



The Center for Field Assistance  
and Applied Research

AN INTRODUCTION

# HIV/AIDS Training Resource Kit

# HIV/AIDS Training Resource Kit

## At-A-Glance

Volunteer Support	Biology of HIV/AIDS	Capacity Building	Behavior Change	Assessment Analysis & Prioritizing Activities	Awareness Raising & Extension Activities	Mitigation and Care	Building Partnerships
Reducing the Volunteers' Risk of STD/HIV Exposure	<p><b>Session 1:</b> Biology of HIV/AIDS</p> <p><b>Session 2:</b> HIV Transmission</p>	<p><b>Session 1:</b> Introduction to Capacity Building in the Peace Corps Context</p> <p><b>Session 2:</b> The Role of the Volunteer in Development —Combating HIV/AIDS</p>	<p><b>Session 1:</b> Behavior Change Theory</p> <p><b>Session 2:</b> Bridge Model of Behavior Change</p> <p><b>Session 3:</b> Understanding Stigma and Discrimination Relating to HIV/AIDS</p> <p><b>Session 4:</b> Behavior Change Tool-kit Sampler</p> <p><b>Session 5:</b> Facts and Myths about HIV/AIDS</p>	<p><b>Session 1:</b> Assessment &amp; Prioritizing Basics for HIV/AIDS Prevention/ Intervention</p> <p><b>Session 2:</b> Culture, Assessment &amp; HIV/AIDS</p> <p><b>Session 3:</b> Using Assessment Data for Targeted Interventions</p> <p><b>Session 5:</b> An Appreciative Approach</p>	<p><b>Session 1:</b> Identifying Awareness Raising Opportunities and Targets</p> <p><b>Session 2:</b> Creating Messages for Target Audiences</p> <p><b>Session 3:</b> Pre-testing, Disseminating, &amp; Evaluating Extension Activities</p>	<p><b>Session 1:</b> Defining the Issues for the Volunteer</p> <p><b>Session 2:</b> Mitigation and Care: Major Issues</p> <p><b>Session 3:</b> Putting It All Together</p>	Partnership as a Strategic Response to HIV/AIDS



INFORMATION COLLECTION AND EXCHANGE

ICE NO. T0136K

# HIV/AIDS Training Resource Kit



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## Table of Contents

### An Introduction

<b>Overview</b> .....	<b>1</b>
<b>Parts of the Kit</b> .....	<b>1</b>
<b>Philosophy and Concepts</b> .....	<b>1</b>
<i>Training in low-prevalence countries</i>	
<b>Trainer/Facilitator</b> .....	<b>2</b>
<b>Training Methodology</b> .....	<b>3</b>
<b>Training Modules</b> .....	<b>3</b>
<b>Sample Training Schedules</b> .....	<b>9</b>
<b>Appendices</b> .....	<b>10</b>

*Resources-at-a-Glance*

*Location of Fact Sheets and Information Handouts*

*Annotated Peace Corps Resources*

*Digitized Videos*

### Training Modules

- 1. Volunteer Support**  
*Session: Reducing Volunteers' Risk of STI/HIV Exposure*
- 2. Biology**  
*Session 1: The Biology of HIV/AIDS*  
*Session 2: The Biology of HIV Transmission*
- 3. Capacity Building**  
*Session 1: Introduction to Capacity Building in the Peace Corps Context*  
*Session 2: The Role of the Volunteer in Development—Combating HIV/AIDS*
- 4. Behavior Change**  
*Session 1: Behavior Change Theory*  
*Session 2: The Bridge Model of Behavior Change*  
*Session 3: Understanding Stigma and Discrimination Relating to HIV/AIDS*  
*Session 4: Behavior Change Toolkit Sampler*  
*Optional Session 5: Facts and Myths about HIV/AIDS*
- 5. Assessment Analysis and Prioritizing Activities**  
*Session 1: Assessment and Prioritizing Basics for HIV/AIDS Prevention/Intervention*  
*Session 2: Culture, Assessment, and HIV/AIDS*  
*Session 3: Using Assessment Data for Targeted Interventions*  
*Optional Session 4: An Appreciative Approach*
- 6. Awareness-Raising and Extension Activities**  
*Session 1: Identifying Awareness-Raising Opportunities and Targets*  
*Session 2: Creating Messages for Target Audiences*  
*Session 3: Pre-testing, Disseminating, and Evaluating Awareness and Extension Activities*
- 7. Mitigation and Care**  
*Session 1: Defining the Issues for Volunteers*  
*Session 2: Major Issues*  
*Session 3: Putting It All Together*
- 8. Building Partnerships**  
*Session: Partnership as a Strategic Response to HIV/AIDS*



# Introduction

## Overview

The Peace Corps *HIV/AIDS Training Resource Kit* is a reference for posts. It provides session plans, fact sheets, and other resources to help tailor HIV/AIDS training in pre-service training and in-service training to the needs of various groups of trainees and Volunteers. The eight modules in the *Resource Kit* were organized around **what is already happening in the field in HIV/AIDS activities**. Reports of what Volunteers are doing were grouped by competencies needed for those activities.

This *Resource Kit* provides a comprehensive set of training resources. The modules should be used as a basis to train all Volunteers in HIV/AIDS-related issues. The amount of time dedicated to training and the types of activities the Volunteers are involved in will determine which modules and session plans to incorporate in your pre-service training or in-service training. Each post may want to modify and/or combine sessions to meet its particular needs.

We look forward to your insight and feedback on how to use these modules and sincerely hope that they will add value to Peace Corps HIV/AIDS programs in the field.

## Parts of the Kit

### Introduction and appendices

This introduction explains the basis for developing the kit, a synopsis of all the training modules and sessions, suggested ways to integrate the sessions with other training, and alternative sample schedules. How and what to train on HIV and AIDS at low-prevalence posts is also addressed. The graphic organizer on the inside front cover is a quick reference to the sessions in each module.

The Appendices will help you locate specific resources within the kit, and related resources from the Information, Collection and Exchange (ICE) unit.

The version of this kit that is in your hands has the introduction and the appendices in hard copy. The accompanying CD-ROM contains these parts plus all of the sessions. The sessions are in Microsoft Word® files so that you can download them and make your own modifications.

## The eight modules, each containing one or more sessions

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*Module 1:* **Volunteer Support**

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*Module 2:* **Biology**

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*Module 3:* **Capacity Building**

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*Module 4:* **Behavior Change**

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*Module 5:* **Assessment Analysis and Prioritizing Activities**

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*Module 6:* **Awareness-Raising and Extension Activities**

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*Module 7:* **Mitigation and Care**

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*Module 8:* **Building Partnerships**

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## Philosophy and Concepts

Two concepts are threaded throughout the sessions

1. The need to address HIV/AIDS as a development issue rather than as a health issue alone; and
2. The significance of gender in addressing HIV/AIDS.

HIV/AIDS impacts every aspect of a country's development: food and economic security, poverty levels, family and household structures, educational systems, the business sector, human resource allocation, population issues, and more. A strategic and effective response to HIV/AIDS requires a coordinated, multi- and cross-sectoral response that addresses all aspects of the pandemic.

The role of gender is recognized as a central issue in the HIV/AIDS pandemic with a disproportionate impact on women and girls. For biological, social, and cultural reasons women are more vulnerable to HIV infection. Male power and control over women present major challenges in preventing the spread of HIV/AIDS.

Two approaches toward development work are stressed throughout the curriculum. These apply to all work by Peace Corps Volunteers and support the

Peace Corps' approach to development as one that builds individual, service provider, organizational, and community capacity and that leads to sustainable development.

1. Peace Corps Volunteers should use *participatory processes* to ensure that their work is culturally appropriate, engages a broad spectrum of the community, and supports efforts to reduce gender inequities. All work should utilize *gender-sensitive strategies*—including gender analysis to understand the varying roles of men and women, approaches that are sensitive to these roles, as well as strategies that will help move communities towards gender equality.
2. Work should utilize *appreciative inquiry and approaches*—with an emphasis on starting with identifying individual and community assets rather than problems and needs.

In addition, in addressing HIV/AIDS, a key aspect of all work should be the greater involvement of people living with HIV/AIDS. Engaging people living with HIV/AIDS supports their human rights, ensures that programs and initiatives are most responsive to their needs, and is effective in reducing the stigma and discrimination that are at the root of many of the challenges in addressing HIV/AIDS.

### Special note for training in low-prevalence countries

Many countries where Peace Corps Volunteers serve are considered to be low prevalence, or countries where the HIV prevalence is less than 1 percent among the population. As a result of this low-prevalence label, HIV awareness, prevention, treatment, and care activities can also be minimal since low prevalence is sometimes equated with low priority. It is important to understand and emphasize to Volunteers that even if a country is classified as low prevalence there is still the need *and* opportunity to implement HIV/AIDS activities, keeping in mind that even those countries with current prevalence rates of 15 percent or greater (high prevalence), were once regarded as low prevalence.

Trainers should be aware of their country's prevalence rate and modify the modules accordingly. All *Resource Kit* modules can be easily adapted for low-prevalence countries and are appropriate for all Volunteers. Four

particular challenges that may be useful to consider when modifying the sessions are

**Low priority** At the policy level, governments with a low HIV-prevalence rate may be reticent to allocate resources to address HIV/AIDS when additional health, education, economic development, and defense concerns appear more critical.

**Risky behaviors do not occur in this country, so there is no need to discuss it** Sometimes low-prevalence countries incorrectly claim that the risky behaviors associated with HIV do not exist in their country and therefore the epidemic is not addressed.

**Limited ability to prioritize an HIV response** Lack of data and vulnerable but stigmatized sub-populations often hinder the direction of a thorough prevention response.

**Low individual perceived risk** The low-prevalence classification frequently provides a false sense of reality since many individuals associate low prevalence with an insignificant presence at the national level. They then adopt the attitude of “it can't happen to me.”

### Trainer/Facilitator

Specific qualifications for trainers are noted for each session. In general, trainers should have knowledge about HIV/AIDS, understand local attitudes and behaviors relating to HIV/AIDS and people living with HIV/AIDS, and appreciate, and be able to respond to, the emotional/psychological aspects of living in communities affected by HIV/AIDS—for community members and Volunteers.

Trainers should know that participants will have a wide range of knowledge, skills, attitudes, and experiences relating to HIV/AIDS. Some will have extensive knowledge—in terms of HIV biology and transmission or in terms of personal experience with family, friends, and partners who are living with, or have died from, HIV/AIDS. Other participants will not have basic knowledge about the virus and may have had no direct contact with a person with HIV/AIDS. Attitudes, behaviors, and fears that may, even unknowingly, perpetuate stigma and discrimination should be noted and addressed.

Volunteers can work with their program managers on how they might use these sessions in their communities.



## Training Methodology

Techniques to engage adult learners, who learn best through experiential and participatory processes, are used throughout the curriculum, including

- Role plays
- Case studies
- Brainstorming
- Cardstorming
- Panel discussions  
(content experts, Volunteers, and people living with HIV/AIDS)
- Group learning/discussion strategies

Role plays and case studies are included for use. **However, trainers are encouraged to use these as a guide for creating scenarios that may be more relevant and applicable for the local communities where Volunteers will work.** Where appropriate, trainees and Volunteers can be asked to create their own scenarios. This is particularly true if sessions are conducted during an in-service training.

Adult learners learn through different styles. A session that trainers should review for their own information about learning styles is found in the Awareness-Raising Module—Session Two.

## Training Modules

The competencies for each module, a synopsis of the sessions, and suggestions for integrating module content into other pre-service training and in-service training topics are described below.

### I. Volunteer Support

#### Competencies

Volunteers should know their role in keeping themselves mentally and physically healthy while at post, particularly in relation to sexually transmitted infections and diseases (STIs and STDs). Specifically, they should be able to

- Discuss common STIs including HIV, their symptoms and modes of transmission.

- Name reasons why trainees/Volunteers may be at risk for HIV/AIDS during service.
- Assess their own risks and identify ways to prevent personal exposure to STIs while serving.

#### Rationale and synopsis of the session

All Peace Corps trainees and Volunteers are sexual beings and therefore may be sexually active during service. Statistics show that 90 percent of Volunteers are sexually active by their close of service and only 30 percent use condoms. This session aims to make trainees aware of factors that may cause them to be less careful than they might predict, and the risks they face if they are not vigilant.

In this session, *Reducing Volunteers' Risk of STI/HIV Exposure*, participants learn/relearn about common STIs including HIV, explore causes of high risk to Volunteers, predict their own risk of exposure, learn about other Volunteers' experiences, and learn several ways to prevent personal exposure.

#### Suggestion for integration with other pre-service training or in-service training sessions

This session may be part of a longer session on health that deals with other local health concerns, and/or it may integrate much of the Biology Module.

## 2. Biology

#### Competencies

Volunteers should have a basic understanding of the biology of HIV/AIDS. They should be able to

- Describe a virus and identify the unique characteristics of HIV.
- Explain the difference between HIV and AIDS.
- Explain how HIV is and is not transmitted, why some seemingly healthy people can transmit HIV and how transmission can be prevented.
- Identify risk factors for contracting HIV, including the role of STIs and the overall increased risk of girls and women.
- Explain the relationship between nutrition and other health factors and HIV/AIDS.
- Explain the role of medication in treatment of opportunistic infections and AIDS.

### Rationale and synopsis of sessions

According to the 2005 International Center for Research on Women (ICRW) publication *Common at Its Core: HIV-Related Stigma Across Contexts*, inadequate knowledge about how HIV is and is not transmitted is a major cause of stigma. If Volunteers can play a key role in HIV education that includes discussion and questions and answers, some of the “what if” scenarios people create might be avoided. This may result in fewer people stigmatized, more people willing to be tested, less transmission, and more people able to live positively with HIV. Consider training all trainees or Volunteers with this module.

*Session One: The Biology of HIV/AIDS* covers the immune system and HIV, the HIV lifecycle and AIDS, the relationship of nutrition and other health factors, and antiretroviral medications.

*Session Two: The Biology of HIV Transmission* covers transmission in great detail, gender and biological risk factors, other risk factors (STI/Ds, needles), and prevention.

### Suggestion for integration with other pre-service training or in-service training sessions

Trainees receive some training in HIV and AIDS during their pre-service training personal health session (see Module 1: Volunteer Support), typically facilitated by the Peace Corps medical officer. The *Resource Kit's* biology sessions can augment that information and be integrated accordingly.

- Explain how to identify and support individuals, families, groups, and organizations to build a community's capacity to address HIV/AIDS.
- Discuss how to link capacity building to local, national, and the Peace Corps' global strategy for addressing HIV/AIDS.

### Rationale and synopsis of sessions

As with all Peace Corps activities, Volunteers' work will be most culturally effective and have the most impact if they collaborate with and build capacity of the people with whom they work.

*Session One: Introduction to Capacity Building in the Peace Corps Context* reviews the Peace Corps concept of development and capacity-building levels, and helps trainees see their potential roles as capacity builders, (with reference to the *Roles of the Volunteer in Development*) specifically in relationship to HIV/AIDS activities through a Peace Corps Volunteer panel and scenarios.

*Session Two: The Role of the Volunteer in Development—Combating HIV/AIDS* helps trainees and Volunteers understand key factors relating to the worldwide pandemic and organizational responses—the “big picture” of who is doing what to address HIV/AIDS in their country and community. With this information, a Volunteer is able to see his or her strategic niche more clearly.

### Suggestion for integration during pre-service training or in-service training sessions

The capacity-building modules can be integrated into the pre-service training sessions on development, and the roles in development that Volunteers play. Additionally, these sessions can reinforce the roles of Volunteers in development during an in-service training.

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## 3. Capacity Building

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### Competencies

Volunteers should be engaged in activities that build human capacity, in keeping with the Peace Corps' approach to development. Volunteers are expected to

- Explain the concept of capacity building, how it relates to HIV/AIDS, and the roles of a Volunteer as a capacity builder.
- Describe how to utilize capacity-building principles in working with individuals (peer education, counterparts, service providers, religious leaders, community leaders), families, organizations (non-governmental organizations [NGOs], faith-based organizations [FBOs], and others), and communities.

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## 4. Behavior Change

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### Competencies

Volunteers should understand the complexities of behavior change and be able to

- Articulate the “Stages of Change Theory” of behavior change.
- Describe how the “Bridge Model” can be used to visualize what is needed to link knowledge to healthy, positive behavior.

- Identify political, gender-related, and economic factors that may prevent individuals (particularly girls and women) from adopting behavior that prevents the transmission of HIV.
- Describe the role of culture, religion, and other belief systems in behavior change.
- Describe how stigma and discrimination act as major barriers to behavior change relating to HIV/AIDS, and how to implement activities to address stigma and discrimination.
- Articulate strategies for achieving behavior change goals.

### Rationale and synopsis of sessions

Changing behavior is a key factor in combating the HIV/AIDS pandemic, but behavior change is a complex issue, even without considering cross-cultural factors.

*Session One: Behavior Change Theory* introduces trainees to the development of a currently used model of behavior change communication. They learn about the steps involved in changing behavior, the factors that influence behavior change, and some strategies that are effective at various levels.

*Session Two: The Bridge Model of Behavior Change* teaches how a life skills program provides context for and skills to change behavior. This session can be used as an introduction to the *Life Skills Manual*.

*Session Three: Understanding Stigma and Discrimination Relating to HIV/AIDS* addresses the factors leading to stigma and discrimination, forms and expressions of stigma and discrimination, effects of stigma and discrimination on testing and caring for people living with HIV/AIDS, and the key role Volunteers can play in educating people about the transmission of HIV and AIDS to help eliminate some causes of stigma and discrimination. (See the Biology Module.)

*Session Four: Behavior Change Toolkit Sampler* is a practicum where trainees or Volunteers learn about existing HIV/AIDS training materials and, in small groups, learn how to select and present a segment of training to a target audience—practicing first on their fellow trainees, and then with a group in the community.

*Optional Session Five: Facts and Myths About HIV/AIDS* helps trainees or Volunteers explore different beliefs that affect attitudes about HIV/AIDS, and how these impact behavior change. This is a cross-cultural session and can be integrated with other cross-cultural sessions.

### Suggestion for integration during pre-service training or in-service training sessions

Sessions One and Two can be incorporated with the *Life Skills Manual* [ICE No. M0063] session that is typically presented during pre-service training. Sessions Three and Five could be linked to the different cross-cultural and diversity sessions that are also part of pre-service training. Session Four with its practical application is an effective way to reinforce behavior change communication and could be combined with activities during a pre-service training practicum. Alternatively, these sessions could also be used as a way to draw upon Volunteer experiences at site and presented during in-service training or reconnect.

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## 5. Assessment Analysis and Prioritizing Activities

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### Competencies

Volunteers need to know how to assess what is currently happening in their community related to HIV/AIDS and be able to

- Identify sources of assessment information for a community and how to access, evaluate, and use this information to assess the prevalence and impact of HIV/AIDS in the community as well as what is currently being done to address HIV/AIDS.
- Use asset-based and participatory processes to learn about the community in a way that informs project planning from the points of view of all segments of the community.
- Use assessment analysis to learn how individuals, institutions, and other stakeholders view issues relating to HIV/AIDS.
- Describe how culture and other aspects of one's identity impact expectations, behaviors, and attitudes relating to HIV/AIDS and work in a cross-cultural setting.
- Explain how to utilize assessment information to prioritize activities and develop multi-sectoral responses to HIV/AIDS.
- Describe basic monitoring, evaluation, and reporting principles and how their periodic reports fit into the Peace Corps system of reporting.

### Rationale and synopsis of sessions

In order to engage in HIV/AIDS activities that are linked to real needs and what others are already doing, Volunteers need the knowledge and the skills to read and use existing assessment data, as well as skills to conduct assessment activities. This module also teaches how to read and interpret surveillance data available from various sources.

*Session One: Assessment and Prioritizing Basics for HIV/AIDS Prevention/Intervention* provides an introduction to the importance of assessment in designing any activity to address HIV and AIDS and the value of appreciative and participatory approaches.

*Session Two: Culture, Assessment, and HIV/AIDS* explores the significance of culture—the trainee's/Volunteer's and the host country's—in thinking about, and ultimately, addressing HIV/AIDS.

*Session Three: Using Assessment Data for Targeted Interventions* helps trainees/Volunteers read and interpret HIV/AIDS assessment data related to prevalence levels, and use it to help target potential activities.

*Optional Session Four: An Appreciative Approach* provides specific training in appreciative inquiry, and may be useful especially for Volunteers during in-service training if they have not had training in this approach.

### Suggestions for integration during pre-service training or in-service training sessions

These sessions can be integrated with any session in pre-service training about participatory analysis for community action (PACA), appreciative approaches, and applied during a practicum. These sessions might also be included with project design and management during pre-service training or in-service training.

and implement awareness and prevention programs that target specific audiences.

- Develop culturally appropriate messages for awareness-raising and extension activities.
- Use knowledge of HIV/AIDS biology, behavior change theory, capacity building, assessment, and culturally appropriate methods to design and implement awareness-raising/extension activities (through existing settings, appropriate teachers/leaders, recognized media and methods).
- Integrate HIV/AIDS awareness raising into multi-sectoral activities.

### Rationale and synopsis of sessions

Most Peace Corps Volunteers will have some opportunity to be involved in raising awareness about HIV/AIDS prevention. This module provides knowledge and skills to help Volunteers be more strategic in their planning.

*Session One: Identifying Awareness-Raising Opportunities and Targets* focuses on how to strategically identify and analyze a project's target audience and communication goal(s) and objectives for awareness-raising and extension activities.

*Session Two: Creating Messages for Target Audiences* provides knowledge and skills related to the development and dissemination of messages that are culturally appropriate and effective. Understanding individual learning styles as an aspect of developing effective messages is part of this session.

*Session Three: Pre-Testing, Disseminating, and Evaluating Awareness and Extension Activities* focuses on how to verify that the message intended is the one received; approaches that engage participation from those with strong influence over the target audience and those directly impacted by HIV/AIDS; and some ways to measure the effects of the campaign.

### Suggestions for integration during pre-service training or in-service training sessions

These sessions can be integrated with PACA and practicum activities during pre-service training and in program design and management at an in-service training. Since some Peace Corps projects specifically focus as extension work, these sessions reinforce the essence of certain Volunteers' service.

## 6. Awareness-Raising and Extension Activities

### Competencies

Volunteers should know how awareness-raising and extension activities can best be organized and carried out and be able to

- Use local, regional, national, and global statistics and HIV/AIDS prevalence information to plan

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## 7. Mitigation and Care

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### Competencies

Volunteers should understand the major issues relating to the care and support of people living with HIV/AIDS and be able to help assess and plan for multi-sectoral approaches to help them live positively. Volunteers should be able to

- Explain what it means to “live positively” with HIV/AIDS.
- Describe how mitigation and care activities can decrease the stigma of living with HIV/AIDS.
- Outline the major issues relating to mitigation and care for people living with HIV/AIDS, their families and communities, including those relating to nutrition, emotional support, home-based care, economic issues, orphans and vulnerable children, and ARV treatment.
- Define the range of mitigation and care activities appropriate for Volunteers.
- Assess for, plan, and implement appropriate and effective multi-sectoral initiatives to support positive living for people living with HIV/AIDS.
- Know about and be able to suggest resources and referrals.

### Rationale and synopsis of sessions

While prevention of HIV/AIDS is the focus for most Peace Corps Volunteers, many prevention projects will take place within the context of mitigation and care for people living with HIV/AIDS, their families, and communities. In addition, some Volunteers will work on primary projects relating to mitigation and care issues for people living with HIV/AIDS. In countries where there is high generalized prevalence of HIV/AIDS, all Peace Corps projects should contribute to creating positive living environments for people living with HIV/AIDS.

*Session One: Defining the Issues for Volunteers* introduces participants to the concept of positive living for people living with HIV/AIDS and provides an overview of what is needed to create an environment where positive living is possible. Ideally, this session includes a panel of people living with HIV/AIDS as both an opportunity for Volunteers to hear directly from those most impacted and as a way to model the role people living with HIV/AIDS should have in their work.

*Session Two: Major Issues* provides a basic understanding of best practices relating to some of the major issues for people living with HIV/AIDS, their families, caretakers and communities, including health and medical issues, social/emotional/psychological support, orphans and vulnerable children, spiritual issues, economic security, and nutrition and food.

*Session Three: Putting It All Together* provides an opportunity to apply knowledge and skills gained in previous sessions to identify areas of need related to HIV/AIDS mitigation and care and to develop action plans for addressing specific gaps in services.

### Suggestions for integration during pre-service training or in-service training sessions

For those countries where HIV/AIDS is a primary project assignment for Volunteers, integrate this module into pre-service training as it promotes positive living environments for people living with HIV/AIDS. In other countries where HIV/AIDS effects focus primarily on awareness raising and prevention, use this module as an in-service training session or as an elective resource.

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## 8. Building Partnerships

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Volunteers should know how to make links with existing groups, service providers, and organizations. Volunteers should be able to

- Describe how partnerships can be a strategic response to HIV/AIDS in a community.
- Utilize participatory processes, such as community asset mapping, to identify appropriate existing and potential partnerships.
- Provide technical assistance and capacity-building support to organizations to help them form and manage partnerships and community coalitions.

### Rationale and synopsis of sessions

Collaboration and partnering are integral aspects of the Peace Corps’ approach to development. This session provides knowledge and skills to help Volunteers understand how organizations function and how to identify and form effective partnerships.

*Session: Partnership as a Strategic Response to HIV/AIDS* helps Volunteers understand the role of collaboration and partnerships in meeting goals to address HIV/AIDS and insight into how organizations func-

tion. The session prepares Volunteers to meet with and interview private sector organization staff and provides an opportunity for community-based learning where Volunteers explore local organizations and their partnerships through face-to-face interviews.

### **Suggestions for integration during pre-service training or in-service training sessions**

This module directly builds upon the four partner levels for the Peace Corps: individual, service provider, organization, and community. It can be integrated with any session that highlights partnering organizations and the ways in which HIV/AIDS affects partnering opportunities when the project plan is presented during pre-service training. During in-service training, conduct this session to further expand the partnering opportunities for a Volunteer.

### **Modules for pre-service training**

Rather than having the HIV/AIDS information presented in a four-day block, post might consider the integration opportunities of this cross-cutting initiative and how these different modules can assist in achieving the training competencies.

**Biology** Incorporate these sessions with personal health during pre-service training as a follow up to the Peace Corps medical officer session (“Avoiding STI/HIV”) for all trainees. The biology and HIV transmission sessions are good reinforcements of the desire to stay healthy during one’s service.

**Capacity Building** Integrate with the roles of the Volunteer in development (RVID) sessions during pre-service training—this suggestion is listed in the synopsis of sessions and though a Volunteer panel may not be the presentation method at each, this topic of RVID is addressed by each post. Additionally, the agency initiative report (IR) is a useful resource in presenting Volunteers’ achievements within the different capacity-building levels. For low-prevalence countries, Session Two might also benefit from utilizing the data in the IRs, the HIV/AIDS task force or committee in discussing the Volunteers’ strategic niche.

**Behavior Change** If the *Life Skills Manual* is used during pre-service training, then staff can conduct Sessions One and Two as components supporting the *Life Skills Manual*. If not, then post might also consider using this manual as a tool for Volunteers and trainees. Sessions Three and Five can be integrated into cross-cultural sessions—especially the reference to the Volunteers’ ability to serve as educators about the biology of HIV and the prevention of its transmission as well as the facts and myths and how these apply in the host country.

**Assessment and Prioritizing Activities** All four sessions are relative to PACA and how Volunteers can be effective with the appropriate targeting. Use appreciative inquiry to segue into an in-service training.

**Modules for in-service training** is the same as above with these additions

- Awareness-Raising and Extension Activities
- Building Partnerships

## Sample Training Schedules

### Four Day Training—Pre-service training

Module	Session	Time	Day
Biology	One: <i>The Biology of HIV/AIDS</i>	2 ½ hours	1
Biology	Two: <i>The Biology of HIV Transmission</i>	1 ¾ hours	1
Capacity Building	One: <i>Introduction to Capacity Building in the Peace Corps Context</i>	2 hours	1
Capacity Building	Two: <i>The Role of the Volunteer in Development—Combating HIV/AIDS</i>	2 ¾ hours	2
Behavior Change	One: <i>Behavior Change Theory</i>	2 to 2 ½ hours	2
Behavior Change	Three: <i>Understanding Stigma and Discrimination Relating to HIV/AIDS</i>	2 ½ hours	2
Assessment Analysis and Prioritizing Activities	One: <i>Assessment and Prioritizing Basics for HIV/AIDS Prevention/Intervention</i>	2 ¾ hours	3
Assessment Analysis and Prioritizing Activities	Two: <i>Culture, Assessment, and HIV/AIDS</i>	2 hours	3
Mitigation and Care	One: <i>Defining the Issues for the Volunteer</i>	2 to 2 ½ hours	3
Awareness-Raising and Extension Activities	One: <i>Identifying Awareness-Raising Opportunities and Targets</i>	2 ¼ hours	4
Awareness-Raising and Extension Activities	Two: <i>Creating Messages for Target Audiences</i>	3 ¼ hours	4
Assessment Analysis and Prioritizing Activities	Four: <i>An Appreciative Approach</i>	1 ¾ hours	4 (Closing)

### Three Day—In-service training

Module	Session	Time	Day
Behavior Change	Five: <i>Facts and Myths About HIV/AIDS</i>	1 ½ hours	1
Behavior Change	Four: <i>Behavior Change Toolkit Sampler—first two parts</i>	3 hours	1
Assessment Analysis and Prioritizing Activities	Three: <i>Using Assessment Data for Targeted Interventions</i>	1 ½ hours	1
Awareness-Raising and Extension Activities	Three: <i>Pre-Testing, Disseminating, and Evaluating Awareness and Extension Activities</i>	2 hours	1
Building Partnership	One: <i>Partnership as a Strategic Response—Part 1</i>	2 hours	2
Building Partnership	One: <i>Partnership as a Strategic Response—Part 2</i>	½ day	2
Building Partnership	One: <i>Partnership as a Strategic Response—Part 3</i>	1 ¾ hours	3
Mitigation and Care	Two: <i>Major Issues</i>	1 hour 50 minutes	3
Mitigation and Care	Three: <i>Putting It All Together</i>	1 hour 50 minutes	3
Behavior Change	Four: <i>Behavior Change Toolkit Sampler—presentations</i>	1 hour	3

## Appendix I: Resources-at-a-Glance

The following cross-references should help you find materials related to various topics in the kit or in ICE. As you work with the *HIV/AIDS Training Resource Kit*, add other HIV/AIDS resources to this chart for future reference. The exact location of fact sheets and other information sheets can be found in Appendix II.

