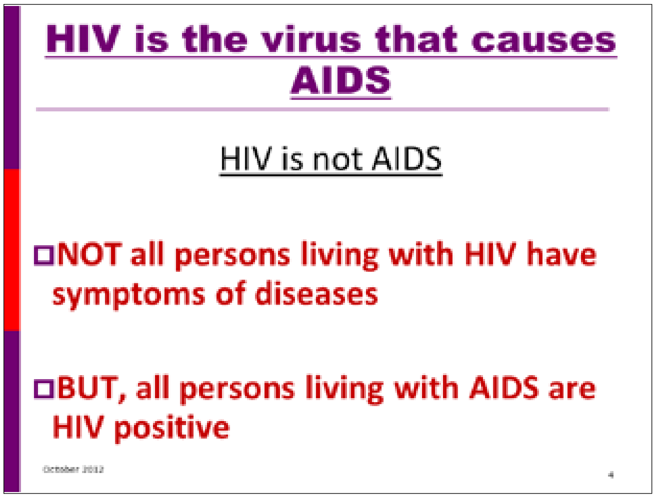
AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases



HIV is the virus that causes AIDS

HIV is not AIDS

☐ NOT all persons living with HIV have symptoms of diseases

☐ BUT, all persons living with AIDS are HIV positive

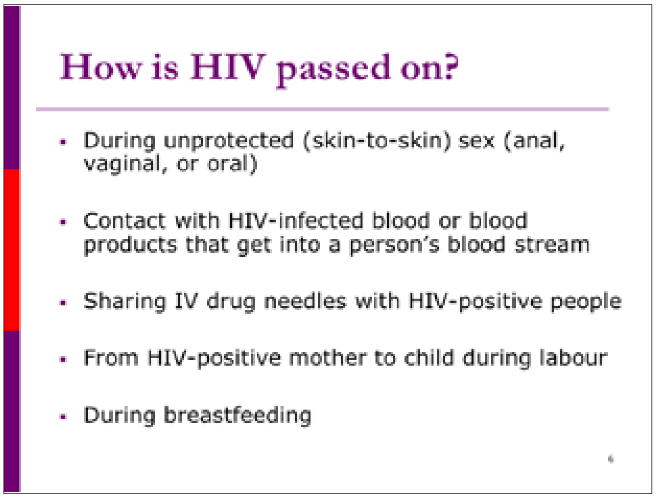
HIV IS FOUND IN THESE BODY FLUIDS

☐ **Blood**

☐ **Semen**

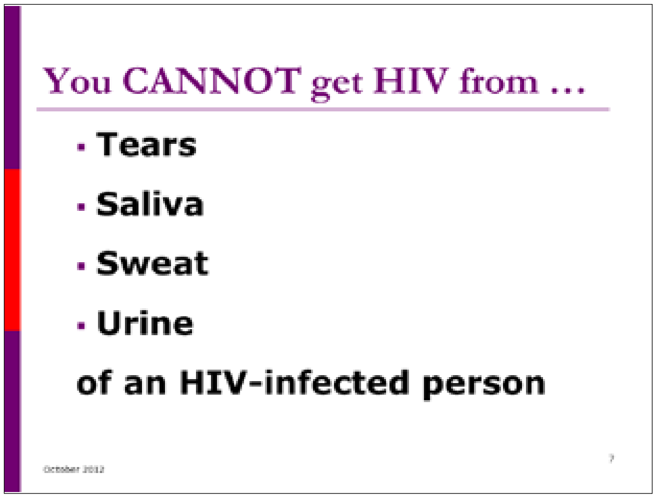
☐ **Vaginal fluid**

☐ **Breast milk**



How is HIV passed on?

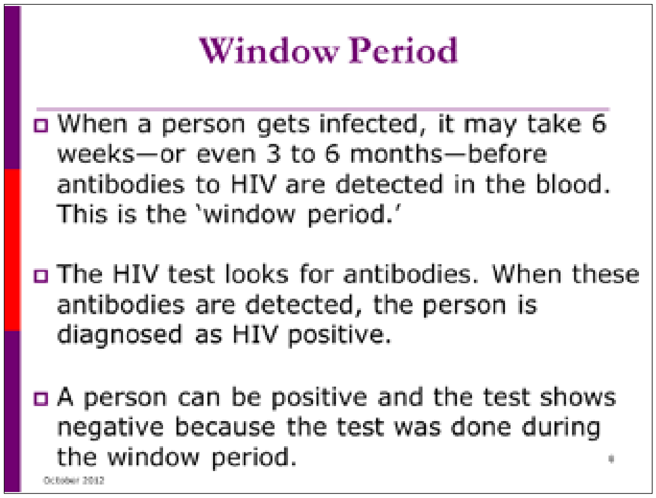
- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding



You CANNOT get HIV from …

- **Tears**
- **Saliva**
- **Sweat**
- **Urine**

of an HIV-infected person

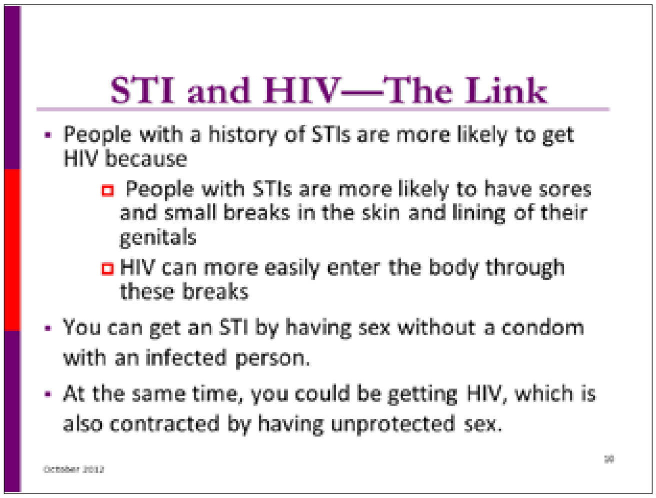


Window Period

- When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- A person can be positive and the test shows negative because the test was done during the window period.

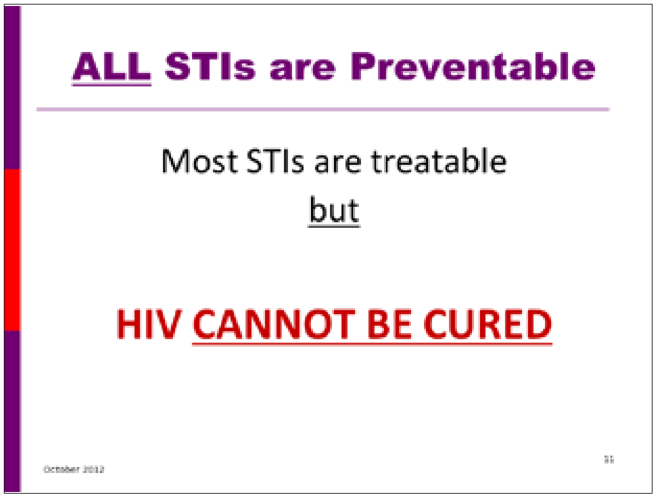
Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for .... things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles



STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
  - People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
  - HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.



ALL STIs are Preventable

Most STIs are treatable

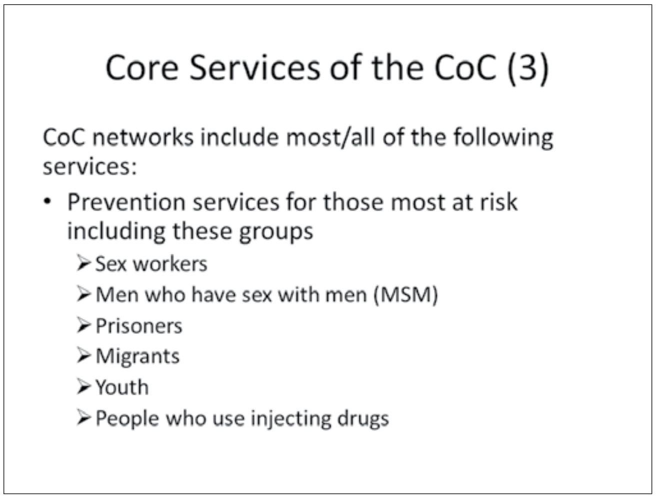
but

HIV CANNOT BE CURED

Prevention Treatment

Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.



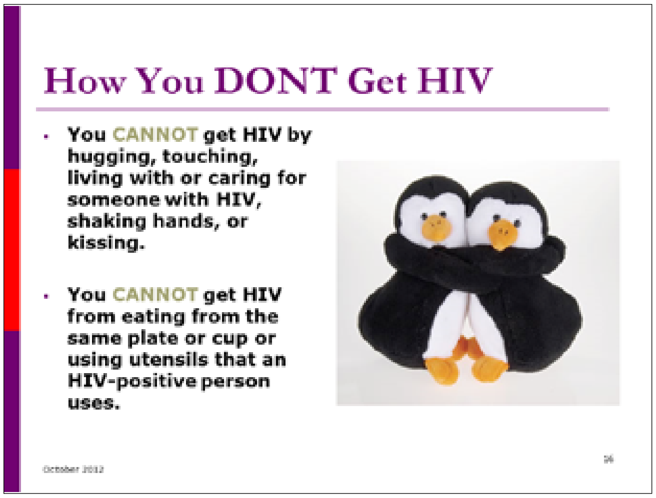
Core Services of the CoC (3)

CoC networks include most/all of the following services:

- Prevention services for those most at risk including these groups
  - ➢ Sex workers
  - ➢ Men who have sex with men (MSM)
  - ➢ Prisoners
  - ➢ Migrants
  - ➢ Youth
  - ➢ People who use injecting drugs

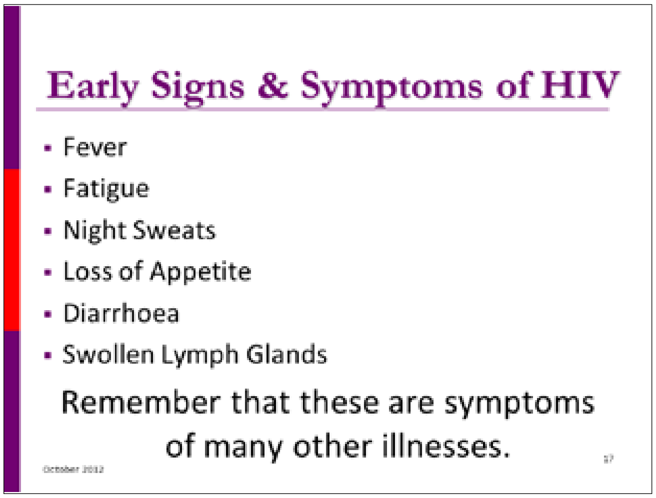
Who is most at risk for HIV?

- Anybody having sex without a condom
- People with more than one partner who don't use a condom during sex
- People whose sex partners have sex with other partners without using a condom



How You DONT Get HIV

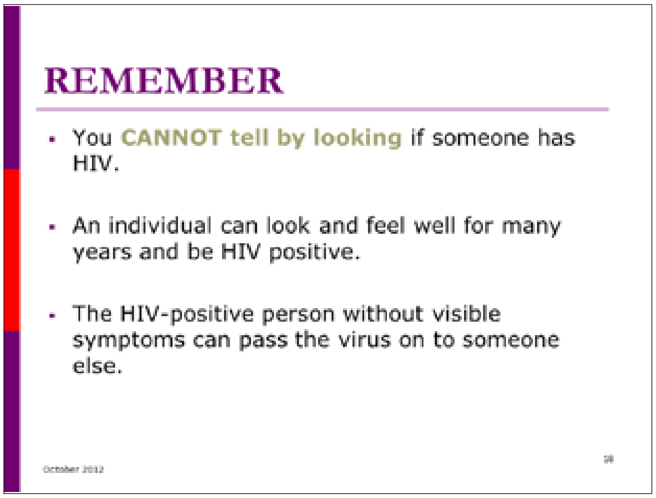
- **You CANNOT get HIV by hugging, touching, living with or caring for someone with HIV, shaking hands, or kissing.**
- **You CANNOT get HIV from eating from the same plate or cup or using utensils that an HIV-positive person uses.**



Early Signs & Symptoms of HIV

- Fever
- Fatigue
- Night Sweats
- Loss of Appetite
- Diarrhoea
- Swollen Lymph Glands

Remember that these are symptoms of many other illnesses.



REMEMBER

- You **CANNOT tell by looking** if someone has HIV.
- An individual can look and feel well for many years and be HIV positive.
- The HIV-positive person without visible symptoms can pass the virus on to someone else.

MODULE 12

Advocacy

What is in this Module?

This module builds on the elements of Positive Health, Dignity, and Prevention (PHDP) from earlier modules to create a greater understanding of policy and advocacy, as well as the process of advocating for change in relation to the elements of PHDP. This module was originally designed to use in conjunction with the module on Combination Prevention and PHDP. They can be used together or separately. The module on Combination Prevention, however, helps participants understand structural issues and their relation to policy and advocacy and PHDP.

The activities were also designed to be as practical as possible, so the module ends with participatory development of an outline for a concrete advocacy plan. There is a policy review section which must be undertaken in relation to key policy issues or documents, depending on local context (National Strategic Plans, discrimination policies, etc.). The number of participants will determine the number of groups, which then might determine the number of objectives in the plan. Some groups might work on the same objective or issue and then combine and compare their work. While the development of the plan is important (especially if this workshop is done with a homogenous group), it is most important that the participants understand the process (inputs and methodology) as well as the products.

OBJECTIVES	**By the end of this module, participants should be able to** ▪ Explain policy and advocacy, and outline the relationship between them ▪ Identify at least two key priority policy issues for PLHIV in relation to PHDP ▪ Develop the outline of an advocacy plan
TIME	Day 1—4 hours 50 minutes Day 2—8 hours 15 minutes Day 3—5 hours to 5 hours 15 minutes
ACTIVITY OVERVIEW	*Facilitator Note: This module is designed to be delivered over a three-day period. However, activities can be extracted and used on their own, depending on time and the purpose of the workshop.* **Day 1** **1.** Introduction (30 minutes) **2.** Key Concepts: Advocacy and Policy (20 minutes) **3.** Other Advocacy-related Key Concepts (2 hours) **4.** The Ecological Model (30 minutes) **5.** Policy Issues Related to HIV in Jamaica (1 hour 30 minutes) **Day 2** **6.** Day 1 Recap (15 minutes) **7.** Introduction to the Advocacy Process (45 minutes) **8.** Steps 1–2: Issue Selection and Analysis (2 hours) **9.** Step 3: Identifying Goals and Objectives Using an Advocacy Matrix (1 hour) **10.** Steps 4–5: Identifying Targets, Allies, and Resources (2 hours 30 minutes) **11.** Step 6: Creating an Action Plan (1 hour 45 minutes)

Day 3

12. Day 2 Recap (15 minutes)
13. Step 7: Creating Key Messages (3 hours)
14. Step 8: Monitoring and Evaluation (1 hour)
15. Being an Advocate: What It Means Personally (15–30 minutes)
16. Next Steps: Refining and Implementing the Plan (10 minutes)
17. Evaluation and Key Messages (20 minutes)

MATERIALS

For PowerPoint presentation

- Laptop
- Projector
- Screen
- Files

Handouts

- The Advocacy Process: Key Definitions
- Effective Representation (legitimacy)
- The Advocacy Process (diagram)
- Advocacy Framework (key steps)
- Advocacy and Related Concepts
- Example—Diagram of Targets and Allies
- Example—Advocacy Action Plan
- How to Choose Appropriate Advocacy Methods
- Methods of Monitoring and Evaluating Advocacy Work
- Key Messages—Advocacy
- Putting Learning into Action: How Can I Use What We've Done? Advocacy

Other

- Flipchart paper
- Flipchart easel
- Markers
- Nametags
- Crayons
- Small sticky notes
- Masking tape (or a system to make key concepts and 'decisions' visible during the workshop)

DAY 1

Activity 1. Introduction

OBJECTIVE	By the end of this activity, participants should be able to explain the process and expected outcomes of the module on advocacy and PHDP.
TIME	30 minutes
MATERIALS	▪ PPT slides ▪ Laptop, projector, screen **OR** ▪ Prepared flipcharts ▪ Flipchart easel

STEPS	Using a PPT or prepared flipcharts, review the following:
	▪ The goal of the workshop: To what broader change does the workshop contribute?
	▪ The specific objectives of the workshop (this module, or this module along with the module on Combination Prevention)
	  ▪ To increase understanding (on advocacy, policy, policy issues)
	  ▪ To increase skills in advocacy planning
	▪ The workshop agenda
	▪ Roles and responsibilities of the
	  ▪ Facilitators
	  ▪ Participants
	  ▪ Administrative staff
	▪ Ground rules and group dynamics
	▪ Logistical issues
	▪ Facilitator and participant expectations
	Make at least some of the steps very participatory, so that everyone has a chance to talk to the full group as well as to his/her neighbours. Work introductions into the dynamics of the steps—it could be something like “name yourself, your organisation, your city, and one thing you would like to emphasise,” or add to the ground rules or use the section on expectations for introductions.

Activity 2. Key Concepts: Advocacy and Policy

OBJECTIVE	By the end of this activity, participants should be able to define advocacy and policy and describe their relationship.

TIME	20 minutes
MATERIALS	▪ PPT slides ▪ Laptop, projector, screen **OR** ▪ Prepared flipcharts ▪ Flipchart easel ▪ Markers ▪ Flipchart paper (blank) ▪ Handout—The Advocacy Process: Key Definitions
STEPS	**1.** Ask, "What is policy?" a. You might need to prepare a few prompts or leading questions, such as: "Is a policy a document? Does this hotel where we're meeting have policies?" **2.** Write key words of responses on flipchart paper. **3.** Discuss with the participants some of the answers that might be more or less appropriate, and agree on a general definition. **4.** Show and read aloud the definition of policy from the prepared flipchart/PPT slide. **5.** Next ask the participants, "What is advocacy?" **6.** Write responses on flipchart paper. **7.** Show and read aloud the definition of advocacy from the prepared flipchart/PPT slide. **8.** Distribute the handout 'The Advocacy Process: Key Definitions.' Use it to talk about how advocacy is different from other approaches to information sharing. Emphasise that the ultimate goal of advocacy is to influence policy change. Depending on time, ask people to read it and prepare a few questions for the following morning.

Activity 3. The Ecological Model

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Describe the ecological model and show/explain how it helps people to understand how relationships are interrelated ▪ Illustrate some concrete policy issues in a person's life—someone who might be affected by those policy issues and who might affect or influence them (directly and indirectly)
TIME	30 minutes
MATERIALS	▪ PPT slides ▪ Laptop, projector, screen

MATERIALS

OR

- Prepared flipcharts
- Flipchart paper (blank)
- Flipchart easel
- Markers
- Tape

Facilitator Note: As much as possible, lay out the circles of the Ecological Model on the floor before the activity begins. 'Draw' the circles, using strips of tape arranged in concentric circles.

STEPS

1. Draw the Ecological Model on flipchart paper, as shown on a PPT slide. Introduce the model to the participants and explain that it is a tool to help people understand how people live within ranges of influence and interaction.
2. Have a discussion about recurring issues and problems for PLHIV. Establish the key pieces of a story of a particular person living with HIV, including a name.
3. Take the group to where the model is drawn on the floor. Place one person at the centre wearing a name tag of the person in the story. Review his or her situation.
4. Place some participants in the first circle around the individual; these comprise the immediate social circle of that person. These people should have name tags which describe their relationship to the central person (mother, sister, best friend, partner, etc.). Discuss issues of influence and support.
5. Place another group of participants in the community circle. Depending on the story of the central person, these might include health services personnel; geographically close individuals, such as neighbours; peers, such as co-workers, occasional friends, or partners; and key community members in the lives of the person, such as a pastor, other PLHIV, etc. Again, give each a name tag describing the relationship to the central person. Discuss the relationships and fluidity between the immediate and community circles.
6. Finally, place some participants in the society circle. These might include politicians, key bureaucrats, business people, representatives of peer organisations and networks, etc. Discuss interactions between this group and the community group regarding the issues of the person.
7. Come back to some of the issues or problems of the person—especially where health and health policy are concerned. Ask: "Who can influence the policies in question? Who can influence those individuals having influence?"
8. Try to tease out issues of direct influence as well as indirect influence and the importance of finding allies and networking. Add some specific issues that disrupt the immediate circle, such as the person being thrown out of his or her home. How does that change the circles and influencers in the life of the person?
9. Review some of the concepts from the earlier exercise, such as vulnerability and social capital, and ask participants to explain the concepts regarding the people in the circles.
10. If this exercise is done in conjunction with the Combination Prevention module, review the biological, behavioural, and structural aspects of prevention as they relate to the person and his or her social circles

Notes:.

STEPS	**11.** Make the central person the focus of a few common situations: Talk about his or her linkages to people on the outside—who can influence whom? **12.** Use examples to show how a situation relates to 'real life.' For example a. A person living with HIV has a new partner and wants to initiate a sexual encounter but is hesitant about using a condom. b. A person living with HIV is with her doctor; however, the doctor doesn't know she has HIV. She fears what will happen if she discloses her status and also fears discussing the fact that she wants a child, naturally. **13.** Ask the group to add other participants who are crucial to some element of the central person's life. Give them identifying tags. Prepare some of these ahead of time but be prepared to add to them based on suggestions from the group.

Activity 4. Other Advocacy-Related Key Concepts

OBJECTIVE	By the end of this activity, participants should be able to define and distinguish between the concepts, such as the following: **1.** Change and social change **2.** Information and evidence **3.** Analysis and synthesis **4.** Networking and decision making **5.** Social mobilisation and social capital **6.** Risk and vulnerability **7.** Lobbying and sensitising **8.** Goal (aim) and objective
TIME	2 hours
MATERIALS	■ PPT slides ■ Laptop, projector, screen **OR** ■ Prepared flipcharts ■ Flipchart easel ■ Markers ■ Flipchart paper (blank) ■ Tape *Facilitator Note: Ensure that the formal definitions of these terms are written on prepared flipcharts or a PPT before the session.*
STEPS	**1.** Divide the group into small groups of three to five people.

STEPS

2. Give each group one of the following pairs of words (either by writing on a piece of paper or telling them). Depending on the number of groups and the local policy situation, you might want to add or subtract terms.
    a. Risk and vulnerability
    b. Change and social change
    c. Information and evidence
    d. Analysis and synthesis
    e. Networking and decision making
    f. Social mobilisation and social capital
    g. Lobbying and sensitising
    h. Goal (aim) and objective (target audience)
3. Instruct each group to take 20 minutes to
    a. Explain each of the terms (give a simple everyday definition)
    b. Explain the difference or relationship between the terms
    c. Identify a person(s) to give a short report back to the large group
4. Reconvene the large group.
5. Ask each small group to make a short three-minute presentation on the words they received (definition and differences/relationship).
6. Ask for questions. Be sure to emphasise key points of distinction in the terms.
7. Distribute Handout—Important Advocacy-related Terminology.

Discuss and ensure that everyone understands the terms by clarifying the definitions using the formal definition of the terms on prepared flipcharts or a PPT. Give examples, if needed.

Activity 5. Policy Issues Related to HIV in Jamaica

OBJECTIVE

By the end of this activity, participants should be able to

- Identify two to three key policy issues and related documents
- Identify one to three priority policies for PLHIV advocacy

Facilitator Note: The policies will depend on the focus, location, and makeup of the group. In the initial workshops, for example, presentations were given on key policy issues related to stigma, discrimination, reporting and redress, and confidentiality in the healthcare system, as well as a summary of the National Workplace Policy on HIV and AIDS and the National Strategic Plan on HIV and AIDS.

TIME

1 hour 30 minutes

MATERIALS

- PPT slides
- Laptop, projector, screen

OR

- Prepared flipcharts

- Flipchart easel
- Markers
- Tape

STEPS

1. Make presentations on key policy issues and documents that have been identified by PLHIV leaders prior to the meeting, using a PPT or prepared flipcharts. If there are recent policy analysis documents that are related to the subjects at hand or relevant, then include them. Try to make the presentations short and focused: key policy issues, a key policy document, particular issues for PLHIV and PHDP.
2. For example, some of the following might be used in the context of Jamaica:
    a. National HIV Workplace Policy (2013)
    b. Health and Safety Occupational Act
    c. National Strategic Plan
    d. National Network of PLHIV Strategic Plan
    e. Report of the Stigma Index Study (2011)
    f. National HIV-related Discrimination Reporting and Redress System in Jamaica (review) (2013)
    g. Situational Analysis of Patient Confidentiality within the Public Health Care Sector (2013)
3. Prepare approximately six slides for each of the policy topics included. Depending on the group, choose three to four key policies. These might include, for example: history of a key policy document, review of key policies from an existing analysis, and a review of issues relevant to PLHIV. After each segment, ask for questions, comments, and additions.
4. At the end of the presentation, have a discussion and, as a group, identify key priority issues related to PHDP and PLHIV.

Facilitator Note: If time permits, you could begin the activity on issue selection from the next section, so participants could decide as a group their focus for the next day.

DAY 2

Activity 6. Day 1 Recap

OBJECTIVE

By the end of this activity, participants should be able to

- Define advocacy and policy
- Describe the Ecological Model and how it might be used in explaining some key concepts
- Define at least four key terms related to advocacy
- Identify at least two key policy issues for PLHIV that are related to PHDP

TIME

15 minutes

MATERIALS

None

STEPS

1. Ask one or more participants to volunteer to describe the main activities of the previous day and the key points they brought out about advocacy.
2. Prepare some leading questions to ask the group on the key points from the previous day.

Activity 7. Introduction to the Advocacy Process[1]

OBJECTIVE

By the end of this activity, participants should be able to

- Define what an advocacy issue is
- Name at least four steps in the advocacy process

TIME

45 minutes

MATERIALS

- Handouts
  The Advocacy Process (diagram)
  The Advocacy Process: Key Steps
  Advocacy and Related Concepts
- Flipchart paper (blank)
- Flipchart easel
- Markers
- Tape

STEPS

1. Green Light
2. As a group, have participants describe a real work problem they recently encountered. It does not necessarily need to be related to policy and advocacy. In one version of this exercise, the group noted that there was a need to make the National Network office friendlier, for example. Note that this is an exercise, so do not spend a great deal of time on choosing the problem.
3. Explain that this exercise is about how to brainstorm constructively and positively. Note that you will ask everyone to offer suggestions for improvement. The ground rules are basic: only constructive, positive input—there are no bad suggestions.
4. Gather ideas from the group on how to concretely solve the problem. Participants are not allowed to make any negative comments and can share only positive ‘green light’ ideas. Each person should be asked to provide the team with his or her ideas on how to solve or diminish the problem.
5. After the ideas are presented, the whole group should brainstorm for the most effective problem-solving strategy. Identify two to three concrete, simple ideas for improving the problem at hand that gain a major consensus.
6. This activity helps the team to openly communicate, formulate best practices, and draw from their core team values.

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[1] Adapted from “Networking for Policy Change: An Advocacy Training Manual” (pp. III 25–26).

Facilitator Note: This exercise could be woven into the previous part of the module. In the discussion, come back to some key points about working together and how sometimes that means creating a supportive environment for dialogue and generating new ideas and creative thinking. A brainstorming or idea-generating session benefits greatly from focusing on the positive—the 'yes, but' answer to community development communication. Begin with the positive solution-oriented ideas before moving on to criticising them.

7. If time allows, divide the group into smaller teams and give them the steps of an advocacy process in separate pieces. Ask each group to put the steps in logical order. Give them a short time to do so (10 minutes). Review the order of the steps with the groups, discussing any variants of opinion and recognising that although flexibility in advocacy is necessary, there are key steps in a process.

8. Distribute the handouts The Advocacy Process: Key Definitions and Advocacy and Related Concepts.

9. If time is limited, simply ask participants to volunteer to read the following:

   a. The steps involved in the advocacy process
   b. The definitions of the key terms
   c. How advocacy and other related concepts differ

10. Explain that the remainder of the session will involve going through the process step-by-step regarding the policy issues identified earlier—also note that steps can be taken individually and sometimes are overlapping or simultaneous.