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>ABC</b>	<i>Biology, Session 2</i>	ABC Approach			<a href="http://www.state.gov/documents/organization/58270.pdf">http://www.state.gov/documents/organization/58270.pdf</a>	
<b>Adults</b>	All sessions in all modules are written for adult learners		Common Sexually Transmitted Infections and Symptoms HIV/AIDS Interventions with Men Who Have Sex with Men Preparing for Guest Speakers Who Are Experts Preparing for Guest Speakers Who Are People Living with AIDS Guidelines/Information for Participation in Peace Corps Volunteer Panels <i>Nonformal Education Manual</i> [ICE No. M0042] See pages 9-10 on adult learning.			
<b>ARV/ART</b>	<i>Biology, Session 1, Part V</i>	Antiretroviral Drugs for HIV/AIDS	Blocking HIV Reproduction: How ARVs Work (diagram)	<i>Life Skills Manual</i> [ICE No. M0063]		
<b>Assessment</b>	<i>Assessment Analysis and Prioritizing Activities</i> <i>Awareness-Raising and Extension Activities Session 1</i>		An Effective HIV/AIDS Strategy Four-D Cycle of Appreciative Inquiry Interpreting Surveillance Data Interviewing Skills (from <i>An NGO Training Guide for Volunteers</i> [ICE No. M0070]) Measures of Success Potential Pre-Test Questions for Awareness-Raising Materials/Follow-up to Pre-Test Roles for Community Participation in Strategic Planning Sources of HIV/AIDS Assessment Information Behavior Change and Communication—Targeting Men with Multiple Partners	<i>HIV/AIDS Idea Book</i> [ICE No. M0081] <i>PACA Idea Book</i> [ICE No. M0086] <i>PACA Training Manual</i> [ICE No. M0053] <i>New Project Design and Management Training Manual</i> [ICE No. T0107] <i>Programming and Training Booklet 2</i> [ICE No. T0114] <i>Working with CCBI</i> [ICE No. M0073]		



Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Awareness Raising</b>	<i>Awareness Raising and Extension Activities, Session 1</i>  <i>Behavior Change</i>		Diffusion of Innovation (with role play) <i>HIV/AIDS Idea Book</i> [ICE No. M0081] <i>Life Skills Manual</i> [ICE No. M0063] Potential Pre-Test Questions for Awareness-Raising Materials/Follow-up to Pre-Test Recommendations for Awareness-Raising Activities Vietnam Case Study Ethiopia Case Study			
<b>Behavior Change (BCC)</b>	<i>Behavior Change</i>  <i>Awareness Raising and Extension Activities</i>		Behavior Change and Communication Strategies (diagram) From Information to Behavior Change: Trends in HIV Prevention Persuading Your Partner to Use a Condom Principles of Behavior Change and How the Life Skills Program Mirrors These Principles Role Plays for Bridge Model of Behavior Change (Life Skills)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>The Roles of the Volunteer in Development</i> [ICE No. T0005]  <i>Life Skills Manual</i> [ICE No. M0063]  <i>Promoting Powerful People</i> [ICE No. T0104]		
<b>Capacity Building</b>	<i>Capacity Building</i>  <i>Mitigation and Care, Session 2</i>		Scenarios for Human Capacity Building Approaches  Volunteer Success Stories	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>The Roles of the Volunteer in Development</i> [ICE No. T0005]  <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Caregivers</b>	<i>Mitigation and Care, Session 2</i>	Supporting People with HIV/AIDS: Community Home-based Care	Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children  Health and Medical Issues (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]		

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Condoms</b>	<i>Biology, Session 2</i>	UNAIDS	Condom Issues— Selection, Technique, and Cooperation  Female Condom  Instruction for Male Condom Use  Persuading Your Partner to Use a Condom			
<b>Counseling and Training</b>	<i>Mitigation and Care, Sessions 1 and 3</i>  <i>Biology, Session 1</i>	HIV Counsel- ing and Testing  Tuberculosis and HIV/AIDS		<i>Life Skills Manual</i> [ICE No. M0063]		
<b>Culture and HIV/AIDS</b>	<i>Capacity Building, Session 2</i>  <i>Assessment Analysis and Prioritizing Activities</i>  <i>Awareness Raising and Extension Activities, Session 2</i>		Cultural Factors Relevant to Capacity Building and HIV/AIDS  <i>Culture Matters</i> , Appendix: How to learn culturally appro- priate ways to talk and learn about HIV/AIDS in communities  Persuading Your Partner to Use a Condom	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Culture Matters</i> [ICE No. T0087]  <i>Culture Matters Trainer's Guide</i> [ICE No. T0103]  <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Food Security</b>	<i>Mitigation and Care, Session 2</i>	HIV/AIDS and Economic Security	Economic Security Issues (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>A Community Eco- nomic Development (CED) Training Guide for Peace Corps Volunteers</i> [ICE No. M0069]  <i>A Microenterprise Training Guide for Peace Corps Volunteers</i> [ICE No. M0068]		

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Gender</b>	<i>Biology, Session 2</i>  <i>Behavior Change, Sessions 1, 3, and 4</i>  <i>Capacity Building, Session 2</i>	Gender and HIV/AIDS	The Female Condom	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Life Skills Manual</i> [ICE No. M0063]  <i>PACA Idea Book</i> [ICE No. M0086]  <i>PACA Training Manual</i> [ICE No. M0053]  <i>In the Classroom: Empowering Girls Idea Book</i> [ICE No. M0083]  <i>Beyond the Classroom: Empowering Girls Idea Book</i> [ICE No. M0080]  <i>Camp Glow: Girls Leading Our World</i> [ICE No. M0056]		
<b>Global HIV/AIDS Epidemic</b>	<i>Capacity Building, Session 2</i>  <i>Assessment Analysis and Prioritizing Activities, Session 1</i>		Global Fund to Fight AIDS, Tuberculosis and Malaria Global HIV/AIDS Epidemic			
<b>Grief and Loss</b>	<i>Mitigation and Care, Session 1</i>					
<b>Home-based Care</b>	<i>Mitigation and Care, Session 2</i>	Supporting People with HIV/AIDS: Community Home-based Care				
<b>Life Skills</b>	<i>Behavior Change, Sessions 1, 2, 3 and 4</i>	Gender and HIV/AIDS		<i>Life Skills Manual</i> [ICE No. M0063]  <i>Working with Youth: Approaches for Volunteers</i> [ICE No. M0067]  <i>Camp Glow: Girls Leading Our World</i> [ICE No. M0056]		
<b>Livelihoods</b>	<i>Mitigation and Care, Session 2</i>	HIV/AIDS and Economic Security	Nutrition and Food Security Issues (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]		

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	
					Resources	Videos
<b>Living Positively with HIV/AIDS</b>	<i>Mitigation and Care, Session 1</i>	Spirituality and Treatment of People Living with HIV  Supporting People with HIV/AIDS: Community Home-based Care  HIV and Economic Security  Antiretroviral Drugs for HIV/AIDS	Case Studies for “What would have helped (X)?”  Profiles of People Living with HIV/AIDS—for readers’ theater/panel  Social/Emotional/Psychological Issues (to discuss with experts)  Spiritual Issues (to discuss with experts)  Nutrition and Food Security Issues (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Monitoring and Evaluation</b>	<i>Awareness-Raising and Extension Activities, Session 3</i>  <i>Assessment Analysis and Prioritizing Activities</i>		Measures of Success  Potential Pre-Test Questions for Awareness-Raising Materials/Follow-up to Pre-Test	<i>Programming and Training Booklet 4</i> [ICE No. T0116]  <i>New Project Design and Management Training Manual</i> [ICE No. T0107]		
<b>NGOs and other organizations</b>	<i>Capacity Building, Session 1</i>  <i>Building Partnerships</i>		Characteristics of Different Types of Organizations	<i>An NGO Training Guide for Peace Corps Volunteers</i> [ICE No. M0070]		
<b>Nutrition</b>	<i>Biology, Session 1</i>  <i>Mitigation and Care, Session 2</i>	Nutrition and HIV/AIDS	Nutrition and Food Security Issues (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Promoting Powerful People</i> [ICE No. T0104]  <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Organizational Responses to HIV/AIDS</b>	<i>Capacity Building, Session 2</i>  <i>Awareness-Raising and Extension Activities, Session 1</i>  <i>Building Partnerships</i>	UNAIDS  The President’s Emergency Plan for AIDS Relief (PEPFAR)	Global Fund to Fight AIDS, Tuberculosis and Malaria  Peace Corps’ Approach to Development  Peace Corps Work in HIV/AIDS  “Three Ones” Key Principles  World Health Organization	<i>An NGO Training Guide for Peace Corps Volunteers</i> [ICE No. M0070]	PEPFAR: Partners: <a href="http://www.pepfar.gov/partners/">http://www.pepfar.gov/partners/</a>  Strategy: <a href="http://www.pepfar.gov/about/c19380.htm">http://www.pepfar.gov/about/c19380.htm</a>	
<b>Orphans and Vulnerable Children (OVC)</b>	<i>Mitigation and Care, Session 2</i>	Care for Orphans and Vulnerable Children	Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children  Orphans and Vulnerable Children (to discuss with experts)	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Working with Youth: Approaches for Volunteers</i> [ICE No. M0067]	<a href="http://www.state.gov/s/gac/rl/fs/2006/65910.htm">http://www.state.gov/s/gac/rl/fs/2006/65910.htm</a>	“Forgotten Children” (USAID)

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Partnerships</b>	<i>Building Partnerships, Session 1</i>		Information to Explore about Organizations (chart) Key Partners for Expanded and Comprehensive (ECR) Strategic Planning Questions About Organizations Role Play for Exploring Partnerships of An Organization	<i>An NGO Training Guide for Peace Corps Volunteers</i> [ICE No. M0070]	Public-Private Partnerships: <a href="http://www.pepfar.gov/c19654.htm">http://www.pepfar.gov/c19654.htm</a> New Partners Initiative: <a href="http://www.pepfar.gov/c19532.htm">http://www.pepfar.gov/c19532.htm</a>	
<b>Pediatric</b>	<i>Biology, Session 2</i>	Care for Orphans and Vulnerable Children	Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children Orphans and Vulnerable Children (to discuss with experts)	<i>A New Beginning: The Child Health Manual</i> [ICE No. T0102]		
<b>Peer Education</b>	<i>Behavior Change, Session 2</i> <i>Awareness-Raising and Extension Activities, Session 3</i>		Should I Use a Peer Education Approach?	<i>Working with Youth: Approaches for Volunteers</i> [ICE No. M0067] <i>Life Skills Manual</i> [ICE No. M0063]		
<b>PEPFAR</b>	<i>Capacity Building, Session 2</i>	The President's Emergency Plan for AIDS Relief (PEPFAR)			PEPFAR funding: <a href="http://www.state.gov/s/gac/progress/other/data/program/">http://www.state.gov/s/gac/progress/other/data/program/</a> Focus Countries: <a href="http://www.state.gov/s/gac/rl/fs/c18692.htm">http://www.state.gov/s/gac/rl/fs/c18692.htm</a>	"Turning Hope Into Action; The Peace Corps Responds to the HIV/AIDS Crisis" (Office of AIDS Relief)
<b>Permaculture</b>	<i>Mitigation and Care, Session 2</i>			<i>HIV/AIDS Idea Book</i> [ICE No. M0081] <i>Life Skills Manual</i> [ICE No. M0063]		
<b>People Living with HIV/AIDS</b>	<i>Behavior Change, Session 3</i> <i>Mitigation and Care Session 1</i> <i>Awareness Raising, Session 2</i>	Supporting People with HIV/AIDS: Community Home-based Care Spirituality and Treatment of People Living with HIV Antiretroviral Drugs for HIV/AIDS HIV/AIDS and Economic Security	Preparing for Guest Speakers Who Are People Living with AIDS Social/Emotional/Psychological Issues (to discuss with experts)	<i>Life Skills Manual</i> [ICE No. M0063]	Supporting Treatment: <a href="http://www.pepfar.gov/about/c19384.htm">http://www.pepfar.gov/about/c19384.htm</a>	

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	
					Resources	Videos
<b>Preventing Mother to Child Trans- mission (PMTCT)</b>	<i>Biology, Session 2</i>	HIV and Its Transmission	Integration of Targeted Prevention Into Other Ser- vices and Sectors  Mother to Child Transmission			
<b>Prevention</b>	<i>Biology, Session 2</i>	HIV and Its Transmission  Tuberculosis and HIV/AIDS	Integration of Targeted Prevention Into Other Ser- vices and Sectors	<i>Life Skills Manual</i> [ICE No. M0063]		
<b>Spirituality</b>	<i>Mitigation and Care, Session 2</i>	Spirituality and Treatment of People Living with HIV	Spiritual Issues (to discuss with experts)	<i>Life Skills Manual</i> [ICE No. M0063]		
<b>Sexually Transmitted Infections (STIs)</b>	<i>Biology, Session 1</i>  <i>Biology, Session 2</i>	HIV and Its Transmission		<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Stigma and Discrimina- tion</b>	<i>Biology, Session 1</i>  <i>Capacity Building, Session 2</i>  <i>Behavior Change, Session 3</i>  <i>Awareness- Raising and Extension Activities, Session 1</i>		Expressions and Forms of Stigma  Examples of Knowledge as a Root Cause of Stigma  Recommendations for Com- bating Stigma  Stigma and Discrimination and HIV/AIDS	<i>Life Skills Manual</i> [ICE No. M0063]	Forgotten Children” (USAID)	
<b>Tuberculo- sis (TB)</b>	<i>Biology, Session 1</i>	Tuberculosis and HIV/AIDS	Global Fund to Fight AIDS, Tuberculosis and Malaria			

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Training</b>			Preparing for Guest Speakers Who Are Experts Preparing for Guest Speakers Who Are People Living with AIDS Guidelines/Information for Participation in Peace Corps Volunteer Panels Case Studies for “What would have helped (X)?” Profiles of People Living with HIV/AIDS—for readers’ theater/panel Role Play for Exploring Partnerships of An Organization Role Plays for Bridge Model of Behavior Change (Life Skills) Scenarios for Human Capacity Building Approaches Ethiopia Case Study and Vietnam Case Study (for awareness raising and extension activities)	<i>The Roles of the Volunteer in Development</i> [ICE No. T0005] <i>Nonformal Education Manual</i> [ICE No. M0042] <i>Life Skills Manual</i> [ICE No. M0063]		
<b>Transmis- sion</b>	<i>Biology, Session 2</i>	HIV and Its Transmission	Biologic Host-Related Factors Affecting Sexual Transmission Biological Risk Factors of HIV Transmission Blocking HIV Reproduction: How ARVs Work (diagram) HIV Prevention in Mobile Populations Stages of HIV/AIDS Infection for Adults Life Cycle of HIV Infection Statement on Kenya and Ugandan Trial Findings Regarding Male Circumcision and HIV (WHO) Universal Precautions	<i>Life Skills Manual</i> [ICE No. M0063] <i>HIV/AIDS Idea Book</i> [ICE No. M0081]		
<b>Virus</b>	<i>Biology, Session 1</i>	HIV and Its Transmission	HIV Life Cycle Activity Life Cycle of HIV (diagram) Measures of Disease Frequency	<i>Life Skills Manual</i> [ICE No. M0063]		
<b>Volunteer Health</b>	<i>Volunteer Support Biology, all sessions</i>		Universal Precautions Volunteers working in High Stigma Communities	<i>Pre-Service Health Training for Volunteers</i> (resource PCMO has)		“Come Back Healthy” (Office of Medical Services)

Topics	Module/ Session Plans	Fact Sheets	Other Information Sheets	References to Other Peace Corps-Produced Publications	Selected Related Electronically Available Resources	Videos
<b>Vulnerable Groups</b>	<i>Capacity Building, Ses- sions 1 and 2</i>	Care for Orphans and Vulnerable Children	HIV/AIDS Interventions with Men Who Have Sex with Men  Reducing HIV in Injection Drug Users  Behavior Change and Communication: Targeting Men with Multiple Partners	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Life Skills Manual</i> [ICE No. M0063]		"Forgotten Children" (USAID)
<b>Youth</b>	<i>Biology, Session 2</i>  <i>Behavior Change, Session 2</i>	Care for Orphans and Vulnerable Children	HIV Interventions with Youth	<i>HIV/AIDS Idea Book</i> [ICE No. M0081]  <i>Life Skills Manual</i> [ICE No. M0063]  <i>Working with Youth: Approaches for Volunteers</i> [ICE No. M0067]  <i>Camp Glow: Girls Leading Our World</i> [ICE No. M0056]  <i>Community Content- based Instruction</i> [ICE No. T0112]  <i>Working with CCBI</i> [ICE No. M0073]		"Forgotten Children" (USAID)

*Note: Inclusion of Web addresses or links to websites in this chart does not indicate endorsement of content or work program.  
All sites last accessed on May 29, 2007.*



## Appendix II: Location of Fact Sheets and Information Handouts

Throughout the modules there are fact sheets and other handouts of information that might be useful in other situations. Below is an alphabetical list to help you quickly locate them.

### Fact Sheets

Title	Location (Module, Session)
<b>ABC Approach</b>	<i>Biology, Session 2;</i> <i>Awareness-Raising and Extension Activities, Session 1</i>
<b>Antiretroviral Drugs for HIV/AIDS</b>	<i>Biology, Session 1;</i> <i>Mitigation and Care, Session 2</i>
<b>Care for Orphans and Vulnerable Children</b>	<i>Mitigation and Care, Session 2</i>
<b>Gender and HIV/AIDS</b>	<i>Capacity Building, Session 2</i>
<b>HIV/AIDS and Economic Security</b>	<i>Mitigation and Care, Session 2</i>
<b>HIV and Its Transmission</b>	<i>Biology, Session 2</i>
<b>HIV Counseling and Testing</b>	<i>Mitigation and Care, Session 2</i>
<b>Nutrition and HIV/AIDS</b>	<i>Biology, Session 1;</i> <i>Mitigation and Care, Session 2</i>
<b>President's Emergency Plan for AIDS Relief</b>	<i>Capacity Building, Session 2</i>
<b>Spirituality and Treatment of People Living with HIV</b>	<i>Mitigation and Care, Session 2</i>
<b>Supporting People with HIV/AIDS: Community Home-Based Care</b>	<i>Mitigation and Care, Session 2</i>
<b>Tuberculosis and HIV/AIDS</b>	<i>Biology, Session 1</i>
<b>UNAIDS</b>	<i>Capacity Building, Session 2</i>

### Information Handouts

Title	Location (Module, Session)
<b>Action Plan</b>	<i>Mitigation and Care, Session 3</i>
<b>An Effective HIV/AIDS Strategy</b>	<i>Assessment Analysis and Prioritizing Activities, Session 3</i>
<b>Appreciative Approach</b>	<i>Assessment Analysis and Prioritizing Activities, Session 4</i>
<b>Appreciative Interview Guide</b>	<i>Assessment Analysis and Prioritizing Activities, Session 4</i>
<b>Behavior Change and Communication Strategies (diagram)</b>	<i>Behavior Change, Session 1</i>
<b>Behavior Change and Communication—Targeting Men with Multiple Partners</b>	<i>Awareness-Raising and Extension Activities, Session 2</i>
<b>Biologic Host-Related Factors Affecting Sexual Transmission of HIV</b>	<i>Volunteer Support</i>
<b>Biological Risk Factors of HIV Transmission</b>	<i>Biology, Session 2</i>

Title	Location (Module, Session)
<b>Blocking HIV Reproduction: How ARVs Work (diagram)</b>	<i>Biology, Session 1</i>
<b>Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children</b>	<i>Capacity Building, Sessions 1 and 2</i>
<b>Case Studies for “What would have helped (X)?”</b>	<i>Mitigation and Care, Session 3</i>
<b>Characteristics of Different Types of Organizations</b>	<i>Building Partnerships</i>
<b>Common Sexually Transmitted Infections and Symptoms</b>	<i>Volunteer Support</i>
<b>Condom Issues: Selection, Technique, and Cooperation</b>	<i>Volunteer Support</i>
<b>Considerations for Varying Types of HIV Epidemics</b>	<i>Assessment Analysis and Prioritizing Activities, Session 3</i>
<b>Contextual Analysis (diagram)</b>	<i>Awareness-Raising and Extension Activities, Session 1</i>
<b>Cultural Factors Relevant to Capacity Building and HIV/AIDS</b>	<i>Capacity Building, Session 2</i>
<b>Culture Matters, Appendix: How to learn culturally appropriate ways to talk and learn about HIV/AIDS in communities</b>	<i>Assessment Analysis and Prioritizing Activities, Session 2</i>
<b>Diffusion of Innovation (with role play)</b>	<i>Awareness-Raising and Extension Activities, Session 3</i>
<b>Economic Security Issues (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>
<b>Ethiopia Case Study</b>	<i>Awareness-Raising and Extension Activities, Session 1</i>
<b>Examples of Knowledge as a Root Cause of Stigma</b>	<i>Behavior Change, Session 3</i>
<b>Expressions and Forms of Stigma</b>	<i>Behavior Change, Session 3</i>
<b>Female Condom</b>	<i>Biology, Session 2</i>
<b>Four-D Cycle of Appreciative Inquiry</b>	<i>Assessment Analysis and Prioritizing Activities, Session 4</i>
<b>From Information to Behavior Change: Trends in HIV Prevention</b>	<i>Behavior Change, Session 1</i>
<b>Global Fund to Fight AIDS, Tuberculosis and Malaria</b>	<i>Capacity Building, Session 2</i>
<b>Global HIV/AIDS Epidemic</b>	<i>Capacity Building, Session 2</i>
<b>Guidelines/Information for Participation in Peace Corps Volunteer Panels</b>	<i>Capacity Building, Session 1</i>
<b>Health and Medical Issues (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>
<b>HIV/AIDS Interventions with Men Who Have Sex with Men</b>	<i>Capacity Building, Sessions 1 and 2</i>
<b>HIV Interventions with Youth</b>	<i>Capacity Building, Sessions 1 and 2</i>
<b>HIV Life Cycle</b>	<i>Volunteer Support</i>
<b>HIV Prevention in Mobile Populations</b>	<i>Capacity Building, Sessions 1 and 2</i>
<b>High-Risk Low-Risk Rating Scale</b>	<i>Volunteer Support</i>
<b>Information to Explore About Organizations (chart)</b>	<i>Creating Partnerships</i>
<b>Instruction for Male Condom Use</b>	<i>Biology, Session 2</i>
<b>Integration of Targeted Prevention Into Other Services and Sectors</b>	<i>Assessment Analysis and Prioritizing Activities, Session 3</i>

Title	Location (Module, Session)
<b>Interpreting Surveillance Data</b>	<i>Assessment Analysis and Prioritizing Activities, Session 1</i>
<b>Interviewing Skills (Excerpts from “Empowering People and Strengthening Organizations through Asset-Based Approaches”)</b>	<i>Assessment Analysis and Prioritizing Activities, Session 2</i>
<b>Key Partners for Expanded and Comprehensive Strategic Planning</b>	<i>Assessment Analysis and Prioritizing Activities, Session 3</i>
<b>Life Cycle of HIV/AIDS Infection</b>	<i>Volunteer Support</i>
<b>Life Cycle of HIV (diagram)</b>	<i>Biology, Session 1</i>
<b>Measures of Disease Frequency</b>	<i>Biology, Session 2</i>
<b>Measures of Success</b>	<i>Awareness-Raising and Extension Activities, Session 3</i>
<b>Mother to Child Transmission</b>	<i>Biology, Session 2</i>
<b>Nutrition and Food Security Issues (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>
<b>Orphans and Vulnerable Children (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>
<b>Persuading Your Partner to Use a Condom</b>	<i>Biology, Session 2</i>
<b>Peace Corps’ Approach to Development</b>	<i>Capacity Building, Session 1</i>
<b>Peace Corps’ Work in HIV/AIDS</b>	<i>Capacity Building, Session 2</i>
<b>Potential Pre-Test Questions for Awareness-Raising Materials/Follow-up to Pre-Test</b>	<i>Awareness-Raising and Extension Activities, Session 3</i>
<b>Preparation for Awareness Raising Worksheet</b>	<i>Awareness-Raising and Extension Activities, Session 2</i>
<b>Preparing for Guest Speakers Who Are Experts</b>	<i>Mitigation and Care, Session 2</i>
<b>Preparing for Guest Speakers Who Are People Living with AIDS</b>	<i>Behavior Change, Session 3; Mitigation and Care, Session 1</i>
<b>Principles of Behavior Change and How the Life Skills Program Mirrors These Principles</b>	<i>Behavior Change, Session 2</i>
<b>Profiles of People Living with HIV/AIDS (for readers’ theater/panel)</b>	<i>Mitigation and Care, Session 1</i>
<b>Questions About Organizations</b>	<i>Building Partnerships</i>
<b>Recommendations for Awareness-Raising Activities</b>	<i>Awareness-Raising and Extension Activities, Sessions 1 and 2</i>
<b>Recommendations for Combating Stigma</b>	<i>Behavior Change, Session 3</i>
<b>Reducing HIV in Injection Drug Users</b>	<i>Capacity Building, Sessions 1 and 2</i>
<b>Role Play for Exploring Partnerships of an Organization</b>	<i>Building Partnerships</i>
<b>Role Plays for Bridge Model of Behavior Change (Life Skills)</b>	<i>Behavior Change, Session 2</i>
<b>Roles for Community Participation in Strategic Planning</b>	<i>Assessment Analysis and Prioritizing Activities, Session 3</i>
<b>Scenarios for Human Capacity Building Approaches</b>	<i>Capacity Building, Session 1</i>
<b>Should I Use a Peer Education Approach?</b>	<i>Awareness-Raising and Extension Activities, Session 3</i>
<b>Social/Emotional/Psychological Issues (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>

Title	Location (Module, Session)
<b>Sources for HIV/AIDS Assessment Information</b>	<i>Assessment Analysis and Prioritizing Activities, Session 1</i>
<b>Spiritual Issues (to discuss with experts)</b>	<i>Mitigation and Care, Session 2</i>
<b>Stages of HIV/AIDS Infection for Adults</b>	<i>Biology, Session 1</i>
<b>Statement on Kenya and Ugandan Trial Findings Regarding Male Circumcision and HIV (WHO)</b>	<i>Biology, Session 2</i>
<b>Stigma and Discrimination and HIV/AIDS</b>	<i>Capacity Building, Session 2;</i>
<b>Symptoms of Various Sexually Transmitted Infections</b>	<i>Volunteer Support</i>
<b>“Three Ones” Key Principles</b>	<i>Capacity Building, Session 2</i>
<b>Universal Precautions</b>	<i>Biology, Session 2</i>
<b>Vietnam Case Study (for awareness-raising and extension activities)</b>	<i>Awareness-Raising and Extension Activities, Session 1</i>
<b>Volunteer Success Stories</b>	<i>Capacity Building, Session 2</i>
<b>Volunteers Working in High Stigma Communities</b>	<i>Behavior Change, Session 3</i>
<b>World Health Organization</b>	<i>Capacity Building, Session 2</i>

## Appendix III: Annotated Peace Corps Resources

This appendix lists additional resources that are related to the following areas

- Assessment, Project Design, Monitoring and Evaluation
- Behavior Change
- Capacity Building
- Culture
- Partnerships

These publications are available to Peace Corps staff and Volunteers free of charge through the Information, Collection and Exchange (ICE) unit. Please contact ICE or your Information Resource Center at post for ordering information.

### Assessment, Project Design, Monitoring and Evaluation

***Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets.*** Kretzmann, John P. and John L. McKnight. Chicago, IL: Northwestern University, 1993. [ICE No. CD051]

This is a guide to asset-based community development, summarizing lessons learned by studying successful community-building initiatives in hundreds of U. S. neighborhoods. The guide outlines what local communities can do to start their own asset-based development, including how to rediscover their local assets; how to combine and mobilize these strengths; and how “outsiders” in government can effectively contribute to the process of asset-based development.

***New Project Design and Management Workshop Training Manual, The.*** Washington, DC: Peace Corps, 2000. [ICE No. T0107]

This training manual is based on a one-and-a-half- to four-day workshop that reinforces the importance of community participation in all local projects. When used during in-service training, sessions show Volunteers and their counterparts how to involve and work with the community through each step of the project

design process, from analysis of community assets and needs to planning, implementation.

***PACA: Participatory Analysis for Community Action.*** Washington, DC: Peace Corps, 2000. [ICE No. M0053]

This is a key training manual for use in pre-service training or in-service training to teach Peace Corps trainees and Volunteers asset-based participatory approaches to community development. Readers learn specific tools like community mapping, transects, and seasonal calendars that may be used with groups within communities to help them identify their collective resources, needs and priorities. The book also establishes or reinforces a process that aims to ensure community members are not excluded from the planning process due to economic status, sex, age, race, religion, and other factors.

***PACA Idea Book.*** Washington, DC: Peace Corps, 2005. [ICE No. M0086]

This idea book addresses key concepts in two earlier Peace Corps' publications, *Participatory Analysis for Community Action (PACA) Manual* [ICE No. M0053], and the *Gender and Development Training Manual* [ICE No. M0054]. Since PACA now has been used in the agency for many years, this idea book was designed to give a focused history and description of PACA, while sharing excellent examples from the field that illustrate how Volunteers and their communities, host country organizations, and Peace Corps projects have used these tools successfully. It is also intended to supplement exercises in the core pre-service training manual *Roles of the Volunteer in Development* [ICE No. T0005]; or reinforce foundational skills during or prior to in-service training—complementing *The New Project Design and Management (PDM) Manual* [ICE No. T0107].

***Programming and Training Booklets.*** Washington, DC: Peace Corps, 2001. [ICE Nos. T0113-T0118]

***Booklet 1—Programming and Training: The Basics***  
This guide helps Peace Corps staff facilitate a partnership with Volunteers, host country partner

agencies, and other stakeholders involved in a project. It describes the Peace Corps and how it does its work; discusses the big picture of “development” and explores the Peace Corps’ approach to development; and describes how the Peace Corps implements its role in development. It also illustrates the programming process that the Peace Corps takes, and provides an overview of steps that lead to good development work. It is the first in a series of booklets that formulates Peace Corps’ programming and training philosophy and standards.

*Booklet 2—How to Design or Revise a Project*

The second booklet in this series discusses the four major steps in the cyclical process of project design and revision: (1) analyze the situation (Where are we now?); (2) develop the project framework (Where do we want to go?); (3) create a strategy (How will we get there?); and (4) develop a monitoring and evaluation plan (How will we know when we get there?). It includes guidance for putting together the results of the design process—documenting the project.

*Booklet 3—How to Integrate Second and Third Goals into Programming and Training*

This booklet explains Peace Corps’ three goals and how they are reflected in the work of Volunteers. It provides ideas on how to integrate second and third goals into project design, training, implementation, monitoring, and evaluation. And it explores activities and resources staff and Volunteers can use to achieve second and third goals in programming and training.

*Booklet 4—How to Assess a Project*

This booklet illustrates how to plan and implement an assessment plan (including monitoring, review and components) by building on and improving current Peace Corps monitoring and evaluation practices. It contains an optional section of examples, sample instruments, and a glossary that defines monitoring and evaluation terms within the Peace Corps context.

*Booklet 5—How to Implement a Project*

Booklet 5 focuses primarily on the “how to” of the four major areas for implementing a project: (1) planning and budgeting; (2) identifying and selecting sites and placing Volunteers; (3) training and supporting Volunteers; and (4) communicating with stakeholders. It also contains site evaluation forms, a community agreement, a supervisor’s handbook, and a Volunteer teacher observation form.

*Booklet 6—How to Integrate Programming and Training*

This book presents how programming and training

intersect and notes information and ideas on how posts can increase their effectiveness by linking programming and training in planning and actualizing Volunteer assignments and support. Sections address task analysis and competency development, training design and implementation, planning and budgeting processes and meeting challenges. This is an excellent resource for both programming and training staff.

***Promoting Powerful People: A Process for Change.***

Washington, DC: Peace Corps, 2000. [ICE No. T0104]

This publication promotes a three-step process for helping people to help themselves: listen and observe, discuss and decide, try something. It focuses on the skills Volunteers need to learn to communicate effectively with community members, and while the sample content is nutrition, the manual includes basic ideas for modifying sessions to other use in technical areas. Sessions are cross-referenced to PACA: *Participatory Analysis for Community Action (PACA) Manual* (M0053) and *Culture Matters: Trainer’s Guide* (T0103). They also incorporate gender and development, community content-based instruction, and strength-based approaches to development. It is a good resource for pre-service training and adaptable to any country.

## Behavior Change

***Camp Glow: Girls Leading Our World.*** Washington, DC: Peace Corps, 2002. [ICE No. M0056]

*Camp GLOW (Girls Leading Our World)* is a week-long leadership camp, but can be easily adapted to incorporate technical sessions for boys or girls, HIV/AIDS, TEFL, life skills or almost any other relevant focus area. The purpose of the original camp was to encourage young women to become active citizens by building their self-esteem and confidence, increasing their self-awareness, and developing their skills in goal setting, assertiveness, and career and life planning. This handbook provides details about organizing camps, schedules, logistics and engaging partners and parents. *Camp GLOW* session content is found in *Choices: A Teen Woman’s Journal for Self-Awareness and Planning* (ICE No. WD135).

***Choose a Future: Issues and Options for Adolescent Boys – A Sourcebook of Participatory Learning Activities.*** Washington, DC: The Centre for Development and Population Activities (CEDPA), 1998.

[ICE No. YD037]

This publication contains 77 games and seven trust activities for participants of all ages and abilities. Author Dale Le Fevre has conducted workshops where different groups who do not normally interact come together and play, relax and build relationships. This compilation contains the most popular games and a simple “game finder” that helps planners easily select the best game for any particular situation. This complements other publications by focusing on games with low equipment needs, non-conflict approaches and general space requirements. It is a good resource for working with special-needs populations or traditionally adversarial groups.

***Choose a Future: Issues and Options for Adolescent Girls.*** Washington, DC: The Centre for Development and Population Activities (CEDPA). [ICE No. WD135]

This publication is a journal designed to strengthen and prepare teenage women for their futures. Full of both real and hypothetical thought-provoking situations to stimulate ideas and direct female teenagers in areas such as decision-making, career possibilities, values, family planning, and self-perceptions.

***Community Content Based Instruction (CCBI) Instruction Manual.*** Washington, DC: Peace Corps, 2004. [ICE No. T0112]

This publication has been field tested in draft form, so experiences and suggestions made by staff and Volunteers around the world have been incorporated in the completed workbook and training manual. These materials are based on the CCBI approach of using local indigenous knowledge and easily accessible resources to make classroom subject matter more relevant to students while engaging community members in ongoing learning experiences. This can be the best of “place-based” learning for youth or adults along with community outreach in any sector. See also the participant’s guide: *Working with CCBI: Volunteer Workbook* (ICE No. M0073).

***Everybody: Preventing HIV and Other Sexually Transmitted Diseases Among Young Teens.*** Schoeberlein, Deborah. Revised Edition, Carbondale, CO: RAD Educational Programs, 2001. [ICE No. HE375]

*Everybody* is a developmentally appropriate research-

based curriculum about HIV and other sexually transmitted diseases (STD) prevention for fifth through ninth grade students. It engages young teens in active learning with twenty-four sequential, student-centered activities correlated to U.S. national science and health education standards. These modular activities include guiding questions, step-by-step directions, assessment measures and lesson extensions. Six additional chapters provide guidance about using *Everybody* plus up-to-date information on HIV/STDs and related topics.

***Idea Book Series: Beyond the Classroom—Empowering Girls.*** Washington, DC: Peace Corps, 2000. [ICE No. M0080]

This idea book provides practical advice for empowering young women through everyday activities. It promotes the use of workshops, camps, clubs, special events, and friendly conversations, which present opportunities to encourage goal setting, teach positive decision making skills, and build confidence outside of the classroom. These events allow Volunteers to help girls increase their confidence and self-esteem, changing their lives for the better.

***Idea Book Series: In the Classroom: Empowering Girls.*** Washington, DC: Peace Corps, 2002. [ICE No. M0083]

This idea book provides background information on the importance of focusing on girls’ education with a holistic approach. It provides specific ideas for creating a girl-friendly learning environment, classroom and curriculum-related activities, co-curricular activities, awards, and incentives and scholarships. It also includes appendices with a model session plan, article on girls’ education festivals, and a school development workshop.

***Life Skills Manual.*** Washington, DC: Peace Corps, 2001. [ICE No. M0063]

This English language book is a revision of the original, Africa-focused *Life Skills Manual* (ICE No. M0061), and provides a comprehensive approach to developing skills needed for life, such as communication, decision-making, and relationship skills. It addresses development of the whole person, including empowering girls and guiding boys toward new values. It also includes 10 session plans that provide

factual information on HIV/AIDS and STDs. Interactive approaches to engaging participants include: role play, games, group discussion, and many other teaching techniques from around the world.

***Working with Community Content Based Instruction (CCBI): Volunteer Workbook.*** Washington, DC: Peace Corps, 2004. [ICE No. M0073]

This publication has been field tested in draft form, so experiences and suggestions made by staff and Volunteers around the world have been incorporated in the completed workbook and training manual. These materials are based on the CCBI approach of using local indigenous knowledge and easily accessible resources to make classroom subject matter more relevant to students while engaging community members in ongoing learning experiences. This can be the best of “place-based” learning for youth or adults along with community outreach in any sector. See also the trainer’s guide: *Community Content-based Instruction Manual* (ICE No. T0112).

***Working with Youth: Approaches for Volunteers.*** Washington, DC: Peace Corps, 2002. [ICE No. M0067]

This comprehensive publication for Volunteers addresses the different needs and circumstances of orphans, in- or out-of-school youth, refugees, and working youth. Volunteers’ roles are discussed in working directly with youth, and enhancing the effectiveness of youth-focused NGOs. Chapters lead the reader through planning, implementing, and evaluating youth activities; using appropriate tools, techniques, and games; and applying many health, education and leadership activities for youth submitted by Volunteers working around the world.

## Capacity Building

***A Community Economic Development (CED) Training Guide for Peace Corps Volunteers.*** Washington, DC: Peace Corps, 2002. [ICE No. M0069]

These self-study materials address how community economic development differs from traditional concepts of economic development, with a focus on helping individuals, families, and communities take control of their own economic futures. It includes examples and techniques for increasing and maintaining citizen participation in CED, gathering community information, developing and implementing a CED

strategic agenda, and monitoring and evaluating progress and impact. Optional trainer’s notes are included.

***HIV Health & Your Community: A Guide for Action,*** Granich, Reuben, MD, MPH and Jonathan Mermin, MD, MPH. Berkeley, CA: The Hesperian Foundation, 2001. [ICE No. HE358]

This is a comprehensive easy-to-understand guide for health-care workers in areas with few medical resources and for people confronting the HIV epidemic in their communities. Written to be easily accessible to those without medical or technical knowledge and without prior training in the prevention of HIV and the care of those with AIDS, it features contemporary examples, most drawn from actual experience, to emphasize the growing prevalence of HIV and to reflect successful prevention.

***Idea Book Series HIV/AIDS: Integrating Prevention and Care into Your Sector.*** Washington, DC: Peace Corps, 2000. [ICE No. M0081]

This guide offers various strategies for evaluating and responding to the affects of HIV in each of the Peace Corps’ project areas, and also offers examples of creative and efficient plans Volunteers use to address the issue of HIV in their activities through partnership with other sectors or by designing activities targeting the areas most affected by AIDS.

***A Microenterprise Training Guide for Peace Corps Volunteers.*** Washington, DC: Peace Corps, 2003. [ICE No. M0068]

These self-study modules describe the critical contributions microenterprises, microfinance institutions, and their support organizations make in reducing poverty and building the foundations of community economic development. Activities and case studies help increase understanding of institutional capacity-building, non-financial business development services, organizational situation analysis, and the potential roles of Volunteers as business counselors and extensionists. Optional trainer’s notes are included.

***Nonformal Education Manual.*** Washington, DC: Peace Corps, 2004. [ICE No. M0042]

The content of the *Nonformal Education Manual* is grounded in the theory and practice of some of the great educational thinkers of our time, including Paulo Freire, Howard Gardner, David Kolb, Malcolm



Knowles and Bernice McCarthy. This new manual includes information from the previous Peace Corps publication as well as current research from the field of education. The manual includes field-tested ideas, activities, and tips drawn from the experiences of Peace Corps Volunteers and staff around the world. Not only for education Volunteers, this manual will help any Volunteer who has to teach, train or facilitate in the field.

***Roles of the Volunteer in Development, The.*** Washington, DC: Peace Corps, 2002. [ICE No. T0005]

The publication contains seven booklets, all of which help maximize Peace Corps Volunteers' effectiveness by addressing a different aspect of the capacity-building roles that Volunteers play. Each booklet has a chart delineating the knowledge, skills, and attitudes needed for the role described; background readings; and activities designed to increase Volunteers' competence in that capacity. The booklets can be used in self-study or in conjunction with a trainer or other training material.

***STD/AIDS Peer Educator Training Manual: A complete guide for trainers of peer educations in the prevention of STDs including HIV/AIDS.*** Washington, DC: Peace Corps, 2000. [ICE No. HE258]

## Culture

***Culture Matters: The Peace Corps Cross-Cultural Workbook.*** Washington, DC: Peace Corps, 1997. [ICE No. T0087]

This illustrated, practical, interactive workbook for Volunteers in all programs, guides the reader through the cross-cultural experience, the major concepts in the intercultural field, and presents exercises, stories, quotations, and descriptive text designed to aid the Volunteer in successfully adapting to the new culture. The workbook examines the behaviors and values of people in other countries and offers ways to compare their behavior to that of Americans. The workbook is an excellent resource for trainers and Volunteers.

***Culture Matters: Trainer's Guide.*** Washington, DC: Peace Corps, 1999. [ICE No. T0103]

This handbook is a guide to help trainers incorporate concepts and topics from *Culture Matters* (ICE No.

T0087) into cross-cultural training, pre-service training, and in-service training. It uses a wide selection of sessions from the workbook and provides supplemental group exercises. It also suggests what trainers may find useful to include in the pre-service training, and how to integrate these ideas with existing cross-cultural programs.

## Partnerships

***NGO Training Guide for Peace Corps Volunteers, An.*** Washington, DC: Peace Corps, 2003. [ICE No. M0070]

These self-study modules describe the function of NGOs in civil society, and how Volunteers can contribute to their efficiency, effectiveness, and sustainability. They discuss the advantages of appreciative inquiry as an approach to NGO development, provide a structured method (NGO capacity profile) to analyze NGO strength, build Volunteer skills in facilitation and training, and explore the role of governance and planning in achieving a sustainable organization.

## Appendix IV: Digitized Videos

The following video resources complement this *Training Resource Kit*.

### “Come Back Healthy”

In 1995 the Peace Corps Office of Medical Services developed this video to help reduce the incidence of HIV among Volunteers. In this Resource Kit it is used in the Volunteer Support module in the session, *Reducing Volunteers’ Risk of STI/HIV Exposure*, and is used by Peace Corps medical officers in their session, *Understanding and Avoiding HIV Infection*.

This video shares the stories of five Peace Corps Volunteers who became infected with HIV while serving in their respective countries. *Come Back Healthy* is available through Information Collection and Exchange, *Peace Corps Digitized Training Resources*, ICE No. RE042.

**Heather** served as a community development extension agent and horticulturalist. Working with her host community, Heather participated in well construction, health education, gardening, fencing the cooperative, and sheep fattening programs. Individually, Heather demonstrated soil conservation techniques, rabbit raising, and the construction of improved cookstoves.

**Jeannine** served in the Guinea worm disease eradication program. Her primary responsibility was working in health education conducting workshops. Jeannine worked on several community development programs assisting villagers in maintaining and improving public health.

**Laura** served as an inland fisheries extension agent. Her primary responsibilities included promotion of the aquaculture program, selection of “model” fish farmers, location of appropriate pond sites, etc. In Laura’s third year, she was chosen to become a Volunteer Leader supervising 12 Volunteers in her area.

**Joel** served as an agroforestry Volunteer/promoter. Joel’s primary responsibilities included assisting local cooperatives in the planning and implementation of tree nursery projects, conducting reforestation education workshops, acting as liaison between farmers and

researchers, and demonstrating farming techniques to communities.

**John** served as a mathematics, physics, and computer science teacher assigned to teach three grades of students at a village high school. Granted a third year extension, John was able to follow a class through its entire high school cycle. In addition to these activities, John organized field trips to local national parks, advised several student clubs, and participated in school sports.

### “Forgotten Children: The Legacy of Poverty and AIDS in Africa”

This 13-minute video was produced by USAID in 2001. Set in Zambia, it chronicles a day in the lives of some of the orphans whose parents have died of AIDS. It is narrated by a young boy whose mother died of AIDS and whose grandfather beat him. He left his village and went to the city. Though the statistics are now out of date, many of the issues remain the same. *Forgotten Children* is available through the Office of AIDS Relief.

This video could be used in various places during HIV/AIDS training, but fits particularly well in the Mitigation and Care Module, Session 2, Major Issues.

### “Turning Hope Into Action: The Peace Corps Responds to the HIV/AIDS Crisis”

Filmed in 2006 by the Peace Corps, this video shows Volunteers in all regions of the world working with HIV/AIDS: in awareness building, education, mitigation and care and youth and adult projects. It could be used as an introduction to HIV/AIDS training or with the Capacity Building Module. This video is available through the Office of AIDS Relief.

A photograph of two women embracing in a field. The woman in the foreground is wearing a patterned dress and has her arms around the woman behind her. The woman behind her is wearing a dark t-shirt and has her arms around the first woman. They are both smiling. The background is a field of dry, brownish vegetation under a clear sky.

# Volunteer Support

**HIV/AIDS TRAINING RESOURCE KIT**

**Session: Reducing Volunteers' Risk of STI/HIV Exposure**



# Session: Reducing Volunteers' Risk of STI/HIV Exposure

## Purpose

Participants will know their role in keeping themselves from contracting sexually transmitted diseases by understanding the particular risks to them while serving as Volunteers; using preventative measures; and by utilizing appropriate treatment guidelines given by the Peace Corps medical officer.

## Rationale

All Peace Corps trainees and Volunteers are sexual beings and therefore may be sexually active during service. Statistics show that 90 percent of Volunteers are sexually active by their close of service and only 30 percent use condoms. HIV and other sexually transmitted infections (STIs) are prevalent in most countries where Volunteers serve. This session is to make trainees aware of the risks involved in unprotected sex while serving as Volunteers.

Trainer's note: This session is a very basic outline of what might be covered with all trainees and focuses mostly on their potential infection through unprotected sex. At various points in the session there are opportunities to refer to or integrate parts of other HIV/AIDS training modules, according to the need at post. Refer to the introduction to this Resource Kit for a synopsis of all the sessions and specific recommendations for low-prevalence posts.

## Target Audience

Peace Corps trainees

## Duration

2 hours, 20 minutes

## Objectives

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

1. Discuss common sexually transmitted infections including HIV, their symptoms, and modes of transmission.
2. Name four reasons why a trainee or Volunteer may be at risk for HIV/AIDS during his or her service even if the statistics for HIV/AIDS at post are very low compared to world statistics.
3. List five ways to prevent personal exposure to sexually transmitted infections while serving as a Volunteer.

## Session Outline

### I. What is Your Risk of Exposure to STIs/HIV?

*(25 minutes)*

### II. Learning (or Relearning) about STIs and HIV

*(35 minutes)*

### III. "Come Back Healthy" Video *(40 minutes)*

### IV. Strategies for Reducing Personal Risk

*(40 minutes)*

## Facilitators/Technical Expertise

- Peace Corps medical officer
- Cross-cultural coordinator and/or language instructor

## Materials and Equipment

Flip charts, markers, tape or tacks

Video: "Come Back Healthy"

Prepared flip charts

1. One chart with each of following at top: "Arm/Penis", "Arm/Vagina", "Arm/Sexual Intercourse", "Arm/Masturbation." Fold the charts in half with the writing covered. Put a number 1 through 4 on the folded up portion.

2. Volunteer Risk
3. Statistics (according to Peace Corps surveys)
4. Chart with names of STIs written across the top. See Handout C for names.

#### Activity Sheets

*Symptoms of Various Sexually Transmitted Infections.* Make one copy and cut each symptom out.

*HIV Stages*

*High Risk-Low Risk Rating Scale*

#### Handouts

- A. *Rates of Sexually Transmitted Infections among Volunteers*, from *Health of the Volunteer*. Prepare at post.
- B. *HIV Rates in Region and Country*. Prepare at post.
- C. *Common Sexually Transmitted Infections and Symptoms*
- D. *HIV Life Cycle*
- E. *The Stages of HIV/AIDS Infection*
- F. *Biologic Host Factors Affecting Sexual Transmission of HIV*
- G. *Condom Issues: Selection, Technique, and Cooperation*

### Preparation Checklist

- Gather statistics on STIs/HIV of Volunteers worldwide and in your geographic region, and general statistics for HIV/STIs in your country. Call the AIDS Center in your capital to get latest statistics/information.
- Read the entire session and determine which activities can be included in the time available. Prepare any specific materials required for the activities. If you wish to include more detailed information on the biology of HIV, including transmission/prevention, use the sessions in the Biology Module.
- Prepare flip charts.
- Make copies of handouts.
- Meet with and prepare the language coordinator or instructor. Use *Handout G: Condom Issues—Selection, Technique, and Cooperation*.

## Methodology

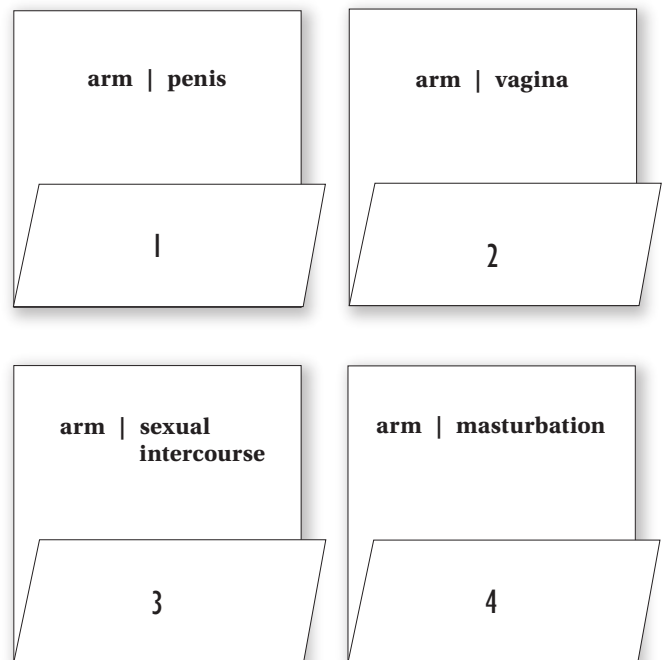
### I. What is Your Risk of Exposure to STIs/HIV?

(25 minutes)

#### Warm up (10 minutes)

**Step 1:** Welcome the participants. Tell them you will start with a quick and energizing activity. Ask them to count off by fours.

**Step 2:** Point out the four charts around the room, each with a number. Ask participants to go to the chart corresponding to their number, reveal the chart, and list as many other names (slang, nicknames, etc.) for the words on the flip chart that they have heard. The charts say “Arm/Penis”, “Arm/Vagina”, “Arm/Sexual Intercourse”, “Arm/Masturbation.”



FLIP SERIES 1

**Step 3:** After five minutes, ask participants to bring their charts to the front and post them. Give them a chance to read the others. Then ask

*Why do sexual terms have more slang names than words related to other body parts?*

*Why was there so much laughing while you worked?*

*How can this adversely affect us for dealing up front with sexually transmitted infections?*

**Volunteer Risk**

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Which Volunteers are at risk of STIs/HIV?

When do higher risk activities begin?

Why are Volunteers at high risk?

FLIP CHART 2

**Statistics  
(According to Peace Corps Surveys)**

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20 percent of trainees are sexually active upon arrival

90 percent of Volunteers are sexually active at close of service

30 percent use condoms consistently/correctly

FLIP CHART 3

**Common Sexually Transmitted Infections (STIs)**

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Gonorrhea

Syphilis

Herpes Simplex

Chancroid

FLIP CHART 4

### What is a Volunteer's risk? (15 minutes)

**Step 1:** Reveal flip chart 2, "Volunteer Risk" and discuss each question. Suggested answers to help guide the discussion follow each question.

*Which Volunteers are at risk for STIs/HIV?*

All Volunteers are at risk. Factors such as age, marital status, or sexual orientation do not limit/increase risk.

*When does high-risk activity begin?*

The three most vulnerable times are

1. Pre-service training because the trainees assume there is a "clean pool."
2. Midservice because something is still missing in their service.
3. Close of service because it is the Volunteer's "last chance" and Volunteers have normally let their guard down in the culture by this time.

*Why are Volunteers at higher risk of contacting STIs?*

Many factors: loneliness; available as a comfort/connection to people; natural maturation; no restraints from home; to gain the ultimate cross-cultural experience; Americans are sought out for relationships; Volunteer has not prepared him/herself for it; alcohol use blurs boundaries/decision-making; sex is an international form of communication, especially if one doesn't speak the local language well.

**Step 2:** Reveal flip chart 3, "Statistics" which gives these sobering numbers

- 20 percent of trainees are sexually active upon arrival
- 90 percent of Volunteers are sexually active at close of service
- 30 percent use condoms consistently/correctly

**Step 3:** Distribute *Handout A: Rates of Sexually Transmitted Infections among Volunteers* and *Handout B: HIV Rates in Region and Country*. On flip chart, write STI/HIV statistics for the host country.

## II. Learning (or Relearning) about STIs and HIV (35 minutes)

### STIs and their symptoms matching game (20 minutes)

**Step 1:** Explain that participants will review the various STIs and their symptoms with a matching activity. Reveal flip chart 4. Ask for a show of hands: How many participants think they know the symptoms of each? (Don't ask for their answers.)

**Step 2:** Have participants choose a slip of paper with a symptom and by working together, if necessary, match the slips with the symptoms with an STI name on the chart. Have the names and symptoms read aloud as each slip is put up on the flip chart under the correct name.

**Step 3:** After all have been matched, cover the symptom cards and again, ask for a show of hands of who knows the symptoms of each. Clarify, if there are

questions. Distribute *Handout C: Common Sexually Transmitted Infections and Symptoms* for reference.

**Step 4:** Discuss

*If HIV is also a sexually transmitted infection, why didn't we include it in this activity?*

Answers will include that symptoms are not so specific as for STIs; this will lead into next activity.

**HIV matching graph activity** (10 minutes)

**Step 1:** Distribute *Activity Sheet: HIV Stages*.

**Step 2:** Ask participants, in pairs, to match the events at the bottom of the graph with the letters on the graph.

**Step 3:** Review the answers with the entire group. Clarify, if there are questions. Distribute *Handout D: HIV Life Cycle* and *Handout E: The Stages of HIV Infection* for reference.

**HIV Transmission Factors** (5 minutes)

**Step 1:** Distribute *Handout F: Biologic Host Factors Affecting Sexual Transmission of HIV*.

**Step 2:** Review the factors. Discuss any factors that merit special attention due to the Volunteers' jobs, host country, or other factors.

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**III. "Come Back Healthy" Video** (40 minutes)

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**High-risk low-risk prediction** (5 minutes)

**Step 1:** Note that in the first part of the session, you have talked about STIs/HIV, what they are, symptoms, and transmission. Now you are going to focus on yourselves.

**Step 2:** Distribute *Activity Sheet: High-Risk Low-Risk Rating Scale*. On the line provided, you should place an "E" to indicate what you expect your actual degree of risk of HIV infection will be during service; an "X" where you imagine your degree of risk of HIV infection during service would be if you were to engage in unprotected sex.

**Video** (25 minutes)

**Step 1:** Introduce the video, and explain that it was made by interviewing Volunteers.

**Step 2:** Show the video.

**Step 3:** Give participants a few minutes to think quietly about what they have just seen. Ask if they have any reactions or comments they wish to share. This is quite an emotional video as the Volunteers featured in this film contracted HIV while serving. Give participants sufficient time to contemplate what they have seen and heard before moving back into more cognitive activities.

**Discussion** (10 minutes)

**Step 1:** Refer the participants back to the high and low risk prediction handout. Ask the group

*Is the E far away from the X on your line? If so, why?*

Ideas may include: low STI statistics in-country; "I'm smarter than that"; "It can't happen to me"; "I'm married"; I'm too old to worry about this stuff."

*What makes you any different than the folks in the video? Where do you think they put their "E"s and "X"s before they contracted HIV?*

**Step 2:** Remind them of the earlier discussion of when and why Volunteers might be at high risk for infection. What did they hear in the video that reinforced these risk periods/reasons?

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**IV. Strategies for Reducing Personal Risk**

(40 minutes)

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**Important phrases in local language** (15 minutes)

**Step 1:** Introduce the language instructor.

**Step 2:** The language instructor reveals phrases on a flip chart and has participants practice them. (Suggested words and phrases: Condom. Wait, let's put on a condom. I won't have sex without a condom. Do you have a condom? I want/don't want to have sex with you [proper and slang]).

**Step 3:** Distribute *Handout G: Condom Issues—Selection, Technique, and Cooperation* for reference.

**Strategies for reducing personal risk** (20 minutes)

**Step 1:** Solicit ways to reduce risk of personal exposure to STIs/HIV by brainstorming and identifying ways discussed during the session.



**Step 2:** Ask each participant to consider the list and determine for him or herself important things to keep in mind.

**Wrap up** *(5 minutes)*

Discuss where to go for help/support during service. Include services of Peace Corps medical officer, support groups for gay and lesbian Volunteers, etc.

**Evaluation**

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**References or Resources**

PST Training Module on HIV and STDs in *Pre-Service Health Training for Volunteers*, Office of Medical Services, Peace Corps: Washington, DC, 1995.

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**Changes to Session**

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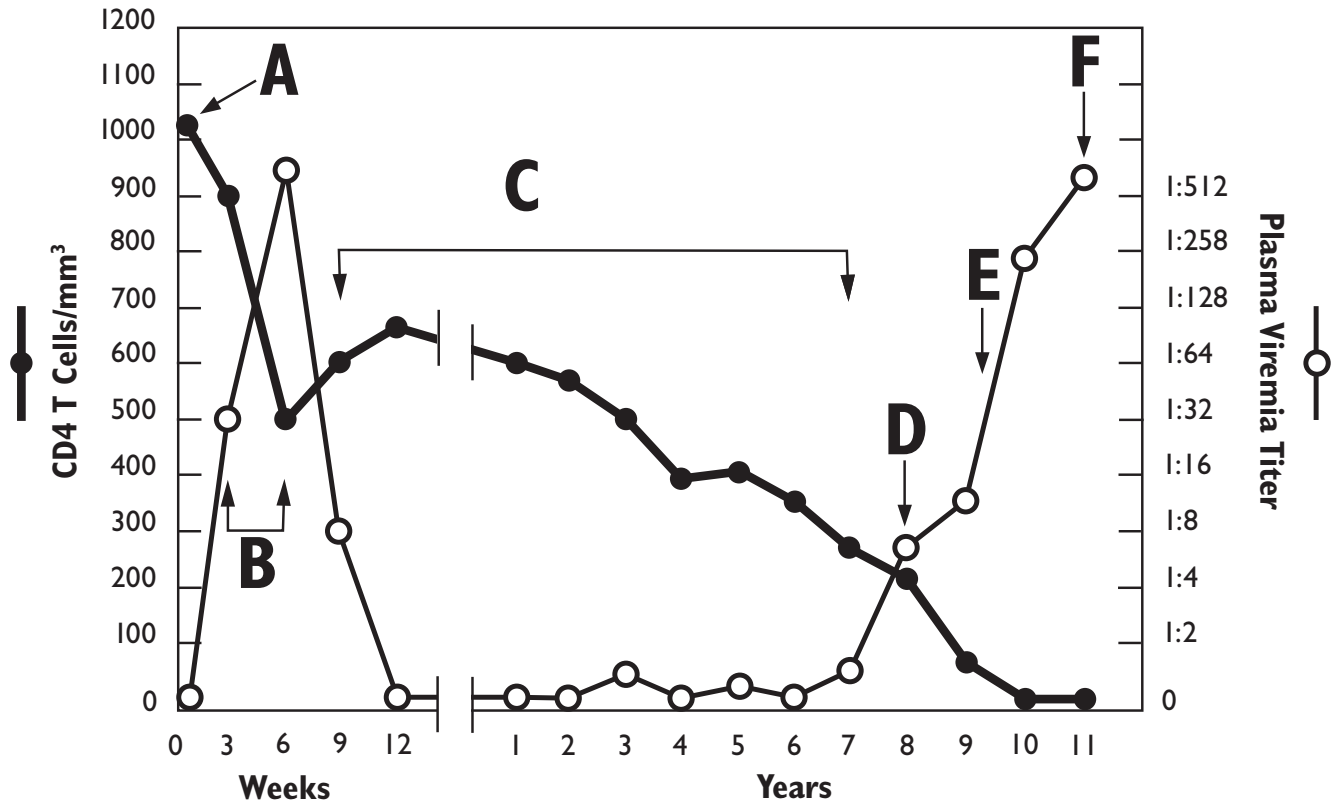
## Activity Sheet: Symptoms of Various Sexually Transmitted Infections

Make one copy of these two pages and cut out each square. Distribute the squares randomly to trainees. Have them bring the symptoms to the flip chart and match with correct STI.

<b>yellow-green or white discharge from penis or vagina</b>	<b>burning sensation during urination</b>
<b>painless sore on penis or in vagina</b>	<b>no cure, treatment is Acyclovir</b>
<b>painful sore on penis or vagina</b>	<b>sore appears 3 to 5 days after exposure</b>
<b>sore appears 10 to 90 days after exposure</b>	<b>small painful blisters on genitals or mouth</b>
<b>possible death or bone deformation in newborn if mother not treated early in pregnancy</b>	<b>possible blindness in newborns if not treated with drops in eyes</b>

<b>greatest risk factor for HIV transmission</b>	<b>possible sterility if untreated</b>
<b>inflammation of lymph gland on one side</b>	<b>non-itching rash on body (palms and soles)</b>
<b>symptoms usually 2 to 14 days after exposure</b>	<b>possible swelling in area of testicles</b>
<b>possibly no symptoms</b>	<b>hair loss, fever, and chills</b>
<b>viral infection</b>	<b>possible death if untreated</b>
<b>severe neurological damage or death to newborns if exposed in birth canal</b>	<b>symptoms may reoccur when under stress</b>

## Activity Sheet: HIV Stages



Match the letters to the correct description of the stages: A - F

- \_\_\_\_\_ Virus spreads all over the body. An HIV test will be positive (+) now.
- \_\_\_\_\_ Other diseases may occur (Kaposi's sarcoma, pneumonia, opportunistic infections, etc.)
- \_\_\_\_\_ Symptoms occur and subject officially has AIDS
- \_\_\_\_\_ Dormant period
- \_\_\_\_\_ Death
- \_\_\_\_\_ Initial infection with flu-like symptoms. An HIV test will be negative (-).

## Activity Sheet: High-Risk Low-Risk Rating Scale

You have information on STIs/HIV, what they are, symptoms and transmission. Now consider yourself.

On the line provided, place

- An “E” to indicate what you expect your actual degree of risk of HIV infection will be during your Peace Corps service.
- An “X” where you imagine your degree of risk of HIV infection during service would be if you were to engage in unprotected sex.



**Low risk**

**High risk**

## **Handout A: Rates of Sexually Transmitted Infections among Peace Corps Volunteers**

Prepare at post using *Health of the Volunteer* as a resource.

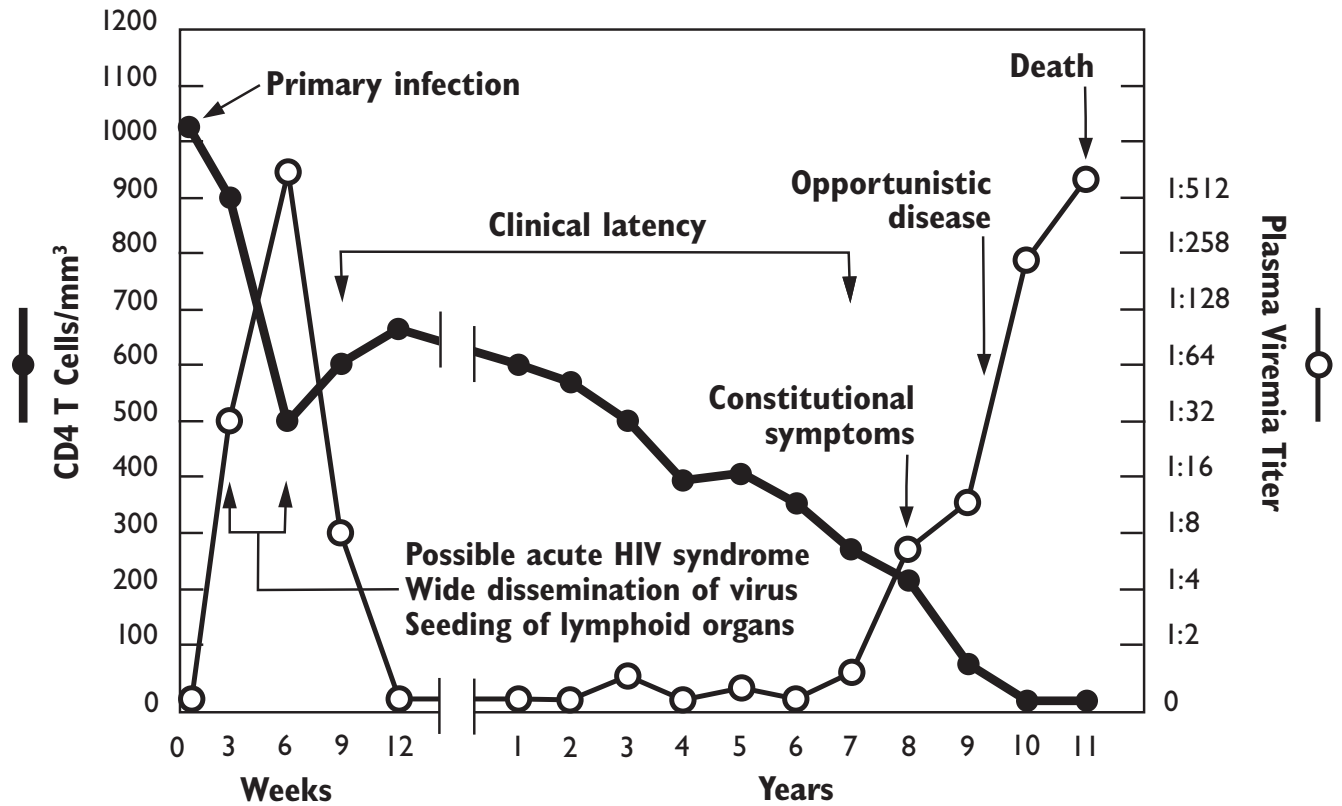
## **Handout B: HIV Rates in (Region) and (Country)**

Prepare at post.