Activity 8. Steps 1–2: Issue Selection and Analysis

OBJECTIVE

By the end of this activity, participants should be able to

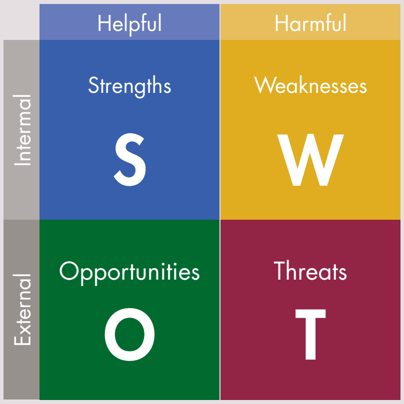
- Identify at least one issue that they want to address through advocacy
- Explain and use an analysis tool such as a Problem Tree and/or a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis

TIME

2 hours

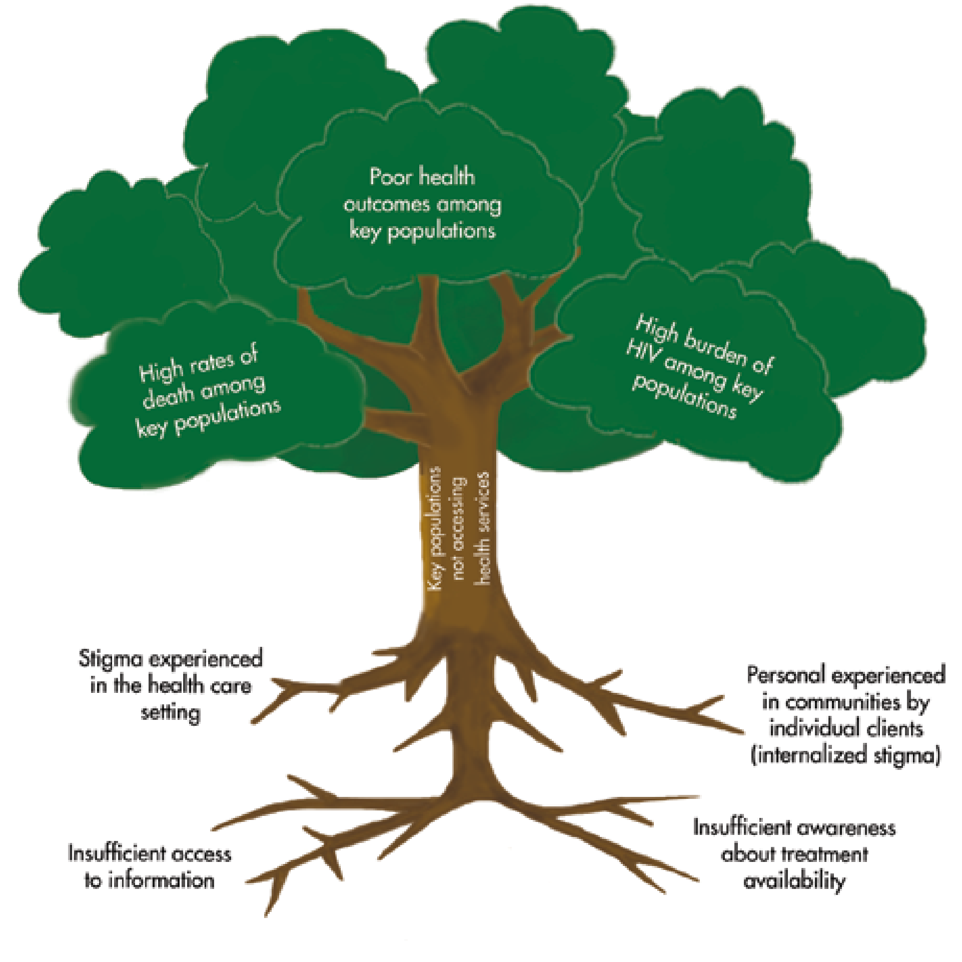
MATERIALS

Prepared Flipchart—Draw a table (similar to the one below) but with the larger letters (S, W, O, and T) removed



MATERIALS

Sample Problem Tree (for display, if needed)



STEPS

1. **Issue Selection**
   - Explain that, at the start of an advocacy process, an issue must be identified to advocate for a policy area that is most appropriate and effective as a focus for a group such as a network of PLHIV.
   - Review the issues from the day before. Instruct participants to brainstorm some of the issues on behalf of which they think it would be good to advocate.
   - Record their responses on the flipchart.
   - Explain that participants are going to rank the issues. Note that there are many ways to do this. For example, one of the most effective ways is to elicit some criteria from the group on what would help to determine priorities (e.g., relevance to the lives of PLHIV, ability of a network to influence, etc.). Then go through the list.
   - If time does not permit this, ask each participant to come up to the list and tick off the three issues that s/he feels are the highest priority or most important for PHDP and PLHIV.

- At the end of the 'voting,' tally the ticks and write the total next to each issue.
- Circle the three issues that receive the largest number of votes.
- Note that group size might mean focusing on only two issues if you have a smaller group, or perhaps expanding to four issues with a larger one. Another approach is to have groups work simultaneously on the same issue.

Facilitator Note: Review the issues to make sure they are appropriate to the work of a PLHIV network in relation to PHDP. If there is a need to narrow the number of issues, you might add the following steps:

- Explain that the next step is to narrow down or focus the issues. In the plenary, discuss the three issues in more detail, using the following questions as a guide:
  - Why is this issue important to the organisation or network at this time?
  - What are some examples of policy solutions for this issue?
  - What exactly does the issue encompass? Is there a particular aspect of the issue on which it might be more appropriate for a network of PLHIV to focus its limited resources and energy?
  - How easy or difficult will it be to build support around the issue?
  - What else is happening with respect to this issue in the external environment?
- Explain that the process is not intended to determine scientifically which issue is the most important. Instead, the purpose is to determine which issue is most crucial to the work and lives of PLHIV. Advocates are most successful when they feel a deep concern or passion for their advocacy issue.
- After each issue has been discussed, help the group reach consensus on the issue as the focus of its advocacy campaign. Remind the group that it will have the opportunity to take on other issues in the future.
- Divide the participants into smaller groups, so they can each take on an issue or an aspect of the issue and look at it in greater detail.
- Explain that there are several tools for exploring issues in a small group and that you will review a few of these.
- Explain the process of SWOT analysis and of a Problem Tree, as outlined below. Other options for analysis can be included.
- Divide the participants into smaller groups (five to eight people), each focusing on one issue. If the group is large and the number of issues small, then have more than one group focus on the same issue.

Facilitator Notes

There may be differing views about the issue or problem, so it is important to take time to discuss them and try to reach agreement. If the group has trouble agreeing, emphasise that this is primarily a learning exercise, so try to agree on something that makes sense in the short term.

Make sure that the groups focus on solutions that can be addressed through advocacy, rather than solutions that can be addressed through other methods. Refer participants to the workshop definition of advocacy.

It is optional to undertake this exercise at the end of the previous afternoon before beginning this section, so the participants have time to think about the issues over the course of the previous evening.

2. Issue Analysis

Issue Analysis: SWOT

Facilitator Note: If the advocacy involves organisational change, doing a SWOT analysis of the issue is important. It helps group members to have a better understanding of the issue for which they're advocating and what the organisation is most capable of undertaking.

- Discuss within the group the organisation's Strengths, Weaknesses, Opportunities, and Threats, as related to the issue, using a prepared flipchart.

STEPS

- Review what has been written. Ask: “Any surprises?”
- Keep the responses as information that will add to the data to be gathered as the advocacy is being monitored. They can also be used to inform the Communications Plan.

Issue Analysis: Problem Tree

- Distribute markers and a blank sheet of flipchart paper to the group.
- Explain how to create a Problem Tree using the following instructions:
  - Draw a tree large enough to fit this paper. Make sure that you draw the roots at the bottom and some branches at the top.
  - Use a concrete example of a Problem Tree, illustrating something from the lives of the participants. This does not necessarily need to deal with a health problem, but make it clear that this is an exercise to explore an issue and decide where you might want to focus. Go through the ‘problem’ with them, eliciting causes and consequences until you have a couple of steps above and below, and then talk about where one could focus for the most effect—and then where a group of PLHIV could focus to make a difference or to add their part to a change.
  - Note in this explanation that, as much as possible, it is a good idea to order the causes and consequences to see how one might lead to another, which then leads to another.
  - In the trunk, write the issue/problem that forms the basis for your exploration.
  - In the space under the roots, write as many causes of the problem/issue as possible. (If time allows, participants may also look at each cause and write down their deeper causes by connecting them with arrows/lines.)
  - In the space on the branches, write as many effects or consequences of the problem/issue as possible. (If time allows, they may also look at each effect and write down their further effects by connecting them with arrows/lines.) Try to see if there are any consequences that lead to others.
  - Review what has been written. Are there any surprises?
- Keep the responses as information that will add to the data to be gathered as the advocacy is being monitored or used to inform the Communications Plan.
- Have the groups present the results of their explorations and discuss at what level or where advocacy might be most effective and most appropriate for a network of PLHIV.
  - The objective is to identify where the advocacy might best focus its efforts—at the causal level or at the consequence level—or how to best use an organisation’s strengths or opportunities (or how to mitigate obstacles or build necessary skills in the process).

Activity 9. Identifying Goals and Objectives Using an Advocacy Matrix

OBJECTIVE

By the end of this activity, participants should be able to

- Explain the difference between a goal and an objective
- Write a goal
- Write specific advocacy objectives for advocacy work
- Begin filling in an advocacy action matrix

TIME

1 hour

OBJECTIVE

- PPT slides
- Laptop, projector, screen

OR

- Prepared flipcharts
- Flipchart easel
- Markers
- Tape

STEPS

3. Goals, objectives, and advocacy matrix

- Explain that there is a difference between a goal and an objective by reviewing the definitions from Day 1 or asking the group to explain the difference again. Use a concrete example (such as the workshop itself).
- Ask whether participants are familiar with the term 'SMART Objectives.' If they are, ask them to volunteer to explain what each letter in the acronym means: S=Specific, M=Measurable, A=Appropriate, R=Realistic, and T=Timebound. Emphasise that it is important for objectives to be SMART.
- Use the groups that were created for policy issues.
- Ask each group to draft one advocacy goal and approximately three advocacy objectives for the advocacy issue(s) on which it is focusing. The goal statement should describe a long-term, desired change related to the issue to which the work of the PLHIV network might contribute. The objectives are the changes by which the group can directly affect and contribute to the goal.
- Allow 30 minutes and ask the groups to write down their goals and objectives.
- In the plenary, ask each group to share its goal and objectives.
- Review each group's goal and objectives by using the following questions to guide the discussion:
  - Is the goal achievable through a series of policy changes? If policy change cannot contribute to achieving a particular goal, it is probably not an advocacy goal.
  - Note that people often confuse an advocacy goal or objective with a service provided by an organisation.
  - In the plenary, discuss how the clarity of the objectives will help determine the clarity of measuring results. Review the objectives according to the SMART criteria outlined above.
- Emphasise that a goal and objectives are the 'changes' the advocacy project should produce or to which it contributes.

Activity 10. Steps 4–5: Identifying Targets, Allies, and Resources

OBJECTIVE

By the end of this activity, participants should have identified and written the following for the advocacy work:

- Their target(s)
- Their allies
- Their resources

TIME

2 hours 30 minutes

MATERIALS

- Handout

Example—Diagram of Targets and Allies

- Flipchart paper (blank)
- Flipchart easel
- Markers
- Tape

STEPS

4. **Explain that it is important to identify both targets and allies for the advocacy work.**
   - Define the target: On whom do we focus our advocacy efforts?
   - Define an ally: With whom can we work in our advocacy efforts?

   Targets—Diagram[5]

   - There are many options for mapping **targets** and **allies**. It is sometimes good to visualise them for your audiences.
   - Explain to participants that they will first create a diagram to help them identify their targets. Refer back to the exercises that used the Ecological Model to help people understand that it is possible to have targets at different levels; sometimes a target becomes an ally to help with another target.
   - Instruct participants to return to their groups. Explain to them that they will write PLHIV COMMUNITY in the middle of a blank flipchart paper and draw a rectangular box around it. Then ask them to do the following:
     - Think about different groups, organisations, government departments, and individuals who can be targeted to influence the proposed changes identified in their objectives. A circle on the paper will represent each group (department, etc.) identified.
     - Before drawing, use the following criteria to best show how the target relates to their objectives:
       - Size of circle = influence on the objective
       - Distance from the objective = closeness of the relationship with the advocates
     - Pick a subject and then plot the targets as a group using a simple example.
   - Discuss the findings.

   Allies—Diagram

   - Explain to participants that they will now plot their targets and allies.
   - Instruct them to return to their groups and, using the same diagram, draw their allies within square/rectangular boxes, using the same criteria of size, distance, and thickness of line as used for the targets.

   Facilitator Note: If time permits, the groups could also explore the following for each ally:

   - What will they gain by joining in your advocacy work?
   - What can they offer to the work?
   - What are the limitations or challenges in working with this ally?
5. **Explain the importance of identifying resources.**
   - In the large group, brainstorm what kinds of resources (material, financial, human, or technological) will be needed for the work.
   - Encourage participants to be as specific as possible about what they need. Refer to the list of allies and review who might help with resources.

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[5] This exercise was developed using an advocacy process originally developed by the International Council of AIDS Service Organizations (ICASO) and used subsequently in a toolkit, "Advocacy to Action," developed by the International HIV/AIDS Alliance in cooperation with ICASO.

Targets and Allies—Matrix

- Ask participants to return to their small groups one final time.
- Distribute blank flipchart paper and markers, and instruct groups to draw a table with four columns labelled as follows:
  - Target
    - What change do we want from them?
  - Ally
    - What contribution do we want from them regarding the change above?

Facilitator Notes: Have a sample of the matrix available on flipchart paper or a PPT. One is to be done for each issue (if time allows). If time is an issue, allow each group to do at least one objective.

- After 10–30 minutes (depending on whether groups are addressing one or three objectives), ask each

Activity 11. Step 6: Creating an Action Plan

OBJECTIVE

By the end of this activity, participants should be able to identify appropriate strategies and activities for moving an Advocacy Action Plan forward.

TIME

1 hour 45 minutes

MATERIALS

- Handouts

  Example—Advocacy Action Plan

  How to Choose Appropriate Advocacy Methods
- PPT slides/prepared flipcharts—Goal, Objective, Activity: How the concepts are related
- Flipchart paper (blank)
- Flipchart easel
- Markers
- Tape

STEPS

6. **Create an advocacy plan.**
   - Do a short presentation (using the PPT ‘Goal, Objective, Activity: How the concepts are related’) on how a project’s goal, objectives, and activities relate.
   - Distribute the handout ‘How to Choose Appropriate Advocacy Methods.’
   - Read the handout or ask a volunteer to read through it, emphasising that activities should take a chosen method into consideration. If possible, hand it out prior to the meeting and have people review it at that point.
   - Ask the small groups to gather together again.
   - Show them the *Goal, Objective, Activity* bull’s-eye that shows the relationship among the goal, objectives, and activities. Emphasise that for this activity, participants are to focus on the activities they will undertake to achieve their objectives.

STEPS

- Distribute blank flipchart paper and markers, and instruct groups to draw a table with four rows labelled as follows (one is to be done for each objective):
  - Objectives
  - Key Activities
  - When
  - Who Is Responsible
- Resources needed (*Facilitator Note: Find out—do they exist or do we need to create them?*)

Objectives	Key Strategies/ Activities	Target Audience	Key Messages and Channels of Communication[6]	Timeline	Outcome Measures
	When: Who Is Responsible: Resources Needed:				

Facilitator Note: Have a sample of the matrix available on flipchart paper or a PPT.

- After 30 minutes, reconvene the large group and allow each small group to present its plans.
- Respond to questions that may arise. Emphasise the need for a network to be realistic in its planning. It's better to keep things simple and focused at the beginning.
- Distribute the handout Example—Advocacy Action Plan.

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[6] Note that Key Messages will be undertaken on Day 3.

DAY 3

Activity 12. Day 2 Recap

OBJECTIVE	**By the end of this activity, participants should be able to** ■ Name at least one criterion that helps to determine whether an issue is suitable for advocacy ■ List the eight steps involved in the advocacy process
TIME	15 minutes
MATERIALS	■ PPT slides ■ Laptop, projector, screen **OR** ■ Prepared flipcharts
STEPS	**1.** Ask one or more participants to volunteer to describe the main activities of the previous day and the key points they brought out about advocacy. **OR** **2.** Conduct a large group discussion on the key points of the previous day. Prepare some leading questions for the group, based on the discussions from the previous day.

Activity 13. Step 7: Creating Key Messages

OBJECTIVE	By the end of this activity participants should be able to identify key messages and communication channels for achieving their advocacy objectives.
TIME	3 hours
MATERIALS	■ PPT slides ■ Laptop, projector, screen **OR** ■ Prepared flipcharts
STEPS	**7.** Explain that one of the critical components of an advocacy plan is communications, centred around the key messages/ideas that support the advocacy work. *Elements of a Message* ■ What is a key message? Have a short group discussion on what constitutes a key message and what media are used to convey messages.

STEPS

- Write the following elements of a message on flipchart paper/PPT:
  - Content/ideas
  - Language
  - Messenger/source
  - Format/medium
  - Time/place
- Explain what each means (see Facilitator Notes).
- Ask the group to brainstorm a list of message media.
- Record the responses. Be sure to include such things as the following:
  - Face-to-face meetings
  - Executive briefing packets
  - Public rallies
  - Factsheets
  - Policy forums
  - Posters, fliers in public places
  - Petitions
  - Public debate
  - Press releases
  - Press conferences
  - Contests to design posters, slogans
  - Quotations or credible sources of information
- Ask the participants to think about the criteria they would use when choosing an appropriate medium. Be sure to include (and explain) the following (see Facilitator Notes):
  - Audience
  - Cost
  - Risk
  - Visibility
  - Time/place

One-minute Message—Introduction

- Introduce the elements of a one-minute message (elevator speech).

  Statement + Evidence + Example + Action Desired
- Explain what each element means.
- Read the following example:

Statement. Domestic violence against women must be stopped. Violence against women has long been tolerated and women have suffered in silence. The seriousness and scope of the problem has been ignored.

Evidence. In Jamaica,13 percent of women surveyed in the Demographic and Health Survey in 2008–9 reported experiencing physical violence by a partner.

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7. Bott S, Guedes A, Goodwin M, Mendoza JA.2012. *Violence Against Women in Latin America and the Caribbean: A comparative analysis of population-based data from 12 countries*. Washington, DC: *Pan American Health Organization*. Retrieved from http://www.paho.org/hq/index.php?option=com_content&view=article&id=8175:violence-against-women-latin-america-caribbean-comparative-analysis-population-data-from-12-countries&Itemid=1519&lang=en

Example. Our network has been supporting a woman named Maria. One year ago, Maria was successfully balancing motherhood and a career. However, she became involved with an abusive partner and her life has never been the same. Maria recently lost her job because of tardiness, and her children have been disciplined at school for aggression and misbehaviour. Maria is one of the millions of women suffering from domestic violence.

- Ask participants what is missing from the message.
- Ask for volunteers to complete the message.

One-minute Message—Practice

- Ask small group members to get together in their groups.
- Instruct them to develop a one-minute message using the four elements.
- After 30 minutes, ask each group to present its message to the specific 'audience' on which they wish to focus.
- After each presentation, lead a discussion using the following questions:
  - Was the central advocacy message clear? What was it?
  - Were you, the 'audience,' informed, persuaded, and/or moved to act?
  - What was the most effective part of the message?
  - When is it appropriate to use personal stories?
  - What, if anything, would you add or do differently?

Activity 14. Step 8: Monitoring and Evaluation

OBJECTIVE

By the end of this activity, participants should be able to

- Describe the difference between a process indicator and an outcome indicator
- Identify one outcome indicator and one process indicator per objective

TIME

1 hour

MATERIALS

- Handouts

  Methods of Monitoring and Evaluating Advocacy Work

  Advocacy Work—Monitoring and Evaluation
- PPT slides on Developing Indicators
- Laptop, projector, screen

OR

- Prepared flipcharts on Developing Indicators

STEPS

8. **Introduction—Monitoring and Evaluation**
   - Ask participants to describe the difference between monitoring and evaluation.
   - Write their responses.
   - Then write the following phrase on the flipchart to distinguish monitoring from evaluation: "We monitor activities (process) and we evaluate results (outcomes or the changes described in objectives)."

STEPS

- Point out that monitoring is a process that tracks the implementation of activities. An important monitoring question is "Did we implement the activities according to the action plan?" Evaluation is a process that assesses the results of the activities. In other words, "Did we achieve our desired results?"
- Distribute the handout Methods of Monitoring and Evaluating Advocacy Work.

Developing Indicators

- Give a presentation using prepared flipcharts or a PPT on Developing Indicators (Facilitator Notes).
- Ask the small groups to reconvene. Instruct them to develop, for each objective
    - At least one result indicator
    - At least one process indicator
- Reconvene the large group and ask participants to present their indicators.
- Evaluate them based on the criteria set out in the presentation.

Facilitator Note: Monitoring and evaluation for advocacy is often difficult, as it can be a long-term process. Sometimes it is important to break down the process into milestones that will allow for some evaluation at distinct points in the process.

Activity 15. Being an Advocate: What It Means Personally

OBJECTIVE

By the end of this activity, participants should be able to explain what being involved in advocacy work will mean for them personally.

TIME

15–30 minutes

MATERIALS

None

STEPS

1. Instruct each participant to pause and reflect on the following:
    a. What is my role in the refinement of this plan?
    b. What is my role in the implementation of this plan?
    c. What does it mean for my commitment in time?
    d. What does it mean regarding any disclosure or other issues that may arise?

Activity 16. Next Steps: Refining and Implementing the Plan

OBJECTIVES

By the end of this activity, participants should have

- Identified, in writing, who will be involved in refining the plan and their possible contributions
- Identified, in writing, who will be involved in implementing the plan, their possible contributions, and how they might get their colleagues involved
- Set the dates for follow-up to refine and implement the plan

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8. Content from Planning and Evaluation Wizard; Southgate Institute for Health, Society and Equity; online tools last updated 11 September, 2014 http://som.flinders.edu.au/FUSA/SACHRU/PEW/evalzone/whatind.htm.

TIME

10 minutes

MATERIALS

- Handout—Effective Representation (legitimacy)
- Flipchart paper
- Easel
- Markers

STEPS

1. Ask participants to indicate whether they are
    a. Willing to do follow-up on the plan as to refining it
    b. Willing to do follow-up on the plan as to implementing it
3. Write their commitments on flipchart paper.
4. Distribute the handout Effective Representation (legitimacy).
5. Discuss the main points made about effective representation.

Activity 17. Evaluation and Key Messages

OBJECTIVE

By the end of this activity, participants should be able to recall the key issues and learnings on advocacy and advocacy planning.

TIME

20 minutes

MATERIALS

Handout—Key Messages—Advocacy

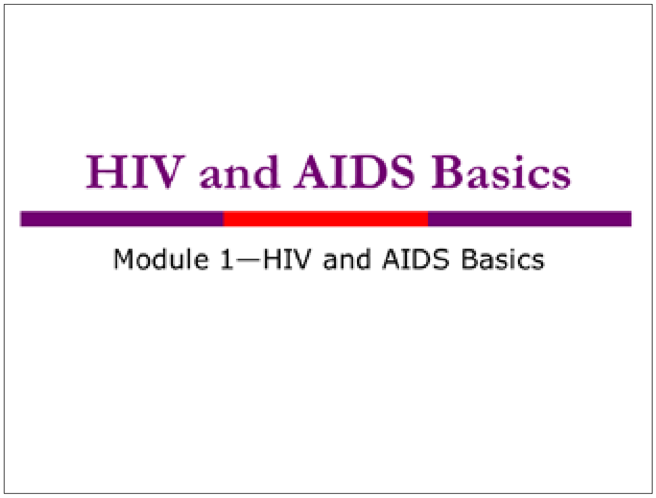
STEPS

Review of Key Messages

1. Explain that the group has finished the Advocacy module
2. Invite participants to share any further comments or reflections that they have at this time. Ask if there are any gaps in their understanding.
3. Explain that the group should conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key learnings about advocacy?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to participants' discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages—Advocacy. Ask one person to read these out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

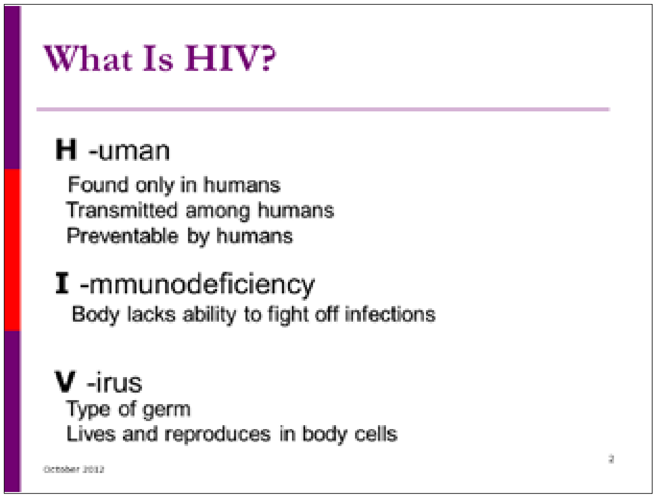
Key Messages

1. Advocacy is the deliberate process of informing and influencing decisionmakers to affect policy change or improve implementation of a particular policy.
2. Policy is a definite course of action, selected from among alternatives and in light of given conditions, to guide and determine present and future decisions.
3. Policy issues related to PHDP and living with HIV
    a. In order to undertake effective advocacy, it is necessary to focus on a particular issue (or issues) that is vital to the well-being of people living with HIV, and where PLHIV have the capacity to influence decisionmakers.
4. Advocacy process
    a. Good advocacy planning requires clear goals and objectives (the changes that you wish to contribute to or bring about), as well as clarity about target audiences and clear messages.
5. Being an advocate
    a. Sometimes, being an advocate requires a person to be subject to public scrutiny or to speak in public about personal issues such as living with HIV. Be clear about where and when you are comfortable sharing personal information.



HIV and AIDS Basics

Module 1—HIV and AIDS Basics



What Is HIV?

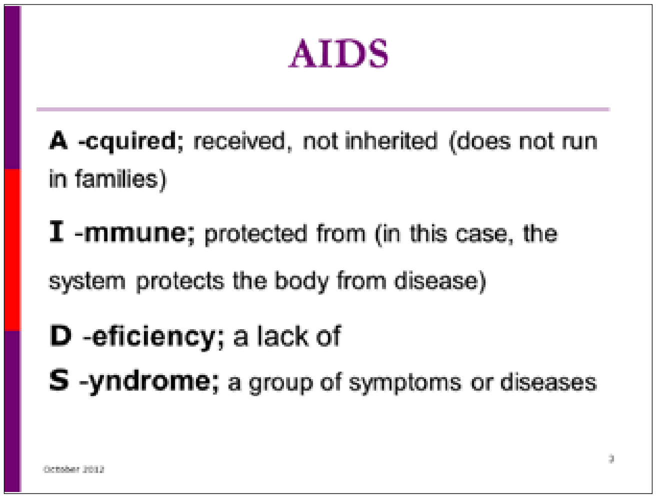
H -uman
Found only in humans
Transmitted among humans
Preventable by humans

I -mmunodeficiency
Body lacks ability to fight off infections

V -irus
Type of germ
Lives and reproduces in body cells

October 2012

2



AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases

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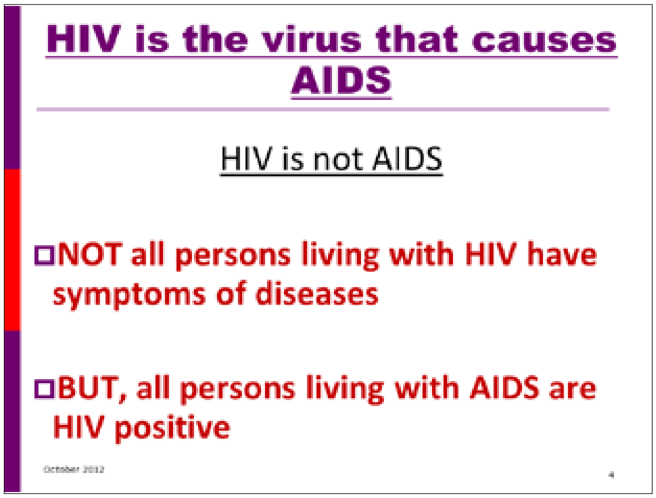

HIV is the virus that causes AIDS

HIV is not AIDS

- NOT all persons living with HIV have symptoms of diseases
- BUT, all persons living with AIDS are HIV positive

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HIV IS FOUND IN THESE BODY FLUIDS

- **Blood**
- **Semen**
- **Vaginal fluid**
- **Breast milk**

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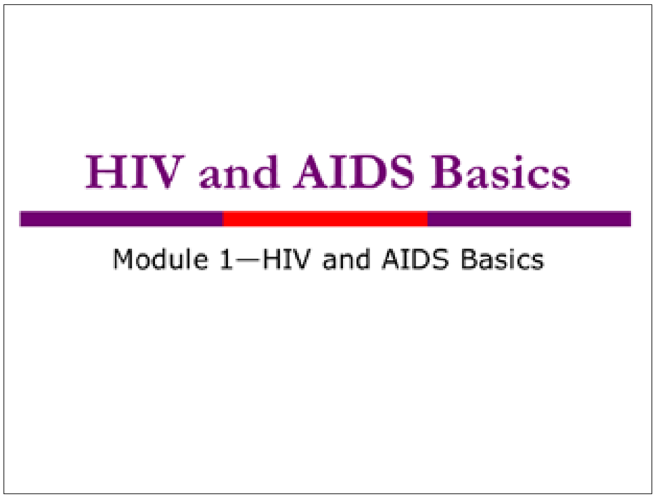

HIV and AIDS Basics

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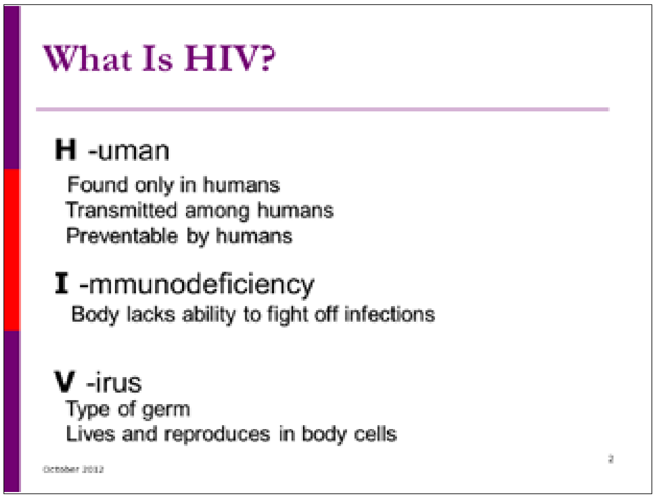

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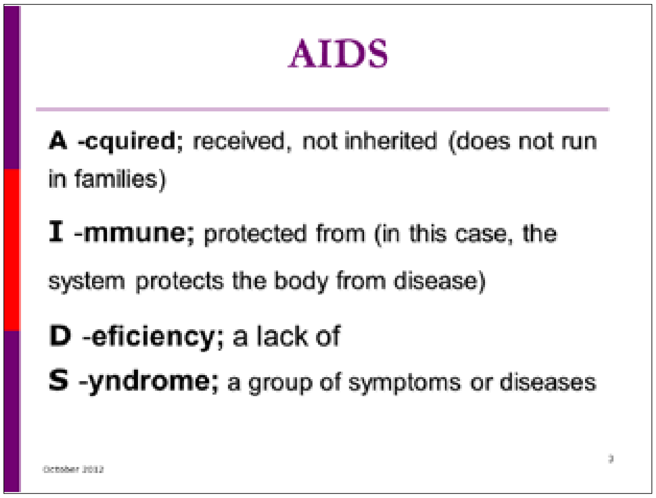

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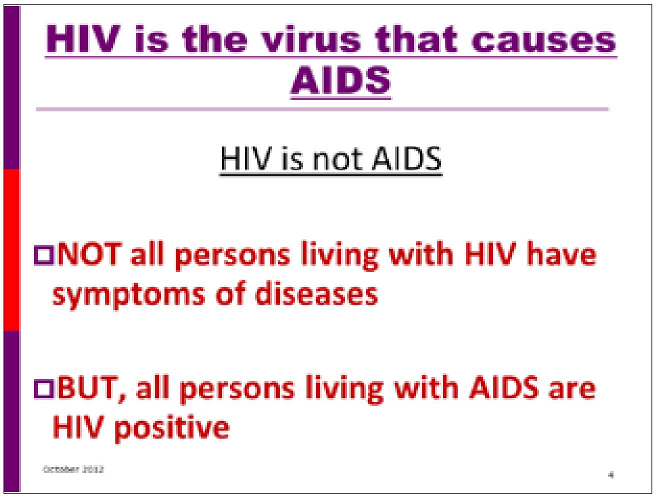

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- ☐**BUT, all persons living with AIDS are HIV positive**

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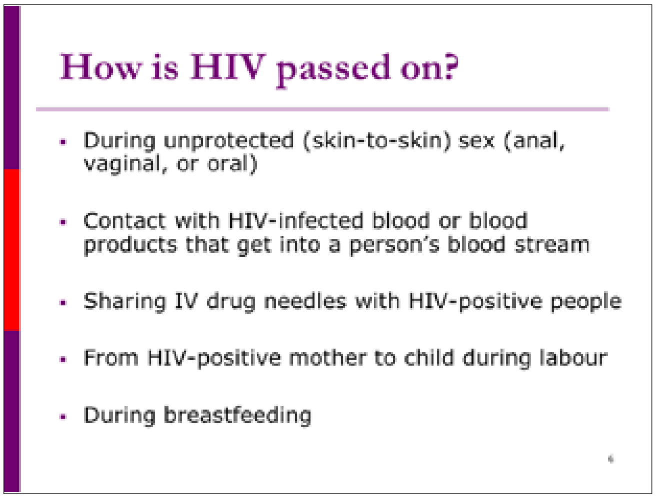

How is HIV passed on?

- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding

You CANNOT get HIV from …

- **Tears**
- **Saliva**
- **Sweat**
- **Urine**

of an HIV-infected person

Window Period

- When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- A person can be positive and the test shows negative because the test was done during the window period.

Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for .... things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles

STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
  - People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
  - HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.

ALL STIs are Preventable

Most STIs are treatable

but

HIV CANNOT BE CURED

Prevention Treatment

Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.

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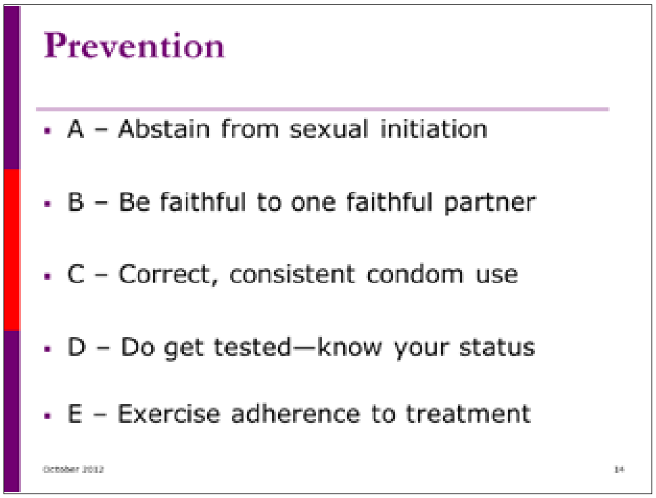

Prevention

- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment

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Who is most at risk for HIV?

- Anybody having sex without a condom
- People with more than one partner who don't use a condom during sex
- People whose sex partners have sex with other partners without using a condom

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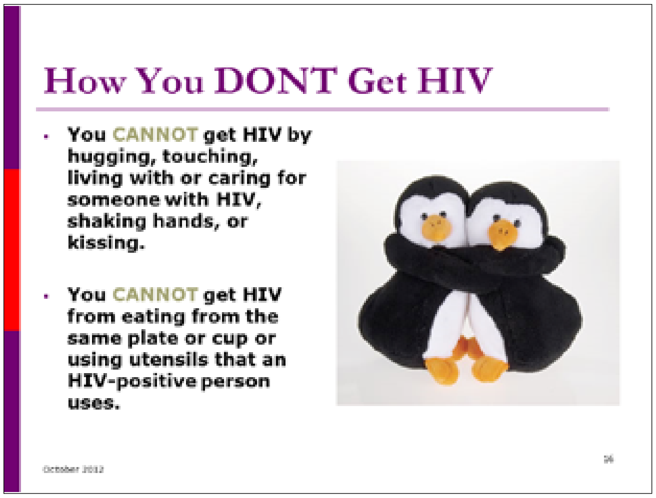

How You DONT Get HIV

- **You CANNOT get HIV by hugging, touching, living with or caring for someone with HIV, shaking hands, or kissing.**
- **You CANNOT get HIV from eating from the same plate or cup or using utensils that an HIV-positive person uses.**

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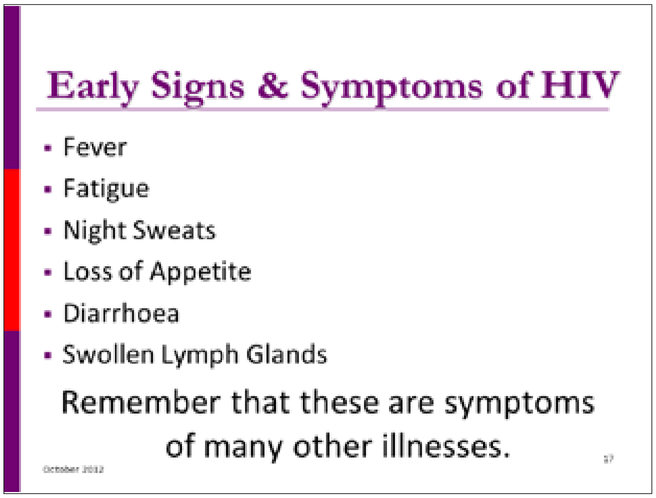

Early Signs & Symptoms of HIV

- Fever
- Fatigue
- Night Sweats
- Loss of Appetite
- Diarrhoea
- Swollen Lymph Glands

Remember that these are symptoms of many other illnesses.

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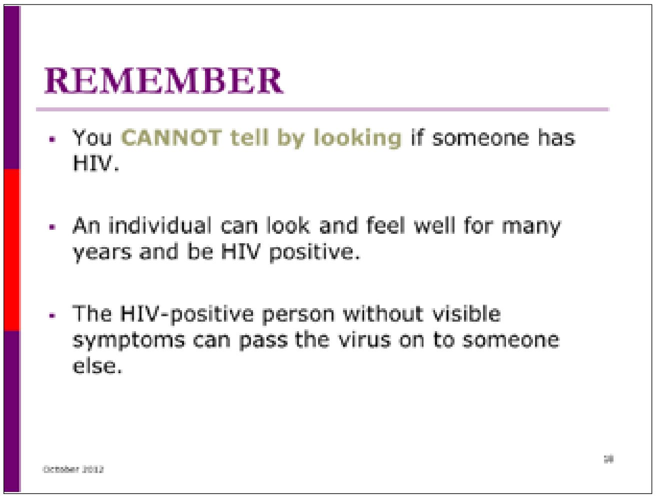

REMEMBER

- You **CANNOT tell by looking** if someone has HIV.
- An individual can look and feel well for many years and be HIV positive.
- The HIV-positive person without visible symptoms can pass the virus on to someone else.

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Getting on with Life

Can YOU support someone living with HIV?

What have we learnt?

Findings

1. Definition of confidentiality
2. What constitutes a breach
3. Provider training issues
4. Health systems considerations (six sub-headings)
5. Framework for addressing breaches
6. S&D and its connection to confidentiality
7. Effects of breaches
8. Ethical dilemmas

Recommendations

1. Leadership and Governance
   - Prepare one policy document on patient confidentiality for the health services.
   - Undertake a revision of the Client Complaint Mechanism.

Recommendations

2. Provider Training on Confidentiality
   - Explore fully the role of professional bodies in training and enforcement of the issues surrounding patient confidentiality.
   - Explore and integrate avenues of pre-service training on patient confidentiality.
   - Revise the human resources approach to orientating and sensitising new staff on the issues surrounding patient confidentiality and develop strategies to reorient existing employees on preserving and maintaining patient confidentiality.

Recommendations

3. Quality Assurance

- Develop and institute quality indicators specific to confidentiality per key groups with reporting schedules outlined for delivery in high-level leadership and governance forums.
- Ensure adherence to existing policy and procedures aimed at facilitating patient confidentiality.

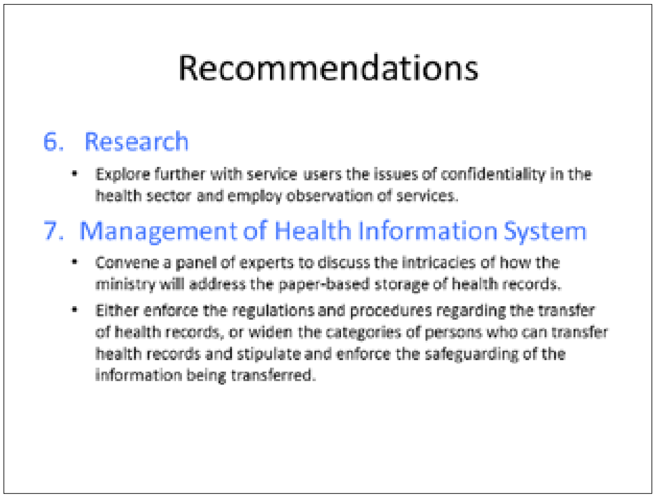
Recommendations

4. Infrastructure

- Continue infrastructural renovations to health facilities to facilitate improved privacy, particularly in A&E and pharmacy departments.

5. Regulatory Body for Advocacy and Monitoring

- Explore the establishment of an independent regulatory body to advocate, monitor, highlight, and report confidentiality concerns. Bring public attention, both local (civil society) and international, to the matter.



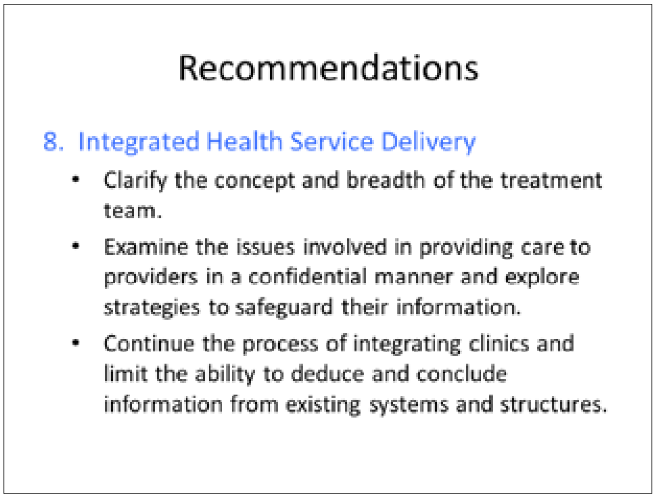
Recommendations

6. Research

- Explore further with service users the issues of confidentiality in the health sector and employ observation of services.

7. Management of Health Information System

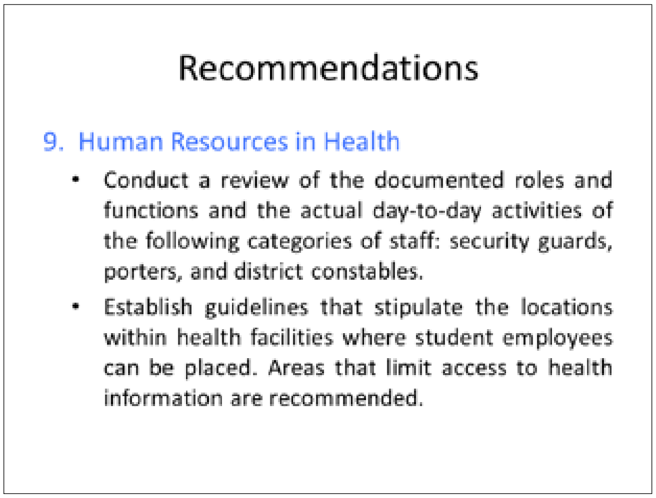
- Convene a panel of experts to discuss the intricacies of how the ministry will address the paper-based storage of health records.
- Either enforce the regulations and procedures regarding the transfer of health records, or widen the categories of persons who can transfer health records and stipulate and enforce the safeguarding of the information being transferred.



Recommendations

8. Integrated Health Service Delivery

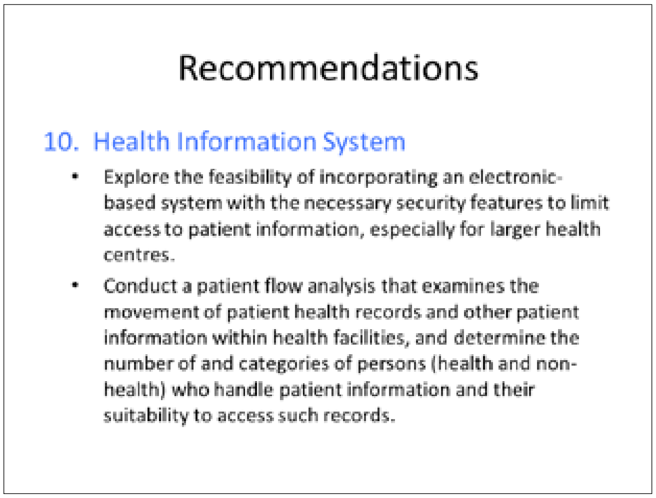
- Clarify the concept and breadth of the treatment team.
- Examine the issues involved in providing care to providers in a confidential manner and explore strategies to safeguard their information.
- Continue the process of integrating clinics and limit the ability to deduce and conclude information from existing systems and structures.



Recommendations

9. Human Resources in Health

- Conduct a review of the documented roles and functions and the actual day-to-day activities of the following categories of staff: security guards, porters, and district constables.
- Establish guidelines that stipulate the locations within health facilities where student employees can be placed. Areas that limit access to health information are recommended.



Recommendations

10. Health Information System

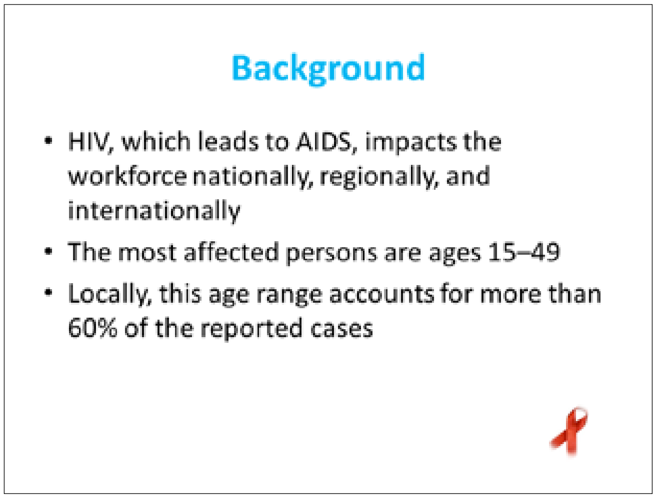
- Explore the feasibility of incorporating an electronic-based system with the necessary security features to limit access to patient information, especially for larger health centres.
- Conduct a patient flow analysis that examines the movement of patient health records and other patient information within health facilities, and determine the number of and categories of persons (health and non-health) who handle patient information and their suitability to access such records.

Workplace Policy

A Rights-based Approach to HIV and AIDS in the Workplace

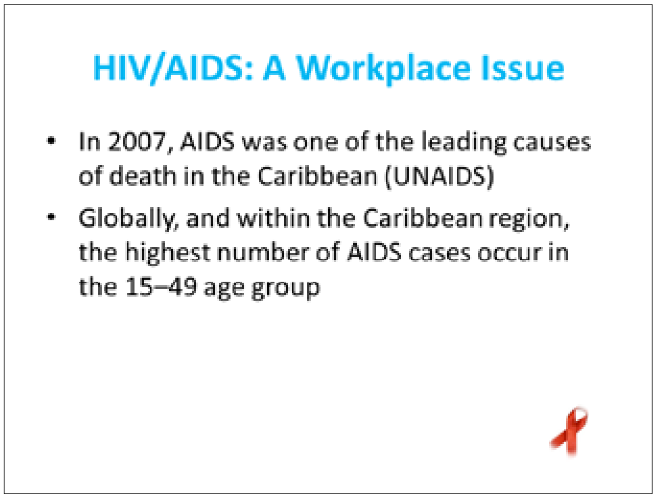
HIV Unit—Occupational Safety and Health Department

Ministry of Labour and Social Security



Background

- HIV, which leads to AIDS, impacts the workforce nationally, regionally, and internationally
- The most affected persons are ages 15–49
- Locally, this age range accounts for more than 60% of the reported cases

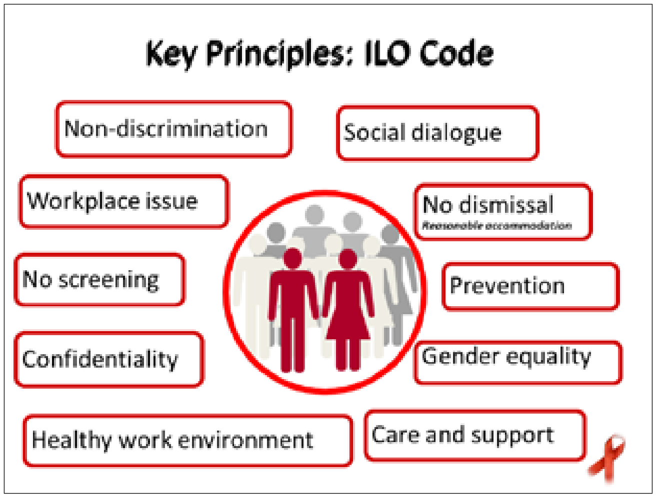


HIV/AIDS: A Workplace Issue

- In 2007, AIDS was one of the leading causes of death in the Caribbean (UNAIDS)
- Globally, and within the Caribbean region, the highest number of AIDS cases occur in the 15–49 age group

The Government's Response to HIV Led by MLSS

- In 2007, the National Workplace Policy on HIV and AIDS was developed
  - 2010—Approved as Green Paper by both Houses of Parliament
  - 2013—Approved as White Paper by both Houses of Parliament



Key Principles: ILO Code

Non-discrimination

Social dialogue

Workplace issue

No dismissal
Reasonable accommodation

No screening

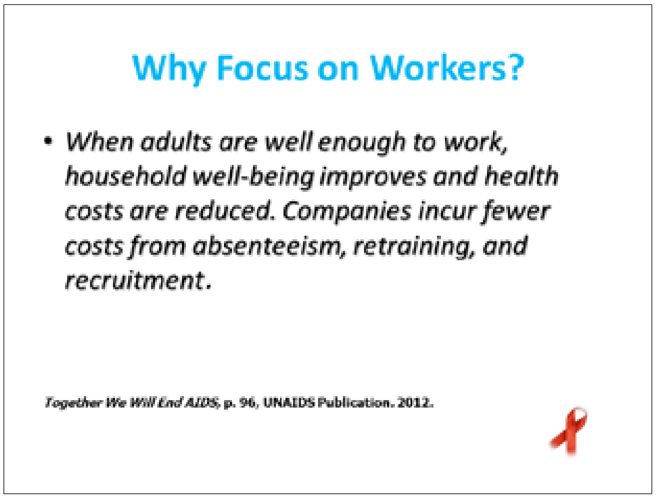
Prevention

Confidentiality

Gender equality

Healthy work environment

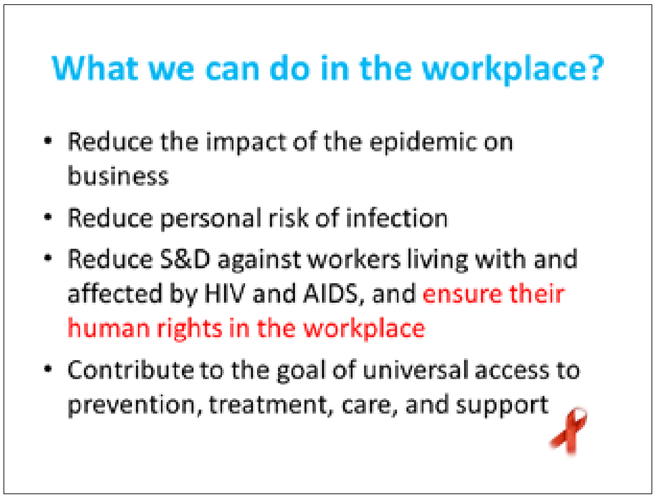
Care and support



Why Focus on Workers?

- *When adults are well enough to work, household well-being improves and health costs are reduced. Companies incur fewer costs from absenteeism, retraining, and recruitment.*

***Together We Will End AIDS*, p. 96, UNAIDS Publication. 2012.**



What we can do in the workplace?

- Reduce the impact of the epidemic on business
- Reduce personal risk of infection
- Reduce S&D against workers living with and affected by HIV and AIDS, and ensure their human rights in the workplace
- Contribute to the goal of universal access to prevention, treatment, care, and support

MODULE 13

Combination Prevention

13

What Is in This Module?

This module was designed to be used in conjunction with the module on Advocacy. It contains an overview of combination prevention; an introduction to and use of an ecological model to help understand combination prevention; and an exercise linking combination prevention to Positive Health, Dignity, and Prevention.

TIME	2 hours 50 minutes
OBJECTIVES	**By the end of this module, participants should be able to** ■ Describe steps to prevention using a Theory of Change model ■ Illustrate how the Ecological Model helps people understand their relationships with other people in their community and society ■ Define the structural, biomedical, and behavioural interventions of combination prevention, using examples ■ Describe how a Cascade of Services is linked to prevention
ACTIVITY OVERVIEW	**1.** Goal of Prevention (20 minutes) **2.** The Ecological Model (1 hour) **3.** Combination Prevention (45 minutes) **4.** Key Messages, How to Put this Module into Action, and Wrap-up (45 minutes)
MATERIALS	**Handouts** ■ Key Messages—Combination Prevention ■ Putting Learning into Action: How Can I Use What We've Done? Combination Prevention **Equipment** ■ Laptop ■ Projector ■ Screen **Other** ■ Flipchart easel ■ Flipchart paper ■ Markers ■ Pens/pencils ■ Sticky notes/name tags ■ Tape

Activity 1. Goal of Prevention

OBJECTIVE	By the end of the activity, participants should be able to describe the goals of prevention and explain that it involves a causal chain using a Theory of Change model.

TIME

20 minutes

MATERIALS

- PPT slides
- Laptop, projector, screen

OR

- Prepared flipcharts
- Flipchart easel
- Markers
- Flipchart paper (blank)
- Tape

STEPS

1. Begin by asking participants, "What is the goal of prevention?"
2. Note ideas on a flipchart or whiteboard.
3. Normally, the end project of prevention would be a decrease in new cases of transmission (decrease in incidence). It could, however, include a further step about maintaining good health.
4. Work back from the ultimate goal to develop steps for reaching that goal. Theory of Change defines long-term goals and then maps backwards to identify necessary preconditions.

5. When you have completed the steps, note that this can change slightly depending on conditions, target audience, or other factors. However, this model helps to understand the interlocking pieces of prevention.
6. Finish the discussion by showing a prepared flipchart/PPT slide on the Goals of Prevention. Talk about how these things might be put into the language of objectives and how project objectives are the elements that people can claim they helped to change in their work (attribution of change).

Activity 2. The Ecological Model

OBJECTIVE

At the end of the session, participants should be able to

- Use the ecological model to illustrate the three components of combination prevention (biological, behavioural, and structural)
- Help to illustrate issues of social mobilisation and building social capital, as well as how they can have influence people's lives and options

TIME

1 hour

MATERIALS

- PPT slides
- Laptop, projector, screen

OR

- Prepared flipcharts
- Flipchart easel
- Markers
- Flipchart paper (blank)
- Tape
- Name tags or sticky notes
- Diagram of the Ecological Model

Special Preparation

- Draw the Ecological Model diagram on the floor (if it wasn't done before) using three circles, each increasingly larger. The circles should be large enough for persons to stand within them and move around. They should also include labels like 'individual,' 'relationship,' 'community,' and 'society.' [1]
- Determine who would serve as key people in the lives of a PLHIV (directly and indirectly) and write their names or titles on name tags or sticky notes. An example list might include the following people:

1. Mother
2. Brother
3. Partner
4. Friend
5. Doctor
6. Nurse
7. Receptionist
8. Neighbour
9. Pastor
10. Friend in support group
11. Pharmacist
12. Nongovernmental organisation (NGO) representative
13. Parish counsellor
14. Head of hospital
15. Board member of clinic
16. National representative
17. MOH NAP director
18. Representative in CCM
19. Chair of JN+

STEPS

1. Ask for a volunteer to be the 'Jane/John Doe (every person)' for the model. S/he should stand in the middle of the smallest circle. Create a scenario for this person about some difficulty in their life. Discuss how biological and personal factors can influence whether a person is a victim of violence or at risk for HIV. Some of these factors include age, education level, income, use of substances, or history of sexual violence.
2. Place other people around the person inside the second circle, identifying them with badges or small cards to place on their forehead (mother, brother, partner, or friend).
    a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)
    b. Ask the other participants, "What do we learn from this circle?"
    c. Note that the second level explores close relationships and the immediate social circle of an individual.
3. Introduce the concepts of 'social capital' and 'social mobilisation,' and define them (see exercise in the Advocacy module). Say that the group should also think about these issues as the exercise continues.
4. Place people within the third circle, identifying them with badges (doctor, nurse, receptionist, neighbour, pastor, friend in support group, pharmacist, or representative of NGO).
    a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)
    b. Ask everyone else the following questions:
        i. What do we observe/learn from the people in this circle?
        ii. Ask about issues related to prevention, such as stigma and discrimination. "How do S&D impede resolution of the problem?"
        iii. How do social capital and social mobilisation affect the interactions between the 'every person' and these people?
    c. Note that this third circle explores the settings—such as workplace, school, neighbourhood, and local clinic—in which social relationships occur.
5. Place people outside the third circle, identifying them with badges (parish counsellor, head of hospital, board member of clinic, national representative, MOH NAP director, representative in CCM, or chairperson of JN+).
    a. Ask the 'every person': "What kind of influence do each of these people have in your life?" (It doesn't have to be HIV related.)
    b. Ask everyone else the following questions:
        i. What do we learn from the people in this circle?
        ii. If these people are not able to be influenced directly by the 'every person,' how could we influence people who could then influence them?
    c. This fourth circle looks at the broader social factors that help to create a climate where prevention is encouraged or inhibited.
    d. Please note that it is at this level especially that much advocacy occurs, but that some advocacy needs to happen simultaneously at the community level.
6. End the activity by asking, "What were the key lessons learned from this exercise?" Ask one of the participants to explain social capital using the circles, and how to build social capital.

Activity 3. Combination Prevention

OBJECTIVE	At the end of the session, participants should be able to name the three components of combination prevention and give two examples of each.
TIME	45 minutes
MATERIALS	■ PPT slides ■ Laptop, projector, screen **OR** ■ Prepared flipcharts ■ Flipchart easel ■ Markers ■ Flipchart paper (blank) ■ Tape ■ Diagram of the three aspects of combination prevention
MATERIALS	**1.** Make a presentation using prepared flipcharts or a PPT on combination prevention. **2.** Discuss the following questions: a. How is combination prevention linked to PHDP? b. What are some of the ways that PLHIV can intervene in terms of the following? i. Biomedical prevention ii. Behavioural prevention iii. Structural prevention c. End by saying that advocacy can involve looking at each aspect of prevention.

Activity 4. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVE	**By the end of this activity, participants should be able to** ■ Name the three components of 'combination prevention' and illustrate them with examples ■ Develop a few action steps regarding how they will use this information in their everyday lives
TIME	45 minutes
MATERIALS	**Handouts** ■ Key Messages—Combination Prevention ■ Putting Learning Into Action—Combination Prevention

STEPS

Review of Key Messages

1. Explain that the group has finished the Combination Prevention module. Note that this can be presented as a subset of the Advocacy module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that the group should conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key learnings about connecting to community?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record responses on a large flipchart.
6. Distribute the handout Key Messages: How Can I Use What We've Done? Combination Prevention. Ask one person to read them out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout for their own future reference.

How to Put this Module Into Action

1. Distribute the handout Putting Learning Into Action: How Can I Use What We've Done? Combination Prevention.
2. Ask people to complete it individually.
3. Ask select people to volunteer to share what they wrote.

Wrap-up

Thank participants for their participation.

Facilitator Notes

The Ecological Model

There are a number of different versions of ecological models, but in general, they recognise that successful activities to promote health, including HIV risk reduction, involve not only changing individual behaviours; they also involve advocacy, organisational change, policy development, economic supports, environmental change, and multi-method programs. According to this model, behaviour is determined by the following:

1. Intrapersonal factors—characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, and skills.
2. Interpersonal processes—formal and informal social network and social support systems, including the family, work group, and friendships.
3. Institutional factors—social institutions with organisational characteristics and formal and informal rules and regulations for operation.
4. Community factors—relationships among organisations, institutions, and informal networks within defined boundaries.
5. Public policy—local, state, and national laws and policies.

Interventions are more successful if they intervene within most, if not all, levels of influence. For example, distributing condoms can reduce barriers such as price and convenience, as well as change the social acceptability of carrying condoms.[1]

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[1] Retrieved from http://www.popcouncil.org/Horizons/ORToolkit/AIDSQuest/cmnbehvrtheo/ecosys.html.

Combination Prevention

I. Definition of the Prevention Area

In 2009, *The U.S. President's Emergency Plan for AIDS Relief (PEPFAR): Five Year Strategy* defined combination prevention as its major approach to HIV prevention, stating that

"Successful prevention programs require a combination of evidence-based, mutually reinforcing biomedical, behavioral, and structural interventions."