## Handout C: Common Sexually Transmitted Infections and Symptoms

Gonorrhea	Syphilis	Herpes Simplex	Chancroid
Yellow-green or white discharge from penis or vagina	Painless sore on penis or in vagina	No cure, treatment is Acyclovir	Painful sore on penis or vagina
Burning sensation during urination	Sore appears 10 to 90 days after exposure	Small painful blisters on genitals or mouth	Sore appears 3 to 5 days after exposure
Symptoms usually 2 to 14 days after exposure	Non-itching rash on body (palms and soles)	Symptoms may reoccur when under stress	Inflammation of lymph gland on one side
Possibly no symptoms	Hair loss, fever, and chills	Viral infection	Greatest risk factor for HIV transmission
Possible swelling in area of testicles	Possible death if untreated	Severe neurological damage or death to newborns if exposed in birth canal	
Possible sterility if untreated	Possible death or bone deformation in newborn if mother not treated early in pregnancy		
Possible blindness in newborns if not treated with drops in eyes			

# Handout D: HIV Life Cycle

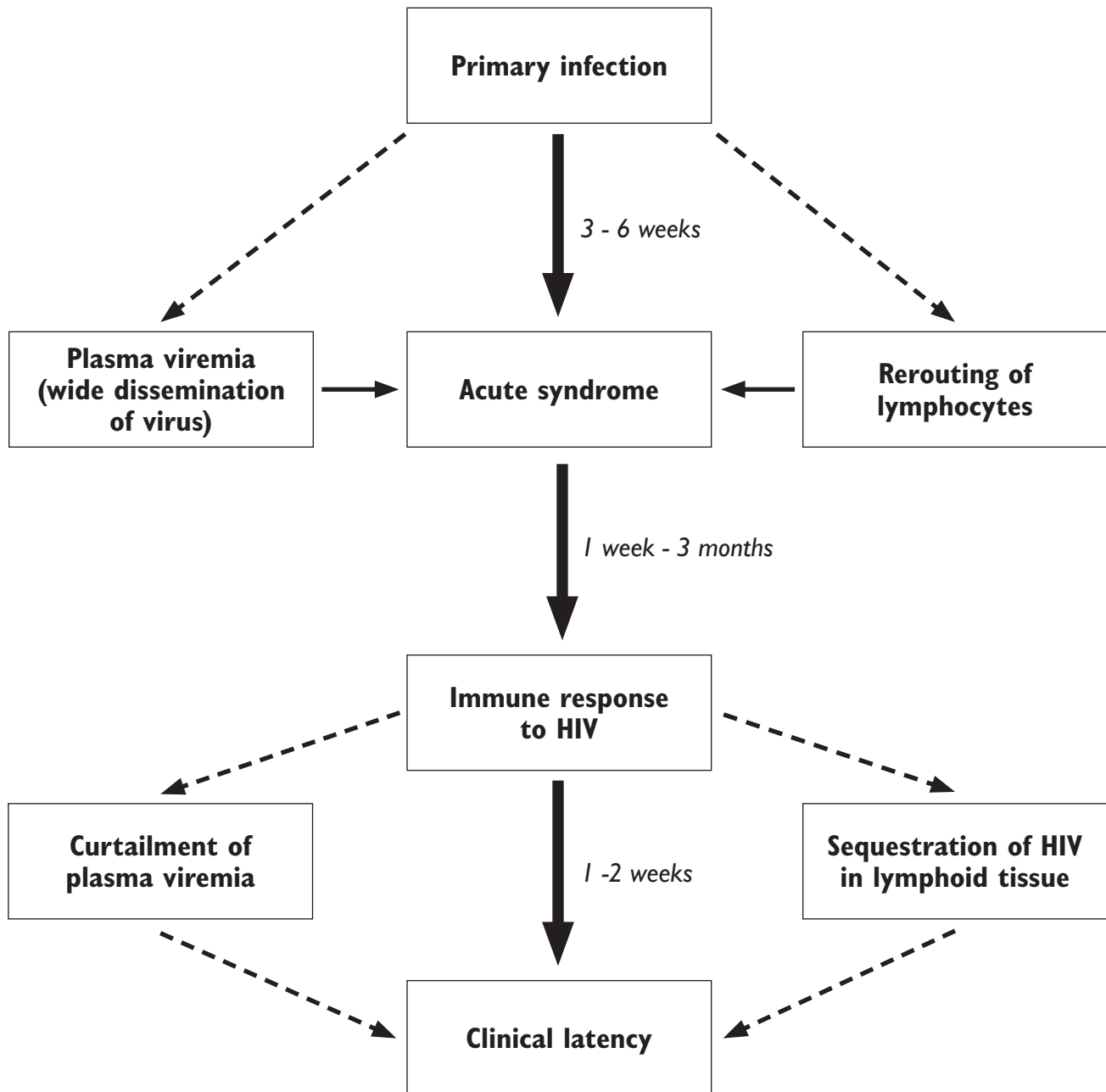


### Typical course of HIV infection

During the early period after primary infection there is widespread dissemination of virus and a sharp decrease in the number of CD4 T cells in peripheral blood. An immune response to HIV ensues, with a decrease in detectable viremia followed by a prolonged period of clinical latency. The CD4 T cell count continues to decrease during the following years, until it reaches a critical level below which there is a substantial risk of opportunistic diseases.



The progression of HIV infection from primary infection through the acute HIV syndrome to the stage of clinical latency.



# Handout E: The Stages of HIV/AIDS Infection

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## A. Acute or primary infection (the first 2-8 weeks after exposure)

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After initial infection, the body's T4 cells rush in to fight the HIV, initiating the body's immune response.

Until the immune system has generated sufficient levels of antibodies for detection in the blood by available tests, HIV tests will be negative. This is the "window period," the time that a person can be infected but test negative. Typically it lasts one to three months, but can be longer.

Most people have mild flu-like symptoms for one to four weeks (sore throat, headache, fever), a skin rash, and tender lymph nodes; however there are insufficient antibodies in the blood to be detected. Symptoms go away on their own.

HIV replicates rapidly during this stage, spreading to many organs, particularly the lymphoid tissues, where the virus can be stored.

As T4 cells become infected and begin to replicate, the viral load in the blood is high.

During this period, patients may be highly infectious, about 10 times more infectious than in the asymptomatic stage

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## B. Sero-conversion (6-12 weeks)

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HIV test is positive.

Host immune response is activated and viral infection rates drop

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## C. Asymptomatic HIV stage (infected for 6-11 years or more) Dormant/Latent Period

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There are no symptoms of HIV.

During this time HIV continues to replicate.

A person with HIV in this stage, like all other stages, can infect others through contact with body fluids, although she or he is less infectious.

The body continues to produce new T4 cells and antibodies to the virus, indicating that the immune system is fighting the virus.

HIV RNA can be measured in the blood; this is thought to be a more reliable indication of disease progression

than the number of T4 cells, but both measures are important in monitoring the spread of HIV.

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## D. Symptomatic HIV stage (this stage may last for months or years)

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The number of T4 cells in the body drops significantly from a normal 1,000/microlitre of blood.

Levels of HIV RNA in the blood increase.

The immune system is weakened, and is less likely to fight off some infections that a healthy immune system can combat.

As in all stages, a person can infect others.

Good nutrition and clean water are very important at this stage. So is self-care: exercise, meditation, staying away from stress, and people with obvious contagious diseases.

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## E. AIDS: Advanced HIV Secondary Diseases

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HIV has progressed to AIDS when the T4 cell count is below 200/microlitre of blood.

The immune system is weakened to the point that it cannot fight off diseases that a healthy person can resist. The person begins to develop opportunistic diseases that vary by geographic region. These include a large range of diseases such as tuberculosis, pneumonia, bowel infection, meningitis, and cancers such as non-Hodgkin's lymphoma and Kaposi's sarcoma.

According to the World Health Organization, tuberculosis is the leading cause of death in people infected with HIV worldwide.

T4 cells are no longer being replaced.

AIDS does not mean immediate death. People get sick and recover from various diseases.

As in all stages, a person can infect others.

Characterized by loss of body weight, or wasting.

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## F. Death

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Death occurs as immune system deteriorates and viral replication overtakes host.

Stine, Gerald J, Ph.D., AIDS Update 2003: An Annual Overview of Acquired Immune Deficiency Syndrome, New Jersey: Prentice Hall, pg. 170-196.

# Handout F: Biologic Host-Related Factors Affecting Sexual Transmission of HIV

Biologic Factor	Description/Importance	HIV in Genital Secretions	Infectiousness	Susceptibility
<b>Mutation of chemokine receptor</b>	Ability for HIV virus to attach to host cells. If both alleles for this gene are mutated, HIV resistance can occur.	?	?	↓↓↓
<b>Late stage HIV infection</b>	High viral load found in secretions. 6-18 percent times greater risk of transmission during this time.	↑↑	↑↑↑	NA
<b>Primary HIV infection</b>	High viral load—peak of transmission of HIV is soon after the person is infected	↑↑	↑↑	NA
<b>Antiretroviral therapy</b>	Decreases concentration in of HIV in seminal fluid. No effect on cervical secretions. 50 percent decrease in HIV transmission	↓	↓↓	↓?
<b>Presence of inflammation or ulcer of the genital/oral/anal mucosa</b>	Genital ulcers increase the risk of HIV acquisition 1.5-7 times. Gonorrhea, chlamydia and trich are associated with 60-340 percent relative increase in the prevalence of HIV. Bacterial vaginosis in women has been associated with HIV acquisition.	↑↑	↑	↑↑
<b>Presence of cervical ectopy</b>	Cervical cell changes and cervical fragility show a relative risk for HIV acquisition (0 to 5.0)	↑↑	↑?	↑↑
<b>Uncircumcised male</b>	The incidence of HIV is 8 times higher in uncircumcised men.	?	↑↑	↑↑
<b>Barrier contraception</b>	Condoms reduce the risk for both sexes.	NA	↓↓↓	↓↓↓
<b>Hormonal contraceptives</b>	Mixed data	↑↑	◆?	◆
<b>Spermicidal agents</b>	Compounds cause vaginal irritation that can lead to increase ability of transmission.	?	↓?	◆
<b>IUDs</b>	Mixed data	?	?	↑↑
<b>Menstruation</b>	Sex during menstruation may increase a woman's risk of acquiring HIV. Men having sex with an HIV-infected, menstruating woman is 3.4 times more likely to become infected.	?	↑↑	↑
<b>Factors that lower vaginal pH</b>		↓?	↓?	↓?
<b>Immune activation</b>		↑?	↑	↑
<b>Genital tract trauma</b>	Open wounds allow for easier transmission	↑?	↑↑	↑↑
<b>Pregnancy</b>	Hormonal changes may affect	↑↑	↑?	↑?

**Key:** ↑↑↑ or ↓↓↓ indicates a VERY STRONG association  
 ↑ or ↓ indicates a true association  
 ◆ indicates there is evidence of both positive and negative association  
 ? unknown or hypothesized association not currently supported by data

Adapted from Royce RA, Sens A, Cates Jr, W, Cohen MS. 1997. Sexual Transmission of HIV. New England Journal of Medicine, 336(15):1072-1078.

## Handout G: Condom Issues— Selection, Technique, and Cooperation

Condoms provide the best and often the most convenient form of protection against sexually transmitted infections as well as pregnancy. To obtain these benefits, however, you must choose good quality condoms and use them correctly. In some cases, you may have to overcome a partner's reluctance.

Of the choice between latex and lambskin, latex is, according to the FDA, more reliable.

In an unopened box, most condoms last about a year. If possible, buy from a store rather than a machine, and keep them in a place they won't be subjected to heat.

Condoms that are lubricated in their packages are least likely to break from dryness. If not lubricated, or for additional protection, coat the condom with spermicidal jelly or cream.

The best time to discuss condom use is before the first kiss, certainly before engaging in genital stimulation or touching.

A man may put on a condom without comment, or announce, "I plan to use a condom. I hope you don't mind."

Before sex, a man or woman might say, "I have a condom with me. If we're going to have intercourse, I want to use it."

What if the partner objects? In the right column of the chart below, you'll find responses to the most common arguments.

<b>If your partner says</b>	<b>You can reply</b>
<i>I know I'm disease-free. I haven't had sex with anyone in months.</i>	As far as I know, I'm clean, too, but either of us could have an infection and not know it.
<i>I can't feel anything when I wear a condom. It's like shaking hands with a rubber glove.</i>	I know there's some loss of feeling and I'm sorry about it. But there are still plenty of sensations left.
<i>Condoms are messy and smell funny.</i>	But with a condom we'll be safe.
<i>Condoms are unnatural and turn me off.</i>	There's nothing great about disease, either.
<i>Condoms destroy the romantic atmosphere.</i>	They don't have to. Using one may be a little awkward at first, but that will pass.
<i>When I stop to put it on, I'll lose my erection.</i>	I'll help you get it back.
<i>I'm insulted! You act like I am a leper!</i>	Nothing of the sort. I care about us and our relationship.
<i>I love you! Would I give you an infection?</i>	Not intentionally. But most people don't know they're infected.
<i>Let's do it just this once without a condom.</i>	Once is all it takes.
<i>I don't have a condom with me.</i>	Let's satisfy each other without needing one, then.
<i>I won't have sex with you if you insist on a condom.</i>	Let's put it off then until we work out our differences.



# Biology

## HIV/AIDS TRAINING RESOURCE KIT

**Session 1: The Biology of HIV/AIDS**

**Session 2: HIV Transmission**



# Session One: The Biology of HIV/AIDS

## Purpose

The purpose of this module is to provide participants with a thorough understanding of the biology of HIV/AIDS, including what happens at the cellular level, during transmission, and the factors that affect its progression.

## Rationale

Since Peace Corps Volunteers have various opportunities to be HIV/AIDS educators, they need firm grounding in the biology of the virus and how it is—and is not—transmitted. Perhaps the most important role Volunteers can play, at least in the first months of their service, is to explain or correct information about the virus. Incorrect information, or incomplete information, is a major cause of stigma and discrimination.

## Target Audience

Peace Corps trainees and Volunteers

## Duration

2 hours, 30 minutes

## Objectives

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

1. Describe a virus and identify the unique characteristics of HIV.
2. Explain how HIV affects the immune system.
3. Describe the basic life cycle of HIV.
4. Explain the difference between HIV and AIDS.
5. Explain the relationship between nutrition and other health factors and HIV.
6. Explain the role of medication in treatment of HIV.

## Session Outline

- 
- I. **Introduction** (5 minutes)
  - II. **The Immune System and HIV** (30 minutes)
  - III. **The HIV Life Cycle and AIDS** (55 minutes)
  - IV. **The Relationship between HIV, Nutrition, and Other Health Factors** (35 minutes)
  - V. **Antiretroviral Treatment** (20 minutes)
  - VI. **Wrap up** (5 minutes)
- 

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- The human immune system
- Cell reproduction
- The biology of HIV/AIDS

It may be helpful to have someone with medical expertise available to assist with the session.

## Materials and Equipment

Flip chart paper, markers, tape or tacks

Blank mural paper for additional drawing

Cards for Matching Game (prepare Terms and Definitions for Part III, Matching Game; see Activity Sheet at end of session)

Prepared flip charts or other drawings

1. Session Outline
2. Definition of Human Immunodeficiency Virus (HIV)
3. The Life Cycle of HIV (see Handout A)
4. Questions Relating to Nutrition and HIV/AIDS
5. Questions Relating to HIV and Tuberculosis
6. Blocking HIV Reproduction: How ARVs Work (or use Handout C)

Handouts

- A. *The Life Cycle of HIV*

- B. *The Stages of HIV/AIDS Infection*
- C. *Nutrition and HIV/AIDS*
- D. *Tuberculosis and HIV/AIDS*
- E. *Blocking HIV Reproduction: How ARVs Work*
- F. *Antiretroviral Drugs for HIV/AIDS*

Candy or other small prize for Part III, Step 5 “Matching Game”

Small ball or other soft item to toss

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Look at the elephant and lion metaphor in the *Life Skills Manual* [ICE No. M0063], pages 65-66, to determine if you want to use it in Part III, HIV and T4 cells, Step 3 (Appendix IV, pg. 26-27 in previous three-ring binder version).
- If co-training with a person with medical expertise, review the session together and determine each co-trainer’s role for each section.
- Prepare flip charts or other drawings.
- Make copies of handouts. Make one extra copy of *Handout B: The Stages of HIV/AIDS Infection*. Cut it apart so each stage is on a separate piece of paper for Part III, Stages of Infection, Step 2.

## Methodology

### I. Introduction (5 minutes)

**Step 1:** Introduce the session. The purpose of this session is to provide an understanding of the biology of HIV/AIDS and how it is and is not transmitted. This information will be important to participants personally, and important in any role they play in addressing the HIV/AIDS pandemic.

Some participants may already have a good understanding of this information; others may need reminding of some of the basics of cell development and human immunology. Those with science backgrounds can assist those who have not had a science class recently.

**Step 2:** Reveal flip chart 1 and go over the outline of the session.

Session One Outline
<b>The Biology of HIV/AIDS</b>
I. Introduction
II. The Immune System and HIV
III. The HIV Life Cycle and AIDS
IV. The Relationship between HIV, Nutrition, and Other Health Factors
V. Antiretroviral Treatment
VI. Wrap up

FLIP CHART 1

### II. The Immune System and HIV (30 minutes)

#### Define disease-causing agents (5 minutes)

- Diseases have diverse causes, which can be classified into two broad groups: infectious and noninfectious.
- **Infectious diseases** can spread from one person to another and are caused by foreign organisms or substances that invade the body. **Noninfectious diseases** are not communicated from person to person.



- **Pathogens** are organisms or substances that cause disease. Pathogens that infect humans include a wide variety of bacteria, viruses, fungi, protozoans and parasitic worms.
- **Bacteria** are microscopic single-celled organisms. Most bacteria are harmless to humans. In fact, many are beneficial and actually prevent disease. But some bacteria cause disease in humans by producing toxins, sometimes simply as a by-product of their normal metabolism, which interact negatively with the body. Examples of human diseases caused by bacteria include leprosy, strep throat, tetanus, tuberculosis and tooth decay.
- **Viruses** are not technically alive. In order to reproduce, a virus must invade a living cell and force it to make new copies. These new viruses are then released into the surrounding tissues, and seek new cells to infect. Viruses often damage or kill the cells they infect, causing disease and sometimes death. Viruses are very specific with regard to the types of cells they can enter and reproduce. For example, the flu virus infects human respiratory tract cells, and hepatitis viruses infect liver cells.

<b>Definition of Human Immunodeficiency Virus (HIV)</b>	
<b>human</b>	it affects humans
<b>immunodeficiency</b>	it affects the immune system
<b>virus</b>	it is a virus

FLIP CHART 2

### Define HIV and the immune system (5 minutes)

**Step 1:** Use flip chart 2 to define human immunodeficiency virus.

HIV (human immunodeficiency virus) is the virus that causes AIDS, Acquired Immune Deficiency Syndrome. HIV enters and reproduces in the cells of the

human immune system, and destroys these cells in the process.

**Step 2:** Ask: *What is the human immune system?*

Allow people to respond.

**Step 3:** Summarize with the following points

The immune system

- Is a very complex network of organs containing cells that recognize foreign substances in the body and destroys them.
- Filters out foreign substances, removes damaged and dead cells and acts as a security system to destroy mutant and damaged cells.
- Is like a puzzle; many pieces come together to form a defense against pathogens. If pieces of the immune system are missing or damaged, illness can occur.

### The cells of the immune system (20 minutes)

Reinforce the information in this section by writing terms as you refer to them on a flip chart. Also, note where there are places to stop and have participants think about or discuss what has just been presented.

**Step 1:** Explain cells and how HIV affects them. There is a lot of information, and it may be helpful for participants to take notes.

**Step 2:** Reveal important facts about the approximately 100 trillion cells in the body

- Your body is exposed to pathogens every second of every day, in the air we breathe, the food we eat, the water we drink, even the surfaces that we touch.
- All cells in the body have special molecules on their surface that identify them as “self,” meaning that they are the body’s own cells.
- The immune system will attack anything in the body that is not carrying the “self” marker.
- Any substance that does not carry the “self” marker is called an **antigen**, and the immune system will try to destroy it. However, not all antigens are dangerous. For example, the immune system will attack a transplanted organ, because the cells from another person have different “self” markers. The immune system will treat the organ as an invader, which can lead to organ rejection. This is why recipients of transplanted organs are required to take immune suppressing drugs for life.
- Antigens that cause disease are pathogens.

**Step 3:** Explain

- The body has both red blood cells and white blood cells: **red blood cells** carry oxygen from the lungs to the rest of the body, and **white blood cells** are involved in the human immune system's response to antigens.
- White blood cells are called **lymphocytes** and they fight infection by attacking antigens that get into the bloodstream. The body has about two trillion of these cells.
- There are two major types of lymphocytes: **B cells** and **T cells**.
- T cells are in charge of the immune system response, and circulate continuously throughout the body looking for antigens. When an antigen is found, T cells alert the immune system and instruct other cells to attack and destroy.
- When activated by the T cells, B cells make **antibodies**, which bind to and destroy specific antigens. The B cells are the worker bees of the immune system.

**Step 4:** Ask participants to turn to a neighbor and discuss in their own words the white cells and their functions. After a few minutes, ask if anyone has questions or are unsure of what has been covered so far. Clarify as needed. Then proceed with the session.

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### III. The HIV Life Cycle and AIDS (55 minutes)

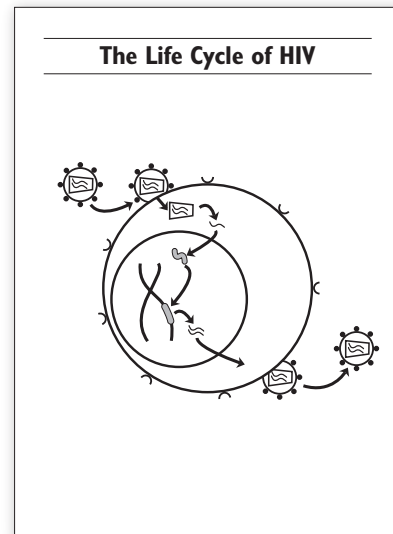
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**HIV and T4 cells** (15 minutes)

**Step 1:** Distribute *Handout A: The Life Cycle of HIV* for participants to use as you speak.

**Step 2:** Use flip chart 3 (information in Handout A) or draw as you explain the following

- **HIV enters the body via infected bodily fluids:** blood, semen, breast milk, and vaginal secretions. (More detail on transmission will be discussed in Biology Session Two).
- Several different kinds of cells have proteins on their surface that are called CD4 receptors. HIV searches for cells that have CD4 receptors, because this is what enables the virus to bind to the cell. Although HIV infects a variety of cells, its main target is the T4 cell (also called the "T helper cell"), which is a type of T cell that has lots of CD4 receptors. The T4 cell is responsible for warning



FLIP CHART 3

the immune system that there are invaders (antigens) in the body.

- Once HIV binds to a cell, it inserts HIV genetic material inside the cell's DNA. The HIV genetic material directs the cell to produce new HIV. This turns the cell into an HIV factory.
- HIV replicates rapidly; in an HIV-infected person, billions of new virus may be produced every day.
- HIV is highly prone to error during replication. As a consequence, many variations of HIV develop in a person. Some mutations will weaken HIV, but others will aid the virus, speeding its replication and increasing its ability to invade the immune system.
- This high rate of mutation underlies HIV's remarkable ability to become resistant to drug therapies and to encumber the production of an HIV vaccine.
- Once the virus reproduces, it leaves the cell to enter other cells and begins the process again, destroying the host cell in the process.
- As HIV destroys the body's T4 cells, the body is no longer able to mount an immune response to pathogens.
- In HIV-infected individuals, a decline in the T4 count signals the deterioration of the immune system, and thus the progressive inability of the body to combat infections.
- As the immune system weakens, the pathogens that are normally easily handled by the body's T4 cells can now cause serious infections by taking advantage of a weaker immune system to establish themselves in the human body. They are known as opportunistic infections.

**Step 3: Stop.** Ask participants to turn to their neighbors again, and discuss in their own words what HIV does to the immune system.

**Option:** Use the elephant and lion metaphor from the *Life Skills Manual* to show participants how they can make this process more visual.

### Reinforcement activity (5 minutes)

**Step 1:** Stand in a big circle.

**Step 2:** Throw a small ball to someone. The person who catches it either states something she or he learned in the session OR asks a question.

**Step 3:** Whoever answers the question gets a small prize (perhaps a red ribbon) and the ball to throw to the next person.

### Stages of infection (20 minutes)

**Step 1:** Explain

- The course of HIV varies considerably from person to person. Researchers are trying to identify what makes HIV and AIDS progress rapidly in one person and slowly in another.
- In general there are four stages of disease progression. You are going to learn about one stage and share that information with others.

**Step 2:** Divide participants into four groups. Provide each group with an information sheet (created from *Handout B: The Stages of HIV/AIDS Infection*) about one stage and allow 10 minutes for the group to learn the information together.

**Step 3:** Now create new groups with one person from each of the four groups. Each person shares the information they learned.

**Step 4:** Ask participants to turn to a neighbor within their group, and in their own words, explain the difference between HIV and AIDS.

**Step 5:** Ask if they have any questions. Distribute a complete Handout B with all the stages.

### Summary (5 minutes)

**Step 1:** Spend a few minutes making sure everyone understands the basics of how the immune system works.

**Step 2:** Ask: *What happens when an antigen enters the body?* The response should be: The antigen enters, the T cells come into action, calling on the immune system to react. B cells are directed to produce antibodies, which attack the invading antigens, and destroy them.

**Step 3:** Explain the unique aspects of HIV

- Unlike other pathogens that enter the human body, HIV infects human immune system cells. HIV targets the T4 cells, which direct the response of the entire immune system. Without T4 cells, the immune system cannot function.
- HIV is a retrovirus. The process it uses to replicate is highly susceptible to mutations, which enables the virus to become resistant to drug therapies and to encumber the production of an HIV vaccine.
- Four stages of HIV infection
  1. Acute or primary infection
  2. Asymptomatic HIV disease stage
  3. Symptomatic HIV disease stage
  4. AIDS: Advanced HIV disease stage

### Matching game (10 minutes)

**Step 1:** Explain that participants will see how well they got the information in the session so far through a game.

**Step 2:** Give directions

- *In a minute we will form teams. Each team will receive a stack of cards with terminology and a stack of cards with definitions/characteristics (developed from the Activity Sheet at the end of this session).*
- *You will have 2-3 minutes to organize yourself, and when I call go, see how fast you can match each terminology card to its correct definition card. Raise your hand when you are done.*
- *Break yourselves into teams of approximately six per team. Those with science backgrounds should divide evenly between the teams.*

**Step 3:** Distribute the cards to the teams. Call, “go.”

**Step 4:** Allow each team to finish, noting first, second, third, and subsequent place winners.

**Step 5:** Reconvene as a large group and check the first place winner’s answers by reviewing all together.

**Step 6:** Award a small prize such as a bag of candy to the winning team.

#### IV. The Relationship between HIV, Nutrition, and Other Health Factors (35 minutes)

##### Introduction

Explain: We are going to talk about how other health factors affect a person with HIV/AIDS.

##### Small group discussion (15 minutes)

**Step 1:** Explain that small groups will work with some source material to learn more about the relationship of nutrition and tuberculosis (TB) to HIV/AIDS.

**Questions Relating to Nutrition and HIV/AIDS**

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*What are some of the factors that might impact the progression of HIV to AIDS or to opportunistic infections once a person is HIV-positive?*

*What are two aspects of the relationship between nutrition and HIV/AIDS?*

*Why is clean drinking water so important for someone infected with HIV or suffering from AIDS?*

*Why is getting sick an issue for people with HIV, even in the early stages of the infection?*

FLIP CHART 4

**Questions Relating to HIV/AIDS and Tuberculosis**

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*What is tuberculosis, how is it spread, how common is it?*

*What is the relationship between HIV and TB?*

*What is the DOT program and why is it important?*

*What is multiple drug-resistant TB?*

FLIP CHART 5

*What are some of the factors that might affect the progression of HIV to AIDS or to opportunistic infections once a person is HIV-positive?*

The overall health of a person infected with HIV affects how quickly the disease progresses. Specific factors that affect overall health in HIV-infected people include

- Drinking alcohol or using drugs
- Getting re-infected with a different strain of HIV
- Not preventing or treating other diseases such as TB or STIs as early as possible
  - Depression
  - Stress
  - Sleep
  - Nutrition
  - Smoking

*What are two aspects of the relationship between nutrition and HIV/AIDS?*

1. A healthy diet can strengthen the immune system.
2. HIV/AIDS leads to malnutrition in specific ways
  - HIV infection can affect the body's ability to absorb nutrients from food.
  - HIV/AIDS may affect appetite.
  - HIV/AIDS may change the body's metabolism and the ability to use nutrients effectively.

**Step 2:** Break into small groups of four to five people each. For half of the groups, post flip chart 4, "Questions Relating to Nutrition and HIV/AIDS" and give each group copies of *Handout C: Nutrition and HIV/AIDS*. For the rest of the groups, post flip chart 5, "Questions Relating to HIV and Tuberculosis" and give groups copies of *Handout D: Tuberculosis and HIV/AIDS*. Ask each group to list their responses on flip charts. They will have 20 minutes to work.

##### Summarize (20 minutes)

**Step 1:** Come back together. Ask for some of the high points of discussion by each group on **Information related to nutrition and HIV/AIDS**. (Trainer's note: If these points are not brought out in the discussion, you should add them.)

*Why is clean drinking water so important for someone infected with HIV or suffering from AIDS?*

Often, newcomers to an area might get sick from the water, while local people are able to drink it without becoming ill. This is because a healthy immune system will "remember" the infectious microorganism from a previous exposure. When that pathogen enters the body again, the immune system "remembers" exactly how to respond to it, and will trigger the release of the particular antibodies to quickly destroy the pathogen before it can cause illness. When a person is first exposed to a pathogen, such as a newcomer first exposed to an infectious microorganism in local water, the immune system does not yet have antibodies for that pathogen; in the time needed for the immune system to produce antibodies, the pathogen can cause illness.

Because their immune systems are compromised, HIV-infected people are more susceptible to getting sick from unclean water, and less able to fight the illness once they have it.

**Step 2:** Ask for some of the high points of discussion by each group on **Information related to tuberculosis and HIV.**

*What is tuberculosis, how is it spread, and how common is it?*

- Tuberculosis (TB) is an infectious bacterial disease that usually affects the lungs, but can affect other parts of the body as well.
- One third of the world's population is infected with the TB bacteria.
- There are two kinds of TB
  1. Latent TB (TB infection): People with latent TB have no symptoms and are not contagious. The immune system isolates the TB bacteria which, protected by a thick waxy coat, can lie dormant for years. When a person's immune system is weakened, the chance of developing TB disease is greater. Latent TB infection can be treated so it does not become active TB disease.
  2. Active TB (TB disease): People with active TB appear to be sick. Common symptoms are: bad cough, chest pain, fever, weakness. Only people with active TB in their lungs are contagious and when they cough, sneeze, talk, or spit, people nearby may breathe in the TB bacteria and become infected. Five to ten percent of people with latent TB (but who are not infected with HIV) will develop active TB at some time during their life. Active TB can be treated and cured; an untreated person may infect on average 10 to 15 people per year.

*What is the relationship between HIV and TB?*

- People who are co-infected with both HIV and latent TB have a much higher risk of developing active TB compared to people not infected with HIV.
- TB progresses faster in HIV-infected people
- TB is the leading cause of death among people who are HIV-positive (and accounts for up to a third of AIDS deaths worldwide).
- TB is harder to diagnose in HIV-positive people.
- TB in HIV-positive people is more likely to lead to death if left untreated.

- Because TB is spread through the air, an increase in active TB among people co-infected with TB and HIV results in
  - more transmission of the TB bacteria;
  - more people with latent TB; and
  - more TB disease in the whole population.

*What is the Directly Observed Therapy (DOT) program?*

- Directly Observed Therapy (DOT) is a strategy to help TB patients take their medicine correctly and consistently:
  - Provides six to eight months of regularly supervised treatment (including direct observation of drug-taking for at least the first two months)
  - Includes a reporting system to monitor treatment progress and program performance
- Produces cures of up to 95 percent even in poorest countries
- Helps to prevent development of drug-resistant strains by ensuring full course of drugs taken

*What is multiple drug-resistant TB?*

- Active TB disease caused by bacteria that is resistant to the most common drugs
- Caused by inappropriate treatment, such as being given an incomplete regimen of drugs, or not taking full course of drugs
- Requires a more expensive, complex treatment which is often more toxic for patients

### Transition

Staying healthy, maintaining good nutrition, and drinking clean water are all important in fighting HIV once infected. People with HIV need to understand this information so they can take action to increase their longevity.

In addition, antiretroviral therapy is extremely important in extending the lives of people with HIV/AIDS.

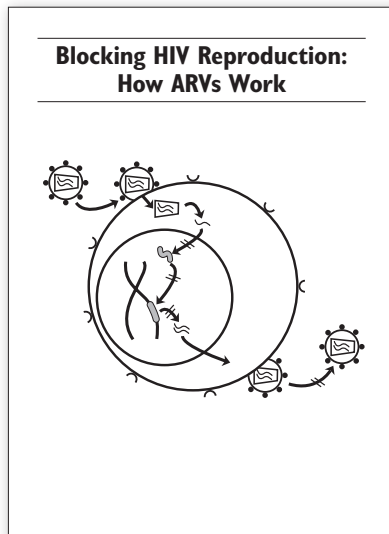
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## V. Antiretroviral Treatment (20 minutes)

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### Explain (10 minutes)

There is no cure for HIV or AIDS. Antiretroviral (ARV) treatment is not a cure, but it can keep HIV-positive people from becoming ill for many years. The treatment consists of drugs that have to be taken every day for the rest of someone's life.