This definition was expanded upon in a 2009 meeting of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Prevention Reference Group and published in the 2010 UNAIDS Discussion Paper on combination prevention, in which combination programming was defined as

"...rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritised to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections."

II. Epidemiological Justification for the Prevention Area

The goal of combination prevention is to reduce the transmission of HIV by implementing a combination of behavioural, biological, and structural interventions that are carefully selected to meet the needs of a population. Also, because individuals' HIV prevention needs change over a lifetime, combination approaches help ensure that people have access to the types of interventions that best suit their needs at different times. Practitioners and researchers currently believe that combination approaches result in synergies in which the total effect of a set of carefully chosen interventions is greater than the sum of its parts, with a greater impact on reducing the transmission of HIV. This hypothesis, however, remains to be proven.

Prevention programmers have used various models to attempt to identify the drivers of the epidemic, provide a guide on which mix of interventions would have the greatest impact, and give strategic choices on combination prevention approaches.

Others caution against the use of models in making strategic prevention decisions, since models may provide outputs that fail to identify the key behaviours that drive an epidemic and are difficult to fit to local epidemics that are heterogeneous across different locations. Therefore, models are a tool that should always be used in conjunction with other data sources to make programmatic decisions.

The evidence base for combination prevention programming is in its infancy. However, a number of evaluations are currently being conducted to help determine the effectiveness of different combination prevention approaches. The National Institutes of Health are supporting HIV combination prevention studies in Botswana, Estonia, Lesotho, Malawi, Uganda, and in North and South America with a range of populations (e.g., men who have sex with men, people who inject drugs, serodiscordant heterosexual couples, and people of reproductive age). PEPFAR is supporting three studies, over four years, to evaluate combination prevention approaches—one in Zambia and South Africa, another in Botswana, and the last in Tanzania.

III. Core Programmatic Components

In August 2011, PEPFAR issued *Guidance for the Prevention of Sexually Transmitted HIV Infections*, and recommended a combination approach to prevention that includes three types of mutually reinforcing interventions:

1. *Biomedical interventions* are those that directly influence the biological systems through which the virus infects a new host, such as blocking infection (e.g., male and female condoms), decreasing infectiousness (e.g., ART as prevention), or reducing acquisition/infection risk (e.g., voluntary medical male circumcision).

2. *Behavioural interventions* include a range of sexual behaviour-change communication programs that use various communication channels (e.g., mass media, community-level, and interpersonal) to disseminate behavioural messages designed to encourage people to reduce behaviours that increase risk of HIV and increase protective behaviours (e.g., risks of having multiple partners and benefits of using a condom correctly and consistently). Behavioural interventions also are aimed at increasing the acceptability and demand for biomedical interventions.
3. *Structural interventions* address the critical social, legal, political, and environmental enablers that contribute to the spread of HIV. PEPFAR uses five categories to describe structural interventions: legal and policy reform, reducing stigma and discrimination against people living with HIV and marginalised groups, gender inequality and gender-based violence, economic empowerment and other multisectoral approaches, and education.

The PEPFAR guidance goes into further detail on which core interventions (i.e., prevention of mother-to-child transmission, voluntary medical male circumcision programs, condom programs, and programs for most-at-risk populations and people living with HIV) should be prioritised and implemented based on UNAIDS' 'Four Knows.' The Four Knows bases selection and scale of interventions on epidemiological evidence, country context, knowledge of other donor programs, and national strategies. Additionally, prevention strategies should be assessed through impact evaluations.

To achieve this, programmers should perform a gap analysis in their countries to determine which key drivers, geographical locations, and range of interventions are lacking, and then include those in their prevention portfolio to try to create synergy among them. To implement the interventions that would be most effective in the country's context, the questions to ask when making prevention portfolio decisions are, "How much, when, and where?"

IV. Current Status of Implementation Experience

Although the term 'combination prevention' is relatively new, the concept itself is not. Countries experiencing HIV epidemics routinely implement complex packages of prevention interventions; yet the scale, intensity, and quality of these interventions is often insufficient. Furthermore, only a minority of programs include interventions designed to address structural drivers of the epidemic. Complex and successful programs have existed for some time in concentrated epidemics, where service packages include biomedical, behavioural, and structural interventions; however, these approaches remain under-implemented and under-evaluated. Often, prevention portfolios are not adequately focused on the populations and the behaviours that actually drive the epidemic, nor are they sufficiently well implemented in the locations where the risk behaviours are most likely to occur. Interventions need to be chosen based on the complexity of behaviours within populations as well as how social and cultural norms influence sexual and health-seeking behaviours. However, current combination prevention programs are building on lessons learned and improving strategies to increase their impact on the epidemic.

A number of countries—such as South Africa, Botswana, India, Namibia, Uganda, and the Ukraine—are implementing combination prevention packages. Combination prevention is a portfolio approach for a given geographic area—whether at the national, state, district, or community level. It is not an individual implementing a partner-level approach, but involves a number of partners who contribute towards a combination prevention approach. For example, in South Africa, several studies have demonstrated a reduction in HIV incidence mostly due to increased condom use among youth and a slight reduction due to antiretroviral treatment. The decline in incidence also seems to coincide with the increase of prevention interventions in the country such as increased distribution and availability of condoms, school-based HIV life skills programs, and a large mass media serial program that depicted how positive and negative behaviours can affect health outcomes.

Social Mobilisation

Social mobilisation is a process that engages and motivates a wide range of partners and allies at national and local levels to raise awareness of and demand for a particular development objective through face-to-face dialogue. Members of institutions, community networks, civic and religious groups, and others work in a coordinated way to reach specific groups of people for dialogue with planned messages. In other words, social mobilisation seeks to facilitate change through a range of players engaged in interrelated and complementary efforts.[2]

Cascade of Services

HIV/AIDS Treatment Cascade Helps Identify Gaps in Care, Retention[4]

The HIV/AIDS treatment cascade is a model that helps to visually depict the number of people living with HIV or AIDS who are fully accessing treatment and care

This model helps to highlight and flag at each step in the cascade where individuals may 'drop off' of the cascade. Full viral suppression is not achieved if individuals are not tested, diagnosed, linked, treated, or retained in care.

These steps are all critical in order to lower the viral load in individuals, to reduce infection, transmission, sickness, and premature death.

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2. Retrieved from http://www.unicef.org/cbsc/index_42347.html.
3. Retrieved from http://blog.aids.gov/2012/07/hivaids-treatment-cascade-helps-identify-gaps-in-care-retention.html.

Key Messages—Combination Prevention

The Ecological Model shows that behaviour is determined by the following:

- Intrapersonal factors
- Interpersonal factors
- Institutional factors
- Community factors
- Public policy

The goal of prevention involves a series of steps that ultimately result in reducing the risk of transmitting HIV.

Combination prevention involves biomedical, behavioural, and structural interventions.

Other Messages

Putting Learning Into Action: How Can I Use What We've Done?

Combination Prevention

1. How can I use lessons from this module in my own personal life? Please list.

2. How might I want to share information from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)
   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

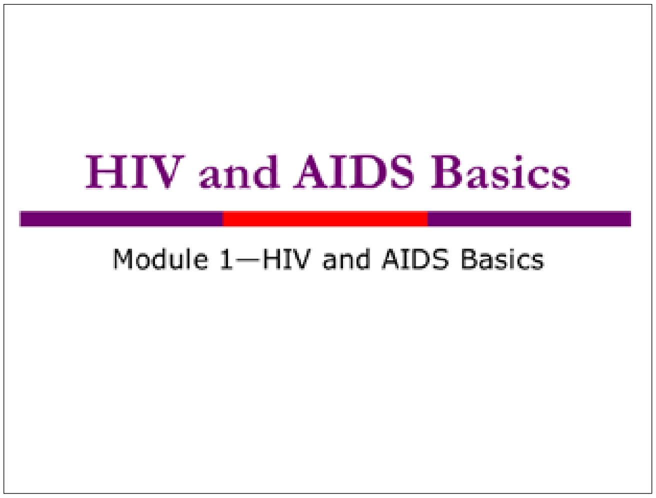
Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

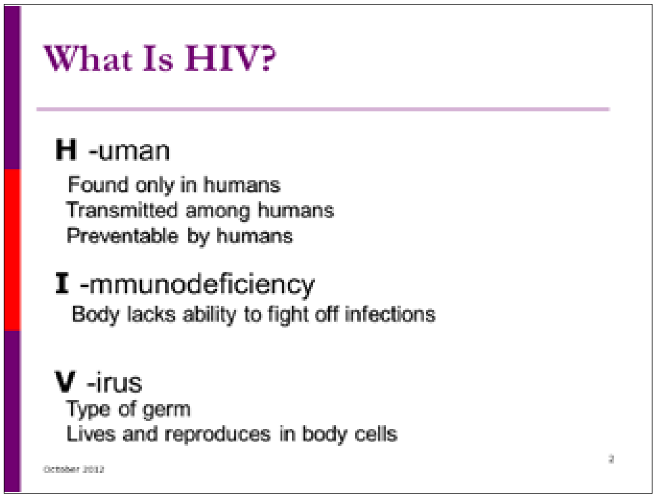
1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?



HIV and AIDS Basics

Module 1—HIV and AIDS Basics

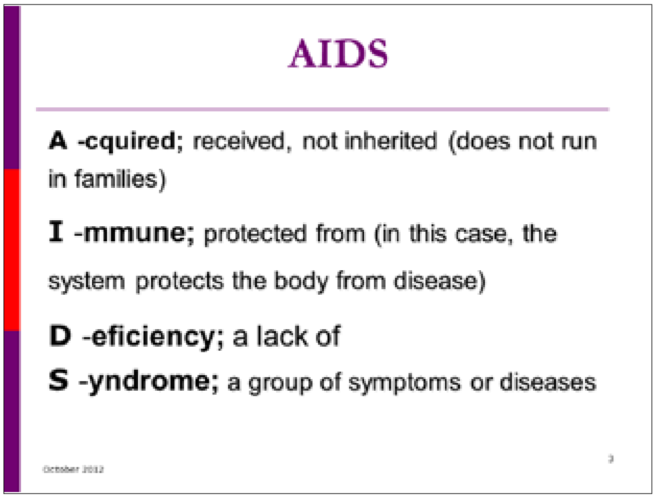


What Is HIV?

H -uman
Found only in humans
Transmitted among humans
Preventable by humans

I -mmunodeficiency
Body lacks ability to fight off infections

V -irus
Type of germ
Lives and reproduces in body cells



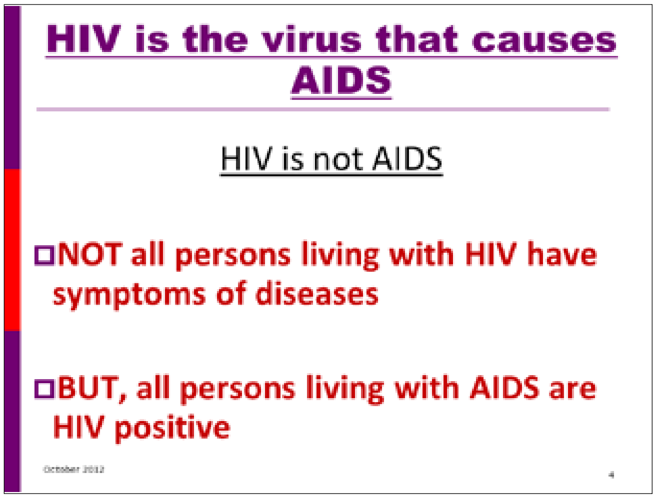
AIDS

A -cquired; received, not inherited (does not run in families)

I -mmune; protected from (in this case, the system protects the body from disease)

D -eficiency; a lack of

S -yndrome; a group of symptoms or diseases



HIV is the virus that causes AIDS

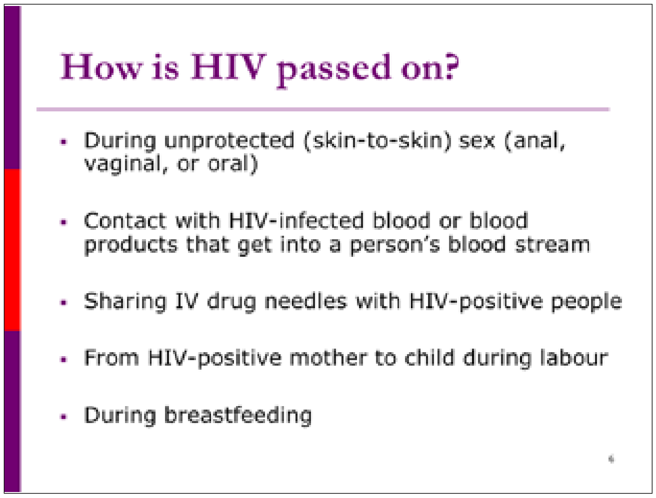
HIV is not AIDS

☐ **NOT all persons living with HIV have symptoms of diseases**

☐ **BUT, all persons living with AIDS are HIV positive**

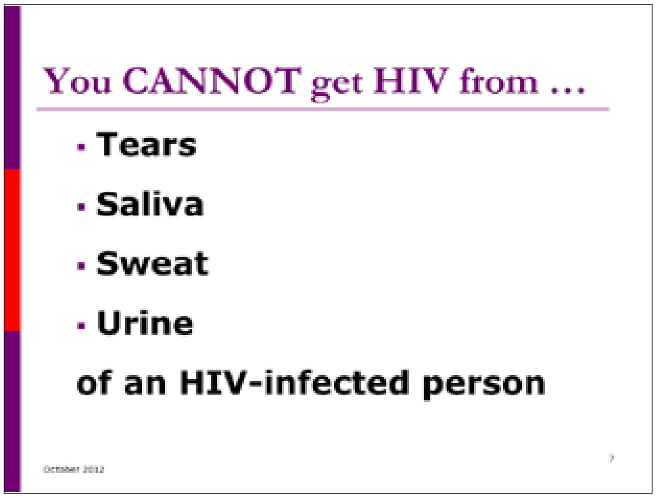
HIV IS FOUND IN THESE BODY FLUIDS

- ☐ **Blood**
- ☐ **Semen**
- ☐ **Vaginal fluid**
- ☐ **Breast milk**



How is HIV passed on?

- During unprotected (skin-to-skin) sex (anal, vaginal, or oral)
- Contact with HIV-infected blood or blood products that get into a person's blood stream
- Sharing IV drug needles with HIV-positive people
- From HIV-positive mother to child during labour
- During breastfeeding



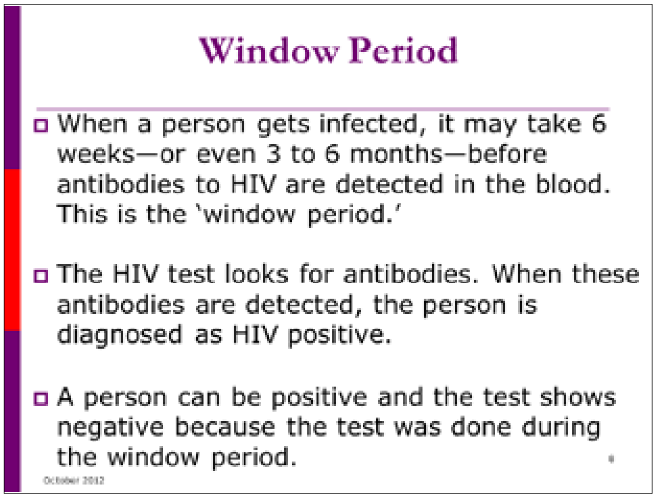
You CANNOT get HIV from …

- Tears
- Saliva
- Sweat
- Urine

of an HIV-infected person

October 2012

7



Window Period

- When a person gets infected, it may take 6 weeks—or even 3 to 6 months—before antibodies to HIV are detected in the blood. This is the 'window period.'
- The HIV test looks for antibodies. When these antibodies are detected, the person is diagnosed as HIV positive.
- A person can be positive and the test shows negative because the test was done during the window period.

October 2012

8

Why are HIV rates not going down?

- Little condom use
- Multiple partners
- Unprotected sex at an early age
- Lack of life skills and sex education
- Stigma and discrimination
- Sex for money or sex for .... things
- Substance abuse: Ganja, cocaine, alcohol
- Homophobia
- Gender inequity and gender roles

October 2012

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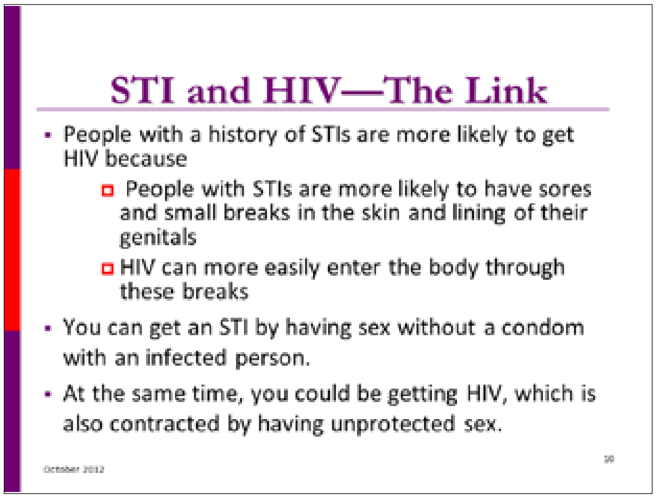

STI and HIV—The Link

- People with a history of STIs are more likely to get HIV because
  - People with STIs are more likely to have sores and small breaks in the skin and lining of their genitals
  - HIV can more easily enter the body through these breaks
- You can get an STI by having sex without a condom with an infected person.
- At the same time, you could be getting HIV, which is also contracted by having unprotected sex.

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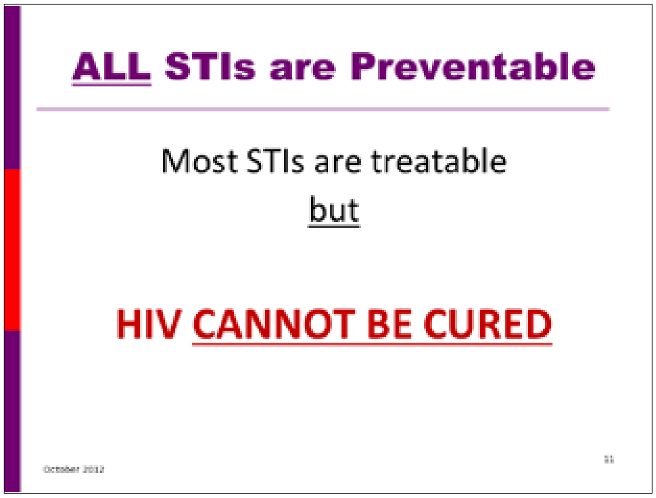


ALL STIs are Preventable

Most STIs are treatable

but

HIV CANNOT BE CURED

October 2012

11

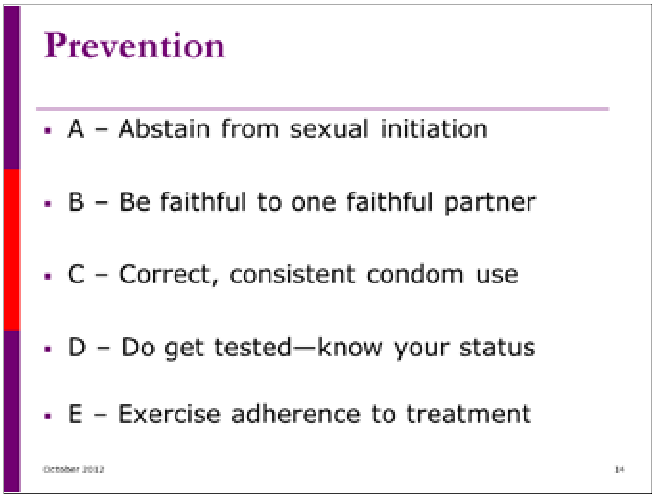
Prevention Treatment

October 2012

12

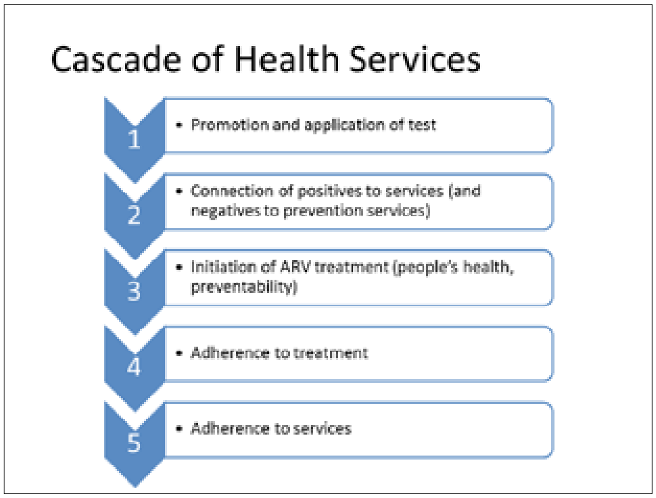
Prevention

- Talk with your partner about HIV.
- Use a condom with your regular and non-regular clients and partners every time you have sex.
- Reduce the number of sexual partners.
- Get tested. Know your status.
  - If HIV+, get treatment.



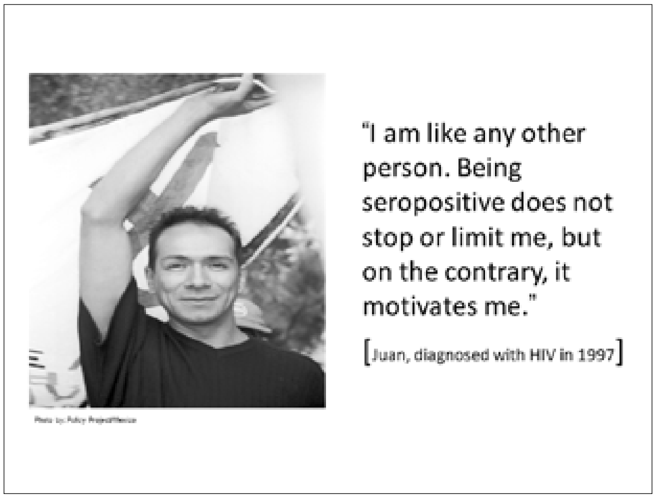
Prevention

- A – Abstain from sexual initiation
- B – Be faithful to one faithful partner
- C – Correct, consistent condom use
- D – Do get tested—know your status
- E – Exercise adherence to treatment



Cascade of Health Services

1. Promotion and application of test
2. Connection of positives to services (and negatives to prevention services)
3. Initiation of ARV treatment (people's health, preventability)
4. Adherence to treatment
5. Adherence to services



"I am like any other person. Being seropositive does not stop or limit me, but on the contrary, it motivates me."

[Juan, diagnosed with HIV in 1997]

Photo by: Policy Project/Mexico

MODULE 14

Self-Care

14

What Is in This Module?

The three activities in this module are focused on self-care. They encourage participants to honestly reflect on how they take care of themselves, particularly in their role as PLHIV leaders.

TIME	4 hours, 20 minutes
OBJECTIVES	**By the end of this module, participants should be able to** ■ Explain key elements of self-care for PLHIV ■ Assess current challenges to and supports for self-care for PLHIV and PLHIV leaders ■ Identify actions/resources that PLHIV/PLHIV leaders can take and use to promote positive health
ACTIVITY OVERVIEW	**1.** Self-Care and Self-Management (20 minutes) **2.** Self-Care among PLHIV Groups (1 hour) **3.** Taking Care of Ourselves: Self-Care as PLHIV Leaders (2 hours, 15 minutes) **4.** Key Messages, How to Put This Module Into Action, and Wrap-up (45 minutes)
MATERIALS	**For PowerPoint presentation** ■ Laptop ■ Projector ■ Screen ■ Files **Handouts** ■ Self-Care among PLHIV Groups ■ Self-Care for PLHIV Leaders: Group Work ■ Key Messages—Positive Health, Health Promotion, and Self-Care ■ Putting Learning into Action—Positive Health, Health Promotion, and Self-Care **Other** ■ Flipchart paper ■ Flipchart easel ■ Markers ■ Crayons ■ Small sticky notes ■ Masking tape

Activity 1. Self-Care and Self-Management

OBJECTIVE

By the end of this activity, participants should be able to

- Define the terms 'self-care' and 'self- management'
- Name two reasons why self-care and self-management are important for positive health

TIME

20 minutes

MATERIALS

- Prepared flipchart or PPT slide with definitions of self-care and self-management
- Flipchart paper
- Markers

STEPS

1. Introduce the activity, explaining that one key element of health promotion and access for PLHIV is how we take care of ourselves.
2. Talk about 'self-care' and 'self-management' using one of the two following methods:
   a. Brainstorming
      i. Ask participants to brainstorm what first comes to mind when they hear the term 'self-care.'
      ii. Record their words on a flipchart. Then do the same for the term 'self-management.'

   b. Tossing a Ball
      i. Say that you are going to toss a ball to someone and that s/he should say one word that comes to mind when they hear the term 'self-care.'
      ii. That person should throw the ball to another participant and s/he should do the same. Facilitator note: After the person has thrown the ball s/he should sit down. This shows that s/he has already responded to the question.
      iii. Repeat until everyone is sitting.
      iv. Record the responses on a flipchart.
3. Share the WHO definitions of these terms, noting that there is a lot of variation in how the terms are used and understood.
4. Ask one person to read each definition.

   Self-Care:

   "Self Care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals."

   —Special Working Group of the World Health Organization (WHO), 1998

   Self-Management:

   The day-to-day decisions that individuals make to manage their illnesses.
5. Facilitate a brief discussion by asking, "Are there any other ideas in the definition that can be added to the ones you've come up with?"
6. Write them on the flipchart with the words that were brainstormed earlier.

Activity 2. Self-Care Among PLHIV Groups

OBJECTIVE

By the end of this activity, participants should be able to

- Discuss the key steps, and related barriers and supports, in identifying and accessing the resources one needs for self-care
- Describe at least three distinct self-care needs among different PLHIV communities (e.g., youth, women, men, MSM, sex workers, other key populations; as well as health status)

TIME

1 hour

MATERIALS

- Handout—Self-Care among PLHIV Groups
- Flipchart paper
- Markers

STEPS

1. Give each person a copy of the handout Self-Care among PLHIV Groups.

Personal Self-Care

2. Instruct them to read the first set of questions that ask about their personal experiences.

3. After 10 minutes, go through each question and ask people to volunteer to share their answers.

Facilitator Note: Emphasise that persons are to think about themselves as they answer the questions.

Self-Care Case Studies

4. Divide participants into four groups and assign each group a particular case to consider. Give each group 20 minutes to work.

5. After 20 minutes, ask each group to report back on its work by answering the questions.

6. After all the questions have been reported back, facilitate a discussion using the following questions:

   a. How was this exercise?

   b. What strikes you about your reflections? Any surprises? New insights?

   c. What additional ideas does this provide about what self-care for positive health includes? About what's needed to support PLHIV self-care? About priority gaps?

7. Conclude the activity by asking for any final comments or questions.

Activity 3. Taking Care of Ourselves: Self-Care as PLHIV Leaders

OBJECTIVE

By the end of this activity, participants should be able to

- Explain why self-care is important to PLHIV leaders
- Identify common challenges to self-care among PLHIV leaders
- Name one action each at the individual, peer, and PLHIV network level that would support self-care among PLHIV

TIME

2 hours, 15 minutes

MATERIALS

- Flipchart paper
- Markers
- Handout—Self-Care for PLHIV Leaders: Group Work

STEPS

Defining Self-Care

1. Facilitate a discussion using the following questions:
   a. What does self-care as a PLHIV leader mean?
   b. Why does it matter?
   c. How is it similar to self-care for PLHIV? Is anything different? If so, what? Why?

Self-Care: An In-depth Review

2. Divide the group into four smaller groups.
3. Assign each group one of the scenarios.
4. Distribute the handout Self-Care for PLHIV Leaders: Group Work.
5. Read through the handout, explaining how the exercise is to be conducted.
6. Answer any questions that may arise.
7. Give the group 40 minutes to (1) answer the questions and (2) prepare their skits.
8. After 40 minutes, reconvene the large group.

Re: Challenges to Self-Care and Actions to Overcome Them

9. Instruct each group to present its flipchart with the answers to the questions and paste them to the wall, divided by question. That is, place all the flipcharts that correspond to Question 1 together, Question 2a together, etc.
10. Review the groups' responses to each question, highlighting both the similarities and differences.
11. Facilitate a group discussion using the following questions:
   a. How was it to do this exercise?
   b. Do these challenges exist among PLHIV leaders?
   c. What do you think of the possible supports to increase self-care? Which ones are easier to put into action? Harder to put into action?

Re: Challenges to Self-Care—Role Plays

12. Explain that we will now have a chance to practice some potential solutions.
13. Introduce how the role plays will work.

    Each group will present its role play one time through. Afterwards, the group will present its role play again, but this time the facilitator will clap his/her hands at key moments in the role play. When the clap happens, an audience member can choose to replace any of the role play actors and perform the role taking more supportive self-care actions.

14. Ask the groups to present their role plays.
15. After each role play, facilitate a brief discussion using the following questions:
   a. How realistic was the role play? Does this happen in real life? In what ways?
   b. What was it like to 'rehearse' other options? What was easy? Hard? Surprising?
   c. Is there any new option you noticed?

STEPS

16. At the end of all role plays, facilitate a discussion to synthesise learning, including the following:
    a. What have you learned from this exercise?
    b. What steps can we take to increase our commitment to take actions that promote self-care among PLHIV?
17. End by thanking everyone for their participation and encourage them to follow-up by 'stopping' and 'changing' to actions that promote self-care among PLHIV leaders.