FLIP CHART 6

ARV treatment works by slowing down the replication of HIV in the body.

Distribute *Handout E: Blocking HIV Reproduction: How ARVs Work* and reveal flip chart 6. Use the diagram to explain the points at which different HIV drugs interfere with the replication of HIV.

Points to make

There are different groups of ARV drugs, and each group interferes with HIV replication in a different way. For example, ARV drugs slow down the replication process

- By interfering with the different proteins that HIV needs to replicate; and
- By preventing HIV from entering new cells.

For ARV treatment to be effective for a long time, it is necessary to take two or more different kinds of ARV drugs at the same time. This strategy is called combination therapy, and it greatly reduces the rate at which HIV drug resistance develops. The term Highly Active Antiretroviral Therapy (HAART) is used to describe a combination of three or more ARV drugs.

### Starting ARV treatment (10 minutes)

Choosing when to begin ARV treatment is a very important decision. There are different views of the benefits of starting HIV treatment earlier or later. However, most guidelines recommend not starting ARV treatment until the advanced stage of HIV infection.

Ask the participants to identify some of the challenges of ARV treatment.

**Duration** Once treatment has begun it must be adhered to, despite side effects and other challenges.

**Adherence or compliance** The simplicity of a regimen has a great effect on adherence. Factors associated with poor adherence include unstable housing, mental illness, and major life crises. Adherence to the HIV drug regimen means taking all of the prescribed anti-HIV drugs at the scheduled times and not missing any doses. Skipping only a few pills can trigger the emergence of drug resistant strains of HIV. This could create a more serious problem than the initial infection because the resistant virus could overwhelm the individual taking the drugs and anyone else to whom the virus is transmitted.

**Cost** Many HIV-positive people cannot afford the life-long cost of ARV drugs. However, some governments provide subsidized ARV treatment, and global HIV initiatives such as the President's Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to fight AIDS, Tuberculosis and Malaria (The Global Fund) are increasing access to ARV drugs. (For more information, please refer to the Capacity Building Module, Session Two, and [www.pepfar.gov](http://www.pepfar.gov).)

**Side effects** Side effects from ARV treatment range from mild to serious health problems. Side effects include: anemia, nausea, headache, hair loss, loss of bone mineral density, high cholesterol levels associated with coronary artery disease, liver disease, severe gastrointestinal irritation or diabetes. Sometimes, patients will need to alter their drug regimen (under consultation with their health-care providers) because they are unable to tolerate the side effects.

For more information about ARV treatment, please see *Handout F: Antiretroviral Drugs for HIV/AIDS*.

## VI. Wrap up (5 minutes)

### Step 1: Review and application

*What did you learn that surprised you?*

*How will understanding the biology of HIV help you in your work?*

### Step 2: Link to stigma and discrimination

Remind participants that stigma and discrimination may keep people from finding out about their HIV status, learning about and changing risky behaviors,

and taking steps to live the most productive (and non-transmitting) lives they can if they test positive. Stigma and discrimination is often based on incorrect or inadequate understanding of the biology of HIV. Volunteers can address stigma and discrimination by helping people learn the facts about HIV and its transmission.

**Step 3: Handouts**

Provide participants with any handouts they did not get during the session.

**Evaluation**

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**References or Resources**

Granich, Reuben, MD, MPH and Jonathan Mermin, MD, MPH, *HIV Health & Your Community: A Guide for Action*, The Hesperian Foundation: Berkeley, CA, 2001. (Chapter 1 – What is HIV? pps. 5-12.)

HIV 101: How the HIV virus reproduces and affects the human body, Powerpoint presentation: Presented by Dr. Paul Jung, Praya Baruch, and Jill Meeks. Peace Corps headquarters, 2005.

*Life Skills Manual*. Peace Corps: Washington, DC, 2001. Part III, “Facing Facts about HIV/AIDS and STDs.” [ICE No. M0063]

Stine, Gerald J, Ph.D., *AIDS Update 2007: An Annual Overview of Acquired Immune Deficiency Syndrome*. New Jersey: Prentice Hall, pg. 127.

World Health Organization. “What is TB? How is it spread?” <http://www.who.int/features/qa/08/en/index.html> (accessed March 12, 2007).

World Health Organization. “Joint HIV/Tuberculosis Interventions.” <http://www.who.int/hiv/topics/tb/tuberculosis/en/> (accessed March 12, 2007).

**Notes**

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**Changes to Session**

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## Activity Sheet: Template for the Matching Game

These are for the matching game in Part III, Step 5. Copy enough to make a set of terms and a set of definitions for every six participants. Cut them out and make sets for each group.

### Terms

<b>lymphocytes</b>	<b>CD4 receptors</b>
<b>bacteria</b>	<b>T4 cells</b>
<b>viruses</b>	<b>pathogen</b>
<b>infectious diseases</b>	<b>antibodies</b>
<b>antigen</b>	<b>receptors</b>



**Definitions**

<p><b>Microscopic single-celled organisms. Some can cause disease in humans by producing toxins that interact negatively with the body, for example: strep throat, tetanus, tuberculosis, and tooth decay.</b></p>	<p><b>Specialized molecules located on the surface of every cell that distinguishes one cell type from another. These enable a cell to communicate with the environment or other cells.</b></p>
<p><b>Specialized white blood cells involved in the immune response. The body has about two trillion of these. There are two major types: B cells and T cells.</b></p>	<p><b>Specific type of T cell responsible for directing the body's immune response against infection. This type of cell is the main target of HIV.</b></p>
<p><b>Diseases that can spread from one person to another and are caused by foreign organisms or substances that invade the body.</b></p>	<p><b>An antigen that causes disease.</b></p>
<p><b>Invades a living cell and forces it to make new copies of itself. They often damage or kill the cells they infect, causing disease and sometimes death. Very specific with regard to the types of cells they can enter and reproduce.</b></p>	<p><b>Produced by the immune system to attack specific antigens.</b></p>
<p><b>Any cell that does not originate in a person's body. There are millions of examples, including bacteria, viruses, fungi, etc.</b></p>	<p><b>The type of receptor that enables the HIV virus to bind to and enter cells. The T4 cell has many of these receptors.</b></p>

**Answer key for trainer**

**Lymphocytes** Specialized white blood cells involved in the immune response. The body has about two trillion of these. There are two major types: B cells and T cells.

**Receptors** Specialized molecules located on the surface of some cells that distinguishes one cell type from another. These enable a cell to communicate with the environment or other cells.

**CD4 receptors** The type of receptor that enables the HIV virus to bind to and enter cells. The T4 cell has many of these receptors.

**T4 cells** Specific type of T cell responsible for directing the body's immune response against infection. This type of cell is the main target of HIV.

**Bacteria** Microscopic single-celled organisms. Some can cause disease in humans by producing toxins that interact negatively with the body, for example: strep throat, tetanus, tuberculosis, and tooth decay.

**Antibodies** Produced by the immune system to attack specific antigens.

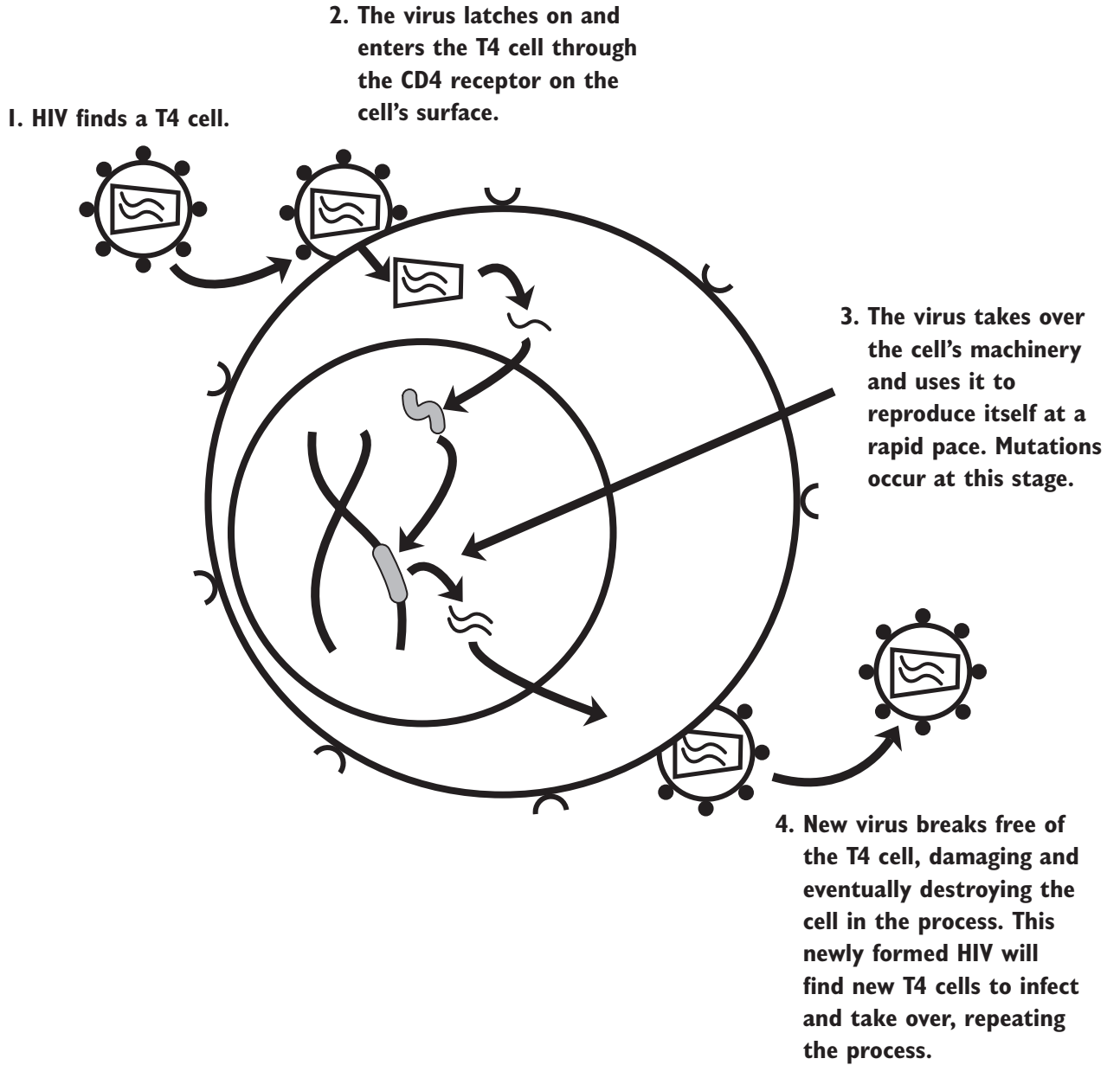
**Antigen** Any cell that does not originate in a person's body. There are millions of examples, including bacteria, viruses, fungi, etc.

**Pathogen** An antigen that causes disease.

**Viruses** Invade a living cell and force it to make new copies of itself. They often damage or kill the cells they infect, causing disease and sometimes death. Very specific with regard to the types of cells they can enter and reproduce.

**Infectious diseases** Diseases that can spread from one person to another and are caused by foreign organisms or substances that invade the body.

# Handout A: The Life Cycle of HIV



## Handout B: The Stages of HIV/AIDS Infection

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### A. Acute or primary infection (the first 2-8 weeks after exposure)

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After initial infection, the body's T4 cells rush in to fight the HIV, initiating the body's immune response.

Until the immune system has generated sufficient levels of antibodies for detection in the blood by available tests, HIV tests will be negative. This is the "window period," the time that a person can be infected but test negative. Typically it lasts one to three months, but can be longer.

Most people have mild flu-like symptoms for one to four weeks (sore throat, headache, fever), a skin rash, and tender lymph nodes; however there are insufficient antibodies in the blood to be detected. Symptoms go away on their own.

HIV replicates rapidly during this stage, spreading to many organs, particularly the lymphoid tissues, where the virus can be stored.

As T4 cells become infected and begin to replicate, the viral load in the blood is high.

During this period, patients may be highly infectious, about 10 times more infectious than in the asymptomatic stage

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### B. Sero-conversion (6-12 weeks)

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HIV test is positive.

Host immune response is activated and viral infection rates drop

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### C. Asymptomatic HIV stage (infected for 6-11 years or more) Dormant/Latent Period

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There are no symptoms of HIV.

During this time HIV continues to replicate.

A person with HIV in this stage, like all other stages, can infect others through contact with body fluids, although she or he is less infectious.

The body continues to produce new T4 cells and antibodies to the virus, indicating that the immune system is fighting the virus.

HIV RNA can be measured in the blood; this is thought to be a more reliable indication of disease progression

than the number of T4 cells, but both measures are important in monitoring the spread of HIV.

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### D. Symptomatic HIV stage (this stage may last for months or years)

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The number of T4 cells in the body drops significantly from a normal 1,000/microlitre of blood.

Levels of HIV RNA in the blood increase.

The immune system is weakened, and is less likely to fight off some infections that a healthy immune system can combat.

As in all stages, a person can infect others.

Good nutrition and clean water are very important at this stage. So is self-care: exercise, meditation, staying away from stress, and people with obvious contagious diseases.

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### E. AIDS: Advanced HIV Secondary Diseases

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HIV has progressed to AIDS when the T4 cell count is below 200/microlitre of blood.

The immune system is weakened to the point that it cannot fight off diseases that a healthy person can resist. The person begins to develop opportunistic diseases that vary by geographic region. These include a large range of diseases such as tuberculosis, pneumonia, bowel infection, meningitis, and cancers such as non-Hodgkin's lymphoma and Kaposi's sarcoma.

According to the World Health Organization, tuberculosis is the leading cause of death in people infected with HIV worldwide.

T4 cells are no longer being replaced.

AIDS does not mean immediate death. People get sick and recover from various diseases.

As in all stages, a person can infect others.

Characterized by loss of body weight, or wasting.

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### F. Death

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Death occurs as immune system deteriorates and viral replication overtakes host.

Stine, Gerald J, Ph.D., AIDS Update 2003: An Annual Overview of Acquired Immune Deficiency Syndrome, New Jersey: Prentice Hall, pg. 170-196.

## Handout C: Nutrition and HIV/AIDS

**FACT SHEET** *This Fact Sheet is based on information summarized from UNAIDS and USAID.*

Proper nutrition is an important part of the overall care of people living with HIV/AIDS since it plays a vital role in improving and prolonging the quality of life of those infected and affected. A healthy diet can help to strengthen the immune system which boosts resistance to disease and infection, increases energy, allows an individual to remain productive and effectively able to contribute to family and community for as long as possible.

### What is the link between nutrition and HIV/AIDS?

There is a strong relationship between HIV and nutrition. Malnutrition leads to a weakened immune system, which allows HIV to more quickly progress to AIDS. Both HIV and malnutrition can independently cause progressive damage to the immune system and increased susceptibility to infection, morbidity, and mortality through opportunistic infections, fever, diarrhea, loss of appetite, nutrient malabsorption and weight loss. HIV **specifically** affects nutritional status by increasing energy requirements, reducing food intake, and adversely affecting nutrient absorption and metabolism.

### What is good nutrition for people living with HIV/AIDS?

Overall, good or adequate nutrition for people living with HIV/AIDS is considered the consumption of a

balanced healthy diet, consisting of locally available foods (animal foods, beans, fruits, nuts, starchy staples and vegetables), and clean water. However, depending upon the age and phase of the virus, individuals infected with HIV can require an additional energy intake of 10 percent (asymptomatic adults) to 100 percent (symptomatic children with weight loss); therefore, their nutrient requirements would be greater than those of healthy individuals.

### What are the components of a nutritional care and support program for people living with HIV/AIDS?

It is important for Volunteers to work with their counterpart(s) when implementing a nutritional care and support program. Additionally, efforts should be made to minimize any aspect that might stigmatize an individual and/or family.

#### Nutrition assessment

- Gather information about the current nutritional status and diet.
- Identify potential risk factors, as well as positive eating habits. Make sure to include: food prices, food seasonality, perceived importance of the food item, local preferences, food assistance program participation, access to clean water sources, and other relevant data. If possible, ascertain the nutritional value of foods most easily accessible and/or grown, and explore ways with community members to diversify the diet.
- When applicable, refer the individual for a physical assessment: measurements of weight,

### Energy requirement increases for people living with HIV/AIDS\*

Population Group	Asymptomatic Phase	Symptomatic Phase
Adults	10% increase	20-30% increase
Pregnant/lactating women	10% increase (in addition to requirements of pregnancy/lactation)	20-30% increase (in addition to requirements of pregnancy/lactation)
Children	10% increase	With no weight loss: 20-30% increase. With weight loss: 50-100% increase.

\* Source: WHO, 2003.

mid-arm circumference, height, and a calculation of body mass index.

### **Nutrition education and counseling**

Include information about

- Adequate nutrient intake
- Food safety and hygiene
- Physical activity
- Healthy lifestyle

### **Symptom management**

Provide people living with HIV/AIDS strategies to manage nutrition-related HIV symptoms and/or side effects: nausea, vomiting, diarrhea, anorexia, difficulty chewing/swallowing, mouth sores, and/or changes in taste.

### **Nutrition management of antiretroviral therapy**

- Address any drug interactions with foods, beverages, and herbs.
- Discuss the management of nutrition related to drug/medication side effects.

### **Psychosocial support**

Listen and allow the person living with HIV/AIDS to voice any concerns and/or emotions about his/her disease and nutritional status.

### **Targeted nutritional supplements**

Know what type of (if any) nutritional supplementation is provided—food rations to micronutrient supplementation.

### **Other support mechanisms**

Inquire about additional resources available in the community that seek to enhance nutrition and food security of individuals and families affected by HIV/AIDS.

## **What can Volunteers do to help improve the nutritional status of people living with HIV/AIDS?**

- Nutrition education
- Promotion of indigenous plants that boost immune system
- Incorporation of the permaculture philosophy into farming
- Support for community gardens
- Enhanced small-scale livestock production
- Hygiene and sanitation education
- Promote access to clean water sources

### **Resources**

Executive summary of a scientific review, WHO, UNAIDS, April 2005.

Food and Nutritional Technical Assistance Project, 2004. *HIV/AIDS: A Guide for Nutritional Care and Support*. [www.fantaproject.org](http://www.fantaproject.org).

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*Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs: President's Emergency Plan for AIDS Relief*, September, 2006. Website: <http://www.pepfar.gov/guidance/>

*Report on Food and Nutrition for People Living with HIV/AIDS*, Washington, DC: The President's Emergency Plan for AIDS Relief, May 2006. Website: <http://www.state.gov/documents/organization/66769.pdf>

## Handout D: Tuberculosis and HIV/AIDS

**FACT SHEET** *This Fact Sheet is based on information summarized from AIDS Update 2007, Family Health International, National Institute of Allergies and Infectious Diseases, and the World Health Organization.*

Tuberculosis (TB) is a chronic bacterial infection. It is spread through the air and usually infects the lungs, although other organs and parts of the body can be involved as well. With an estimated two billion people (one-third of the world's population) infected, TB is one of the most common infections among humans, and a leading killer of adults worldwide.

Not everyone infected with TB becomes sick. There are two kinds of TB

1. **Latent TB (TB infection)** Most people who are infected with TB have latent TB. They have no symptoms and are not contagious. The immune system isolates the TB bacteria which, protected by a thick waxy coat, can lie dormant for years. The risk of developing active disease is greatest in the first year after infection, but active disease can also occur many years after initial infection. When a person's immune system is weakened, the chance of developing TB disease is greater. Five to ten percent of people with latent TB (but who are not infected with HIV) will develop active TB at some time during their lives. Latent TB infection can be treated so it does not become active TB disease.
2. **Active TB (TB disease)** People with active TB are sick (common symptoms: bad cough, chest pain, fever, weakness). Only people with active TB in their lungs are contagious. The bacteria are put into the air when a person with active TB coughs, sneezes, talks, or spits. People nearby may breathe in the TB bacteria and become infected. An untreated person may infect on average 10 to 15 people per year. Active TB is almost entirely curable. According to World Health Organization (WHO) estimates, each year, eight million people worldwide develop active TB and nearly two million die.

### What is the relationship between HIV and tuberculosis?

Many of the world's TB cases are latent, but they can become active when a person's immune system is depressed as a result of other factors, particularly HIV/AIDS. HIV and TB form a lethal combination, each speeding the other's progress. TB is a leading cause of death among people who are HIV-positive; it is estimated to account for greater than 30 percent of AIDS-related deaths worldwide.

Although HIV has increased the incidence of TB, it is an infectious disease that is not confined to HIV-positive individuals. Because TB is spread through the air, an increase in active TB among people co-infected with TB and HIV results in

- more transmission of the TB bacteria;
- more people with latent TB; and
- more TB disease in the whole population.

As one of the first opportunistic infections to appear in HIV-infected people, TB may be the earliest sign of HIV infection. For this reason, addressing TB offers the opportunity for early HIV intervention. HIV-positive people can be screened for TB. If they are infected they can be given prophylactic treatment to prevent development of the disease or curative drugs if they already have the disease. TB programs can make a major contribution to identifying eligible candidates for ARV treatment.

### What is the impact of TB/HIV on women?

In most of the world, more men than women are diagnosed with active TB and die from it. TB is nevertheless a leading infectious cause of death among women. Annually, about three-quarters of a million women die of TB, and more than three million contract the disease. Since tuberculosis affects women mainly in their economically and reproductively active years, the impact of the disease is also strongly felt by their children and families.

While poverty is the underlying cause of much infection in rural areas, poverty is also aggravated by the impact of TB. In 1996, a study by the World Bank, World Health Organization (WHO), and Harvard

University reported TB as a leading cause of “healthy years lost” among women of reproductive age.

### What is being done to combat the spread of TB?

The internationally recommended approach to TB control is Directly Observed Therapy (DOT), an inexpensive strategy that could prevent millions of TB cases and deaths over the coming decade. The DOT strategy for TB control consists of five key elements

1. Government commitment to sustained TB control;
2. Detection of TB cases through sputum smear microscopy among people with symptoms;
3. Regular and uninterrupted supply of high-quality anti-TB drugs;
4. Six to eight months of regularly supervised treatment (including direct observation of drug-taking for at least the first two months); and
5. Reporting systems to monitor treatment progress and program performance.

Once patients with active TB have been identified, health and community workers or trained volunteers observe patients swallowing the full course of the correct dosage of anti-TB medicines.

Testing is repeated after two months to check progress, and again at the end of treatment. The recording and reporting system ensures that the patient’s progress can be followed throughout treatment. It also allows assessment of the proportion of patients who are successfully treated, giving an indication of the quality of the program.

#### The DOT Strategy

- Produces cure rates of up to 95 percent even in the poorest countries.
- Prevents new infections by curing infectious patients.
- Prevents the development of drug resistance by ensuring that the full course of treatment is followed.
- Is ranked by the World Bank as one of the “most cost-effective of all health interventions.”

### Multiple Drug-Resistant TB (MDR-TB)

Until 50 years ago, there was no medication to cure TB. Now, strains that are resistant to a single drug have been documented in every country surveyed; what is more, strains of TB resistant to all major anti-TB

drugs have emerged. Drug-resistant TB is caused by inconsistent or partial treatment, when patients do not take all their medicines regularly for the required period because they start to feel better, because doctors and health workers prescribe the wrong treatment regimens, or because the drug supply is unreliable. A particularly dangerous form of drug-resistant TB is multidrug-resistant TB (MDR-TB), which is defined as the disease caused by TB bacilli resistant to the two most powerful anti-TB drugs. Rates of MDR-TB are high in some countries, and threaten TB control efforts.

While drug-resistant TB is generally treatable, it requires extensive (up to two years) treatment that is often prohibitively expensive (often more than 100 times more expensive than treatment of drug-susceptible TB), and is also more toxic to patients.

### What can Peace Corps Volunteers do?

Because Volunteers work at the community level, they are in a key position to spread awareness of TB and of the deadly relationship between TB and HIV. World TB Day, held on March 24 each year, is an occasion for people around the world to raise awareness about the international health threat presented by TB. This is just one of the opportunities Volunteers can use to raise awareness in their communities. People who have been cured of TB are excellent advocates; Volunteers can identify these people in their community and encourage them to come forward to speak of the benefits of treatment. Getting involved in TB-DOT programs to facilitate the control of TB in a village or region is important and is an area where Volunteers can help to train, facilitate, and share information on TB and HIV/AIDS. The co-infection of TB-HIV is an important area to focus HIV/AIDS activities to address the problem.

### Resources

Family Health International. “Tuberculosis and HIV/AIDS.” <http://www.fhi.org/en/Topics/Tuberculosis+and+HIV-AIDS+topic+page.htm> (accessed March 12, 2007).

National Institute of Allergies and Infectious Diseases. “Tuberculosis.” <http://www.niaid.nih.gov/factsheets/tb.htm> (accessed March 12, 2007).

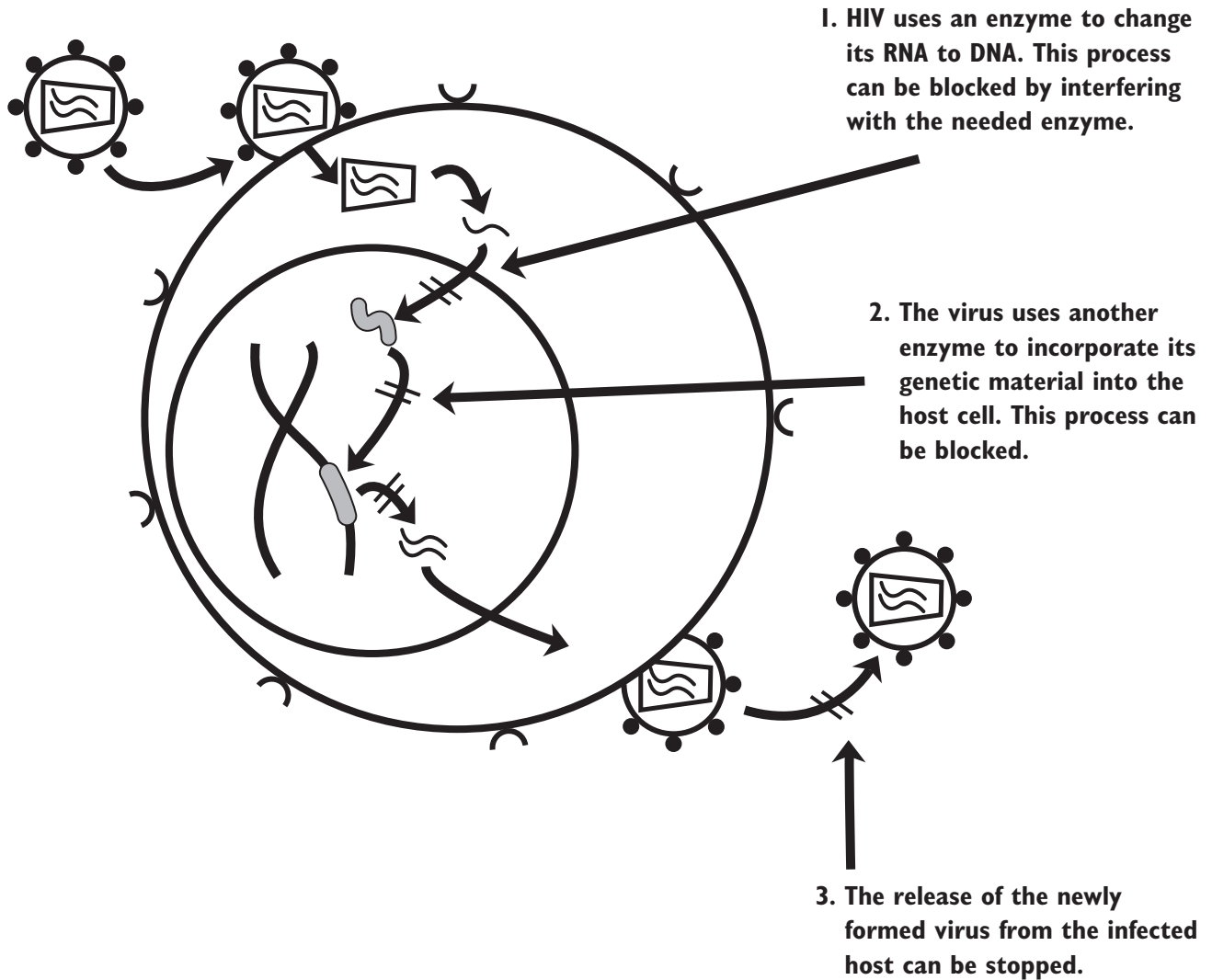
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## Handout E: Blocking HIV Reproduction— How ARVs Work





# Handout F: Antiretroviral Drugs for HIV/AIDS

**FACT SHEET** *This Fact Sheet is based on information summarized from Family Health International.*

## Safe and effective introduction of antiretroviral (ARV) drugs for HIV/AIDS

The introduction of antiretroviral drugs as part of HIV clinical care has made AIDS more of a manageable chronic illness with restored economic productivity and social functioning. But these effects have been seen only in settings where resources were available to make the drugs affordable and there are health service capacities to optimize their sustained, safe and effective use. There are multiple requirements for such an effect that can be grouped into three areas: (1) the drugs, (2) the client, and (3) the health system.

### Antiretroviral drugs

A dramatic reduction in viral load (the level of virus in the blood) with resulting arrest in immune damage is achieved by combining at least three drugs from the various classes of antiretroviral drugs into a “cocktail.” This three-drug cocktail is called “Highly Active Antiretroviral Therapy” (HAART). Each class of anti-HIV drugs attacks the virus at a different stage of replication while it is growing in the human cell. Drug-related issues that influence their use include the following

- All ARVs are still costly, even with recent dramatic price reductions, when compared to sexually transmitted disease (STD) or tuberculosis (TB) drugs, for example. However, many resource-poor countries are benefiting from worldwide efforts, such as the President’s Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), to expand drug availability.
- Side effects of the drugs are common and need to be clinically monitored. Side effects may lead to stopping or changing the drug, or making lifestyle or diet changes.
- HIV can easily become resistant to ARVs, hence the need to combine different kinds of ARVs to treat patients.
- Some ARVs interact with other drugs commonly used in the treatment of opportunistic diseases such as tuberculosis and fungal infections. This requires adjusting the dosage of the drugs and careful monitoring of the patient.
- Many ARVs have strict medication schedules or storage requirements (although medical advances are developing new drugs and drug combinations to make them easier to take with fewer side effects).
- ARVs must be taken for a lifetime if AIDS is to be a manageable chronic illness. It requires a lifelong relationship between client and the health team.

### The client on ARV

Adherence (also called compliance or concurrence) to ARV therapy is crucial for effective results, and lessens the chance that HIV will become resistant to ARVs. The following are issues from the client’s perspective that should be considered and incorporated in planning

- Starting ARVs is a commitment to lifelong medication and entails enduring an initial period of unpleasant side effects. It also requires identifying financial resources necessary for regular medical visits, costs of laboratory tests and treatment costs. The self-discipline and financial burden associated with ARVs should be discussed at the start of treatment.
- Continuous drug information and counseling by the health-care provider is important for adherence.
- There should be links between drug treatment, home-based care, and palliative care.
- ARVs may create a false hope of safety among users and may result in increased high-risk behavior. Services should include ongoing counseling about the need to continue protective action for clients and their sexual partners.
- ARVs are neither a cure nor a preventive tool. Information and education for communities and society on the realities of ARV use should also be in place.

## The health systems

To optimize the benefits of ARVs for greatly reduced morbidity, mortality, and improved quality of life, the following need to be addressed simultaneously

- Training health teams (doctor, nurse, counselor, pharmacist, laboratory staff) in both the public and private sectors, with regular updates on treatment and care options.
- Reorganizing services to integrate HIV care in outpatient departments and at health centers to allow for space, privacy, and time and links with tuberculosis Directly Observed Therapy (TB-DOT) and sexually transmitted infection (STI) programs.
- Strengthening rapid registration of new drugs and drug procurement and management systems to ensure continuous availability of the drugs and avoidance of pilferage and misuse.
- Expanding and integrating quality voluntary counseling and testing into health systems as an entry point to prevention and care.
- Strengthening and upgrading laboratory facilities. Although viral load measurements may not be essential for safe and effective use, CD4 counts or cheaper alternatives are needed to help providers and clients decide together when to start and when to switch or stop treatment. There needs to be laboratory monitoring for potential side effects.
- Communicating to the public at large on the benefits and risks of ARV treatment.
- Strengthening and scaling up comprehensive care programs (management of opportunistic infections, preventive therapies, TB-DOT, home care, palliative care, social support) to accommodate ARV use and continue to care for a majority of patients not on ARVs.
- Strengthening prevention programs to link closely with care and ARV treatment programs and reinforce the need for prevention as a primary goal within and beyond the health sector.

In summary, the good news is that ARVs are becoming a welcome addition to greatly improve the quality of life of many more people living with HIV/AIDS. All efforts need to be made to ensure that patients can adhere and health systems can accommodate these new interventions.

## What can Peace Corps Volunteers do?

Volunteers can play an important role in ARV programs by helping to educate people living with HIV/AIDS, family, friends and other care givers about ARV compliance, benefits and risks of ARV treatment, and strengthening prevention programs that are closely linked to care and treatment activities that include ARVs. Volunteers can also advocate and facilitate the points outlined above to strengthen in-country systems for the management and distribution of ARVs.

## Source

Family Health International. "Safe and Effective Introduction of Antiretroviral (ARV) Drugs for HIV/AIDS." <http://www.fhi.org/en/HIVAIDS/pub/fact/introarv.htm> (accessed March 12, 2007).

## Resources

AIDSinfo: HIV/AIDS Information from the U.S. Department of Health and Human Services. <http://www.hivatis.org>

Johns Hopkins AIDS Service. <http://www.hopkins-aids.edu>

National Minority AIDS Council. <http://www.nmac.org>

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# Session Two: The Biology of HIV Transmission

## Purpose

To provide an understanding of how HIV is transmitted.

## Rationale

Information about how HIV can and cannot be transmitted is necessary to develop prevention education and to help reduce the stigma and discrimination that people living with HIV/AIDS experience.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours 5 minutes to 2 hours 15 minutes

## Objectives

By the end of the session participants will be able to

1. Explain how HIV is transmitted.
2. Identify populations at higher risk for HIV.
3. Identify factors that increase the risk of HIV.
4. Explain how to prevent transmission of HIV.
5. Explain the general characteristics of an HIV epidemic.

## Session Outline

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**I. Introduction** (5 minutes)

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**II. HIV Transmission** (30 minutes)

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**III. Biological Risk Factors of HIV Transmission**  
(15 minutes)

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**IV. Prevention** (50-60 minutes)

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**V. Characteristics of an HIV Epidemic** (20 minutes)

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**VI. Wrap up** (5 minutes)

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## Facilitators/Technical Expertise

It may be helpful to have someone with medical expertise available to assist with the session. Facilitator must be knowledgeable about the biology of HIV/AIDS.

## Materials and Equipment

Flip charts, markers, tape or tacks

Copy of the *Life Skills Manual* [ICE No. M0063]

Prepared flip chart with session outline

Handouts

- A. *HIV and Its Transmission*
- B. *Biological Risk Factors of HIV Transmission*
- C. *Statement on Kenyan and Ugandan trial findings regarding male circumcision and HIV*
- D. *Universal Precautions*
- E. *The ABC Approach*
- F. *Instructions for Male Condom Use*
- G. *The Female Condom*
- H. *Persuading Your Partner to Use a Condom*
- I. *Mother-to-Child Transmission*
- J. *Measures of Disease Frequency*

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Make copies of handouts.
- Make an extra copy of *Handout B: Biological Risk Factors of HIV Transmission*. Cut it into the three sections to be used for group work in Part III, Step 2.
- Research country policy on needle exchange and drug user services for Part IV, Prevention for injection drug users.

## Methodology

### I. Introduction (5 minutes)

Session Two Outline
<b>The Biology of HIV Transmission</b>
<b>I. Introduction</b>
<b>II. HIV Transmission</b>
<b>III. Biological Risk Factors of HIV Transmission</b>
<b>IV. Prevention</b>
<b>V. Characteristics of an HIV Epidemic</b>
<b>VI. Wrap up</b>

**Step 1:** Reveal flip chart with session outline.

**Step 2:** Explain

- This session will focus on how HIV **is** and **is not** transmitted. There are many myths and fears related to HIV transmission. Developing an accurate understanding of HIV transmission is key to a Volunteer's role as a prevention educator, and in helping to reduce the stigma and discrimination against people living with HIV/AIDS.
- A study on stigma done by the International Center for the Research of Women (ICRW) showed that even though people had learned a little about transmission, it was not enough to really understand it, and their "what if" scenarios created great fear that lead to stigma and discrimination. The study showed that people need more than hearing messages; they need to talk about what they heard and to have their "what ifs" answered. We will learn more specifically about the ICRW study in the Behavior Change Module.

### II. HIV Transmission (30 minutes)

#### Body fluids (5 minutes)

**Step 1:** *Handout A: HIV and its Transmission* can be handed out before this segment so that participants can follow along.

**Step 2:** Explain: In order to become infected with HIV, a person must be in direct contact with one of four main body fluids that transmit HIV. Ask

*What are the four fluids that transmit HIV?*

Write on flip chart paper under a heading, "Fluids that transmit HIV."

- Blood
- Semen
- Vaginal fluid
- Breast milk

State that HIV has been found in saliva and tears in very low quantities from some AIDS patients, but it is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV has not been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

#### Portal of entry (5 minutes)

To become infected, these fluids need a portal of entry into the body. Ask

*What is a "portal of entry?"*

A portal of entry is a cut, sore, or opening in the skin or through the mucous membranes. HIV enters the body through the mucous membranes of the vagina, penis, rectum, and mouth.

#### Mechanisms of transmitting HIV (10 minutes)

**Step 1:** Ask participants to form two groups, one group by each flip chart paper hung on wall.

**Step 2:** Ask one group to define the most common mechanisms of transmitting HIV. Ask the other group to list mechanisms that do not transmit HIV. Give participants five minutes to make lists.

**Step 3:** Bring groups back together, share and discuss lists. Answers should include

**Most common ways of transmitting**

- Vaginal, anal, and oral sex
- Through exposure to non-sterile equipment and medical procedures (including needles and syringes)
- Through direct blood transfusions of untested blood
- From mother to infant during pregnancy, delivery, or breast-feeding

**Ways HIV is NOT transmitted**

- Through sweat, coughing, or sneezing
- Being near a person with HIV
- Sharing cups, eating utensils, or bathrooms
- By hugging or kissing people with HIV when blood is not present
- Sharing toothbrushes (only if blood is **not** present on the brush)
- By blood-sucking insects (mosquitoes and bedbugs)

**High risk/low risk/no risk (10 minutes)**

Explore transmission further by thinking about other situations in which an individual can become infected with HIV.

Call out different activities. If participants consider the activity

**No risk**, participants should stay seated.

**Low risk**, participants should stand.

**High risk**, participants should stand and stretch arms above their heads.

If there is no agreement about an activity, stop to talk about it.

*What is the risk of catching HIV from a person living with HIV/AIDS during each of the following activities?*

Pause after each to allow them to stay seated, stand, or stand and stretch arms up. If there is disagreement, ask why.

- *Hugging*  
No risk—no exchange of body fluids.
- *Deep kissing*  
Low risk (extremely low)—Deep or open-mouthed kissing is considered a very low-risk activity because HIV is present in saliva in only extremely minute quantities, insufficient to lead to HIV infection alone.  
Of the 65 million people infected with HIV/AIDS to date, there is only one documented case

where HIV was transmitted by kissing, and both partners had serious gum disease. Investigators believe that the HIV was transmitted via blood present in their mouths, not by saliva.

- *Having sex without a condom*  
High risk—exchange of HIV containing body fluids.
- *Sleeping in the same room*  
No risk—no exchange of body fluids.
- *Sharing cups, plates, or utensils*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.
- *Using the same toilet*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.
- *Cleaning up spilled blood*  
Low risk— if universal precautions are not taken (See *Handout D: Universal Precautions*), there could be a risk of body fluid exchange if the person has open cuts or sores on his hands.
- *Eating food prepared by someone with HIV*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.
- *Eating from the same plate as someone with HIV*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.
- *Drinking from the same cup as someone with HIV*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.
- *Birth to HIV-positive mother*  
Depends. Low risk to high risk (see Part IV, Prevention of Mother-to-Child Transmission) —depends on whether the mother was given ARV drugs during pregnancy and/or delivery.
- *HIV-positive mother breast-feeding her child*  
Depends. Low risk to high risk (see Part IV, Prevention of Mother-to-Child Transmission) — depends on whether the mother is breast-feeding the child exclusively (low risk), or giving the child other food (higher risk).
- *Being bitten by mosquitoes*  
No risk. Insects inject their own saliva into a person, not the blood of another person. Also, HIV cannot infect a mosquito's cells, and cannot survive in a mosquito's body.
- *Carrying someone who died of AIDS to the cemetery*  
No risk— no exchange of body fluids
- *Using unsterilized needles*  
High risk— exchange of HIV-containing body fluids.

- *Using someone else's razor*  
Low risk—if there are cuts on the person's head, and the razor has blood on it (even if you can't see it), then there could be an exchange of HIV-containing body fluids.
- *Having sex with a condom*  
Low risk—while condom use does not fully protect a person from HIV infection, it can drastically reduce the risk of infection if used properly.
- *Receiving blood transfusion*  
Depends. Low to high risk—if the blood has been properly screened and tested (very low risk), or if the blood has not been screened or tested (high risk).
- *Being spat on by someone with HIV*  
No risk—no exchange of the type of body fluids that contain enough HIV to be infectious.

### III. Biological Risk Factors of HIV

#### Transmission (15 minutes)

**Step 1:** Explain that there are many factors (such as social, cultural, and behavioral) that can put an individual at a higher risk for contracting HIV. In this session, we will focus on the biological risk factors related to transmission.

In your group you will read and discuss the information provided on a particular biological risk factor. After discussion, each group will have one person present a summary of your information for the entire group. Groups will have 10 minutes to work.

**Step 2:** Ask participants to divide themselves into three groups. Provide each group the appropriate information from *Handout B: Biological Risk Factors of HIV Transmission*

- Presence of sexually transmitted infections
- Type of sexual intercourse
- Male circumcision

**Step 3:** Each group spends time learning and discussing key points from its information sheet.

**Step 4:** Ask one person from each group to provide key points about the topic to the large group. Ask for any questions after each presentation; clarify information if necessary.

**Step 5:** Distribute Handouts A and B to everyone for future reference.

### IV. Prevention (50-60 minutes)

#### Introduction (5 minutes)

Explain

*HIV/AIDS prevention is a topic that we will talk about from many perspectives. In this session, we will focus on the “biology” of HIV prevention.*

#### Prevention in medical settings/universal precautions (5 minutes)

Ask participants

*Who knows what the term ‘universal precautions’ means?*

“Universal precautions” is a term usually used by health-care professionals working in hospital and clinic settings. It means that people should always protect themselves “universally” from diseases that are transmitted via blood and body fluids (such as HIV and hepatitis). You should not decide to use barriers for protection from infectious bodily fluids based on how sick a person may look or how at risk they appear to be.

Volunteers should never be in situations where they are exposed to blood and bodily fluids. However, information on universal precautions can be shared with health-care professionals to ensure they have the knowledge to protect themselves.

Refer participants to *Handout D: Universal Precautions*.

#### Prevention for injection drug users (5 minutes)

Sharing contaminated needles and drug equipment is a highly efficient means of HIV transmission, and is the primary driver of HIV epidemics in some countries and regions of the world. Prevention programs for injection drug users (IDUs) focus on reducing individual risk, and reducing the risk environment.

Some examples of prevention programs to reduce individual risk

- HIV-prevention education programs targeted to IDUs
- Disinfection and needle-exchange programs
- Risk-reduction counseling

Some examples of prevention programs to reduce the risk environment

- Creating safe environments for IDUs to adopt healthier behavior

- Mobilizing IDUs and their communities to take action and reduce risks
- Ensuring members of the community have the necessary knowledge, skills, and capacity to respond to the IDU population.

**Prevention of sexual transmission of HIV: abstinence, faithfulness, and correct and consistent use of condoms** (25 minutes, longer if there are demonstrations included)

Handouts E, F, G, and H can be distributed as this segment begins so that participants can follow along or add notes, or they can be distributed after the discussion below.

**Step 1:** Explain: Because sexual transmission remains the primary mode of HIV infection, sexual prevention should be a major component of any HIV/AIDS intervention strategy.

**Step 2:** Ask participants to name the three ways in which sexual transmission of HIV can be prevented or reduced (the ABCs: practicing abstinence, being faithful, and correct and consistent condom use). Write them on a flip chart entitled “Preventing Sexual Transmission.” Make the following points in your discussion

- **Abstinence**  
Abstaining from all sexual activities that can transmit HIV is the only certain way to protect from sexual exposure to HIV and other STIs. Note that in the *Life Skills Manual* (in the newer version see page 174; in the older, three-ring binder version see Part V, pg. 13) there is a session on delaying sex.
- **Being faithful (i.e., practicing monogamy)**  
Being faithful with a mutually faithful and uninfected partner reduces (but does not eliminate) the risk of sexual transmission of HIV.  
An individual, even if faithful themselves, can still be at risk of becoming infected if his or her spouse or regular partner is not faithful.  
The fewer lifetime sexual partners a person has, the lower the risk of contracting or spreading HIV or another STI.
- **Correct and consistent condom use reduces, but does not eliminate, the risk of HIV infection.**  
Condoms protect by forming a barrier to prevent contact with semen, vaginal fluids, and open sores.

To achieve the protective effect of condoms, people must use them *correctly and consistently, at every sexual encounter*. Failure to do so diminishes the protective effect and increases the risk of acquiring an STI because transmission can occur with even a single sexual encounter.

**Step 3:** Distribute *Handout E: The ABC Approach* and ask participants to read it.

**Step 4:** Check to see if they have questions. Remind them about or show them a copy of the *Life Skills Manual*. They will be introduced to the manual in another session; they should all have a copy.

**Step 5:** Optional demonstration: If not yet covered, demonstrate the appropriate use of the male condom and, if available in the country, the female condom.

**Male condoms** (*Handout F: Instructions for Male Condom Use*)

- The male condom covers the penis to create a barrier against STIs, HIV, and sperm.
- Check the expiration date before use.
- Keep condoms in cool areas—do not store condoms in sunlight, glove compartments, or wallets for long periods of time.
- Check that the condom has not been left too long in the sun by feeling for an air pocket in the wrapper.
- Walk participants through the appropriate steps of condom use

**Female condoms** (*Handout G: The Female Condom*)

- The female condom lines the vagina to create a barrier against STIs, HIV, and sperm.
- The condom is a pre-lubricated sheath with flexible rings at either end. The inner ring is used for insertion and it holds the condom in place. The outer ring stays on the outside of the vagina.
- Female condoms are made of polyurethane (not latex), therefore they are not susceptible to damage from heat or humidity.

**Step 6:** Explain that we will talk about sexual prevention of HIV transmission in more detail in other sessions (Behavior Change, Capacity Building).

### Prevention of mother-to-child transmission (PMTCT) (10 minutes)

*Handout I: Mother-to-Child-Transmission* can be handed out as this segment begins so that participants can follow along or add notes, or it can be handed out after the discussion below.

**Step 1:** Explain that mother-to-child HIV transmission (MTCT) is responsible for the greater majority of the estimated 700,000 new annual HIV infections in children worldwide. Without intervention, approximately one-third of infants born to HIV-positive mothers will become infected with HIV.

**Step 2:** There are three ways that mothers can transmit HIV to their children. Ask participants if they can name the three ways and write them on a flip chart entitled “Modes of MTCT”

- During pregnancy
- During labor and delivery
- Through breast-feeding

**Step 3:** Explain: While it is impossible to completely prevent MTCT, the risk can be significantly reduced.

Refer back to your flip chart entitled “Modes of MTCT” ask participants how the risk of MTCT can be reduced during each of these steps. Key points

- During pregnancy HIV can cross over from the mother to the baby’s bloodstream. The risk can be reduced by the mother taking ARV drugs during pregnancy.
- During labor and delivery HIV infection can occur when blood or other infected maternal fluids present during delivery pass into the baby’s body. The risk can be reduced through delivery by cesarean section, and through administering ARV drugs during labor and delivery.
- Through breast-feeding:  
If it is economically feasible, it is best for an HIV-positive mother not to breast-feed her baby. However, in resource-poor settings where access to clean water and adequate replacement food is limited, the increased risk of disease, malnutrition, and death from not breast-feeding must be weighed against the risk of HIV transmission.

In these cases, it is recommended that an HIV-positive mother breast-feed exclusively (infant is given breast milk only, with no other

food or liquids) for the first few months of life, and wean the baby as soon as possible. Exclusive breast-feeding may reduce the risk of HIV transmission because unclean food/water can cause gastrointestinal illness in the infant, which creates an environment where HIV infection is more likely.

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## V. Characteristics of an HIV Epidemic (20 minutes)

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### Definitions of incidence and prevalence

**Step 1:** Distribute *Handout J: Measures of Disease Frequency*.

**Step 2:** Explain the difference between incidence and prevalence in the context of HIV/AIDS.

**Incidence:** the rate at which new cases of HIV are occurring in a population during a given time (usually a year).

**Prevalence:** the percentage of the population that is infected with HIV; includes both new cases and existing cases.

### For example, in a population of 1,000 people

- If 100 people are infected with HIV, the **prevalence** will be 10 percent.
- If 30 of the 100 cases are new infections (in a given time period), the **incidence** will be 3 percent.

**Step 3:** Explain what incidence and prevalence tell us.

Incidence tells us more about how a disease is spreading in a population. Changes in HIV incidence can be an indicator of whether prevention efforts are successfully reducing the number of new infections.

In a population, the availability of life-extending treatments like ARV therapy can lead to an increase in HIV prevalence. This is because fewer people are dying, which contributes to overall percentage of the HIV-positive population.

*(Trainer’s note: referring to Handout J, explain that this scenario is analogous to less water leaving the basin.)*



**Different countries and areas of the world have different types of HIV epidemics.**

**Step 1:** Explain that there are many types of HIV epidemics around the world. Behavioral, cultural, and biological risk factors all contribute to the type of epidemic a country will experience. We are going to discuss the three general types of HIV epidemics, and some characteristics of each.

**Step 2:** On a flip chart, write the three types of HIV epidemics—low level, concentrated, and general—and discuss the following points.

1. **Low-level epidemic** HIV prevalence is less than one percent in the general population and in all subpopulations practicing high-risk behavior.

HIV infection may have existed for many years, but it has never spread to significant levels in any groups with high-risk behavior.

Infection largely occurs among persons with higher-risk behavior, such as commercial sex workers (CSWs), injection drug users (IDUs), and men who have sex with men (MSM).

2. **Concentrated epidemic** HIV prevalence is less than one percent in the general population, but more than five percent in any subpopulation practicing high-risk behavior.

HIV has spread in one or more groups with high-risk behavior (CSWs, IDUs, MSMs, etc.) but has not become well established in the general population.

The future of the epidemic is determined by the frequency and nature of links between the highly infected subpopulations and the general public.

Note: Some of the most heavily populated countries in the world currently report a low prevalence in the population. However, an overall low prevalence can mask significant sub-epidemics in certain regions of the country or groups with high-risk behavior, for example.

3. **Generalized epidemic** HIV prevalence is more than one percent in the general population.

HIV is firmly established in the general population.

Although some high-risk groups may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic.

**VI. Wrap up (5 minutes)**

**Step 1:** Ask a few people to share their feelings at this point about HIV/AIDS.

**Step 2:** Remind participants about the important role of Volunteers in educating others about HIV transmission and prevention. The major source of stigma and discrimination comes from incorrect beliefs or incomplete information about transmission. If these can be reduced, the number of people who will be tested and treated will increase.

**Step 3:** Be sure to end on a note of hope.

- You can protect yourself if you are aware and careful.
- Learn the percentage of your population that is not infected. Remember that prevention is the only vaccine against HIV!

**Evaluation**

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## Notes

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## Handout A: HIV and its Transmission

**FACT SHEET** *This Fact Sheet is based on information summarized from "HIV and Its Transmission." Centers for Disease Control and Prevention. July 1999.*

Research has revealed a great deal of valuable medical, scientific, and public health information about the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). The ways in which HIV can be transmitted have been clearly identified. Unfortunately, false information or statements that are not supported by scientific findings continue to be shared widely through the Internet or popular press. Therefore, the Centers for Disease Control and Prevention (CDC) has prepared this fact sheet to correct a few misperceptions about HIV.

### How HIV is transmitted

HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly (and now very rarely in countries where blood is screened for HIV antibodies), through transfusions of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth.

In the health care setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into a worker's open cut or a mucous membrane (for example, the eyes or inside of the nose). There has been only one instance of patients being infected by a health care worker in the United States; this involved HIV transmission from one infected dentist to six patients. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected physicians, surgeons, and dentists, and no other cases of this type of transmission have been identified in the United States.

Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (such as through air, water, or insects), the pattern of reported AIDS

cases would be much different from what has been observed. For example, if mosquitoes could transmit HIV infection, many more young children and pre-adolescents would have been diagnosed with AIDS.

All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with the assistance, guidance, and laboratory support from CDC. No additional routes of transmission have been recorded, despite a national sentinel system designed to detect just such an occurrence.

The following paragraphs specifically address some of the common misperceptions about HIV transmission.

### HIV in the environment

Scientists and medical authorities agree that HIV does not survive well in the environment, making the possibility of environmental transmission remote. HIV is found in varying concentrations or amounts in blood, semen, vaginal fluid, breast milk, saliva, and tears. (See page 3, Saliva, Tears, and Sweat.) To obtain data on the survival of HIV, laboratory studies have required the use of artificially high concentrations of laboratory-grown virus. Although these unnatural concentrations of HIV can be kept alive for days or even weeks under precisely controlled and limited laboratory conditions, CDC studies have shown that drying of even these high concentrations of HIV reduces the amount of infectious virus by 90 to 99 percent within several hours. Since the HIV concentrations used in laboratory studies are much higher than those actually found in blood or other specimens, drying of HIV-infected human blood or other body fluids reduces the theoretical risk of environmental transmission to that which has been observed—essentially zero. Incorrect interpretation of conclusions drawn from laboratory studies have unnecessarily alarmed some people.

Results from laboratory studies should not be used to assess specific personal risk of infection because (1) the amount of virus studied is not found in human specimens or elsewhere in nature, and (2) no one has been identified as infected with HIV due to contact with an environmental surface. Additionally, HIV

is unable to reproduce outside its living host (unlike many bacteria or fungi, which may do so under suitable conditions), except under laboratory conditions, therefore, it does not spread or maintain infectiousness outside its host.

### Households

Although HIV has been transmitted between family members in a household setting, this type of transmission is very rare. These transmissions are believed to have resulted from contact between skin or mucous membranes and infected blood. To prevent even such rare occurrences, precautions, as described in previously published guidelines, should be taken in all settings—including the home—to prevent exposures to the blood of persons who are HIV infected, at risk for HIV infection, or whose infection and risk status are unknown. For example,

- Gloves should be worn during contact with blood or other body fluids that could possibly contain visible blood, such as urine, feces, or vomit.
- Cuts, sores, or breaks on both the care giver's and patient's exposed skin should be covered with bandages.
- Hands and other parts of the body should be washed immediately after contact with blood or other body fluids, and surfaces soiled with blood should be disinfected appropriately.
- Practices that increase the likelihood of blood contact, such as sharing of razors and toothbrushes, should be avoided.
- Needles and other sharp instruments should be used only when medically necessary and handled according to recommendations for health-care settings. (Do not put caps back on needles by hand or remove needles from syringes. Dispose of needles in puncture-proof containers out of the reach of children and visitors.)

### Businesses and other settings

There is no known risk of HIV transmission to co-workers, clients, or consumers from contact in industries such as food-service establishments (see information on survival of HIV in the environment). Food-service workers known to be infected with HIV need not be restricted from work unless they have other infections or illnesses (such as diarrhea or hepatitis A) for which any food-service worker, regardless of HIV infection status, should be restricted. CDC recommends that all food-service workers follow recommended standards and practices of good personal hygiene and food sanitation.

In 1985, CDC issued routine precautions that all personal-service workers (such as hairdressers, barbers, cosmetologists, and massage therapists) should follow, even though there is no evidence of transmission from a personal-service worker to a client or vice versa. Instruments that are intended to penetrate the skin (such as tattooing and acupuncture needles, ear piercing devices) should be used once and disposed of or thoroughly cleaned and sterilized. Instruments not intended to penetrate the skin but which may become contaminated with blood (for example, razors) should be used for only one client and disposed of or thoroughly cleaned and disinfected after each use. Personal-service workers can use the same cleaning procedures that are recommended for health care institutions.

CDC knows of no instances of HIV transmission through tattooing or body piercing, although hepatitis B virus has been transmitted during some of these practices. One case of HIV transmission from acupuncture has been documented. Body piercing (other than ear piercing) is relatively new in the United States, and the medical complications for body piercing appear to be greater than for tattoos. Healing of piercings generally will take weeks, and sometimes even months, and the pierced tissue could conceivably be abraded (torn or cut) or inflamed even after healing. Therefore, a theoretical HIV transmission risk does exist if the unhealed or abraded tissues come into contact with an infected person's blood or other infectious body fluid. Additionally, HIV could be transmitted if instruments contaminated with blood are not sterilized or disinfected between clients.

### Kissing

Casual contact through closed-mouth or "social" kissing is not a risk for transmission of HIV. Because of the potential for contact with blood during "French" or open-mouth kissing, CDC recommends against engaging in this activity with a person known to be infected. However, the risk of acquiring HIV during open-mouth kissing is believed to be very low. CDC has investigated only one case of HIV infection that may be attributed to contact with blood during open-mouth kissing.

### Biting

In 1997, CDC published findings from a state health department investigation of an incident that suggested blood-to-blood transmission of HIV by a human bite. There have been other reports in the medical litera-

ture in which HIV appeared to have been transmitted by a bite. Severe trauma with extensive tissue tearing and damage and presence of blood were reported in each of these instances. Biting is not a common way of transmitting HIV. In fact, there are numerous reports of bites that did not result in HIV infection.

### Saliva, tears, and sweat

HIV has been found in saliva and tears in very low quantities from some AIDS patients. It is important to understand that finding a small amount of HIV in a body fluid does not necessarily mean that HIV can be transmitted by that body fluid. HIV has not been recovered from the sweat of HIV-infected persons. Contact with saliva, tears, or sweat has never been shown to result in transmission of HIV.

### Insects

From the onset of the HIV epidemic, there has been concern about transmission of the virus by biting and bloodsucking insects. However, studies conducted by researchers at CDC and elsewhere have shown no evidence of HIV transmission through insects—even in areas where there are many cases of AIDS and large populations of insects such as mosquitoes. Lack of such outbreaks, despite intense efforts to detect them, supports the conclusion that HIV is not transmitted by insects.

The results of experiments and observations of insect biting behavior indicate that when an insect bites a person, it does not inject its own or a previously bitten person's or animal's blood into the next person bitten. Rather, it injects saliva, which acts as a lubricant or anticoagulant so the insect can feed efficiently. Such diseases as yellow fever and malaria are transmitted through the saliva of specific species of mosquitoes. However, HIV lives for only a short time inside an insect and, unlike organisms that are transmitted via insect bites, HIV does not reproduce (and does not survive) in insects. Thus, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites. HIV is not found in insect feces.

There is also no reason to fear that a biting or blood-sucking insect, such as a mosquito, could transmit HIV from one person to another through HIV-infected blood left on its mouth parts. Two factors serve to explain why this is so—first, infected people do not

have constant, high levels of HIV in their blood-streams and, second, insect mouth parts do not retain large amounts of blood on their surfaces. Further, scientists who study insects have determined that biting insects normally do not travel from one person to the next immediately after ingesting blood. Rather, they fly to a resting place to digest this blood meal.

### Effectiveness of condoms

Condoms are classified as medical devices and are regulated by the Food and Drug Administration (FDA). Condom manufacturers in the United States test each latex condom for defects, including holes, before it is packaged. The proper and consistent use of latex or polyurethane (a type of plastic) condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting sexually transmitted diseases, including HIV infection.

There are many different types and brands of condoms available—however, only latex or polyurethane condoms provide a highly effective mechanical barrier to HIV. In laboratories, viruses occasionally have been shown to pass through natural membrane (“skin” or lambskin) condoms, which may contain natural pores and are therefore not recommended for disease prevention (they are documented to be effective for contraception). Women may wish to consider using the female condom when a male condom cannot be used.

For condoms to provide maximum protection, they must be used consistently (every time) and correctly. Several studies of correct and consistent condom use clearly show that latex condom breakage rates in this country are less than 2 percent. Even when condoms do break, one study showed that more than half of such breaks occurred prior to ejaculation.

When condoms are used reliably, they have been shown to prevent pregnancy up to 98 percent of the time among couples using them as their only method of contraception. Similarly, numerous studies among sexually active people have demonstrated that a properly used latex condom provides a high degree of protection against a variety of sexually transmitted diseases, including HIV infection.

### Resources

For more detailed information about condoms, see the CDC publication “Male Latex Condoms and Sexually Transmitted Diseases.”

# Handout B: Biological Risk Factors of HIV Transmission

## Presence of sexually transmitted infections (STIs)

Sexually transmitted infections (STIs) increase one's chances of becoming infected with HIV, and can also indicate high-risk sexual behavior, which facilitates the transmission of HIV infection.

- STIs that cause ulcerative genital sores (such as herpes, syphilis, and chancroid) create an easy entry for HIV to enter and infect the body.
- Non-ulcerative STIs (such as gonorrhea and chlamydia) can cause microscopic breaks in tissue, which are associated with HIV transmission.
- Lymphocytes (the types of blood cells most likely to become infected if exposed to HIV) have a tendency to concentrate in the genital tract of people with STIs. This makes someone with an STI both more likely to transmit HIV and more vulnerable to it.
- In people infected with HIV, the additional presence of an STI can increase the amount of virus in their genital secretions, which can make it more likely that their sexual partners will become infected with HIV.

## Type of sexual intercourse

### Anal intercourse

Anal sex, the insertion of a male's penis into a person's anus (male or female), is one of the riskiest forms of sexual activity in terms of getting or giving an STI, including HIV.

In general, the person receiving the semen is at greater risk of getting HIV because the lining of the rectum is thin and easily lacerated, and may allow the virus to enter the body during anal sex. However, a person who inserts his penis into an infected partner is also at risk because HIV can enter through the urethra (the opening at the tip of the penis) or through small cuts, abrasions, or open sores on the penis.

### Vaginal intercourse

Vaginal intercourse, the insertion of a male's penis into a female's vagina, is a high-risk sexual activity for both the male and female. However, certain biological factors can put the female at particular risk of HIV infection

- There is greater exposed surface area in the female genital tract than the male's.
- There are higher concentrations of HIV in semen than in vaginal fluids.
- A larger amount of semen is exchanged during intercourse than vaginal fluids.
- Coercive or forced sex may lead to abrasions in the vagina that facilitate entry of the virus.
- Young girls are at higher risk for rips and tears in vaginal lining and cervical wall during intercourse.

### Oral sex

Numerous studies have demonstrated that oral sex, which involves giving or receiving oral stimulation (e.g., sucking or licking) to the penis, the vagina, and/or the anus, can result in the transmission of HIV and other STIs. However, the risk of HIV transmission through oral sex is smaller than the risk of HIV transmission from anal or vaginal sex. Several co-factors can increase the risk of HIV transmission through oral sex, including: oral ulcers, bleeding gums, genital sores, and the presence of other STIs. HIV can be transmitted through exposure of the mucous membranes of the mouth (especially if the tissue is cut or torn), to vaginal secretions, menstrual blood, and semen. The potential for transmission is greater during early and late-stage HIV infection, when the amount of virus in the blood is expected to be highest.

### Possible risk reduction: male circumcision

Male circumcision is the surgical removal of some or all of the foreskin (or prepuce) from the penis. Results from recent studies in Africa have demonstrated that male circumcision significantly reduces the risk of men becoming infected with HIV. Biologically, the inner mucosa of the foreskin has a higher density of target cells for HIV infection, and has been shown to

be more susceptible to HIV infection in laboratory studies compared to the dry external skin surface. The foreskin may also have greater susceptibility to tears during intercourse, providing a portal of entry for HIV.

Ecologic studies have also indicated a strong association between lack of male circumcision and HIV infection at the population level. Although links between circumcision, culture, religion, and risk behavior may account for some of the differences in HIV-infection prevalence, the countries in Africa and Asia with prevalence of male circumcision of less than 20 percent have an HIV-infection prevalence several times higher than countries in those regions where more than 80 percent of men are circumcised.

Male circumcision does not provide complete protection against HIV infection. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Male circumcision should never replace other known effective prevention methods.

Further studies are underway to assess the impact of male circumcision on the risk of HIV transmission to female partners.