Activity 4. Key Messages, How to Put This Module Into Action, and Wrap-up

OBJECTIVE

By the end of this activity, participants should be able to

- Recall the key issues and lessons on self-care
- Develop a plan of action regarding how they will use the information they have learned in their everyday lives

TIME

45 minutes

MATERIALS

- Flipchart paper
- Flipchart easel
- Markers
- Masking tape

Handouts

- Key Messages—Self-Care
- Putting Learning Into Action—Self-Care

MATERIALS

Review of Key Messages

1. Explain that we have finished the Self-Care module.
2. Invite participants to share any further comments or reflections that they have at this time.
3. Explain that we want to conclude this module by reflecting on key take-away messages.
4. Ask participants to take three minutes to discuss with a partner, "What are your key lessons about self-care?" Ask participants to note their responses so they can share them out loud.
5. After three minutes, ask for responses to people's discussions. Record the responses on a large flipchart.
6. Distribute the handout Key Messages—Self-Care. Ask one person to read it out loud.
7. Facilitate a brief discussion, recognising key messages already identified by participants, highlighting any new ones, and clarifying any questions. Invite participants to include their additional responses on the Key Messages handout, for their own future reference.

How to Put This Module Into Action

1. Distribute the handout Putting Learning into Action–Self–Care.
2. Ask participants to complete it individually.

MATERIALS	**3.** Ask for volunteers to share what they wrote. For actions that would involve any organised activity among PLHIV leaders (such as support group materials or advocacy items for the PLHIV networks), ask what some of the next steps might be for participants to move their ideas forward. **Wrap-Up** Thank participants for their participation

Self-care for PLHIV Leaders: Group Work

Part One: Challenges to Self-Care and Actions to Overcome Them

Discuss the following questions. Write your answers using four flipchart papers (one per question).

1. What are five challenges that you encounter as a PLHIV leader as you try to practice self-care?
2. What are five skills or actions that
   a. An individual PLHIV can take to promote self-care?
   b. Peers or PLHIV networks can take to promote self-care among PLHIV leaders?
   c. Other organisations and donors could take to promote self-care among PLHIV leaders?

Part Two: Challenges to Self-care—Role Plays

1. What might this person's care and support needs include?
2. How would this person know what support they might need?
3. What challenges and gaps might they face …
   a. In knowing what they need?
   b. In whether these supports are available and/or accessible?

Prepare a two-minute role play that shows a situation in which a PLHIV leader is experiencing challenges to self-care. Please be sure to include challenges to self-care from a variety of sources (self, families, peers, networks, other organisations).

Key Messages—Positive Health, Health Promotion, and Self-care

1. The Recipe for Positive Living

KNOWLEDGE + DETERMINATION TO LIVE
with actions for a
HEALTHY MIND + HEALTHY BODY + HEALTHY SOUL
= A LONG, HEALTHY LIFE

2. Positive health includes a healthy mind, healthy body, and healthy soul. These all interact with each other. Studies increasingly document what many of us have seen: our mental health affects our physical health. In turn, our physical health can affect our mental health. We need a holistic approach to health and well-being.
3. Health promotion and access for positive living requires at least four levels of strategies; each of these levels contributes to positive health, and each level depends on the others. These include the following:
    - Individual knowledge, attitudes/motivation, and skills
    - Positive relationships and psychosocial support
    - Supportive community organisations and available, accessible, high-quality, holistic health services
    - A broader enabling environment
    - Community engagement and leadership by and for PLHIV at all levels
4. Health promotion and access for PHDP and positive living rest upon and contribute to existing international and regional mandates. Some unique features or special considerations specific to positive health in the Jamaican context include [fill in based on our group reflections] …

Additional key messages or learnings include the following (please fill in, based on your own reflections and those of others. Use the back of the page if needed):

Putting Learning Into Action: How Can I Use What We've Done?

Positive Health and Health Promotion

1. How can I use information from this module in my own personal life? Please list.

2. How might I want to share learnings from this module with others? (For example, in support groups, at work, in advocacy with healthcare providers, or ...)

   a. With whom would I want to share? Please list.

   b. For each person or group with whom I would like to share, please consider the following:

Person 1 or group 1: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 2 or group 2: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

Person 3 or group 3: ________________________

1. What do I want to share?
2. How will I share the information? (For example, conversation, presentation, use of methods or materials from the curriculum, or ...)
3. If I am going to use methods or materials from the activities I've just done, what other preparation or adaptation might I need to consider?

3. What additional support or information do I want? How can I get it?

MODULE 15

Treatment Literacy

Acknowledgements

We gratefully acknowledge the creativity, commitment and technical contributions to this module. The module was drafted by Dr. Tina Hylton-Kong, with inputs from Ken Morrison in close partnership with the GIPA Unit of the Ministry of Health led by Ainsley Reid, Devon Gabourel and the PLHIV community, including "Cohort Three" and the Jamaican Network of Seropositives (JN+). Special thanks to Sara Bowsky for her technical inputs to this document.

What Is in This Module?

This module is aimed at improving treatment literacy among participants, empowering them to practice and impart to others the steps for achieving the maximal benefits of antiretroviral therapy (ART). The module is designed for adults living with HIV, not for adolescents and children. (Adaptations would be needed to serve the latter.) The module begins with exercises that allow participants to reflect upon, document, and share their experiences in their own treatment journeys, and discuss some treatment literacy successes, issues, and concerns before exploring their understanding of key definitions and concepts. This exploration is followed by brief, simple presentations and exercises on the natural history of HIV and antiretroviral therapy (ART), along with a few activities designed to demonstrate the application of the knowledge gained and explore their role in achieving the maximal benefits of ART and viral load suppression. The module ends with a review of key messages and personal reflections.

TIME	6 hours
OBJECTIVES	**By the end of this module, participants should be able to** ▪ Explain the basics of ART to enhance adherence to clinical care for themselves and confidently support others
ACTIVITY OVERVIEW	**1.** My Personal Path to Treatment (30 minutes) **2.** Treatment Literacy – Issues and Concerns (40–45 minutes) **3.** Key Concepts 1 (30 minutes) **4.** Disease Progression (40 minutes) **5.** HIV Life Cycle – How Do ARVs Work? (30 minutes) **6.** Smart About ART (45 minutes) **7.** Key Concepts 2 – Jeopardy on ART (30 minutes) **8.** Ecological Model (30 minutes) **9.** Minding the Gaps – Treatment Cascade (40 minutes) **10.** Carousel – Essential Action Stations (30 minutes) **11.** Wrap-up – Key Messages, Reflections (15 minutes)
MATERIALS	**For PowerPoint presentation** ▪ Laptop ▪ Projector ▪ Screen ▪ Files **Handouts** ▪ Key concepts for treatment literacy ▪ Jeopardy cards ▪ Summary page, Jamaican Treatment Guideline

MATERIALS

- Scenarios for ecological model
- Roles of PLHIV

Other

- Flipchart paper
- Flipchart easel
- Markers
- Light-colored sticky notes
- Masking tape

Activity 1. My Personal Path to Treatment

OBJECTIVE

By the end of this activity, participants should be able to

- Illustrate, using a flow chart, their personal treatment history from diagnosis to present
- Reflect on critical steps in their treatment journey

TIME

30 minutes

MATERIALS

For the PowerPoint presentation

- Laptop
- Projector
- Screen
- Files

Flipchart paper

Markers

Light-colored sticky paper

STEPS

1. Have flipchart paper, markers, and sticky notes for each participant
2. Make a presentation using the PowerPoint presentation on the weight loss program (or draw a flow chart on a flipchart) to explain the activity to participants
3. Instruct participants to draw a diagram (in the form of a flow chart) that outlines their personal history from diagnosis to treatment to the present
4. Display each of the diagrams on the wall for the duration of the workshop
5. As the workshop progresses, encourage participants to use sticky notes to add to their diagrams
    a. Pink – issues or problems that need to be addressed
    b. Green – things that went well and might be "good practice"
    c. Yellow – opportunities for peer support
    d. Blue – other issues or things you would like to note

Activity 2. Treatment Literacy – Issues and Concerns

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Identify common issues or concerns in ART and clinical care ▪ Define treatment literacy ▪ Identify gaps in treatment literacy
TIME	40–45 minutes
MATERIALS	▪ Flipchart paper ▪ Markers ▪ Light-colored sticky paper
STEPS	**1.** Divide the large group into smaller groups of four to five people **2.** Instruct participants to identify three to five challenges, issues, and/or concerns about treatment and its process, based on personal paths; for example: "I do not understand the doctor's explanations"; " I'm afraid to tell the doctor that I am not taking medication" **3.** Let one participant from each group write these concerns on a flipchart and post it on the wall **4.** Walk about, debrief, and provide a synthesis of specific issues relating to treatment so as to more fully discuss the definition of treatment literacy **5.** Note which issues will be covered in the workshop and which will not (issues not covered now are "parked" in the parking lot) **6.** Remind participants to review and add sticky notes to their treatment paths on the wall

Activity 3. Key Concepts 1

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Define key terms related to the HIV life cycle
TIME	30 minutes
MATERIALS	▪ For the PowerPoint presentation a. Laptop b. Projector c. Screen d. Files ▪ Flipchart paper ▪ Markers

STEPS	**1.** Divide participants into small groups (the same or different groups of four or five) **2.** Using the PowerPoint presentation Key Concepts 1, display the instructions and list of words to define, or distribute four to five concepts cut from the list printed on letter-size paper for each group **3.** Instruct them to take 10 minutes to write spontaneous, simple definitions of the concepts in their own words **4.** Call out each concept and allow each group to present its definition **5.** Compare the concepts to the definitions they provide **6.** Have a brief discussion to clarify definitions and field questions

Activity 4. Disease Progression

OBJECTIVE	**By the end of this activity, participants should be able to** ■ Review the stages of HIV infection ■ Identify the parts of the body that common opportunistic infections (OIs) affect ■ Identify the usefulness of the monitoring blood tests—CD4 count and viral load
TIME	40 minutes
MATERIALS	■ PowerPoint presentation on HIV Disease Progression ■ For the PowerPoint presentation a. Laptop b. Projector c. Screen d. Files ■ Flipchart paper with a drawing of body and OI labels ■ Markers
STEPS	**1.** Make a presentation using the PowerPoint slides on HIV Disease Progression **2.** Answer questions and comments **3.** Ask participants to work in the small groups to label the drawing of the body with an OI that affects each part of it as indicated **4.** Compare the charts and answer questions or leave them for the parking lot

Activity 5. HIV Life Cycle – How do ARVs work?

OBJECTIVE

By the end of this activity, participants should be able to

- Recognize the name and class of locally available antiretrovirals
- Describe how HIV works in the body
- List the points at which antiretrovirals work on CD4

TIME

30 minutes

MATERIALS

- For the PowerPoint presentation
  a. Laptop
  b. Projector
  c. Screen
  d. Files
- Flipchart paper
- Markers
- ARV cards

STEPS

1. Make a presentation using the PowerPoint on the HIV life Cycle
2. Answer questions and comments
3. Ask participants to work in pairs to draw the points at which the antiretrovirals work in the T cell (optional)
4. Display ARV groups (family names) at different parts of the room
5. Explain to participants that a “first name” or a “last name” is on the card and they must find their partner to complete the correct name—for example, Zido – Vudine. Then tell them to stay in that “family” group. (*Option to identify first-line and second-line therapy: find people in other families needed to result in complete combination therapy)
6. Distribute the ARV cards face down (or write the ARV name on strips of paper, fold them, and ask participants to pick one)
7. Have participants say the name when everyone has found the correct group
8. Answer questions and comments

Activity 6. Smart About ART

OBJECTIVE

By the end of this activity, participants should be able to

- Define ART
- State when to start ART
- List common side effects

OBJECTIVE	▪ Define a drug or food interaction ▪ Define IRIS ▪ Review the importance of adherence ▪ Define ARV drug resistance Explain what it means when the viral load is said to be "undetectable" ▪ Identify the importance of multidisciplinary care ▪ Describe the treatment cascade
TIME	45 minutes
MATERIALS	▪ For the PowerPoint presentation a. Laptop b. Projector c. Screen d. Files ▪ Flipchart paper ▪ Light-colored sticky paper
STEPS	**1.** Make a presentation using the PowerPoint slides prepared on Smart About ART **2.** Answer questions and comments **3.** Allow participants to reflect on and review personal treatment paths

Activity 7. Key Concepts 2 – Jeopardy on ART

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Define key terms used in ART
TIME	30 minutes
MATERIALS	▪ PowerPoint presentation Jeopardy on ART (or Jeopardy cards) ▪ For the PowerPoint presentation a. Laptop b. Projector c. Screen d. Files ▪ Jeopardy cards (optional) ▪ Flipchart paper ▪ Markers

STEPS

1. Divide participants into two teams for a game of Jeopardy
2. Give instructions for Jeopardy
3. Have a facilitator be the judge/keeper of scores
4. Make a PowerPoint presentation on Jeopardy on ART or use the jeopardy cards for the game

Activity 8. Ecological Model

OBJECTIVE

By the end of this activity, participants should be able to

- Identify the role of multidisciplinary care
- Identify the role of peer support

TIME

30 minutes

MATERIALS

- Case scenarios
- Flipchart paper for labels
- Markers
- Masking tape

STEPS

1. Ask participants to describe an ecological social model (refer to module 9, pp. 175 and 185
2. Choose a participant who will apply the ecological social model
3. Read the case scenario
4. Designate which participants are key people, based on the scenario in their immediate circle (friends, lovers, and family [FLAF]); in their community (Health and Social Services and Resources [HASSAR]); and in society (Policy Implementation, Networking Opportunities, and Monitoring [PINOM])
5. Set up the circles of the ecological model on the floor (use masking tape to delineate circles—person, entourage, community, society). Let each participant label the other participants with the role drawn from the categories of key people, using a light-colored sticky paper or masking tape with their identity written on it ("mother," for example) as they navigate the issue in the scenario
6. Use flipcharts to record the different levels
7. Debrief, pulling out key themes
8. If time allows, use a second scenario that describes a different kind of situation (i.e., the first scenario might have more to do with a personal issue in the health facility environment, whereas the second might be more about the home environment or address an issue that recurs in a health facility and needs more of a "political" intervention)

Activity 9. Minding the Gaps – Treatment Cascade

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Tabulate the conditions required to achieve the goals for each step in the cascade ▪ Propose roles PLHIV can play in achieving these goals
TIME	40 minutes
MATERIALS	▪ Flipchart paper with matrix table ▪ Flipchart or cards that define each step in cascade and the corresponding goal ▪ Markers
STEPS	**1.** Divide the larger group into smaller groups of four or five **2.** In the small groups, for each step in the cascade, identify a. What services are important in that step b. Three conditions needed to best achieve uptake for that step c. Roles PLHIV peers might undertake to help ensure that those conditions are met

Activity 10. Carousel – Essential Action Stations

OBJECTIVE	**By the end of this activity, participants should be able to** ▪ Discuss possible concrete actions to improve care
TIME	30 minutes
MATERIALS	▪ PowerPoint with questions for stations ▪ For PowerPoint presentation a. Laptop b. Projector c. Screen d. Files ▪ Flipchart paper with stations labeled ▪ File markers
STEPS	**1.** Explain the dynamics of the carousel: teams revolving around stations **2.** Divide the larger group into three teams to attend to the three stations **3.** Instruct each team to begin with one station and answer the questions. The three stations will be

STEPS

- ARV treatment and well-being
- Peer navigation and learning
- Policy monitoring and networking

Key questions for each station:

a. WHAT
   What do we need to improve this situation? What questions do we want or need answered? From health providers? From facility policymakers? From our constituents?

b. WHO/WHERE
   Who might we ask for answers? Where might we go?

c. HOW
   Three stepwise suggestions for moving forward

4. Allow 10 minutes to the first group. After that, ring a bell
5. Instruct the team to move to the next station and review what the previous team has written and make any additions or suggestions
6. After five minutes, instruct the groups to move to the next station, where they will review, comment and, if necessary, make a clean copy for a presentation
7. Post the final flipchart papers and discuss—tease out key takeaways

Activity 11. Wrap-up – Key Messages, Reflections

OBJECTIVE

By the end of this activity, participants should be able to

- Review key messages and concepts learned
- Reflect on their role in achieving the well-being of themselves and other PLHIV
- Develop a plan of action regarding how they will use this information in their everyday lives

TIME

15 minutes

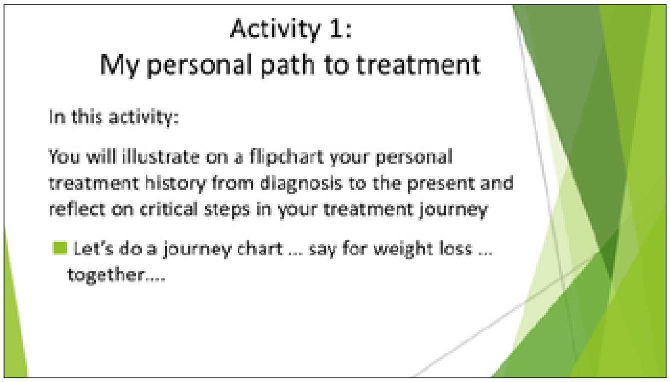
MATERIALS

- Note paper
- Flipchart
- Markers
- Handout: Key Messages

STEPS

1. Have the participants reflect on their paths to treatment based on the knowledge they have gained
2. Allow them to identify next steps in their treatment paths
3. Discuss key take-away messages, referring back to personal paths
4. Summarize points of agreement among participants about these issues: Support early diagnosis? Linkage? Retention in services? Adherence?
5. Discuss the role of PLHIV leaders in improving treatment literacy

1

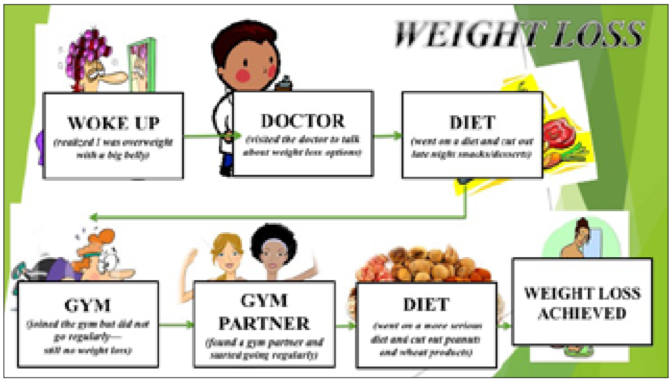


Activity 1:
My personal path to treatment

In this activity:

You will illustrate on a flipchart your personal treatment history from diagnosis to the present and reflect on critical steps in your treatment journey

- Let's do a journey chart … say for weight loss … together….



WEIGHT LOSS

WOKE UP
(realized I was overweight with a big belly)

DOCTOR
(visited the doctor to talk about weight loss options)

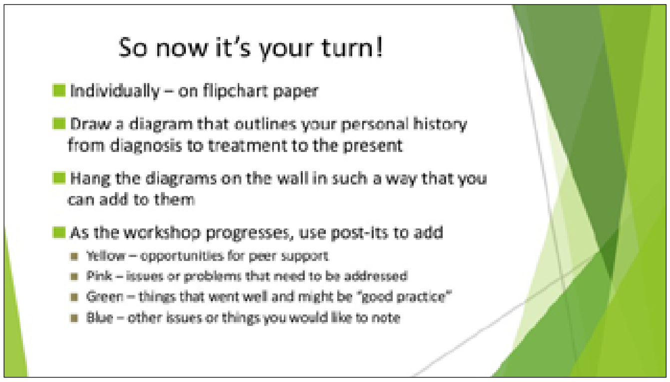
DIET
(went on a diet and cut out late night snacks/desserts)

GYM
(joined the gym but did not go regularly— still no weight loss)

GYM PARTNER
(found a gym partner and started going regularly)

DIET
(went on a more serious diet and cut out peanuts and wheat products)

WEIGHT LOSS ACHIEVED



So now it's your turn!

- Individually – on flipchart paper
- Draw a diagram that outlines your personal history from diagnosis to treatment to the present
- Hang the diagrams on the wall in such a way that you can add to them
- As the workshop progresses, use post-its to add
  - Yellow – opportunities for peer support
  - Pink – issues or problems that need to be addressed
  - Green – things that went well and might be "good practice"
  - Blue – other issues or things you would like to note

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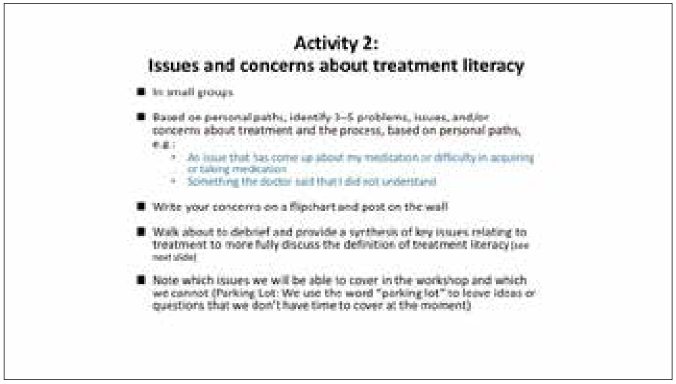
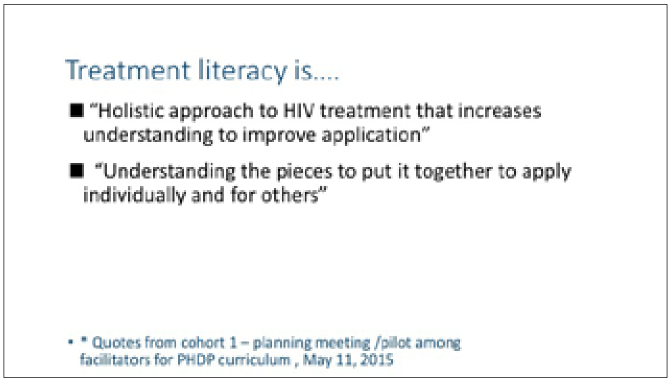
Activity 2:
Issues and concerns about treatment literacy



Activity 2:
Issues and concerns about treatment literacy

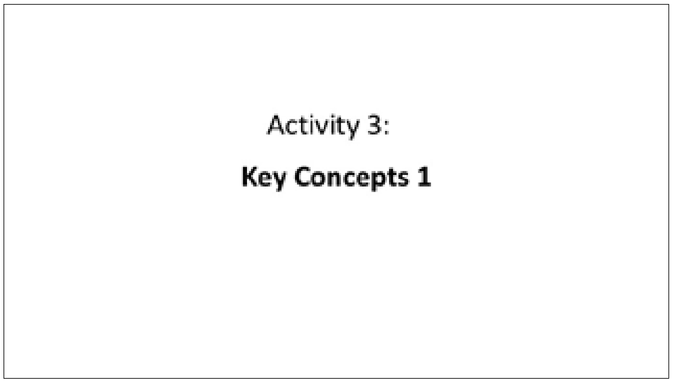
- In small groups
- Based on personal paths, identify 3–5 problems, issues, and/or concerns about treatment and the process, based on personal paths, e.g.:
  - An issue that has come up about my medication or difficulty in acquiring or taking medication
  - Something the doctor said that I did not understand
- Write your concerns on a flipchart and post on the wall
- Walk about to debrief and provide a synthesis of key issues relating to treatment to more fully discuss the definition of treatment literacy (see next slide)
- Note which issues we will be able to cover in the workshop and which we cannot (Parking Lot: We use the word "parking lot" to leave ideas or questions that we don't have time to cover at the moment)



Treatment literacy is….

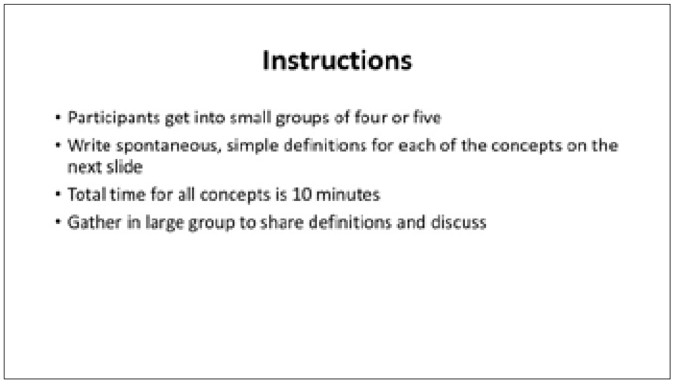
- "Holistic approach to HIV treatment that increases understanding to improve application"
- "Understanding the pieces to put it together to apply individually and for others"

- * Quotes from cohort 1 – planning meeting /pilot among facilitators for PHDP curriculum , May 11, 2015



Activity 3:

Key Concepts 1

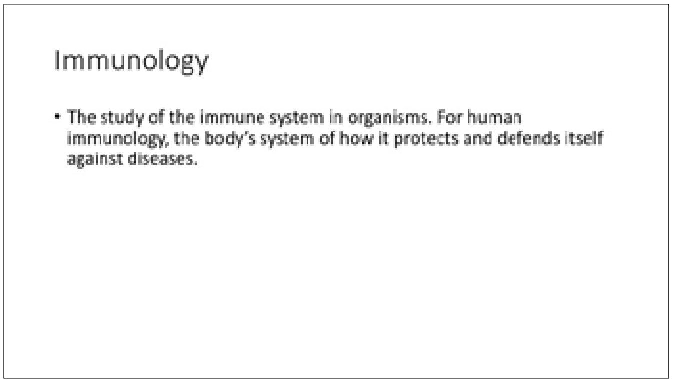


Instructions

- Participants get into small groups of four or five
- Write spontaneous, simple definitions for each of the concepts on the next slide
- Total time for all concepts is 10 minutes
- Gather in large group to share definitions and discuss

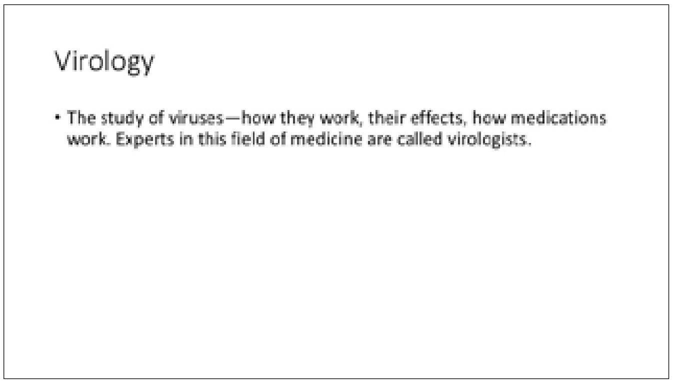
Concepts

- Immunology
- Virology
- Retrovirus
- Antiretroviral (ARV)
- Antiretroviral therapy/treatment (ART)



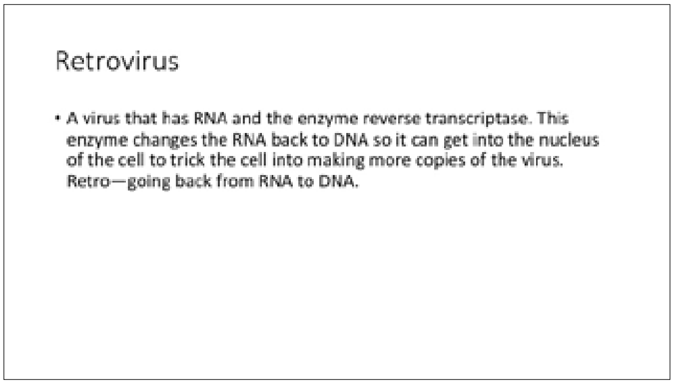
Immunology

- The study of the immune system in organisms. For human immunology, the body's system of how it protects and defends itself against diseases.



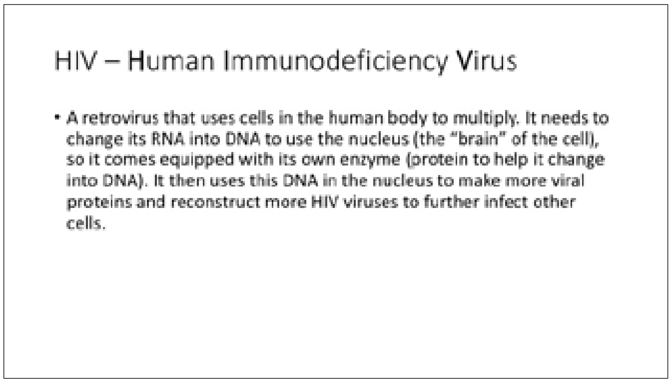
Virology

- The study of viruses—how they work, their effects, how medications work. Experts in this field of medicine are called virologists.



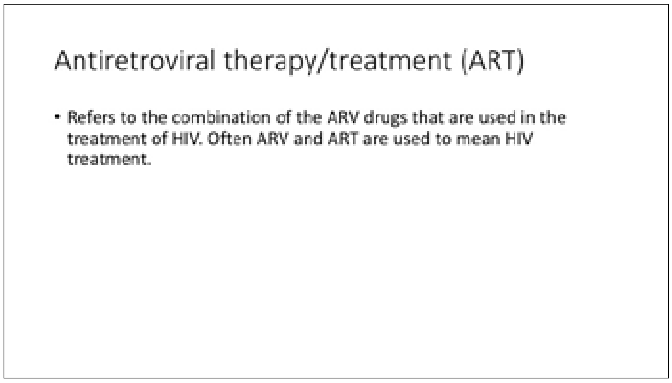
Retrovirus

- A virus that has RNA and the enzyme reverse transcriptase. This enzyme changes the RNA back to DNA so it can get into the nucleus of the cell to trick the cell into making more copies of the virus. Retro—going back from RNA to DNA.



HIV – Human Immunodeficiency Virus

- A retrovirus that uses cells in the human body to multiply. It needs to change its RNA into DNA to use the nucleus (the "brain" of the cell), so it comes equipped with its own enzyme (protein to help it change into DNA). It then uses this DNA in the nucleus to make more viral proteins and reconstruct more HIV viruses to further infect other cells.



Antiretroviral therapy/treatment (ART)

- Refers to the combination of the ARV drugs that are used in the treatment of HIV. Often ARV and ART are used to mean HIV treatment.