### **Resources**

For more information on male circumcision, please refer to:

CDC: Male Circumcision and Risk for HIV Transmission Factsheet, December 2006: <http://www.cdc.gov/hiv/resources/factsheets/circumcision.htm>

NIH: *Questions and Answers NIAID-Sponsored Adult Male Circumcision Trials in Kenya and Uganda*, December 13, 2006: [http://www3.niaid.nih.gov/news/QA/AMC12\\_QA.htm](http://www3.niaid.nih.gov/news/QA/AMC12_QA.htm)

PEPFAR: *Ambassador Mark Dybul's Statement on Findings of Adult Medical Male Circumcision Trials*, December 13, 2006: <http://www.pepfar.gov/press/77790.htm>

## Handout C: Statement on Kenyan and Ugandan trial findings regarding male circumcision and HIV

*Statement developed by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the World Bank and the UNAIDS Secretariat  
13 December 2006*

### **Male circumcision reduces the risk of becoming infected with HIV, but does not provide complete protection**

GENEVA—The Joint United Nations Programme on HIV/AIDS and its Cosponsors, WHO, UNFPA, UNICEF and the World Bank, note with considerable interest today's announcement by the US National Institutes of Health that two trials assessing the impact of male circumcision on HIV risk are being stopped on the recommendation of the NIH Data Safety and Monitoring Board (DSMB).

The two trials, funded by the US National Institutes of Health, were carried out in Kisumu, Kenya, among men aged 18-24 years and in Rakai, Uganda, among men aged 15-49 years. The trials, which completed enrolment of patients in 2005, were stopped by the DSMB evaluating the results of interim analyses. The role of the DSMB is to assess progress of the trials and recommend whether to continue, modify or terminate them. Although no detailed results have been released at this time, the National Institutes of Health statement makes it clear that the studies are being stopped because they revealed an approximate halving of risk of HIV infection in men who were circumcised.

The results support the findings of the South Africa Orange Farm Intervention Trial, funded by the French Agence Nationale de Recherches sur le SIDA (ANRS) and published in late 2005, which demonstrated at least a 60% reduction in HIV infection among circumcised men.

A further trial to assess the impact of male circumcision on the risk of HIV transmission to female partners from HIV-infected men, led by researchers at Johns Hopkins University, is currently under way in Uganda, with results expected in 2008. The effect of male circumcision on reducing the risk of HIV transmission among men who have sex with men has not been studied in a randomized controlled trial. WHO

and the UNAIDS Secretariat will rapidly convene a consultation to examine the results of these trials to date and their implications for countries, particularly those in sub-Saharan Africa and elsewhere with high HIV prevalence and low male circumcision levels.

Although these results demonstrate that male circumcision reduces the risk of men becoming infected with HIV, the UN agencies emphasize that it does not provide complete protection against HIV infection. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Male circumcision should never replace other known effective prevention methods and should always be considered as part of a comprehensive prevention package, which includes correct and consistent use of male or female condoms, reduction in the number of sexual partners, delaying the onset of sexual relations, and HIV testing and counselling.

It is anticipated that news of these results will heighten interest in male circumcision from governments, non-governmental institutions, and the general public in a number of countries, in addition to increasing demand for male circumcision services. WHO, the UNAIDS Secretariat and their partners will review the detailed trial findings and will then define specific policy recommendations for expanding and/or promoting male circumcision. These policy recommendations will need to take into account

- Cultural and human rights considerations associated with promoting circumcision;
- The risk of complications from the procedure performed in various settings;
- The potential to undermine existing protective behaviours and prevention strategies that reduce the risk of HIV infection; and
- The observation that the ideal and well-resourced conditions of a randomized trial are often not replicated in other service delivery settings.

Countries or health care institutions which decide to offer male circumcision more widely as an additional way to protect against HIV infection must ensure that it is performed safely by well-trained practitioners in sanitary settings under conditions of informed



consent, confidentiality, risk reduction counseling and safety. These countries or institutions must also ensure that male circumcision is promoted and delivered in a culturally appropriate manner and that sufficient and correct information on the continuing need for other HIV prevention measures is provided. This will be necessary to prevent people from developing a false sense of security and, as a result, engaging in high risk behaviours which could negate the protective effect of male circumcision.

In order to support countries or institutions that decide to scale up male circumcision services, WHO, the UNAIDS Secretariat and their partners are developing

- Technical guidance on ethical, rights-based, clinical and programmatic approaches to male circumcision;
- Rapid assessment toolkits for a) determining circumcision prevalence, determining acceptability, identifying key providers, and estimating costs and b) monitoring numbers of circumcisions performed, their safety, and their potential impact on sexual behaviour; and
- Guidance on training, standard setting, certification, and accreditation.

WHO, UNFPA, UNICEF, the World Bank, the UNAIDS Secretariat and their partners will continue to work together to support governments and other development partners and to provide coordinated, consistent and up-to-date guidance for service delivery, including for the monitoring and evaluation of services and follow-up of men who have been circumcised. These groups will also work cooperatively to identify the best means of increasing the delivery of safe circumcision services in countries that choose to do so.

## Handout D: Universal Precautions

Universal precautions is a term usually used by health-care professionals working in hospital and clinic settings. It means that people should always protect themselves “universally” from diseases that are transmitted via blood and body fluids (such as HIV and hepatitis). You should not decide to use barriers for protection from infectious bodily fluids based on how sick a person may look or how at risk they appear to be.

When handling blood, semen, vaginal secretions, or breast milk, you must create a barrier between the fluid and the portals of entry. When dealing with any of the above fluids

- Use latex gloves. If you are allergic to latex, use vinyl gloves.
- Clean up blood spills immediately: wear latex gloves and wipe up spills with a bleach and water solution; then dispose of soiled items in plastic bags.
- Put used injection needles in puncture-proof “sharps” containers. Do not recap needles, as this is the most common way that health-care workers have infected themselves.
- If a person you are with begins to bleed, hand him or her a cloth to stop the bleeding (if possible) until medical help arrives.
- If working in a situation where blood could be splattered in your face, cover your eyes with glasses and your nose and mouth with a mask, if possible.
- Wash your hands frequently.
- At your school or worksite, keep a first-aid kit with gloves and bandages and antiseptic available.
- If you do become exposed, contact a medical officer immediately for possible prophylactic treatment.

Proper disposal of the protective barrier, such as gloves, is also important, as is hand washing after the event. These precautions also protect you from hepatitis, which is much more infectious than HIV.

Source: The United States President’s Emergency Plan for AIDS Relief. “Report on Blood Safety and HIV/AIDS, June 2006.” <http://www.pepfar.gov/progress/76858.htm> (accessed May 25, 2007).

# Handout E: The ABC Approach

## Defining the ABC Approach

The “ABC Approach” (Abstinence, Be Faithful, and correct and consistent Condom use) employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness; partner reduction for sexually active adults; and correct and consistent use of condoms. It is important to note that ABC is not a program; it is an approach to infuse throughout prevention programs. The ABC approach is distinctive in its targeting of specific populations, the circumstances they face, and behaviors within those populations for change. This targeted approach results in a comprehensive and effective prevention strategy that helps individuals personalize risk and develop tools to avoid risky behaviors under their control.

**Abstinence** programs encourage unmarried individuals to abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Abstinence until marriage programs are particularly important for young people, as approximately half of all new infections occur in the 15- to 24-year-old age group. Delaying the first sexual encounter can have a significant impact on the health and well-being of adolescents and on the progress of the epidemic in communities. Internationally, a number of programs have proven successful in increasing abstinence until marriage, delaying first sex, and achieving “secondary abstinence” (returning to abstinence) among sexually experienced youth. These programs promote the following

- Abstaining from sexual activity as the most effective and only certain way to avoid HIV infection.
- The development of skills for practicing abstinence.
- The importance of abstinence in eliminating the risk of HIV transmission among unmarried individuals.
- The decision of unmarried individuals to delay sexual debut until marriage.
- The adoption of social and community norms that support delaying sex until marriage and that denounce cross-generational sex, transactional sex and rape, incest, and other forced sexual activity.

**Be faithful** programs encourage individuals to practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Once a person begins to have sex, the fewer lifetime sexual partners he or she has, the lower the risk of contracting or spreading HIV or another sexually transmitted infection.

Be faithful programs promote the following

- The elimination of casual sexual partnerships.
- The development of skills for sustaining marital fidelity.
- The importance of mutual faithfulness with an uninfected partner in reducing the transmission of HIV among individuals in long-term sexual partnerships.
- HIV counseling and testing with their partner for those couples that do not know their HIV status.
- The endorsement of social and community norms supportive of refraining from sex outside of marriage, partner reduction, and marital fidelity, by using strategies that respect and respond to local cultural customs and norms.
- The adoption of social and community norms that denounce cross-generational sex and transactional sex, and rape, incest, and other forced sexual activity.

**Correct and consistent condom use** programs support the provision of full and accurate information about correct and consistent condom use reducing, but not eliminating, the risk of HIV infection; and support access to condoms for those most at risk for transmitting or becoming infected with HIV.

Behaviors that increase risk for HIV transmission include: engaging in casual sexual encounters; engaging in sex in exchange for money or favors; having sex with an HIV-positive partner or one whose status is unknown; using drugs or abusing alcohol in the context of sexual interactions; and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home.

To achieve the protective effect of condoms, people must use them *correctly and consistently, at every sexual encounter*. Failure to do so diminishes the protective effect and increases the risk of acquiring a sexually transmitted infection (STI) because transmission can occur with even a single sexual encounter.

Condom-use programs promote the following

- The understanding that abstaining from sexual activity is the most effective and only certain way to avoid HIV infection.
- The understanding of how different behaviors increase risk of HIV infections.
- The importance of risk reduction and a consistent risk-reduction strategy when risk elimination is not practiced.
- The importance of correctly and consistently using condoms during every sexual encounter with partners known to be HIV-positive (discordant couples), or partners whose status is unknown.
- The critical role of HIV counseling and testing as a risk-reduction strategy.
- The development of skills for obtaining and correctly and consistently using condoms, including skills for vulnerable persons.
- The knowledge that condoms do not protect against all STIs.

### Implementing the ABC Approach

Effective implementation of the ABC approach requires careful evaluation of risk behaviors that fuel local epidemics. Although prevention interventions are most successful when they are locally driven and responsive to local cultural values, epidemiological evidence can identify risky behaviors within populations and guide specific behavioral messages. For example, in some communities, as many as 20 percent of girls aged 15 to 19 are infected, compared to 5 percent of boys the same age. Coupled with high prevalence among older men, such data can point to transmission that is fueled by cross-generational sex. Prevention approaches must then address the risks

of cross-generational and transactional sex through abstinence programs for youth and be faithful programs for men that foster collective social norms that emphasize avoiding risky sexual behavior.

### Source

The United States President's Emergency Plan for AIDS Relief. "ABC Guidance #1 (Abstinence, Be Faithful and correct and consistent Condom use)." <http://www.pepfar.gov/guidance/c19545.htm> (accessed May 25, 2007).

### Resources

The President's Plan for Emergency AIDS Relief, Office of the U.S. Global AIDS Coordinator. "ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief." <http://www.state.gov/documents/organization/57241.pdf> (accessed May 25, 2007).

## Handout F: Instructions for Male Condom Use

Although many people assume that all men know how to correctly use condoms, incorrect use is common and is a major cause of condom failure.

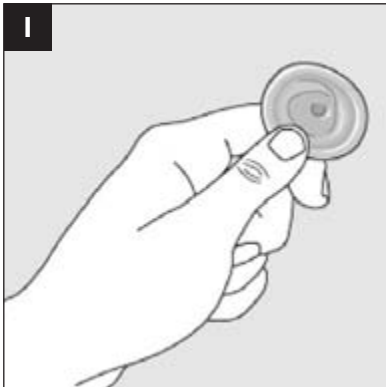
### Remember

- Do not use grease, oils, lotions, or petroleum jelly to make the condom slippery. These substances can make the condom break. Use only jelly or cream that does not have oil in it.
- Use a new condom each time you have sex.
- Use a condom once only.
- Store condoms in a cool, dry place.

### Do not use a condom if

- The package is broken.
- The condom is brittle or dried out.
- The color is uneven or has changed.
- The condom is unusually sticky.
- It is old or damaged.

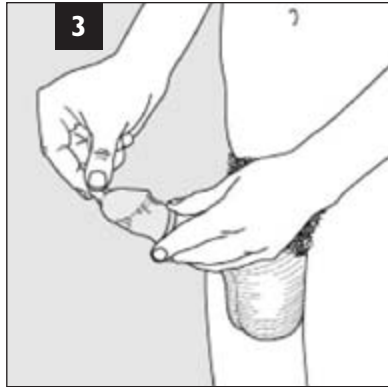
### Before intercourse



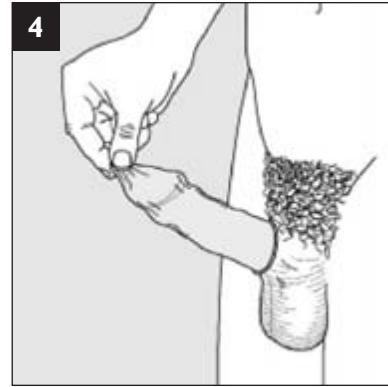
Carefully open the package so the condom does not tear. (Do not use teeth or a sharp object to open the package.) Do not unroll the condom before putting it on.



If you are not circumcised, pull back the foreskin.  
Put the condom on the end of the hard penis.  
Note: If the condom is initially placed on the penis backwards, do not turn it around.  
Throw it away and start with a new one.

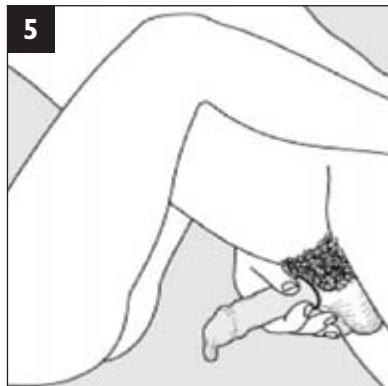


Pinching the tip of the condom to squeeze out air, roll on the condom until it reaches the base of the penis.



Check to make sure there is space at the tip and that the condom is not broken. With the condom on, insert the penis for intercourse.

### After intercourse



After ejaculation, hold onto the condom at the base of the penis. Keep the condom on and pull the penis out before it gets soft.



Slide the condom off without spilling the liquid (semen) inside the condom. Dispose of the used condom.

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## Handout G: The Female Condom

### What is it?

- The female condom is a new, safe, pre-lubricated contraceptive for women.
- It is made of strong, soft rubber.
- It gently lines the vagina to create a barrier against germs that cause sexually transmitted diseases (STDs) such as gonorrhoea, syphilis and HIV/AIDS and sperms that cause pregnancy.
- It has a flexible ring at each end. The inner ring is used for insertion and helps to hold the condom in place. The outer ring remains outside the vagina when the condom is inserted and forms the opening to the vagina.

### Why is it important?

- It is the only method for the woman, that provides protection against both STDs, HIV/AIDS, and unwanted pregnancy.
- It allows the woman to take the responsibility to protect herself and her partner against STDs, HIV/AIDS, instead of relying on her partner's willingness to use the condom.

### Who can use it?

- Women who are concerned about unwanted pregnancy and STDs.
- Women whose partners cannot or would not use male condoms.
- Women who have had their wombs removed.
- Women who are menopausal.
- Women who are allergic/sensitive to latex.
- Women who want to share responsibility with partners, taking turns wearing the condom.
- Young women/older women.
- Lactating women.

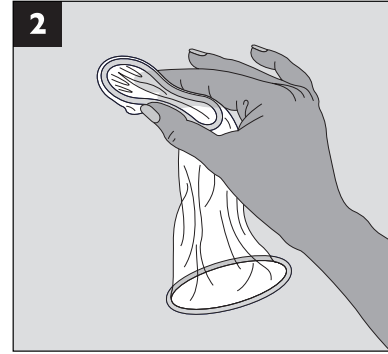
### Advantages Disadvantages

- Generates heat and therefore increases sexual stimulation.
- Does not interrupt foreplay and there is no risk of partner losing his erection because it can be inserted ahead of time.
- Can use oil based and water based lubricants.
- May be difficult to insert initially, but this improves with continued use.
- It is messy and can be noisy.
- May not be appropriate for all sexual positions; appears to work best when the woman lies on her back.
- Some side-to-side movement of the condom may occur during sex. This is normal and will not affect the effectiveness of the condom.

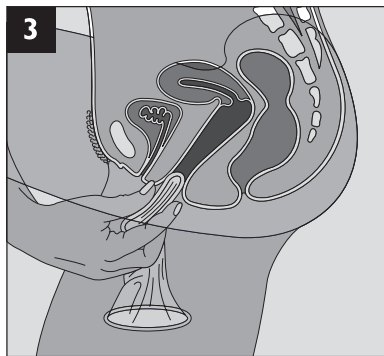
## How to use the female condom



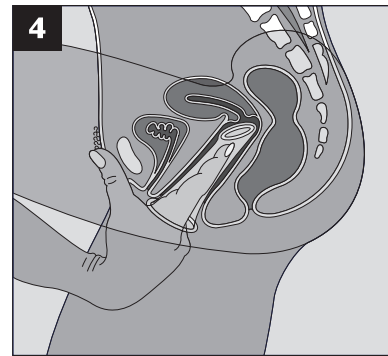
Open the package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.



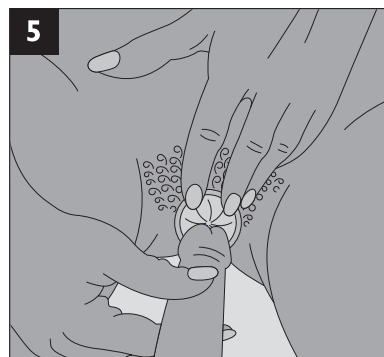
While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.



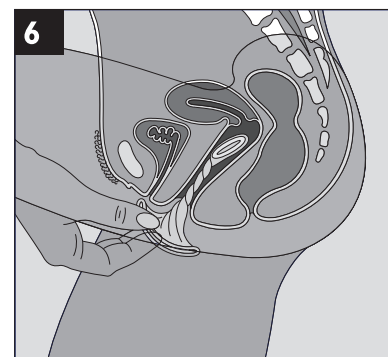
Choose a position that is comfortable—squat, raise one leg, sit or lie down. Make sure the condom is lubricated. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.



Place the index finger on the inside of the condom, and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.



When you are ready, gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly—be sure that the penis is not entering on the side, between the sheath and the vaginal wall.



To remove the condom, twist the outer ring and gently pull the condom out. Try to do this before standing up. After use wrap the condom well. Put it in a dust-bin. Do not flush down the toilet.



## Handout H: Persuading Your Partner to Use a Condom

As highlighted in the Peace Corps' *Life Skills Manual*, negotiating condom use is an important skill to have and to practice. The following list of common excuses and **possible** responses can assist with negotiation skill-building. **Facilitators/trainers can and should adapt these suggestions for use when discussing condom use for in-country use.**

Excuse	Possible Response
<i>I don't need to use a condom. I haven't had sex in a long time, so I know I don't have any diseases.</i>	That's good to know. As far as I know, I'm disease-free, too. But I'd still like to use a condom because either of us could have an infection and not know it.
<i>I can't feel anything when I wear a condom.</i>	I know there's a little less sensation, but there's not a lot less. Why don't we put a drop of lubricant on the condom? That'll make it feel more sensitive.
<i>You're a woman. How can you possibly ask me to use a condom? How can I respect you after this?</i>	You should respect me even more because I am acting responsibly. I'm suggesting this because I care about you and respect myself enough to protect myself. That's enough for me.
<i>If I have to stop and put it on, I won't be in the mood anymore.</i>	I can help you put it on. That way, you'll continue to be aroused, and we'll both be protected.
<i>Condoms are messy, and they smell odd.</i>	Their smell isn't that odd. Sex can be a little messy sometimes. But this way, we'll be able to enjoy it and both be protected from pregnancy and HIV or STIs.
<i>Let's not use condoms just this once.</i>	No. Once is all it takes to get pregnant or get an infection.
<i>I don't have a condom with me.</i>	That's okay. I do.
<i>You never asked me to use a condom before. Are you having an affair?</i>	No, but one of us could have an infection and not know it. It's best to be safe.
<i>If you really loved me, you wouldn't make me wear one.</i>	If you really loved me, you'd want to protect yourself—and me—from infections and pregnancy so that we can be together and healthy for a long time.
<i>Why are you asking me to wear a condom? Do you think I'm dirty or something?</i>	It's not about being dirty or clean. It's about avoiding pregnancy and the risk of infection.
<i>Only people who have anal sex need to wear condoms, and I'm not like that.</i>	That's not true. A person can get an infection during any kind of sex, including what we do together.
<i>Condoms don't fit me.</i>	Condoms can stretch a lot—they can stretch to fit over a person's arm! So we should be able to find one that fits you.

Excuse	Possible Response
<i>Why should we use condoms? They just break.</i>	Actually, they told me that condoms are tested before they're sent out—so while they have been known to break, it happens rarely, especially if you know how to use one correctly—and I do.
<i>What happens if it comes off? It can get lost inside you, and you'll get sick, or could even die. Do you want that?</i>	It's impossible for the condom to get lost inside me. If it came off, it'd be inside my vagina, and I could just reach in and pull it out.
<i>If you don't want to get pregnant, why don't you just take the birth control pill?</i>	Because the birth control pill only protects against pregnancy. The condom protects against both pregnancy and infections.
<i>My religion says that using condoms is wrong.</i>	It might help to talk with one of your religious leaders. A lot of people from different religions use condoms, even though their religion is against it. They figure that preventing infection or unintended pregnancy is more important than worrying about the morality of condoms.
<i>Well, I'm not going to use a condom, and that's it. So let's have sex.</i>	No. I'm not willing to have sex without a condom.
<i>No one else uses them. Why should we be so different?</i>	Because a lot of people who didn't use them ended up with HIV.

# Handout I: Mother-to-Child Transmission

Mother-to-child HIV transmission (MTCT) is responsible for the majority of new HIV infections in children worldwide. Without intervention, approximately one third of infants born to HIV-positive mothers will become infected with HIV.

There are three ways in which HIV can be transmitted from mother to child

1. During pregnancy
2. During labor and delivery
3. Through breast-feeding

The risk of MTCT is affected by several factors, including the stage of infection of the mother, delivery method (e.g., cesarean section or vaginal), the breast-feeding pattern and duration, presence of oral or breast lesions, gastrointestinal illness of the child, and whether the mother and child were given antiretroviral (ARV) therapy during labor and after birth.

## Estimated risk and timing of mother-to-child transmission of HIV in the absence of interventions

Timing	Transmission Rate
During pregnancy	5-10%
During labor and delivery	10-15%
During breast-feeding	5-20%
Overall risk without breast-feeding	15-25%
Overall risk with breast-feeding for 6 months	20-35%
Overall risk with breast-feeding for 18 to 24 months	30-45%

*Adapted from HIV and Infant Feeding. A guide for health-care managers and supervisors: World Health Organization, 2003.*

While it is impossible to completely prevent mother-to-child transmission of HIV, it is possible to greatly reduce the risk of HIV infection of the infant.

### During pregnancy, labor, and delivery

- During pregnancy, HIV can cross over from the mother to the baby's bloodstream.
- During labor and delivery, HIV infection can occur when blood or other infected maternal fluids pass into the baby's body.
- Delivery by cesarean section, and distribution of ARV treatment late in pregnancy and/ or during labor and delivery reduces the risk of HIV transmission.

### Through breast-feeding

- Several conditions can increase the risk of MTCT during breast-feeding, such as the mother's HIV viral load, the duration of breast-feeding, oral thrush in the infant, and the presence of bleeding nipples, breast inflammation, and mastitis.
- Mixed feeding (feeding both breast milk and other foods or liquids) may also increase the risk of HIV transmission. Supplemental foods and liquids can cause gastrointestinal illness in infants, which can increase the risk of HIV infection.
- Women who become infected with HIV while they are breast-feeding are more likely to transmit HIV to their infants through breast-feeding because of the higher viral load associated with acute infection.

### Infant feeding options for HIV-positive women

- Lack of breast-feeding has been shown to expose children to an increased risk of malnutrition and life-threatening infectious illnesses other than HIV, particularly in the first year of life. This is especially true in developing countries, where more than one-half of deaths under the age of five are associated with malnutrition.
- The risks associated with not breast-feeding vary according to the mother's economic status, and the availability of appropriate replacement food and clean water.

- When deciding on the best infant feeding option for an HIV-positive mother, the increased risks of infant morbidity and mortality associated with replacement feeding must be weighed against the risk of HIV transmission.

**The most recent guidelines from organizations such as WHO, UNICEF, UNFPA, and UNAIDS on infant feeding for HIV-positive women state**

- When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breast-feeding by HIV-infected mothers is recommended. Otherwise, exclusive breast-feeding (where an infant receives only breast milk and no other liquids or solids, not even water) is recommended for the first months of life and should be discontinued as soon as the above conditions are met. Exclusive breast-feeding may reduce the risk of HIV transmission because unclean food/water can cause gastrointestinal illness in the infant, which creates an environment where HIV infection is more likely.
- To minimize the risk of HIV transmission, breast-feeding should be discontinued as soon as possible, taking into account local circumstances, such as the individual woman's economic situation and the availability of replacement feeding.
- When HIV-positive mothers choose not to breast-feed from birth or stop breast-feeding later, they should be provided with specific guidance and support for at least the first two years of the child's life to ensure adequate replacement feeding.
- All HIV-positive mothers should receive counseling, which includes provision of general information about the risks and benefits of various infant feeding options, and specific guidance in selecting the option most likely to be suitable for their situation.

**HIV testing issues for infants born to HIV-positive mothers**

- Early diagnosis of HIV infection in young children is important because HIV progresses more rapidly in young children.
- Infants automatically acquire their mother's antibodies and may carry them for two years or more.
- Diagnosis of HIV infection in young children (younger than 18 months of age) is difficult because standard HIV tests are not able to differentiate between maternal and infant HIV antibodies. Hence, an infant may test positive for HIV, even if they are not infected with the virus, because they are carrying their mother's HIV antibodies.
- More sensitive HIV tests able to detect HIV infection in children younger than 18 months exist, but are more expensive and not available in all settings.

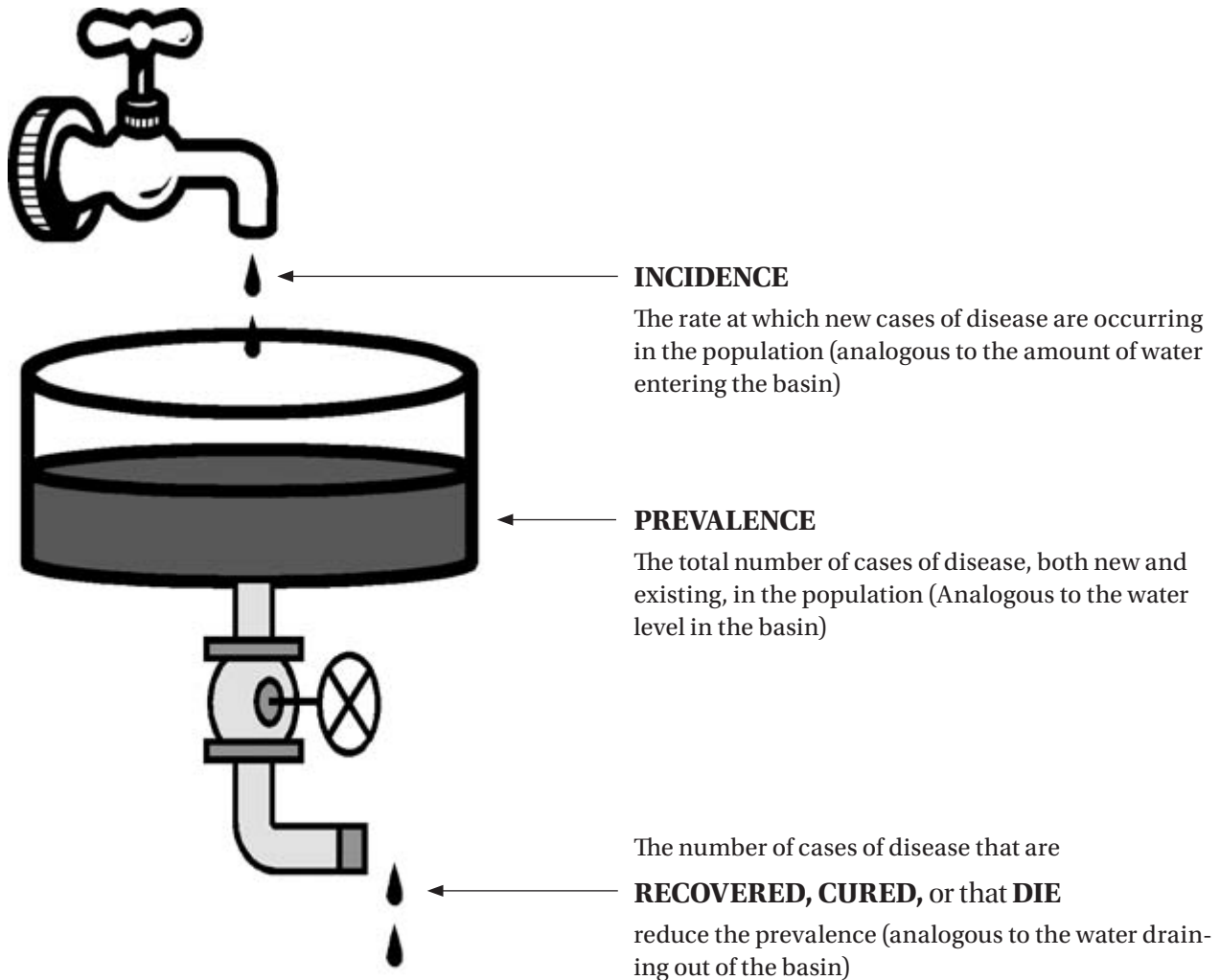
**Resources**

For more information, please refer to

World Health Organization, Child and Adolescent Health and Development. "Nutrition: Infant and Young Child." [http://www.who.int/child-adolescent-health/NUTRITION/HIV\\_infant.htm](http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm) (accessed May 25, 2007).

The United States President's Emergency Plan for AIDS Relief, Office of the U.S. Global AIDS Coordinator. "Guidance for United States Government In-Country Staff and Implementing Partners for a Preventive Care Package for Children Aged 0-14 Years Old Born to HIV-Infected Mothers\* - #1, April 2006" <http://www.pepfar.gov/documents/organization/77005.pdf> (accessed May 25, 2007).

## Handout J: Measures of Disease Frequency







# Capacity Building

## HIV/AIDS TRAINING RESOURCE KIT

**Session 1: Introduction to Capacity Building in the Peace Corps Context**

**Session 2: The Role of the Volunteer in Development—Combating HIV/AIDS**





# Session One: Introduction to Capacity Building in the Peace Corps Context

## Purpose

Peace Corps participants will gain an understanding of what capacity building means within the context of the Peace Corps. They will begin to identify the specific kinds of activities that might build capacity to address HIV/AIDS.

## Rationale

The Peace Corps' approach to development is from the perspective of human capacity building. This session will help participants understand the kinds of activities that build human capacity and introduce them to the roles they may play as Volunteers.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours

## Objectives

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

1. Explain the concept of capacity building and relate it to HIV/AIDS.
2. Identify activities that build capacity in individuals, service providers/professionals, organizations, and communities.

## Session Outline

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**I. Introduction/Opening Activity** (5-10 minutes)

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**II. What is Capacity Building?** (25 minutes)

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**III. Scenario** (30 minutes)

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**IV. Volunteer Panel** (50 minutes)

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**V. Wrap up: Favorite Stories** (10 minutes)

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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Promising practices on capacity building and how it relates to HIV/AIDS
- Volunteer cross-sectoral roles in the field relating to HIV/AIDS
- Gender-sensitive approach

## Materials and Equipment

Flip charts, markers, tape or tacks

Prepared banner (or flip chart) for Part I, Step 3

Prepared flip charts

1. Session One Outline
2. The Peace Corps' Approach to Development
3. Four Levels of Capacity Building

Tip Sheet

*Guidelines/Information for Participation in Peace Corps Volunteer Panel*

Activity sheets

*Origami Cup Instructions*

*Scenarios for Human Capacity Building Approaches*

Handouts

- A. *The Peace Corps' Approach to Development*
- B. *Reducing HIV in Injection Drug Users*
- C. *HIV Prevention in Mobile Populations*
- D. *HIV/AIDS Interventions with Men Who Have Sex with Men*
- E. *Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children*
- F. *HIV Interventions with Youth*

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Read scenarios and determine if you need to adapt any of them to your post's situation—or just choose which to use.
- Select a proverb or saying for the opening activity and write it on a banner or flip chart.
- Choose which experiential activity to use in Part II, A or B.

### For Option A: Folding a paper cup

- Teach yourself how to fold the paper cup
- Cut four 6x6 inch paper squares for each participant
- Copy instruction handout for each participant
- Pitcher of water

### For Option B: Two skits

- Select a few participants (or staff) in advance to prepare the two skits.
- Prepare flip charts.
- Review Handouts B-F. Choose the handouts relevant to the vulnerable populations in the country.
- Make copies of handouts.
- Identify Volunteers for panel. Adapt the Tip Sheet: "Guidelines/Information for Participation in Peace Corps Volunteer Panel" for your activity, and send it to your panelists.