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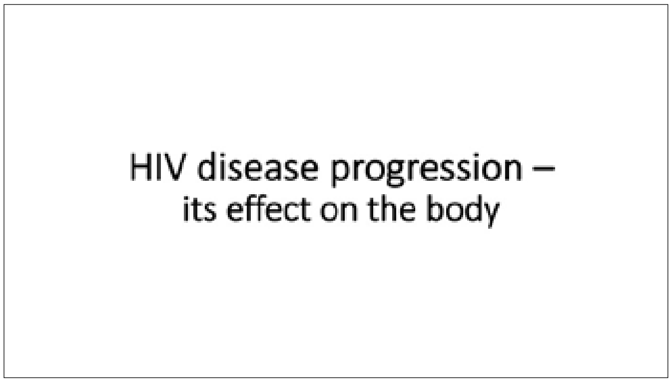
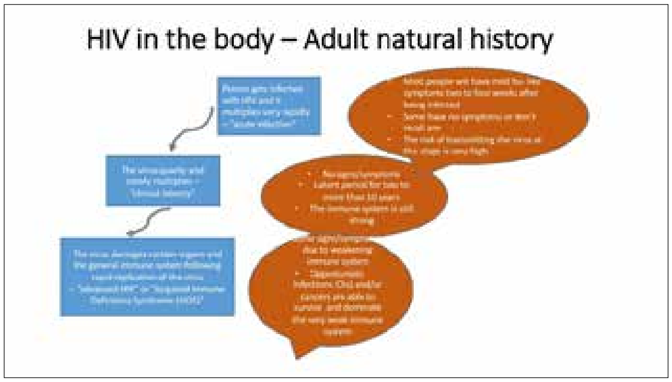


HIV disease progression – its effect on the body



HIV in the body – Adult natural history

Person gets infected with HIV and it multiplies very rapidly – "acute infection"

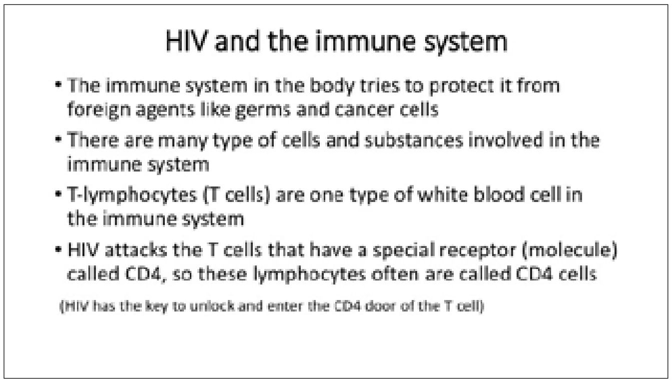
The virus quietly and slowly multiplies – "clinical latency"

The virus damages certain organs and the general immune system following rapid replication of the virus – "advanced HIV" or "Acquired Immune Deficiency Syndrome (AIDS)"

Most people will have mild flu-like symptoms two to four weeks after being infected
- Some have no symptoms or don't recall any
- The risk of transmitting the virus at this stage is very high

- No signs/symptoms
- Latent period for two to more than 10 years
- The immune system is still strong

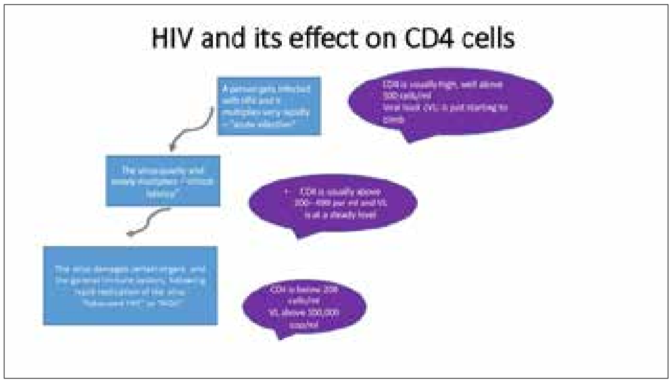
signs/symptoms due to weakening immune system
- Opportunistic infections (OIs) and/or cancers are able to survive and dominate the very weak immune system



HIV and the immune system

- The immune system in the body tries to protect it from foreign agents like germs and cancer cells
- There are many type of cells and substances involved in the immune system
- T-lymphocytes (T cells) are one type of white blood cell in the immune system
- HIV attacks the T cells that have a special receptor (molecule) called CD4, so these lymphocytes often are called CD4 cells

(HIV has the key to unlock and enter the CD4 door of the T cell)



HIV and its effect on CD4 cells

A person gets infected with HIV and it multiplies very rapidly – "acute infection"

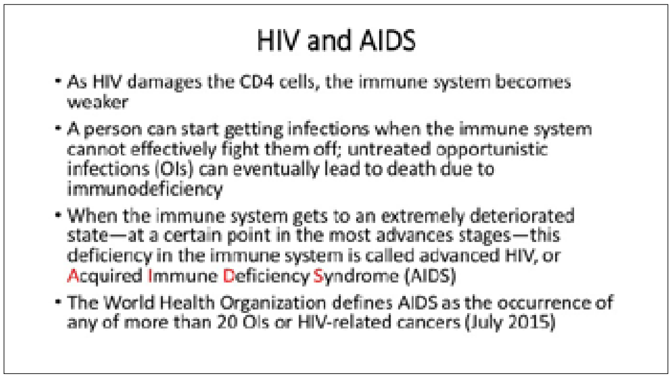
The virus quietly and slowly multiplies – "clinical latency"

The virus damages certain organs and the general immune system, following rapid replication of the virus "Advanced HIV" or "AIDS"

CD4 is usually high, well above 500 cells/ml
Viral load (VL) is just starting to climb

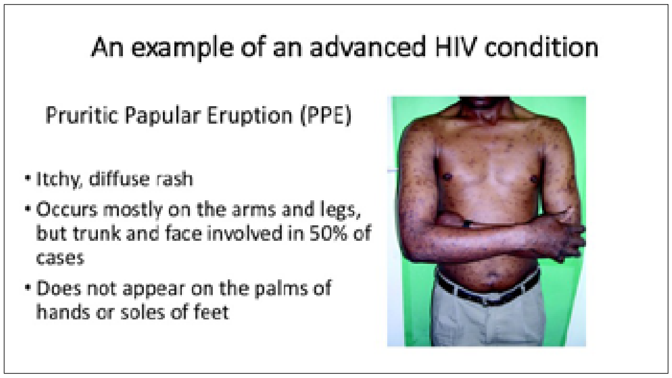
- CD4 is usually above 200–499 per ml and VL is at a steady level

CD4 is below 200 cells/ml
VL above 100,000 copies/ml



HIV and AIDS

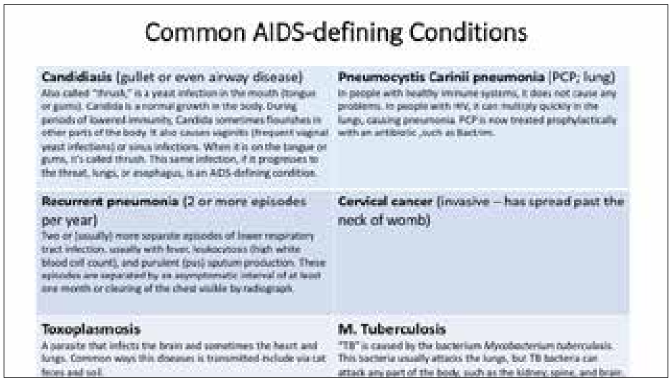
- As HIV damages the CD4 cells, the immune system becomes weaker
- A person can start getting infections when the immune system cannot effectively fight them off; untreated opportunistic infections (OIs) can eventually lead to death due to immunodeficiency
- When the immune system gets to an extremely deteriorated state—at a certain point in the most advances stages—this deficiency in the immune system is called advanced HIV, or Acquired Immune Deficiency Syndrome (AIDS)
- The World Health Organization defines AIDS as the occurrence of any of more than 20 OIs or HIV-related cancers (July 2015)



An example of an advanced HIV condition

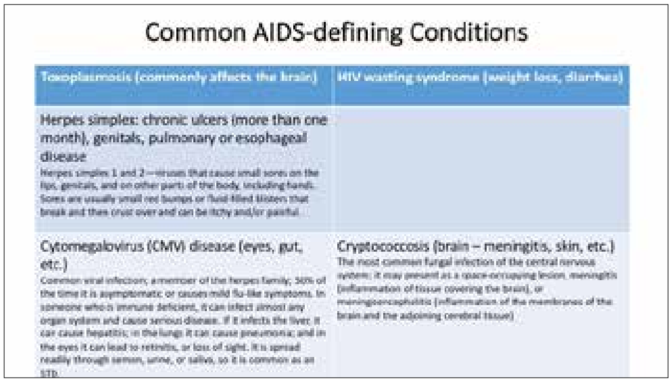
Pruritic Papular Eruption (PPE)

- Itchy, diffuse rash
- Occurs mostly on the arms and legs, but trunk and face involved in 50% of cases
- Does not appear on the palms of hands or soles of feet



Common AIDS-defining Conditions

Candidiasis (gullet or even airway disease) Also called "thrush," is a yeast infection in the mouth (tongue or gums). Candida is a normal growth in the body. During periods of lowered immunity, Candida sometimes flourishes in other parts of the body. It also causes vaginitis (frequent vaginal yeast infections) or sinus infections. When it is on the tongue or gums, it's called thrush. This same infection, if it progresses to the throat, lungs, or esophagus, is an AIDS-defining condition.	**Pneumocystis Carinii pneumonia** (PCP; lung) In people with healthy immune systems, it does not cause any problems. In people with HIV, it can multiply quickly in the lungs, causing pneumonia. PCP is now treated prophylactically with an antibiotic ,such as Bactrim.
Recurrent pneumonia (2 or more episodes per year) Two or (usually) more separate episodes of lower respiratory tract infection, usually with fever, leukocytosis (high white blood cell count), and purulent (pus) sputum production. These episodes are separated by an asymptomatic interval of at least one month or clearing of the chest visible by radiograph.	**Cervical cancer** (invasive – has spread past the neck of womb)
Toxoplasmosis A parasite that infects the brain and sometimes the heart and lungs. Common ways this diseases is transmitted include via cat feces and soil.	**M. Tuberculosis** "TB" is caused by the bacterium *Mycobacterium tuberculosis*. This bacteria usually attacks the lungs, but TB bacteria can attack any part of the body, such as the kidney, spine, and brain.

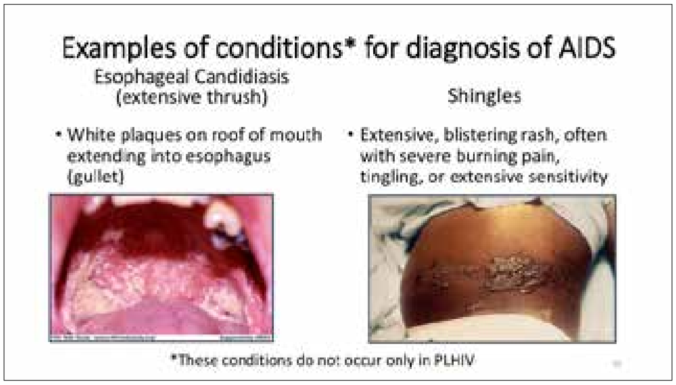


Common AIDS-defining Conditions

Toxoplasmosis (commonly affects the brain)	HIV wasting syndrome (weight loss, diarrhea)
Herpes simplex: chronic ulcers (more than one month), genitals, pulmonary or esophageal disease Herpes simplex 1 and 2—viruses that cause small sores on the lips, genitals, and on other parts of the body, including hands. Sores are usually small red bumps or fluid-filled blisters that break and then crust over and can be itchy and/or painful.	
Cytomegalovirus (CMV) disease (eyes, gut, etc.) Common viral infection; a member of the herpes family; 50% of the time it is asymptomatic or causes mild flu-like symptoms. In someone who is immune deficient, it can infect almost any organ system and cause serious disease. If it infects the liver, it can cause hepatitis; in the lungs it can cause pneumonia; and in the eyes it can lead to retinitis, or loss of sight. It is spread readily through semen, urine, or saliva, so it is common as an STD.	Cryptococcosis (brain – meningitis, skin, etc.) The most common fungal infection of the central nervous system; it may present as a space-occupying lesion, meningitis (inflammation of tissue covering the brain), or meningoencephalitis (inflammation of the membranes of the brain and the adjoining cerebral tissue)

Less Common AIDS-defining Conditions

Coccidioidomycosis (fungal infection of lungs and other organs)	Lymphomas (lymph nodes)
Cryptosporidiosis (parasitic infection of gut, causing diarrhea)	Mycobacterial disease (TB or similar germ spreading all over the body)
HIV-related encephalopathy (brain)	Salmonella (blood and gut)
Isosporiasis (parasitic infection of gut, causing diarrhea)	Progressive multifocal leukoencephalopathy (brain)
Kaposi's sarcoma (skin, internal organs)	



Examples of conditions* for diagnosis of AIDS

Esophageal Candidiasis
(extensive thrush)

- White plaques on roof of mouth extending into esophagus (gullet)

Shingles

- Extensive, blistering rash, often with severe burning pain, tingling, or extensive sensitivity

*These conditions do not occur only in PLHIV

Factors that may improve survival (delay the time to AIDS)

- Staying in HIV care
- Closely adhering to your health provider's recommendations
- Eating nutritious foods
- Taking care of yourself – exercise, rest, no cigarette smoking, no illicit drugs, safer sex
- Your genetic make-up
- Taking antiretroviral therapy

Initial and regular checks that should be done

- Weight
- Complete blood count (CBC)
- CD4 cell count
- Syphilis test
- Urine test
- Pap smear
- Blood chemistry (liver function tests, kidney function tests, blood glucose, lipids)
- Hepatitis B
- HTLV I/II *

*Human T lymphotropic virus – also retroviruses

Checks that your doctor may order to check for OI

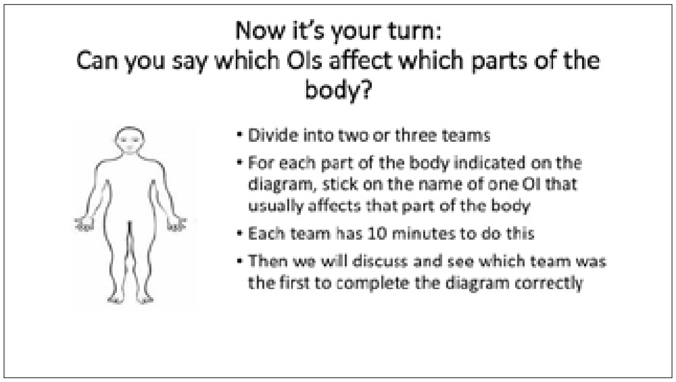
- Cytomegalovirus (CMV) antibody test
- Toxoplasma antibody test
- Skin test for latent TB infection
- Chest x-ray or other radiogram
- Dilated retinal examination (refer to eye clinic)

Prevention of opportunistic infections in Jamaica

- OI prophylaxis – Medications given to people who present when the immune system is already weak to prevent the development of an OI
- If CD4 is below 350, people should be given Cotrimoxazole (Bactrim) once daily to prevent PCP and toxoplasmosis
- If CD4 is below 50, people should be given Azithromycin once per week to prevent Mycobacterium Avium Complex (MAC)
- MAC is a type of non-tuberculous mycobacterial (NTM) infection

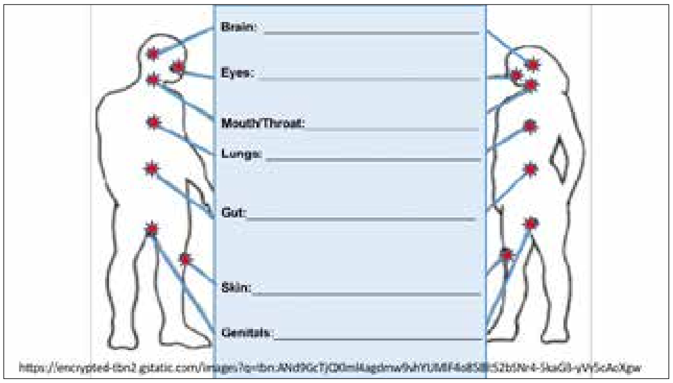
Key Points

- Some people do not have signs of HIV and may not be aware of their HIV status
- A blood test is the best way to know HIV status
- A thorough physical assessment of all body systems may uncover signs of OI, indicating that the person has AIDS
- A blood test (CD4, viral load, and others) to check the immune status is required, even if there are no signs of HIV
- Some people may need OI prophylaxis to prevent illnesses and further damage to their immune system
- Consistent use of ART maximizes supressed viral load, stops HIV progression and can prevent mother-to-child transmission and sexual transmission (PrEP) of the virus



Now it's your turn: Can you say which OIs affect which parts of the body?

- Divide into two or three teams
- For each part of the body indicated on the diagram, stick on the name of one OI that usually affects that part of the body
- Each team has 10 minutes to do this
- Then we will discuss and see which team was the first to complete the diagram correctly



Brain:

Eyes:

Mouth/Throat:

Lungs:

Gut:

Skin:

Genitals:

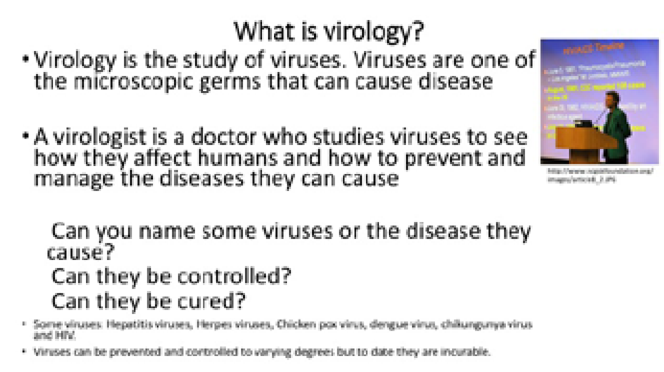
https://encrypted-tbn2.gstatic.com/images?q=tbn:ANd9GcTjQ0mI4agdmw9vhYUMF4o8S8IS2b5Nr4-5kaG8-yVy5cAoXgw

5

HIV Life Cycle and the impact of ART

Overview

- What is virology?
- What is so "special" about this HIV?
- How does it do its thing inside the body?
- What is ARV?
- What ARV are available in Jamaica?
- How do they work?
- What is ART?



What is virology?

- Virology is the study of viruses. Viruses are one of the microscopic germs that can cause disease
- A virologist is a doctor who studies viruses to see how they affect humans and how to prevent and manage the diseases they can cause

Can you name some viruses or the disease they cause?
Can they be controlled?
Can they be cured?

- Some viruses: Hepatitis viruses, Herpes viruses, Chicken pox virus, dengue virus, chikungunya virus and HIV.
- Viruses can be prevented and controlled to varying degrees but to date they are incurable.

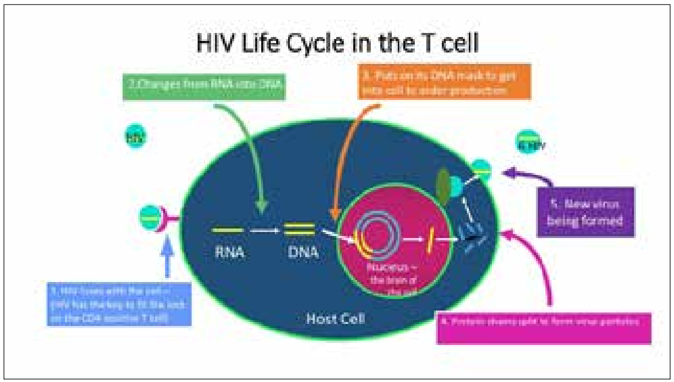
What is so "special" about this Human Immunodeficiency Virus (HIV)?

HIV is a retrovirus: It is a virus that can mask itself inside the body, enter a cell and take over the cell, then it makes more of itself and takes off the mask, going on to infect more cells

- **Retro**—going back from RNA to DNA

HIV is a retrovirus: A virus that has RNA and the enzyme,* reverse transcriptase, that changes it back to DNA, so it can get into the nucleus of the cell to trick the cell into making more copies of the virus.

- Enzyme: a substance that speeds up a reaction in the body



HIV Life Cycle in the T cell

1. HIV fuses with the cell – (HIV has the key to fit the lock on the CD4 positive T cell)

2.Changes from RNA into DNA

3. Puts on its DNA mask to get into cell to order production

4. Protein chains split to form virus particles

5. New virus being formed

The diagram on the previous slide shows how the virus operates in the CD4

1. The HIV joins on to the cell at a receptor (docking bay) on the CD4 cell.
2. It changes its genes (RNA) to be like the CD4 cell's genes (DNA).
3. So now it can get into the nucleus (the brain of the CD4 cell) to give orders to multiply.
4. It forms these long chains, which have to be split, and the CD4 cell is turned into a "factory" to make more and more HIV.
5. HIV components gather inside the perimeter of the infected CD4 cell; these smaller chains fit to form new virus particles (copies) that are assembled into new HIV viruses, which then "bud" off from the host CD4 cell.
6. After the new virus buds from the infected CD4 cell, it has all of the necessary parts to infect other CD4 cells, but it first has to mature. During the maturation process, the protease enzyme cuts the HIV proteins into smaller units that reassemble into a mature virus that can infect other cells. Without the enzyme protease, this maturation cannot occur, and HIV cannot go on to infect other cells.

What an is ARV?

- Antiretroviral (ARV) – a drug used to control HIV in the body
- Do you know any?

Antiretrovirals

- There are six main drug classes:
- Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
- Nucleoside reverse transcriptase inhibitors (NRTIs, or Nukes)
- Nucleotide reverse transcriptase inhibitors (NtRIs)
- Protease inhibitors (PIs)
- CCR5 inhibitors
- Integrase inhibitors

Available in Jamaica

Nucleoside Reverse Transcriptase Inhibitors(NRTI) Nucleosides, or "Nukes"

- Zidovudine (AZT, ZDV)
- Lamivudine (3TC)
- Abacavir (ABC)

Nucleotide Reverse Transcriptase Inhibitors (NtRIs)*

Tenofovir (TDF)

Non-Nucleoside Reverse Transcriptase Inhibitors(NNRTIs)

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- Efavirenz (EFV)
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- Entravirine (ETR)

Antiretrovirals available in Jamaica (cont'd)

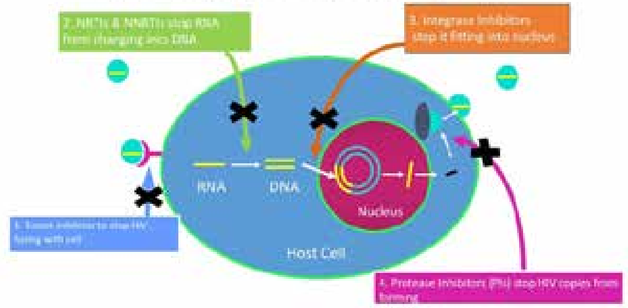
- Protease Inhibitors (PIs)
- Lopinavir (LPV)
- Atazanavir (ATV)
- Darunavir (DRV)
- Ritonavir (r) – the booster for other PIs

Integrase inhibitors

- Raltegravir (RAL)

How do these ARVs work?

HIV Life Cycle and Classes of ARV



Notes for previous slide:

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What is Antiretroviral Therapy/Treatment (ART)?

- ART refers to the combination of antiretrovirals that are used in the treatment of HIV
- Multiple drug therapy (ART) is needed, as it is easy for the HIV to get used to (develop resistance) to one ARV
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What are the ART fixed-dose combinations available in Jamaica?

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Fixed-dose combinations have become the standard of care

Past

Present

http://www.drugs.com/stribild-images.html

Goals of Antiretroviral Therapy (ART)

- **Decrease the amount of HIV in the blood by blocking the HIV at different points in its life cycle**
- Suppress the virus
- Restore the immune system
- Treat the complicating illnesses
- Minimize the risk of resistance and toxicity
- Improve the quality of life and clinical outcome

- **TO TREAT THE WHOLE PERSON, not just the diseases they have, and for the person to have a long healthy life**

Goals of Antiretroviral Therapy (ART) (continued)

- Decrease chance of transmission to another person when someone has an undetectable viral load – treatment as prevention
- Prevent HIV transmission in HIV-negative people who are at high risk of being exposed to HIV (PrEP)
- Prevent HIV transmission in HIV-negative people who have been exposed to HIV (PEP)

Key Messages?

- HIV is a retrovirus (RNA changes to DNA)
- Antiretrovirals block HIV at different points in its life cycle
- Use ART, a combination of antiretrovirals, to stop HIV in the body
- Decrease chance of transmission to another person when someone has an undetectable viral load – treatment as prevention
- Prevent HIV transmission in HIV-negative people who are at high risk of being exposed to HIV (PrEP)
- Prevent HIV transmission in HIV-negative people who have been exposed to HIV (PEP)
- ART can restore our immune system to make us healthy for a long time!

Questions?

6

HIV Life Cycle and the impact of ART

Overview

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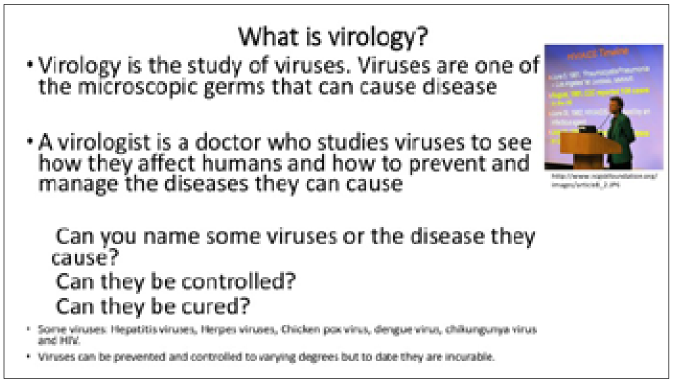

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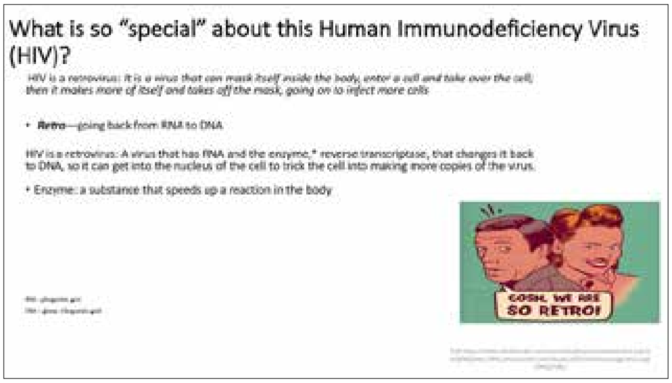

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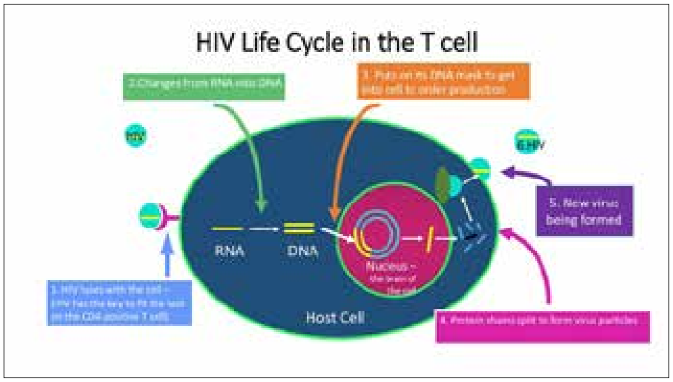
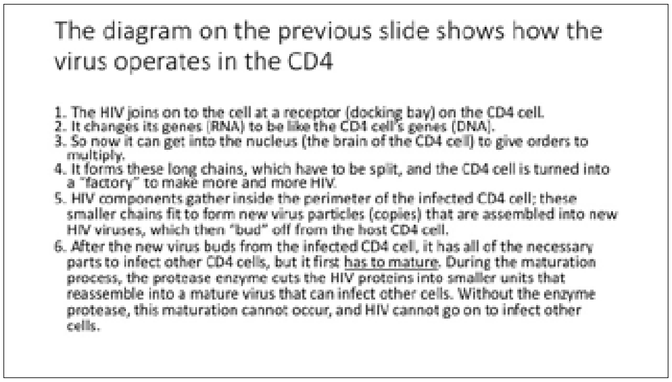


HIV Life Cycle in the T cell



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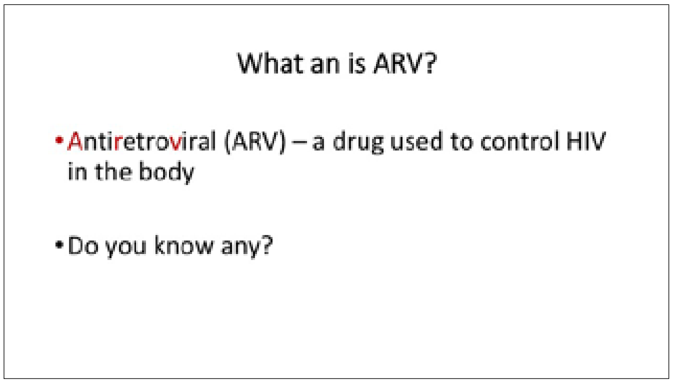

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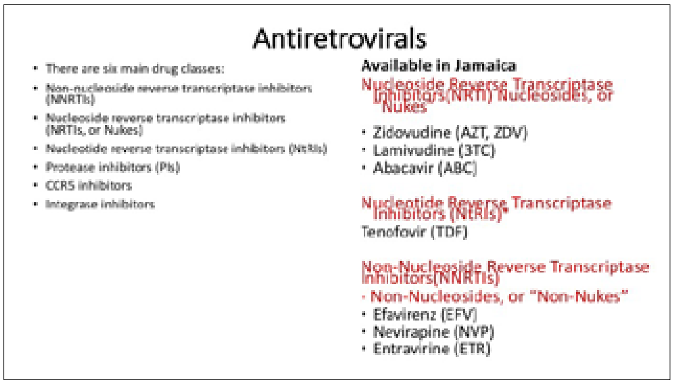

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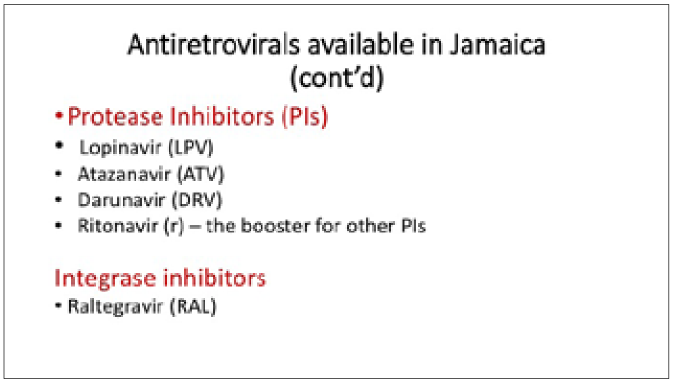

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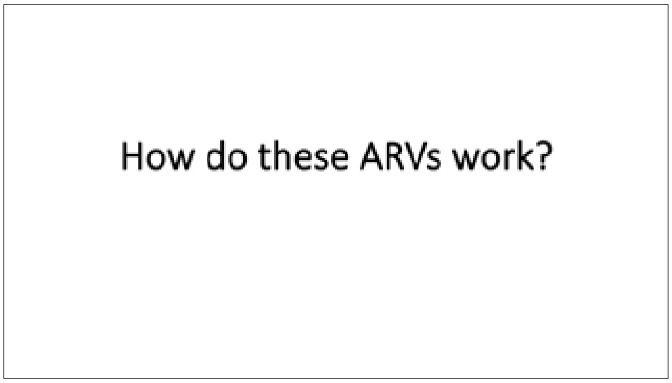

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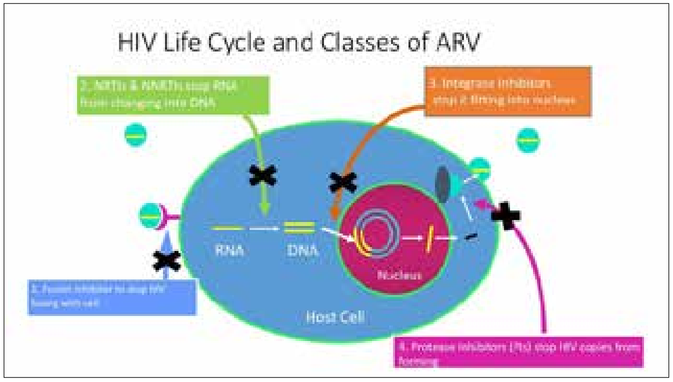
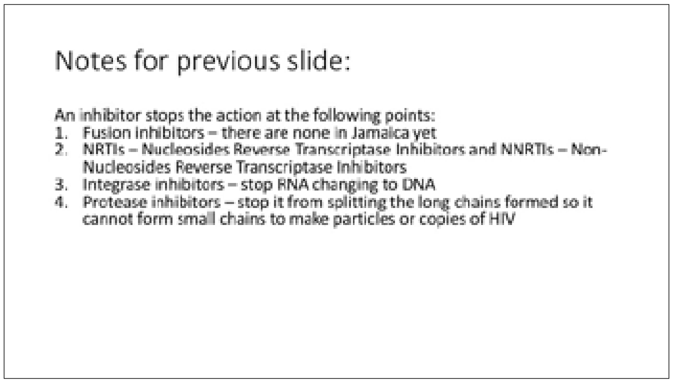


HIV Life Cycle and Classes of ARV



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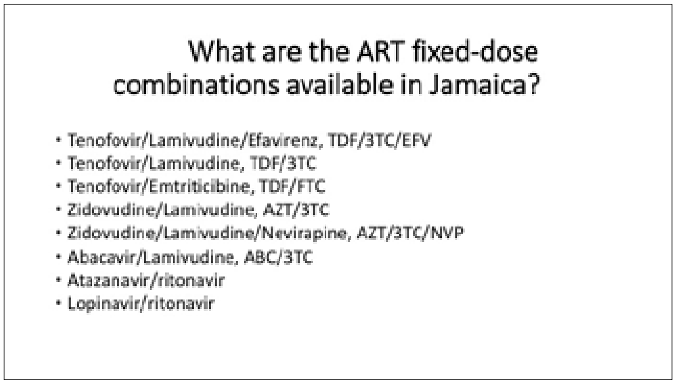

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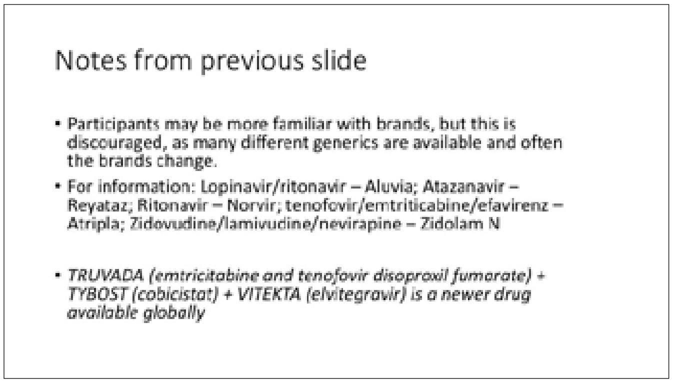

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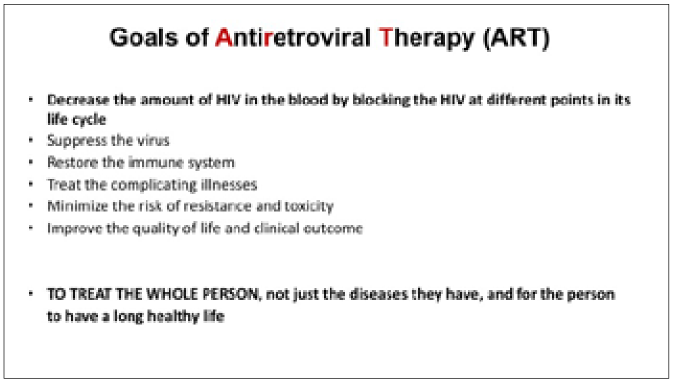

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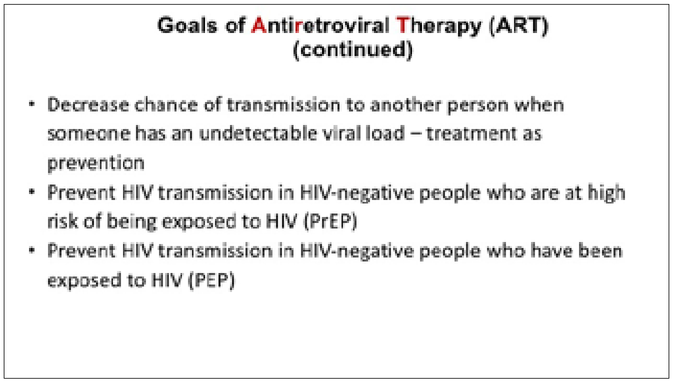

Goals of Antiretroviral Therapy (ART) (continued)

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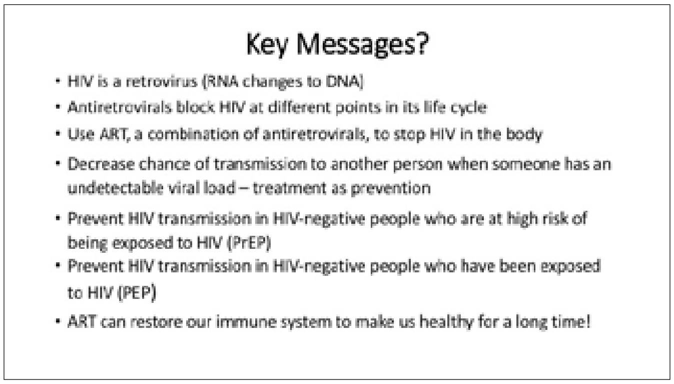
- Prevent HIV transmission in HIV-negative people who are at high risk of being exposed to HIV (PrEP)
- Prevent HIV transmission in HIV-negative people who have been exposed to HIV (PEP)



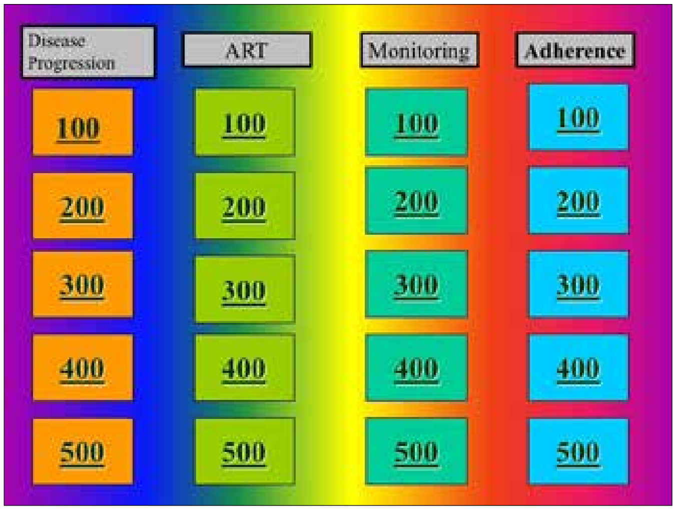
Key Messages?

- HIV is a retrovirus (RNA changes to DNA)
- Antiretrovirals block HIV at different points in its life cycle
- Use ART, a combination of antiretrovirals, to stop HIV in the body
- Decrease chance of transmission to another person when someone has an undetectable viral load – treatment as prevention
- Prevent HIV transmission in HIV-negative people who are at high risk of being exposed to HIV (PrEP)
- Prevent HIV transmission in HIV-negative people who have been exposed to HIV (PEP)
- ART can restore our immune system to make us healthy for a long time!

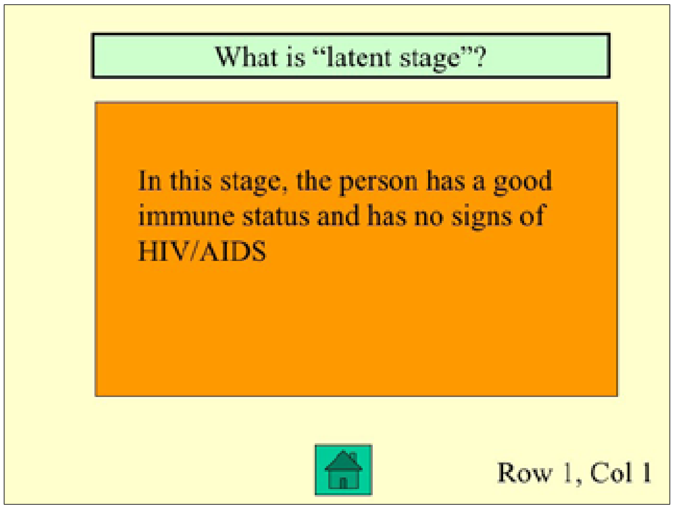
Questions?

JEOPARDY!

Hosted
by
PHDP Jamaica



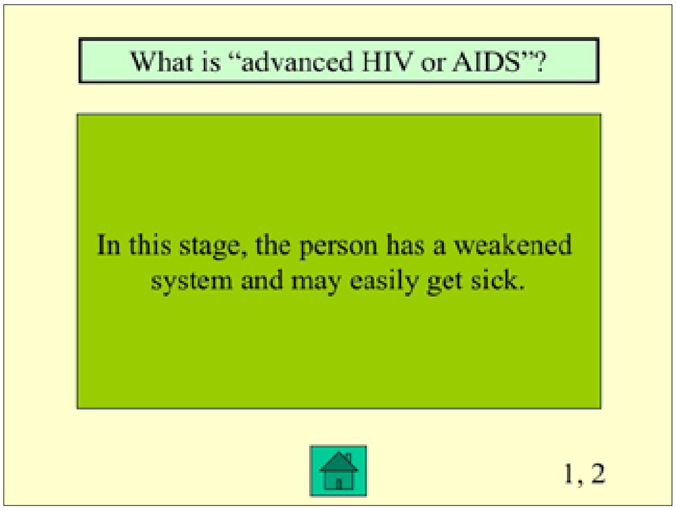
Disease Progression	ART	Monitoring	Adherence
100	100	100	100
200	200	200	200
300	300	300	300
400	400	400	400
500	500	500	500



What is "latent stage"?

In this stage, the person has a good immune status and has no signs of HIV/AIDS

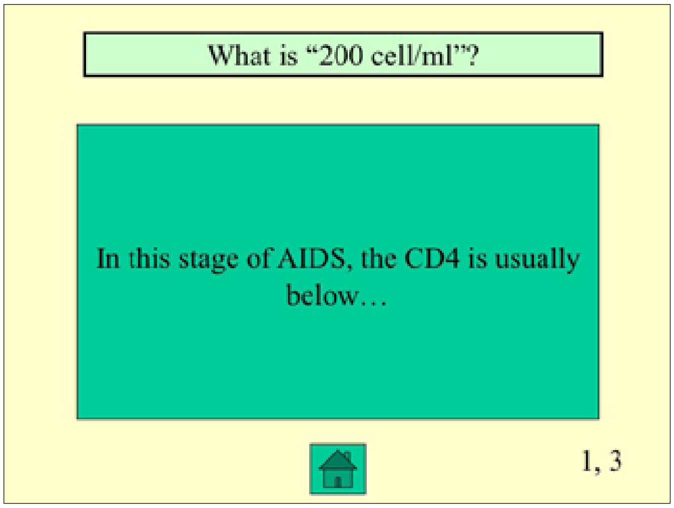
Row 1, Col 1



What is "advanced HIV or AIDS"?

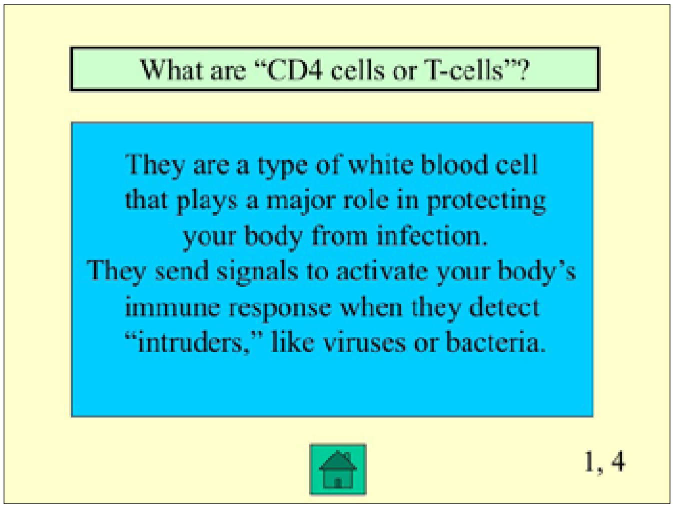
In this stage, the person has a weakened system and may easily get sick.

1, 2


What is “200 cell/ml”?

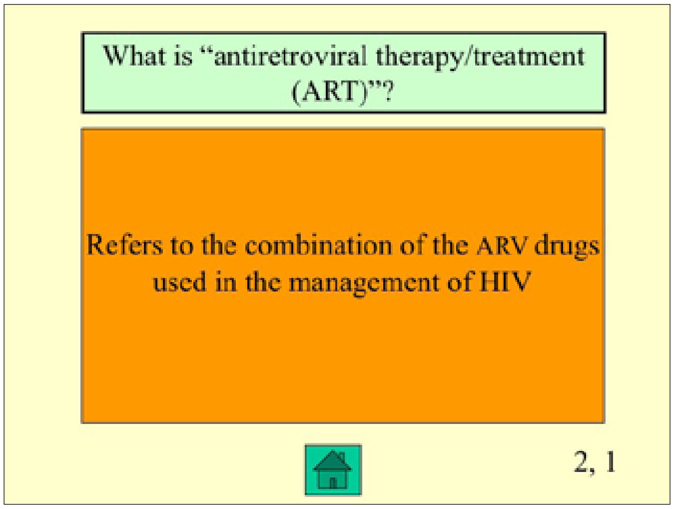
In this stage of AIDS, the CD4 is usually below…

1, 3


What are “CD4 cells or T-cells”?

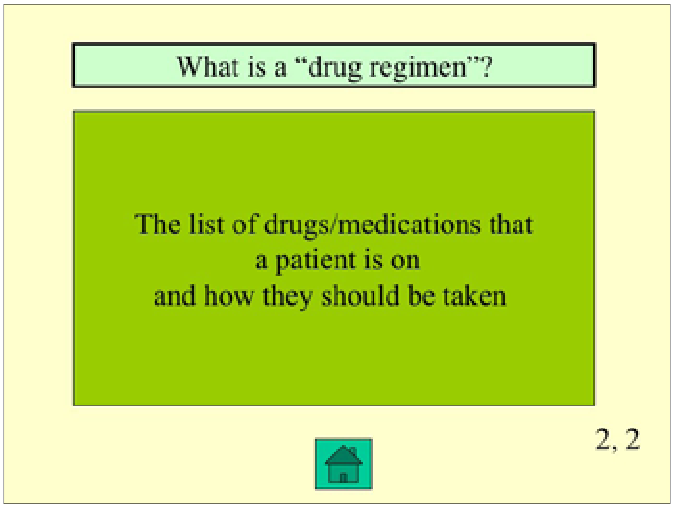
They are a type of white blood cell
that plays a major role in protecting
your body from infection.
They send signals to activate your body’s
immune response when they detect
“intruders,” like viruses or bacteria.

1, 4


What is “antiretroviral therapy/treatment (ART)”?

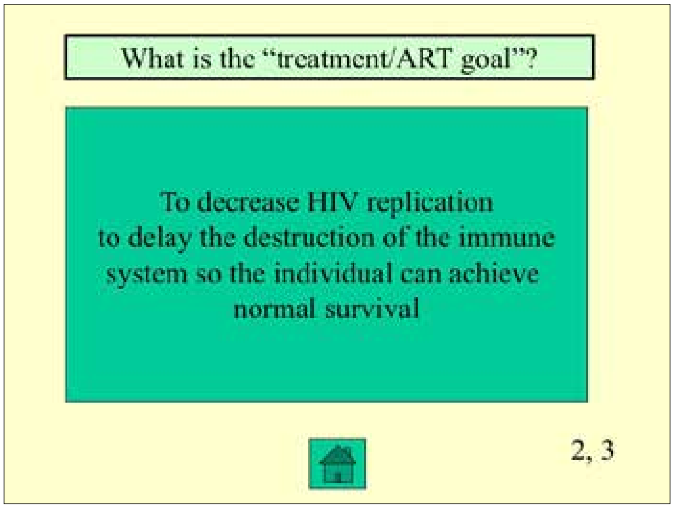
Refers to the combination of the ARV drugs
used in the management of HIV

2, 1


What is a “drug regimen”?

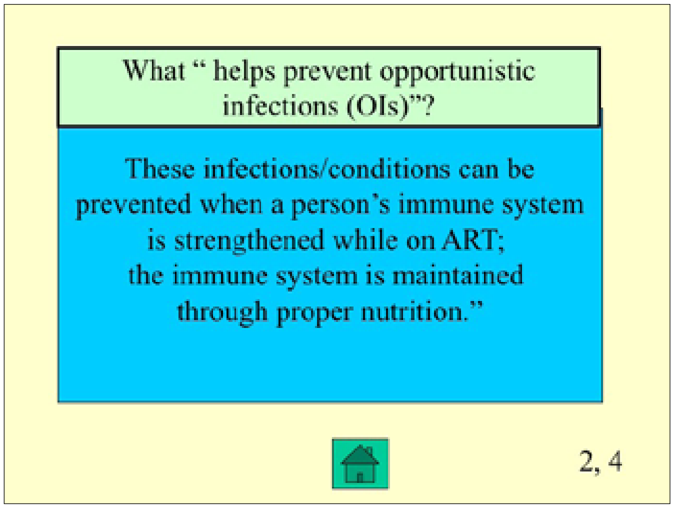
The list of drugs/medications that
a patient is on
and how they should be taken

2, 2


What is the “treatment/ART goal”?

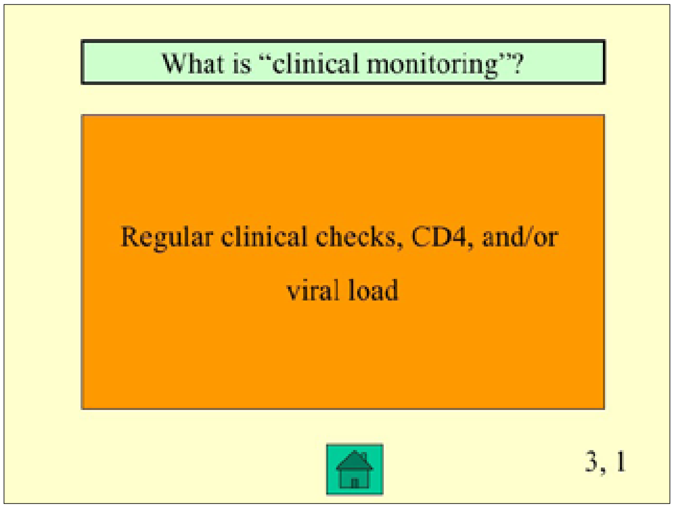
To decrease HIV replication
to delay the destruction of the immune
system so the individual can achieve
normal survival

2, 3


What “ helps prevent opportunistic infections (OIs)”?

These infections/conditions can be
prevented when a person’s immune system
is strengthened while on ART;
the immune system is maintained
through proper nutrition.”

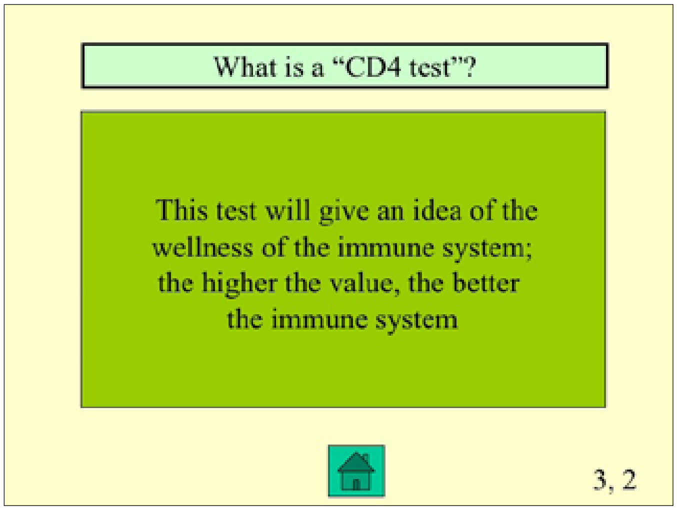
2, 4



What is "clinical monitoring"?

Regular clinical checks, CD4, and/or viral load

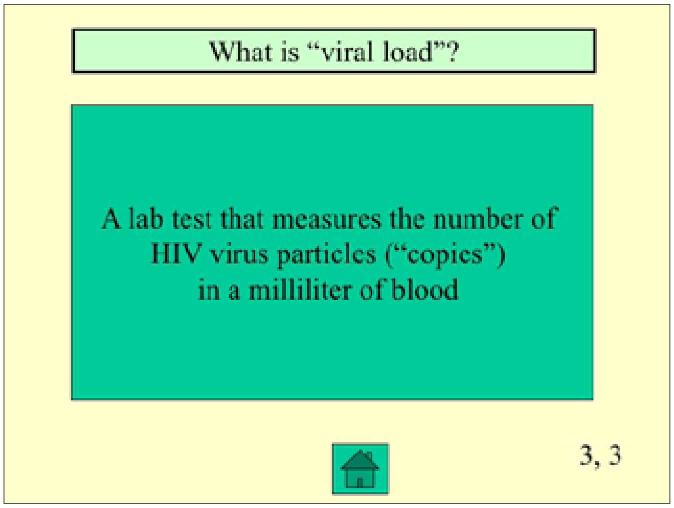
3, 1



What is a "CD4 test"?

This test will give an idea of the wellness of the immune system; the higher the value, the better the immune system

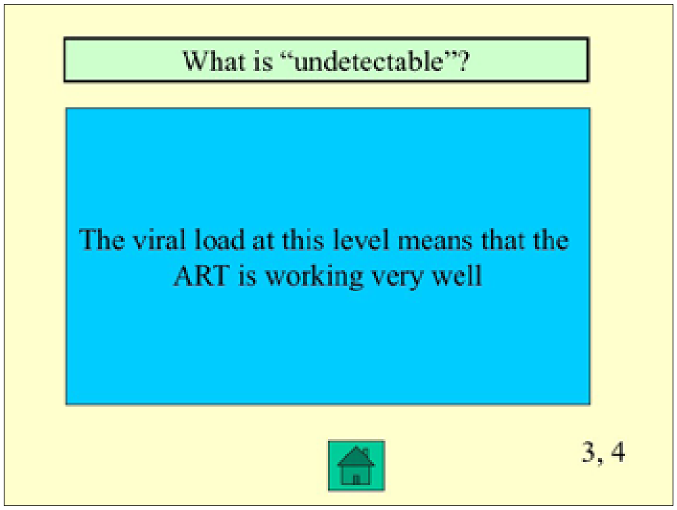
3, 2



What is "viral load"?

A lab test that measures the number of HIV virus particles ("copies") in a milliliter of blood

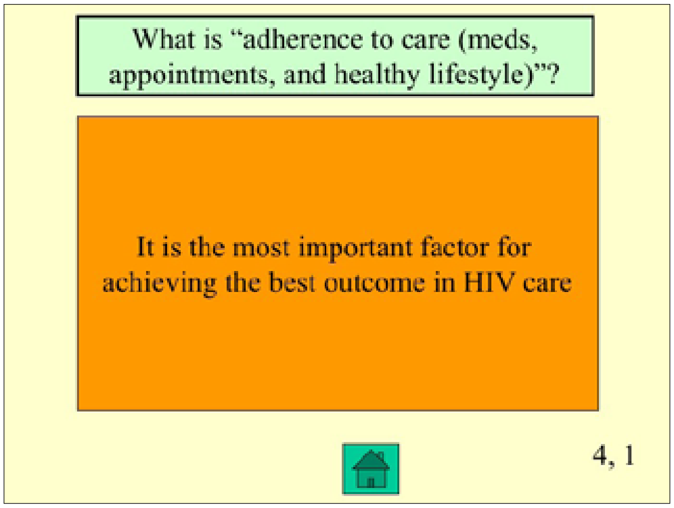
3, 3



What is "undetectable"?

The viral load at this level means that the ART is working very well

3, 4



What is "adherence to care (meds, appointments, and healthy lifestyle)"?

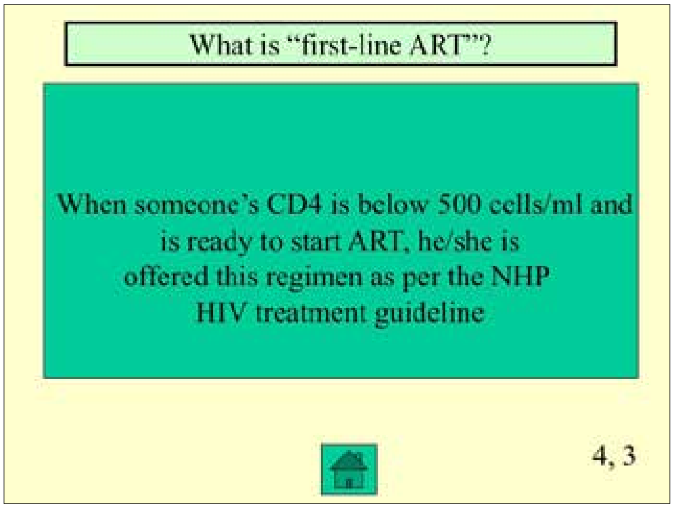
It is the most important factor for achieving the best outcome in HIV care

4, 1

What is "multidisciplinary care"?

Adherence to care usually means follow-up appointments, not only with the doctor, but also with the social worker, adherence counselor, nutritionist, pharmacist, and other members of the team. This team approach is also referred to as…

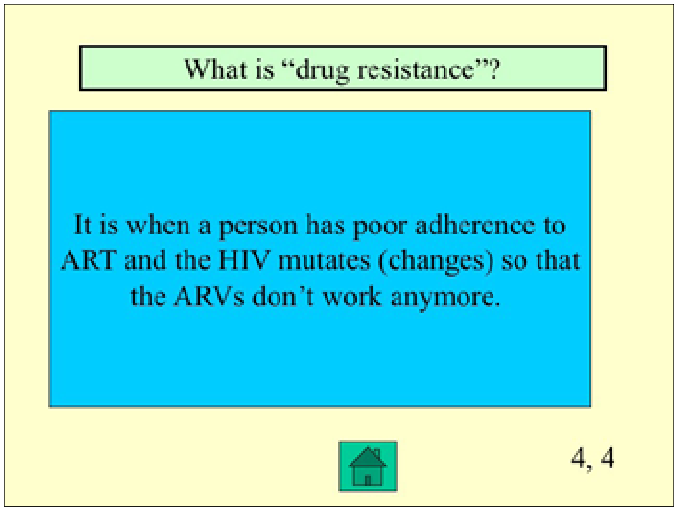
4, 2



What is "first-line ART"?

When someone's CD4 is below 500 cells/ml and is ready to start ART, he/she is offered this regimen as per the NHP HIV treatment guideline

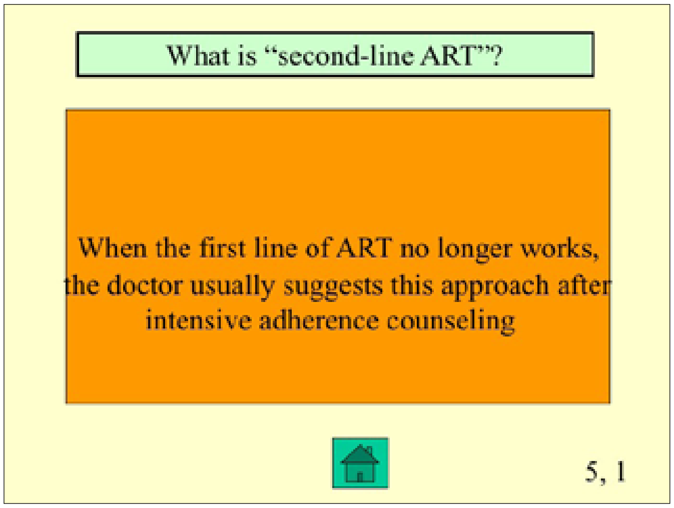
4, 3



What is "drug resistance"?

It is when a person has poor adherence to ART and the HIV mutates (changes) so that the ARVs don't work anymore.

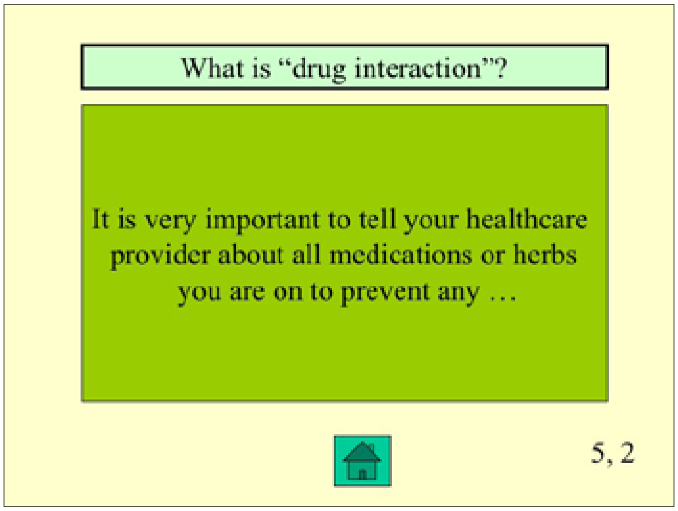
4, 4



What is "second-line ART"?

When the first line of ART no longer works, the doctor usually suggests this approach after intensive adherence counseling

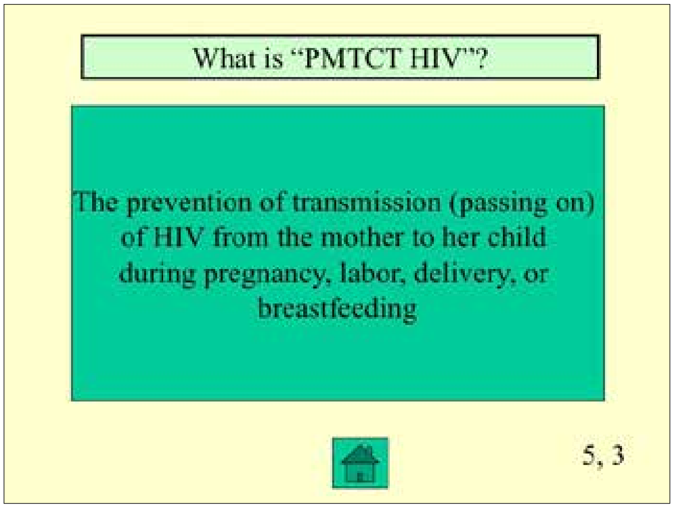
5, 1



What is "drug interaction"?

It is very important to tell your healthcare provider about all medications or herbs you are on to prevent any …

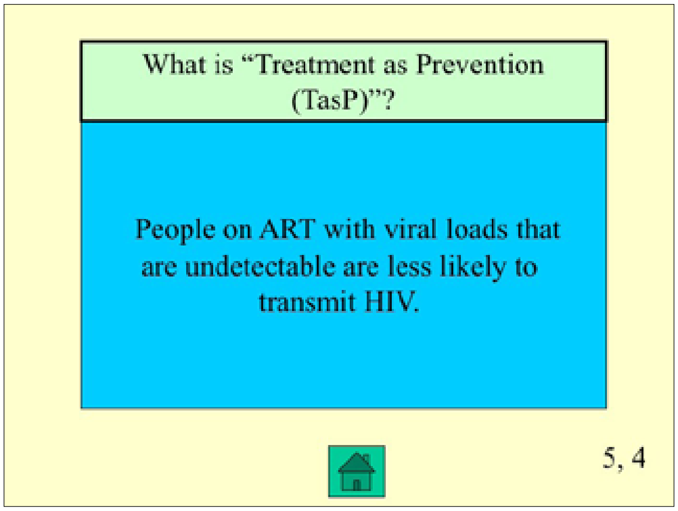
5, 2



What is "PMTCT HIV"?

The prevention of transmission (passing on) of HIV from the mother to her child during pregnancy, labor, delivery, or breastfeeding

5, 3

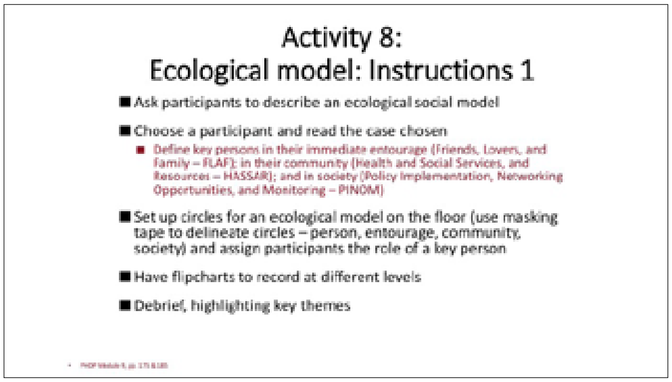


What is "Treatment as Prevention (TasP)"?

People on ART with viral loads that are undetectable are less likely to transmit HIV.

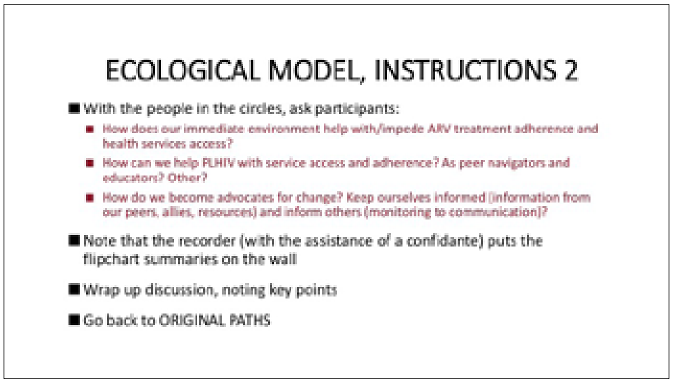
5, 4

8



Activity 8:
Ecological model: Instructions 1

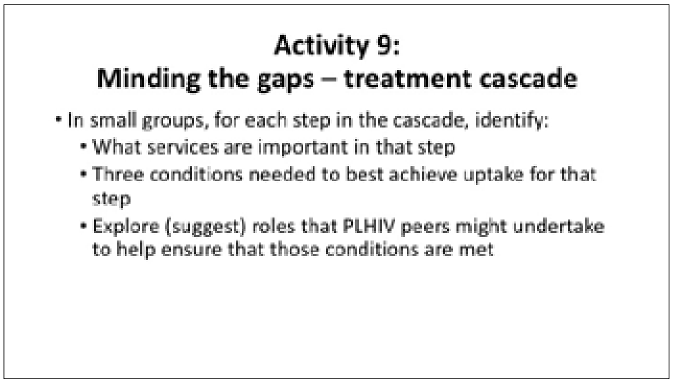
- Ask participants to describe an ecological social model
- Choose a participant and read the case chosen
  - Define key persons in their immediate entourage (Friends, Lovers, and Family – FLAF); in their community (Health and Social Services, and Resources – HASSAR); and in society (Policy Implementation, Networking Opportunities, and Monitoring – PINOM)
- Set up circles for an ecological model on the floor (use masking tape to delineate circles – person, entourage, community, society) and assign participants the role of a key person
- Have flipcharts to record at different levels
- Debrief, highlighting key themes



ECOLOGICAL MODEL, INSTRUCTIONS 2

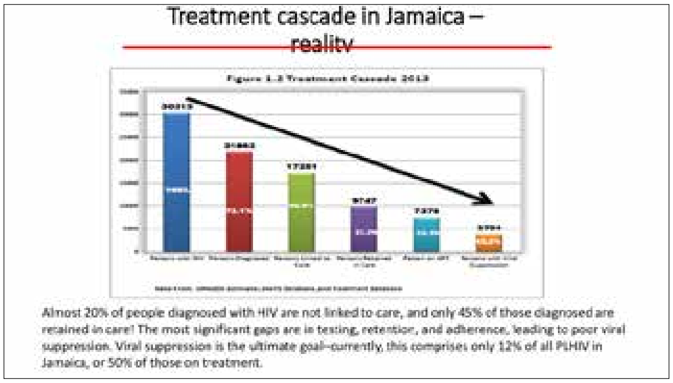
- With the people in the circles, ask participants:
  - How does our immediate environment help with/impede ARV treatment adherence and health services access?
  - How can we help PLHIV with service access and adherence? As peer navigators and educators? Other?
  - How do we become advocates for change? Keep ourselves informed (information from our peers, allies, resources) and inform others (monitoring to communication)?
- Note that the recorder (with the assistance of a confidante) puts the flipchart summaries on the wall
- Wrap up discussion, noting key points
- Go back to ORIGINAL PATHS

9



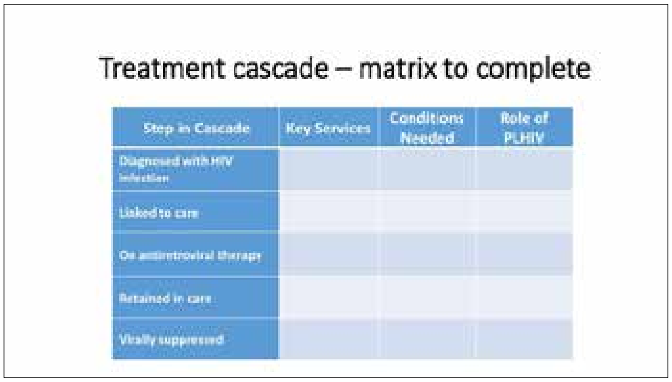
Activity 9:
Minding the gaps – treatment cascade

- In small groups, for each step in the cascade, identify:
  - What services are important in that step
  - Three conditions needed to best achieve uptake for that step
  - Explore (suggest) roles that PLHIV peers might undertake to help ensure that those conditions are met



Treatment cascade in Jamaica – reality

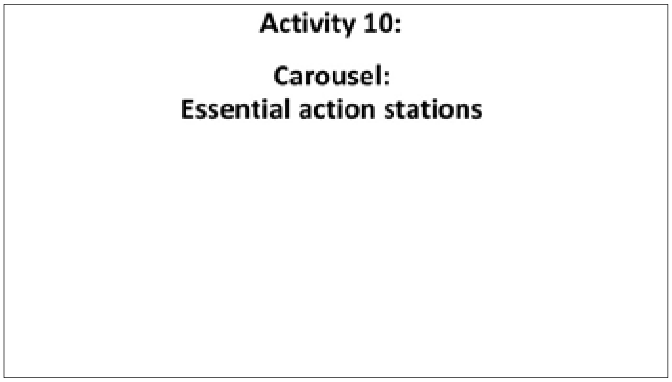
Almost 20% of people diagnosed with HIV are not linked to care, and only 45% of those diagnosed are retained in care! The most significant gaps are in testing, retention, and adherence, leading to poor viral suppression. Viral suppression is the ultimate goal–currently, this comprises only 12% of all PLHIV in Jamaica, or 50% of those on treatment.



Treatment cascade – matrix to complete

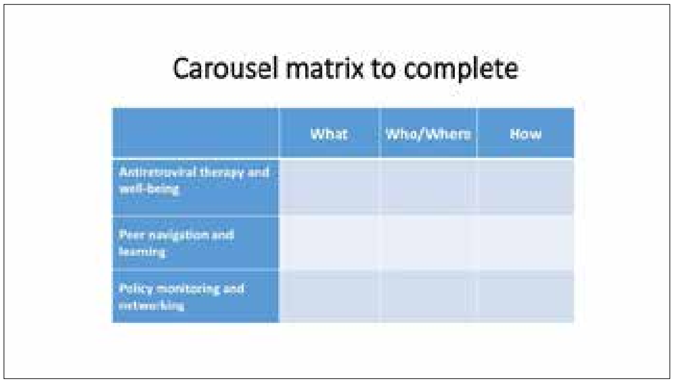
Step in Cascade	Key Services	Conditions Needed	Role of PLHIV
Diagnosed with HIV infection			
Linked to care			
On antiretroviral therapy			
Retained in care			
Virally suppressed			

10



Activity 10:

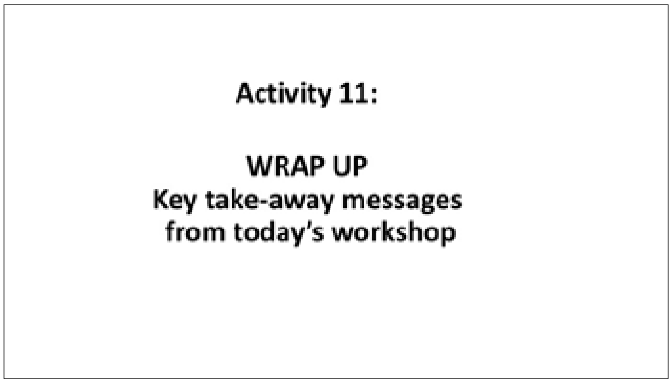
Carousel:
Essential action stations



Carousel matrix to complete

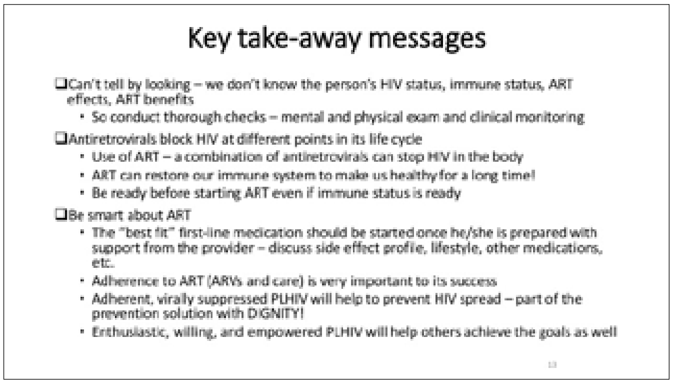
	What	Who/Where	How
Antiretroviral therapy and well-being			
Peer navigation and learning			
Policy monitoring and networking			

11



Activity 11:

WRAP UP
Key take-away messages from today's workshop



Key take-away messages

☐ Can't tell by looking – we don't know the person's HIV status, immune status, ART effects, ART benefits
  - So conduct thorough checks – mental and physical exam and clinical monitoring

☐ Antiretrovirals block HIV at different points in its life cycle
  - Use of ART – a combination of antiretrovirals can stop HIV in the body
  - ART can restore our immune system to make us healthy for a long time!
  - Be ready before starting ART even if immune status is ready

☐ Be smart about ART
  - The "best fit" first-line medication should be started once he/she is prepared with support from the provider – discuss side effect profile, lifestyle, other medications, etc.
  - Adherence to ART (ARVs and care) is very important to its success
  - Adherent, virally suppressed PLHIV will help to prevent HIV spread – part of the prevention solution with DIGNITY!
  - Enthusiastic, willing, and empowered PLHIV will help others achieve the goals as well

Case Scenarios for Activity 8 – Ecological Model

Case 1

Desmond was very happy that he finally got a job as a groundsman at a business office in town. It was near his home and the employer seemed nice … but … oh no, he will only have a day off on Sundays, so how will he fill the prescription for his ARV and attend his clinic appointment next month? He doesn't want to ask for a day off, as he just started two days ago. What can he do?

Case 2

Jasmine was advised by her doctor that her CD4 was 300 and she should start ARV. She likes the fact that it would only be one tablet at night but is thinking of postponing starting the treatment until next year. She wants to complete the last year of her course, which she takes after work three nights per week. She just can't afford to be drowsy, as she has to stay up late to study! What can she do?

Case 3

Marjorie has decided to stop taking her ARV, as she is tired of taking so many pills … three of them twice a day for "this condition," two more twice a day for her high blood pressure, and still another one three times a day for her blood sugar! What, if anything, can be done to support people like Marjorie who experience pill fatigue?

Key Concepts/Definitions

Immunology – The study of the immune system in organisms. Human immunology is the study of how the body's system protects and defends itself against diseases.

Initiation of antiretroviral therapy (ART) – The time recommended by the treatment guidelines to start ART once the patient is ready. Currently, the recommendation in Jamaica is the suggested initiation of ART if the CD4 count is less than 350 cells/ml. It will soon reflect the WHO 2013 guidelines' recommendation of initiation if the CD4 count is less than 500 cells/ml.

Guidelines in Jamaica: The Ministry of Health guidelines recommend ART if the patient is co-infected with TB; has an active Hepatitis B infection; and in the case of all children, regardless of the CD4 count. All HIV-positive pregnant women are offered ART, which is discontinued after pregnancy if the CD4 count is more than 350 and the woman is not breast-feeding. The National HIV Program in Jamaica will soon adopt Option B+ (meaning continuing ART after pregnancy) and initiate ART if the CD4 count is less than 500. The most recent global guidelines (World Health Organization, 2015) recommend to test and treat regardless of the CD4 count.

Virology – The study of viruses: how they work, their effects, the diseases they cause, and how medications work. Experts in this field of medicine are called virologists.

Retrovirus – A virus that has both RNA and the enzyme reverse transcriptase. Once the virus is inside the cell, it goes through a process called reverse transcription, in which the core of the virus breaks open and releases its RNA and the enzyme reverse transcriptase, which turns its RNA into viral DNA. The viral DNA is then integrated into the cell's normal DNA. Once this happens, the cell is turned into a "factory" to make more and more copies of the virus. "Retro" means reversing from RNA to DNA.

HIV – Human Immunodeficiency Virus, a retrovirus that uses cells in the human body to multiply. It needs to change its RNA to DNA so it can use the nucleus (the "brain" of the cell). For this reason, it comes equipped with its own enzyme (reverse transcriptase, a protein that helps it change its RNA to viral DNA). It then uses this viral DNA in the nucleus of the cell to make more viral proteins and create more HIV viruses that go on to infect other cells.

ARV – Antiretroviral, a drug used to control HIV in the body.

ART – Antiretroviral therapy/treatment; refers to the combination of ARV drugs that are used in the treatment of HIV. ART cannot cure HIV but, when taken consistently, it allows a person to live a long and healthy life and reduces the risk of HIV transmission. ARV and ART often are used interchangeably to mean HIV treatment.

Acute stage – Also called "acute HIV infection" or "primary HIV infection." This is the HIV disease stage at which a person has recently contracted the virus. Approximately half of the people who get infected do not notice anything, whereas the other half experience symptoms within two to four weeks. These symptoms include fever, sore throat, muscle or joint pains, and/or a skin rash. This stage is also considered one of the most infectious times for HIV transmission; that is, the risk of passing HIV to another person during this period is high because the number of HIV particles in the blood is much higher during acute HIV infection than later on.

Latent stage – After the acute stage of HIV infection, the disease moves into a stage called the "latent" or "clinical latency" stage. This stage is also called "asymptomatic HIV infection" or "chronic HIV infection." "Latent" means a period during which a virus is living or developing in a person but is not creating any symptoms. During this stage, people who have HIV do not have any HIV-related symptoms, or only mild ones. Also, the HIV virus is reproducing, but at very low levels. People who take ART at this time can stay in this stage for decades. People who do not take ART can stay in this stage for up to 10 years, after which their health rapidly declines. It is important to remember that although people in this stage most often do not have any symptoms, they are still able to transmit HIV to others even if they are on ART, although ART greatly reduces the risk of transmission.

AIDS (Acquired Immunodeficiency Syndrome) OR Advanced HIV Infection – This is the final HIV disease stage, at which a person's immune system is very weak and the CD4 count is below 200 cells/mm3. (In someone with a healthy immune system, CD4 counts are between 500 and 1,600 cells/mm3.) A person is also considered to have progressed to AIDS if she/he develops one or more opportunistic illnesses, regardless of the CD4 count. Without treatment, people who progress to AIDS typically live for three years. However, once they acquire an opportunistic infection, life expectancy without treatment falls to one year. With treatment and a decreased viral load, a person will likely never progress to AIDS. AIDS/Advanced HIV Infection is the last of three stages, including the "acute infection" and "clinical latency" (inactivity or dormancy) stages. Details for CD4 counts and the different stages appear in Table 1 below.

TABLE 1. HIV INFECTION STAGE, BASED ON AGE-SPECIFIC CD4+ T-LYMPHOCYTE COUNT OR CD4+ T-LYMPHOCYTE PERCENTAGE OF TOTAL LYMPHOCYTES*

Stage*	Age on date of CD4 T-lymphocyte test					
	<1 year		1-5 years		6 years through adult	
	Cells/µL	%	Cells/µL	%	Cells/µL	%
1	≥1,500	≥34	≥1,000	≥30	≥500	≥26
2	750–1,499	26–33	500–999	22–29	200–499	14–25
3	<750	<26	<500	<22	<200	<14

*The stage is based primarily on the CD4+ T-lymphocyte count; this count takes precedence over the CD4 T-lymphocyte percentage, and that percentage is considered only if the count is missing. If none of the above applies (e.g., because of missing information on CD4 test results), the stage is U (unknown).

Opportunistic infections (OIs) – Infections or conditions that occur more frequently in a person whose immune system is weak. Such infections do not usually cause illness when the immune system is working well.

OI prophylaxis – Medications—for example, Bactrim or Cotrimoxazole—given to patients before or after beginning ART to help prevent opportunistic infections.

Drug regimen – The drugs/medicines plan for patients, including how and when drugs should be taken.

Adherence – Sticking to the plan: taking medicines as prescribed and following up with appointments with a doctor. Adherence is the main ingredient for successful ART and so must be pursued and supported.

ARV drug resistance – This means that a drug no longer works very well or does not work at all in the body; the HIV found a way to change itself (mutate) to get around the drug, so it continues multiplying at a greater rate.

CD4 – CD4 cells (or T-cells or CD4 lymphocytes) are a type of white blood cell that play a major role in protecting the body from infection. They send signals to activate the body's immune response when they detect "intruders," like viruses or bacteria. **Adapted from AIDS.gov. “Basic facts.”** Available at: **https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/cd4-count/.**

The CD4 count measures the number of these cells; usually, the higher the count, the better the immune status of the patient. These cells are also the prime target of HIV, which can cause their numbers to decrease over time. Too few CD4 cells means that the immune system will no longer function as it should.

Viral load test – A lab test that measures the number of HIV particles in a milliliter of blood. These viral particles are called “copies.” A viral load test helps provide information on a person’s health status and how well ART is controlling the virus. The goal of ART is to move the viral load down—ideally to undetectable levels.

Undetectable viral load – In general, a person’s viral load will be declared “undetectable” if it is under 20 to 75 copies in a sample of the blood. The exact number depends on the lab that analyzes the test. It is much more difficult to transmit the virus when a person has an undetectable viral load. **Adapted from AIDS.gov. “Basic facts.”** Available at: **https://www.aids.gov/hiv-aids-basics/just-diagnosed-with-hiv-aids/understand-your-test-results/cd4-count/.**

Clinical monitoring – Monitoring progress, which usually entails having a CD4 test and/or viral load test, along with a clinical assessment to check on the progress of a patient. Monitoring may also include screening for other chronic diseases or possible side effects of ART.

Multidisciplinary care – This term refers to the team of health providers involved in the care of people living with HIV (PLHIV). The team usually consists of a nurse, doctor, contact investigator, family nurse practitioner, adherence counselor, social worker, psychologist, mental health officer, nutritionist, pharmacist, laboratory worker, and dental health provider.

First-line therapy – The usual list of combinations of ARVs recommended for use when initiating ART.

Second-line therapy – The usual list of combinations of ARVs recommended for use when the first-line therapy fails.

ARV drug interaction – Occurs when another drug, food, other substance, such as alcohol, affects the levels of the ARV, or the ARV affects the level of the substance in the body when both are taken together.

IRIS – Immune reconstitution inflammatory syndrome, also known as immune restoration disease; in this disease, the immune system begins to recover but then reacts to a previously acquired opportunistic infection with an overwhelming inflammatory response that paradoxically makes the symptoms worse. **Wikipedia.** Available at: **https://en.wikipedia.org/wiki/Immune_reconstitution_inflammatory_syndrome.**

Pre-exposure prophylaxis (PrEP) – Offering ARV medication (dual or triple ARV) before sexual intercourse to uninfected partners to prevent acquiring HIV.

Post-exposure prophylaxis, PEP – Offering ARV medication (dual or triple ARV) after sexual exposure (such as rape) to prevent acquiring HIV.

Vertical transmission/mother-to-child transmission of HIV – The transmission (passing on of) HIV from a mother to her child during pregnancy, labor, delivery, or breastfeeding.

Treatment as Prevention (TasP) – The decreased risk of HIV transmission to persons accidentally exposed to PLHIV whose HIV is controlled by ART (viral load undetectable).

Treatment cascade – Sometimes referred to as the HIV Care Continuum, a treatment cascade is a model that outlines the sequential steps or stages of HIV medical care that PLHIV go through, from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body), and shows the proportion of PLHIV engaged at each stage; PLHIV undiagnosed, PLHIV diagnosed, PLHIV linked to care, PLHIV retained in care, PLHIV on ART, or PLHIV with viral suppression while on ART.

Treatment failure – Any combination or all of the following: clinical failure, immunologic failure, or virologic failure. Contributing factors include drug resistance, drug toxicity, or poor treatment adherence.

ANNEX

Criminalisation and HIV in Jamaica

Legislation is considered an important aspect of a policy response to HIV that can facilitate or hinder an enabling environment for prevention, care, and treatment. Criminalisation (legislation that makes something illegal) is one form of legislation that shapes the policy environment and the response. The following document provides a brief overview of the situation for key and vulnerable populations in Jamaica, as well as international guidance on criminalisation and sources for more information.

1. Men who have sex with men (MSM)[1]

'Buggery' and "any act of gross indecency with another male person" are criminalised in Jamaica under Sections 76, 77, and 79 of the ***Offences against the Person Act****. Although the 'buggery' offence does not make a distinction as to whether the act is between a man and another man, or a man and a woman, it is mostly applied to same-sex sexual acts. Despite the recognition by the National HIV/AIDS Policy, Jamaica 2005 (being reviewed in 2014) and the Jamaica HIV National Strategic Plan for MSM 2012–2017 that homophobia in Jamaica is a powerful cultural influence which forces MSM underground, stigma and discrimination represent significant barriers to HIV prevention, treatment, and care for MSM in Jamaica.*

2. Sex workers

Sex work (living on the earnings of prostitution and solicitation) is criminalised in Jamaica under Section 68 of the ***Offences against the Person Act, Section 23 of the Sexual Offences Act, and Section 3(r) of the Towns and Communities Act. Criminalisation of sex work*** *makes it difficult to reach this mobile and vulnerable population, especially the most invisible sex workers such as those who are MSM and those who work through the internet or telephone. The recognition of the* ***link between criminalisation and marginalisation of and discrimination against sex workers, and their vulnerability to HIV*** *within the national response, has not translated into legal or policy reforms.*

3. Women´s reproductive rights

Abortion is illegal in Jamaica, and key informants have expressed concerns about safeguards against the lack of full informed consent in routine HIV testing of pregnant women, as well as instances of forced abortions on and involuntary sterilisation of HIV-positive women.

4. Transmission

Jamaica does not have an HIV-specific criminal law, and there has been no prosecution or conviction related to HIV transmission. HIV transmission can be prosecuted under Section 22 of the ***Offences against the Person Act****. A person living with HIV can be isolated under Section 14 (1) of the* ***Public Health Act of 1985****. In 2010, a successful submission was made to the Cabinet to have HIV and AIDS removed from the Public Health (Class 1 Notifiable Diseases) Order. Some government officials have advocated for an HIV-specific law to criminalise intentional transmission. Politicians, religious leaders, and the public do not seem to be well-informed about international standards concerning criminalisation of HIV transmission.*

5. Youth access to health services and prevention tools

The Sexual Offences Act creates a criminal offence if a person engages in sexual acts with a girl or a boy under the age of 16, even though data show that many boys and girls have a sexual debut below that age. The Access to Contraceptives Policy for Minors of 2007 outlines the procedure for provision of contraceptive advice, counselling, and treatment to persons under 16 years of age by a healthcare provider; however, service delivery is at the discretion of health professionals, who may be reluctant for fear of aiding and abetting in criminal acts.

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[1] Citations from: UNDP Jamaica. 2013. *Legal Reforms, Social Change: HIV/AIDS, Human Rights and National Development in Jamaica (HIV and AIDS Legal Assessment Report for Jamaica).*

Do punitive laws make a difference?

Criminalisation is much talked about but not extensively and rigorously studied. There is, however, international evidence to support the following conclusions:

1. Criminalisation affects the dynamics of an epidemic, such as prevalence related to HIV
    a. Criminalisation has not been shown to reduce HIV transmission.
    b. Evidence points toward the fact that criminalisation creates an environment that hinders prevention efforts.
2. Health access
    a. Criminalisation impedes access to health and prevention services for key populations.
    b. A recent report investigated HIV financing and found a powerful correlation between criminalisation of same-sex behaviour and lack of investment in services.
3. Human rights
    a. Criminalisation is not consistent with human rights accords that countries such as Jamaica have signed.

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International guidelines

The International Guidelines on HIV/AIDS and Human Rights from the Office of the United Nations High Commissioner for Human Rights and UNAIDS state the following:

1. Guideline 4: Criminal Laws and Correctional Systems
    a. States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV or targeted at vulnerable groups.
    b. Criminal law prohibiting sexual acts (including adultery, sodomy, fornication and commercial sexual encounters) between consenting adults in private should be reviewed, with the aim of repeal. In any event, they should not be allowed to impede provision of HIV prevention and care services.
2. Guideline 5: Anti-discrimination and Protective Laws
    a. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV and people with disabilities from discrimination in both the public and private sectors, that will ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation and provide for speedy and effective administrative and civil remedies.
3. Guideline 8: Women, Children and Other Vulnerable Groups
    a. States should, in collaboration with and through the community, promote a supportive and enabling environment for women, children and other vulnerable groups by addressing the underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.
4. Guideline 11: State Monitoring and Enforcement of Human Rights
    a. States should ensure monitoring and enforcement mechanisms to guarantee HIV-related human rights including those of people living with HIV, their families and communities.

Regional Caribbean guidelines are consistent with these international guidelines.

Sources

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For more information, contact:

Health Policy Project
Futures Group
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@futuresgroup.com
www.healthpolicyproject.com