**Who:** The panel can be made up of three to four Volunteers, or two Volunteers and their counterparts. Ideally they will represent different sectors to emphasize the idea of multisectoral work to address HIV/AIDS. Look at ways to utilize the panelists in other ways to make the trip worthwhile for them—they may stay and talk informally with trainees over a meal or for the evening and they may be able to participate in other sessions.

**How to prepare:** Ask panelists to talk about their roles as capacity builders in addressing HIV/AIDS, including: the process of finding a way to build capacity, their successes, and their challenges.

Provide panelists with information to make sure their definition of capacity building matches what you are trying to impart to participants. Provide an outline they can follow in structuring their presentations and be clear about how long they should speak.

Be sure that panelists address issues relating to women and other higher risk populations.

## Methodology

### I. Introduction/Opening Activity (5-10 minutes)

The suggested opening activity is intended to engage participants immediately in the topic of capacity building. The activity would be improved by having a proverb or saying that comes from the local culture.

### Welcome the participants

**Step 1:** Reveal the session outline flip chart and review with participants.

Session One Outline
<p><b>Introduction to Capacity Building in the Peace Corps Context</b></p> <p><b>I. Introduction/Opening Activity</b></p> <p><b>II. What is Capacity Building?</b></p> <p><b>III. Scenario</b></p> <p><b>IV. Volunteer Panel</b></p> <p><b>V. Wrap up: Favorite Stories</b></p>

FLIP CHART 1

**Step 2:** Explain that in this session they will gain an understanding of what capacity building means in the context of the Peace Corps and begin to identify the specific kinds of activities that might build capacity to address HIV/AIDS.

**Step 3:** Use the following activity or use an opener of your choice.

Display a proverb or saying that relates to capacity building. Suggestions

*"Give a man a fish and you feed him for a day. Teach him how to fish and you feed him for a lifetime." Lao Tzu*

*When the best leader's work is done the people say, "We did it ourselves." Lao Tzu*

Have a few trainees share reactions to the saying or proverb. If the group is large, divide into smaller groups. Leave the saying posted on wall.

**Step 4:** Transition to the next activity.

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## II. What is Capacity Building? (25 minutes)

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**Step 1:** Choose one of the following activities (A or B).

### A. Folding a paper cup

The trainer motivates the group by holding up a sample paper cup. Ask

*Can this paper cup hold water?*

Pour some water in.

- Give everyone four squares of paper. Teach how to fold an origami cup, step by step. Everyone makes a cup.
- Distribute the instructions, and everyone makes a cup independently. Anyone who needs help gets it from the presenter or someone else who can do it.
- Instructions are taken away or turned over (so they are out of sight). Everyone makes another cup.
- Everyone makes a cup with eyes closed! Those who can do it are asked to help others until all participants succeed.

### B. Two skits

Have the prepared skits presented back-to-back, without discussion—the first without capacity building, the second with (two minutes each).

*Skits:* John, a Volunteer, is meeting with two people from the organization with which he works. They suggest that he spend the next two weeks going house to house to distribute leaflets about how HIV is transmitted. John asks if the activity will involve any training. He is told, no, the purpose is to get the information to as many people as possible. The organization representatives indicate how great it is to now have someone who they can ask to do these kinds of tasks, since they are very short-staffed.

*Skits:* John, a Volunteer, is meeting with two people from the organization with which he works. He is asked to spend the next two weeks going house to house to distribute leaflets about how HIV is transmitted. John suggests that they look at ways to get community participation to get the leaflets out to far more people than he could do alone. He wonders if secondary school students might want to be involved. John says he knows there is a girls' club involved in some HIV-prevention work—maybe this project would be a way to engage a broader group of students. He suggests they provide some basic HIV-prevention education to the young people and then have them distribute literature house to house. The organization representatives agree to set up a meeting with the secondary school principal to talk about this idea.

**Step 2:** Analysis.

### A. Paper cup

Ask participants to list the steps of what happened and what they would call each, for example

- Demonstration/teaching
- Practice/guided help
- Harder practice
- Teaching each other

What would be the next step? Teaching to some new people

### B. Skits

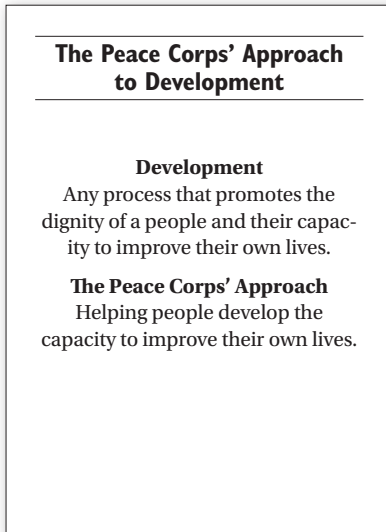
Discuss

*What happened in the first skit?*

*The second?*

*What is the difference for the organization/community/individuals (including students, organizational representatives, John) in the outcome of the second?*

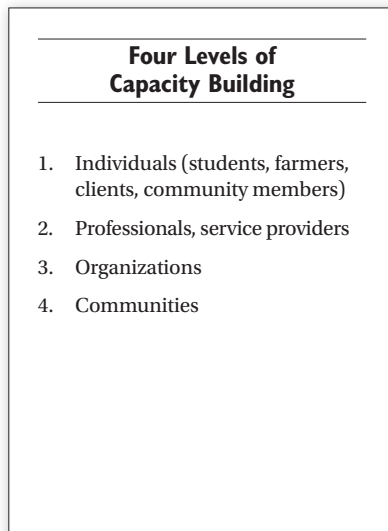
**Step 3:** Define the Peace Corps' approach to development. Refer to flip chart 2 and provide Handout A now or save it for later.



FLIP CHART 2

Explain: The Peace Corps uses the term “development” in human, people to people terms: helping people develop the capacity to improve their own lives. The focus of the work is on the development of people, not things. The capacity-building approach focuses on helping people learn to identify what they would like to see changed, use their own strengths, and learn new skills to achieve what they believe is important.

Capacity building happens at four levels (use flip chart 3):



FLIP CHART 3

**Step 4:** Targeting interventions.

Trainer’s note: See other related sessions, specifically in the Assessment Module—Session One *Assessment and Prioritizing Basics for HIV/AIDS Prevention/Inter-*

*vention* and Session Three *Using Assessment Data for Targeted Interventions*.

Explain: Although anyone can become infected with HIV, certain individuals and populations are at higher risk. (Distribute the handouts on vulnerable populations (B-F) that are relevant for your specific country.)

Certain populations are at higher risk than others

- Women, for social, economic, and biological reasons, are at higher risk than men.
- Adolescents are more vulnerable than adults.
- Young girls are more vulnerable than young boys.
- Poor people are more vulnerable than those with more resources.

Other vulnerable populations include

- Migrant workers
- Refugees
- Sex workers and their clients
- Trafficked women and children
- Street children
- Uniformed servicemen
- Men who have sex with men
- Intravenous drug users

### III. Scenario (30 minutes)

The goal of the activity is to help participants begin to think analytically and strategically about how to develop capacity-building activities related to HIV/AIDS. A significant aspect of the exercise is the development of critical questions that can be used as part of planning and decision-making processes in the future. In Step 3, the goal is not to come up with an exhaustive list of activities, but to think critically about whether the project is one that can be defined as capacity building. Developing the list of activities/projects and a list of critical questions for determining “capacity-building potential” should be done simultaneously. The activity in Step 3 elicits critical questions that can be used in the evaluation process. Suggest that the trainees write these questions down to take away a process they can use in the future. Other points: use opportunities to help trainees distinguish between projects that may have value but do not necessarily build capacity and those that are really capacity building. Steer the list to one that touches on different sectors.

Points that can add to the discussion

- Some activities have value and purpose but don't contribute to capacity building.
- A project may build capacity in a community, but may not be linked to agreed upon strategies for addressing HIV/AIDS.

**Step 1:** Introduce the activity.

*We are going to talk about a scenario and think about how to address it using a human capacity-building approach.*

**Step 2:** Distribute selected scenario from *Activity Sheet: Scenarios for Human Capacity Building Approaches*.

**Step 3:** Ask trainees to envision themselves as the Volunteer in this community.

*What kinds of projects/activities could be defined as building the capacity of the community to meet their goals? (List on one flip chart.)*

As suggestions are made, ask

*What kinds of questions should they be asking to determine if an activity really builds capacity? (List on adjoining flip chart.)*

Responses for activities could include

#### All cases

- Learning more about the local language and culture relating to HIV/AIDS and the affect of HIV on individuals (point out that this activity builds your own capacity)
- Engaging people living with HIV/AIDS and target populations as partners in the planning, development, and implementation of activities
- Provide training in HIV/AIDS prevention to various segments of the population (groups that practice high-risk behavior and the general population) in culturally appropriate ways
- Promote activities and attitudes that reduce stigma and discrimination
- Projects aimed at improved agriculture and improved nutrition
- Organizational capacity building
- Training for income-generating activities
- Training for youth and peer educators about HIV
- Life skills training for youth and community members

- Developing women's and girl's clubs simultaneously to build awareness about the need for education
- Projects that identify and build girl leaders
- Projects that engage boys and men as partners in gender equality

#### Low-level epidemic

- Activities that focus on creating awareness and education for STIs, including HIV

#### Generalized epidemic

- Activities to improve care, treatment, and mitigation
- Activities to improve the delivery and acceptance of voluntary counseling and testing
- Activities to work towards preventing mother-to-child transmission, e.g., antenatal care, education about and access to treatment/strategies to prevent mother-to-child transmission
- The development of better services for families caring for orphans and vulnerable children
- The development of home-care systems

#### Concentrated epidemic

- Training peer educators to target groups that practice high risk behavior with information on HIV prevention and transmission
- Capacity building of organizations that provide services to high risk populations

Responses relating to capacity building should include answers to the following critical questions

*Is the activity appropriate in terms of language and culture?*

*Does it relate to expressed desires and needs of community members?*

*Is it connected to national/local/organizational strategies for addressing HIV/AIDS?*

*Does it lead to skills acquisition for one or more individuals?*

*Does it promote leadership and decision making?*

*Does it facilitate participation by youth/women/community members/people living with HIV/AIDS?*

*Is it sustainable? Will it last?*

**Step 4:** Post the list of critical questions in a place it can be referred to during the training. Encourage trainees to make a copy to take with them.

**Step 5:** Wrap up (if there is time). Small ball toss (or other activity that reviews the material): Toss a small ball to someone. As each person receives the ball, he or she should share something learned from the activity before tossing the ball to a new person.

15 minute break

**IV. Volunteer Panel** (50 minutes)

**Step 1:** Introduce the panel. (5 minutes)

**Step 2:** Panel members—7 minutes each. (approximately 30 minutes)

**Step 3:** Question and answer period. (15 minutes)

Be sure to raise and discuss the idea that this panel of Volunteers represents only a sampling of the approaches that can be used.

**V. Wrap up: Favorite Stories** (10 minutes)

**Step 1:** Ask participants to break into pairs and spend five minutes sharing a story from their own experience where they were engaged in a capacity-building activity, relating to any kind of work. Have them list the skills they used on a flip chart.

**Step 2:** Bring the group back together. Post flip charts. Ask participants to look over the charts. Then ask them to reflect on this session: What did they learn? What skills will they take to post? (Don't report out.)

**Evaluation**

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**References or Resources**

*HIV/AIDS—Integrating Prevention and Care Into Your Sector Idea Book*, Washington, DC: Peace Corps, 2000. [ICE No. M0081]

*Life Skills Manual*, Peace Corps, 2001. [ICE No. M0063]

*Roles of the Volunteer in Development: Toolkits for Building Capacity*, Washington, DC: Peace Corps, July 2002. [ICE No. T0005]

**Notes**

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# Tip Sheet: Guidelines/Information for Participation in Peace Corps Volunteer Panel

## The Role of the Volunteer in Capacity Building Related to HIV/AIDS

### Panel goal

To provide trainees the opportunity to hear how Volunteers implement HIV/AIDS activities that fit within Peace Corps' framework of development.

### Structure of the day (to be completed by trainer)

Arrival: \_\_\_\_\_

Prior to the panel: (Will trainees be invited to participate in the training that precedes the panel?)

Panel: Insert exact time \_\_\_\_\_

-

After the panel: 10 minute session wrap up—panel can observe

Dinner? Evening activity?

Departure: \_\_\_\_\_

### Panel structure

- The panel will be made up of three to four Volunteers or two Volunteers and their counterparts.
- A facilitator will introduce the panel participants.
- Each panel member will talk for seven minutes.
- A 15-minute question and answer period will follow the panelists' statements.

### What should you talk about?

Provide a summary of HIV/AIDS capacity-building activities you are engaged in, identifying

- The community and where it is located
- Activity goals
- Your partners
- Your role in relation to those with whom you are working
- Any other significant information
- The human face of the work—give at least one example of how your work is affecting a person/people in your community

- Challenges you have overcome or are facing (if there is time)
- What you enjoy about the work

### The Peace Corps' approach to development—a review

The Peace Corps uses the term “development” in human, people to people terms: helping people develop the capacity to improve their own lives. The focus of work is on the development of people, not things. The capacity-building approach focuses on helping people learn to identify what they would like to see changed, use their own strengths, and learn new skills to achieve what they believe is important.

HIV/AIDS activities, like all activities, should be approached from a gender-sensitive, culturally appropriate, and appreciative perspective.

### Capacity building happens at four levels

1. Individuals
2. Professionals, service providers
3. Organizations
4. Communities

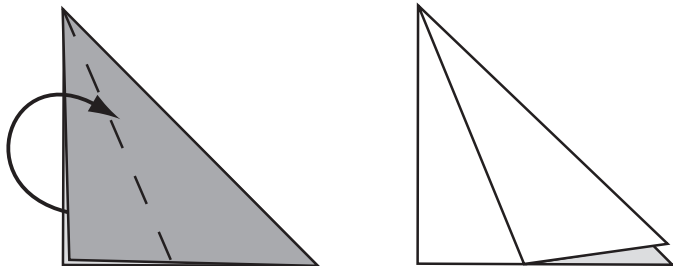
### Capacity-building activities

- Are appropriate in terms of language and culture.
- Relate to expressed desires and needs of community members.
- Connect to national/local/organizational strategies for addressing HIV/AIDS.
- Lead to skills acquisition for one or more individuals.
- Promote leadership and decision making.
- Facilitate participation by youth/women/community members/people living with HIV/AIDS.
- Are sustainable—they will last after you leave.

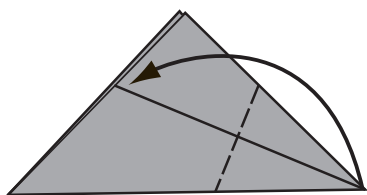
Thank You!



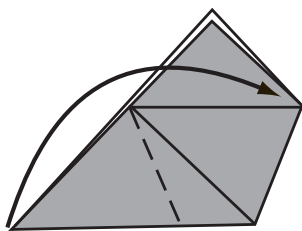
## Activity Sheet: Origami Cup Instructions



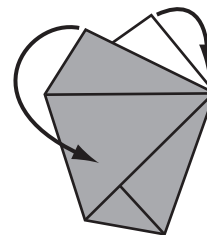
**Step 1:** Fold a square of white paper in half to form a triangle. Then taking the top layer only, fold it edge to edge (along the dotted line in the diagram) and unfold it again.



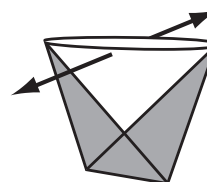
**Step 2:** Turn the triangle so that the crease you just made is running from the bottom right corner to the opposite side. Fold the bottom left corner to that point on the opposite edge where the crease bisects it.



**Step 3:** Fold bottom left corner to the opposite edge in the same way.



**Step 4:** Fold the front top flap down; then fold the back top flap down on the other side.



**Step 5:** Gently pull the two sides apart to open the cup, fill (cold liquids only, no hot liquids) and drink!

# Activity Sheet: Scenarios for Human Capacity Building Approaches

Select and copy the scenario of choice. Or, modify or create one more appropriate to your post.

## Scenario 1: Generalized epidemic

You are a secondary teacher in a community that has been strongly affected by HIV/AIDS. It is estimated that 25 percent of the population aged 15-49 is HIV-positive, yet only 10 percent of those infected are aware of it. Women are increasingly affected. The number of girls leaving school is increasing as they remain home to take care of younger children and the home. The community has few systems in place to take care of orphans and extended families are having a hard time caring for children orphaned by AIDS. People living with HIV/AIDS experience high levels of stigma and discrimination—in their families, their workplaces, and in the community at large. The local health-care system cannot meet the needs of so many people or provide the complex care needed by some patients with HIV.

The leadership in your community has recently committed itself to the new national strategic plan to combat HIV/AIDS. Key elements of the plan are to reduce the stigma and discrimination experienced by people living with HIV/AIDS; drastically increase the number of people who are tested for HIV; keep girls in school longer; identify and address the needs of vulnerable children; improve nutrition for people living with HIV/AIDS and their families; and create a strong home health-care system.

## Scenario 2: Low level epidemic

You are a youth development Volunteer in a country where the incidence rate for HIV/AIDS is less than 1 percent in the general population and in groups that practice risky behavior. There is little awareness of HIV/AIDS and strong cultural and religious taboos regarding talking about sexual behavior. There are negative stereotypes about who gets HIV/AIDS, with corresponding high stigma and discrimination against those who are known to be HIV-positive.

There is no national strategic plan to address HIV/AIDS and community leaders do not see the need for one. Your community has several NGOs who are working to target populations at high risk for HIV/AIDS (e.g., sex workers, injection drug users and youth).

## Scenario 3: Concentrated epidemic in the injection drug user population

You are a business development Volunteer in a community that has a fairly low (less than 1 percent), but rapidly increasing, incidence of HIV/AIDS. The majority (75 percent) of newly registered HIV-positive cases are injection drug users, with 25 percent infected through sexual transmission. The number of individuals affected through sexual transmission has increased by 50 percent in the past year. The majority of the infected population today is male (but indications are this will change) and ages 20-29. There is increasing concern about HIV-infected sex workers, and an unknown number of sex workers are trafficked women and girls. Additionally, there is a high rate of STDs and HIV among the prison population.

The country has a multisectoral national strategic plan with three main strategies

- HIV prevention among vulnerable populations through harm reduction interventions;
- HIV prevention among youth through education, information, and communication; and
- providing treatment, care, and support to people living with HIV/AIDS.

## Scenario 4: Generalized epidemic

You are a community development Volunteer in a community with a high prevalence of HIV/AIDS. Few people are willing to be tested for HIV because of the stigma and discrimination associated with HIV/AIDS. Pregnant women are particularly vulnerable because they receive no prenatal HIV education or counseling even though rates of mother-to-child-transmission are high. Additionally, the number of orphans and vulnerable children is on the rise

The national strategic plan includes in its targeted goals

- the increase of voluntary counseling and testing;
- the development of a strong antenatal care system through training and capacity building; and
- increased coordination among various service providers and systems.

# Handout A: The Peace Corps' Approach to Development

## What is development?

Development in its broadest sense is any process that promotes the dignity of a people and their capacity to improve their own lives. For people to live the fullest lives possible they sometimes must struggle to overcome such obstacles as climate, geography, economics, and social conditions. Peace Corps Volunteers become catalysts for facilitating such change.

## What is the Peace Corps' approach to development?

The Peace Corps uses the term “development” in human, people-to-people terms: helping people develop the capacity to improve their own lives. By working within a human capacity-building framework, the focus of the work is on the development of people, not things. Many development activities might seem to center around “things” such as community gardens, wells, or a school library. The capacity-building approach focuses on helping people learn to identify what they would like to see changed, use their own strengths, and learn new skills to achieve what they believe is most important. A community garden, for example, is part of the picture; by creating and then maintaining a community garden a village or other group realizes its own potential to accomplish self-defined goals.

## Capacity-building framework

Capacity building, to be an effective approach to development, needs to happen at a number of levels.

1. **Individual members of the community, project participants** They could be the students in a classroom, farmers in a cooperative, members of a household, or clients served by a nongovernmental organization (NGO). Building capacities at the individual level is usually a major focus of the Volunteer.
2. **Professionals, service providers** These could be teachers in a school, leaders of an NGO, or managers of a farmers' cooperative. While each Volunteer has an identified community partner who may or may not be a service provider, there are others at the

same level of leadership as Volunteers who provide services to the individual members of the community. Strengthening capacities at this level helps ensure local leadership for continuing activities into the future. Capacity-building activities might include training workshops, modeling improved technical methods, or supporting a community activity.

3. **Organizations** Examples include schools, NGOs, or farmers' cooperatives where Volunteers are placed. Strengthening organizational capacities, such as management skills within an NGO, working with teachers to develop organizational skills and materials for a school, and helping health workers develop a record-keeping system for a clinic all help root other activities in an ongoing, functioning, and supportive environment.
4. **Communities** These include the village or neighborhood in which the Volunteer lives or the area served by the project in which the Volunteer is working. Reaching out into communities and building capacities with activities, such as co-organizing a community health committee, a parent teacher association, or an Earth Day cleanup campaign, helps broaden the base of participation and ensures continuity. Taken as a whole, this framework provides the structure for planning and evaluating sustainable development work in any sector.

## “Sustainable” development

Development work is said to be “sustainable” when the community is able to continue on its own without outside support. The Peace Corps sees sustainable development as a process whereby people learn to build on their own strengths to take charge of their lives, and to address their expressed needs. Planning for sustainability requires considering all of the following factors

**Culturally sustainable** Does the basic approach or concept fit within and build on local beliefs and traditions, or will it be seen as an “outsider's idea” and not be acceptable or continued when the Volunteers leave?

**Politically sustainable** When there is no longer an outsider, such as a Peace Corps Volunteer, in the project, will it be sustainable within the sociopolitical context?

**Economically sustainable** Will there be sufficient local resources or the capacity to generate them when supportive outsiders, such as Volunteers, leave?

**Managerially sustainable** Will there be the local management capacity to carry on the work when the Volunteers leave?

**Environmentally sustainable** As the project grows, will the environment be able to sustain the use of resources?

### **Long-term versus short-term approaches**

Human capacity building is by its nature a long-term process. In development it is often more appealing to work on short-term goals that can be completed quickly. For example, in an area that needs clean water, it might appear to be most efficient to simply build village wells so that people can have clean water. A hired crew could come in and do it quickly and leave. In a capacity-building approach, the real goal is building the capacity within the community to identify the changes they want to make, identify their strengths, plan the project, and build and maintain the wells themselves. This approach might include working with a youth development NGO focused on job skills training, helping them teach young people well digging and maintenance skills. This might take a year or more, but it builds capacities that last over time.

*From Roles of the Volunteer in Development: Toolkits for Building Capacity, page 7, Washington, DC: Peace Corps. [ICE No. T0005]*

## Handout B: Reducing HIV in Injection Drug Users

HIV incidence continues to rise among injection drug users (IDUs). Injection drug use accounts for only 5 percent to 10 percent of cumulative HIV infections globally, but in some parts of the world it is the major mode of HIV transmission. For example, it is estimated that in China, Malaysia, and Vietnam at least half of HIV infections are associated with drug injection. In parts of Central and Eastern Europe and the newly independent states of the former Soviet Union, the rapid spread of HIV through shared use of contaminated injection equipment has been observed. In some cities, such as Svetlogorsk in Belarus, HIV prevalence among IDUs rose to more than 55 percent within one year of identifying HIV among the city's IDU population.

HIV epidemics among IDUs are distinguished from those of other populations by their potential for rapid spread of the virus within the IDU community and outward into the general population. In Bangkok, New York and Odessa, experience has shown that once HIV prevalence reaches a threshold of about 10 percent, it can surpass 40 to 50 percent within one to four years. Most of these infections result from sharing or reusing contaminated equipment (mainly needles and syringes) or from injecting tainted drug preparations.

A public health strategy that promotes behavior change through comprehensive HIV prevention and care programs for injection drug users is essential to HIV programming. Using lessons learned internationally, this strategy aims to keep HIV prevalence low in IDU populations by emphasizing that sharing contaminated drug equipment—not drug use itself or even drug injecting—carries the greatest risk of HIV infection. A comprehensive approach also addresses issues surrounding sexual transmission.

This approach is compatible with proven public health principles, which view drug use or abuse as a public health issue rather than only as a law-and-order issue. It gives drug users options to reduce their risk at various levels and focuses on supportive rather than punitive strategies. It recognizes that while stopping drug use altogether is the ideal goal, intermediate steps (such as drug substitution and safer injection

techniques) are frequently just as effective in countering the spread of HIV.

These five steps can help implement a comprehensive approach

1. Gain the support of policymakers and stakeholders.
2. Provide options for reducing risk of HIV infection.
3. Establish an effective peer outreach team to access and educate IDUs.
4. Build a peer-driven program in which IDU network leaders help design interventions.
5. Create necessary links between drug treatment and substitution programs, HIV counseling and testing, programs and primary health care services.

### Lessons learned

Evidence indicates that the HIV epidemic associated with injection drug use can be slowed, stopped or even reversed. At least three essential prevention components have been associated with containing the epidemic: implementing prevention initiatives early, while HIV prevalence is less than 5 percent; engaging in community outreach that provides IDUs with HIV information and helps them trust health care providers; and distributing sterile injection equipment widely. Specific lessons that arise from experiences with IDU programming initiatives include

**Law enforcement policies** Police in some countries have devised an approach known as “responsible demand enforcement” in which law enforcement officials work with health care providers to help drug users access services rather than face incarceration. These efforts have helped steer drug users from crime and possible imprisonment. These policies create an environment in which individual drug users can reduce their risk behaviors over the long term.

**Syringe exchange and availability** The rationale behind syringe exchange is that because many IDUs are unable or unwilling to stop injecting, intervention strategies must be used to reduce their risk of HIV

infection and transmission. Providing sterile needles and syringes is a simple, inexpensive way to achieve this goal, and also helps establish contact with drug users through outreach services.

**Education and outreach programs** Drug education materials with a focus on comprehensive HIV prevention and care programs are already available in numerous countries. These materials advise drug users about ways to inject more safely and how to otherwise reduce the risks associated with injecting. They do not promote drug use.

**Methadone programs** Methadone is a synthetic opiate substitute whose long-lasting effects reduce the user's need to resort to street drugs. Numerous studies have shown that methadone can reduce deaths, reduce the drug user's involvement in crime, curb the spread of HIV and hepatitis and help drug users regain control of their lives.

### Source

Family Health International. "Reducing HIV in Injection Drug Users (IDUs)." <http://www.fhi.org/en/HIVAIDS/pub/fact/reducingidus.htm> (accessed March 12, 2007).

## Handout C: HIV Prevention in Mobile Populations

Extended or repeated overnight travel away from home and community is associated with HIV infection. This travel can be divided into three types: voluntary and job-related (truckers, traders, freelance sex workers); legally required (members of the military, deported immigrants); or coerced (political refugees, trafficked sex workers, persons displaced due to war-related population shifts). Work-related mobility often creates an imbalance in the ratio of women to men, which facilitates the sharing of sex partners. Extreme examples are truck stops where female sex workers, vendors and drink shop owners outnumber the men who may be transiting through. The reverse is true in military and mining camps, where men greatly outnumber women.

Mobile populations that regularly cross international borders need access to a complete spectrum of HIV prevention options, including diagnosis and treatment of sexually transmitted infections (STI), affordable condoms and information on assessing, reducing and eliminating one's risk of infection. Many settings with mobile populations especially need policy-focused, contextual interventions to foster individual behavior change. One approach to cross-border HIV prevention is to concentrate interventions at international border crossings because they are high-risk environments where national prevention programming is weak.

The experiences of numerous agencies in cross-border STI/HIV/AIDS prevention activities have produced the following program guidelines

- Link prevention services on both sides of the border.
- Consider communities on opposite sides of the border as a single extended town with heavy interaction between border populations.
- Forewarn mobile populations that there is an unusually high risk for STI/HIV at cross-border areas and that they must anticipate the need for protection when traveling through.
- Produce communication materials in all of the major languages spoken at a border, usually two or more.

### Implementing cross-border interventions requires

**Listing cross-border locations** Cross-border sites are not only contiguous land borders; water transportation can connect “sister” port towns. Compiling a complete list of cross-border crossings is impossible because sites change by the month. With the building or expansion of roads and bridges, new sites open while others may close or temporarily shut down. But it is important to try to establish a working list, mindful that including some unofficial sites may jeopardize refugees' welfare.

**Selecting sites for format assessment** Based on the established list, selecting sites for further intervention requires making an informed judgment on the role of each site as a contributor or potential contributor to the regional HIV epidemic. This judgment is made after considering the population, the historical STI and HIV incidence, the commercial sex industry, the availability of drugs and alcohol, the presence of an established entertainment sector, the number of unformed service personnel and migrant laborers, and existing coverage with medical and social services.

**Conducting a preliminary rapid assessment and prioritization** Because cross-border areas tend to be remote and receive less coverage than major cities, there are limited resources to support cross-border activities. Identifying priorities based on a quick data collection effort—a “rapid assessment”—is important. The methods used in rapid assessments are most often qualitative, including in-depth focus group discussions, but also can be quantitative. Rapid assessment guidelines can be found in the UNAIDS publication “APICT Task Force on Migrant Labor and HIV Vulnerability and Initiating Cross-Border HIV/AIDS Prevention Programmes: Practical Lessons from Asia.”

**Preparing the intervention program** While the rapid assessment will generate information needed for selecting and prioritizing intervention sites, designing an intervention program requires more detailed information about the cross-border community. In Asia, where the bulk of cross-border HIV implementation activity has occurred, two methods have been used. In one, the Participatory Rural Appraisal and the Par-

ticipatory Learning and Action methodologies have been adapted to allow maximum community input. In the other, multi-disciplinary teams have performed technical assessments of communities, reviewing data with key local informants to design strategies that local groups will implement. In choosing between the two methods, the degree of urgency to implement prevention interventions must be weighed against long-term community development.

**Implementing interventions** The special challenges of cross-border settings require adaptations of state-of-the-art interventions used elsewhere. The most successful projects started locally before gradually sought the support of national governments. As early as possible, identify and engage the key stakeholders in the cross-border areas and forge partnerships among agencies across borders. Establish a project advisory committee whose members—from both sides of the border—can guide and support the implementing agencies.

**Evaluating the program** Evaluation, an essential component of all programs, is particularly difficult in cross-border programs because the populations' high mobility limits contact time for prevention activities. The great number of languages and dialects spoken in border areas is another complicating factor. And the relative absence of social and legal controls in border areas means that interventions designed to modify norms in migrant communities will be especially challenging. Evaluation efforts might be best focused on tracking risk behaviors and STI/HIV prevalence rates in certain community subgroups over time; qualitative methods could be used to assess the risk environment in the community as a whole.

International border trade towns and seaports consistently have the highest HIV prevalence among societies around the world. Epidemics tend to originate in these sites before progressing inland. If effective prevention programs are implemented in these locations, the return on investment (in terms of fewer new infections) should be one of the greatest in the field of prevention.

#### Source

Family Health International. "HIV Prevention in Mobile Populations." <http://www.fhi.org/en/HIVAIDS/pub/fact/mobile-pop.htm> (accessed March 12, 2007).



## Handout D: HIV/AIDS Interventions with Men Who Have Sex with Men

In some parts of the world, men who have sex with men (MSM) have been disproportionately affected by the HIV epidemic. In countries where such information is gathered, HIV infection rates among MSM are often higher than in the general population. Multiple sex partners, unprotected anal sex and the hidden nature of MSM sexual relations in many communities all contribute to the prevalence of HIV among MSM.

Many countries deny the existence of MSM, resulting in an alarming lack of prevention and care services directed at men at risk. This denial and discrimination against MSM feed the secrecy in which many MSM live, increasing their risk taking and making it difficult to reach them with HIV prevention interventions. Developing and implementing interventions for this population is also difficult because of varying definitions and perceptions of gender, sexual roles, stigma, homophobia and internalized homophobia. Due to societal pressure, many MSM have both male and female partners, increasing the HIV risk for their female partners and decreasing the likelihood that MSM self-identify as MSM.

Securing the participation of members of the MSM community is essential for developing and implementing comprehensive interventions. These interventions should address not only personal factors directly related to health (such as risk practices, condom use and sexually transmitted infections) but also personal factors (enhancing self-esteem and empowerment) and structural factors (laws criminalizing homosexual sex and access to non-judgmental STI services).

### Lessons learned

Some important elements for implementing successful MSM programs include

- Making formative assessments to determine the risks and needs of MSM.
- Involving MSM in the design and implementation of interventions.
- Using interpersonal approaches to behavior change communication, such as peer education programs and appropriate community-level interventions to reduce risk through safer sex practices.
- Creating “safe spaces” where MSM can discuss personal issues and access STI care, counseling and referral services.
- Linking interventions to condom distribution and promotion activities.
- Strengthening public and private STI services within health delivery systems used by MSM.
- Ensuring quality HIV voluntary counseling and testing (VCT) services.
- Ensuring care and support services for those affected by HIV, including quality clinical services and support groups for people living with HIV/AIDS.

To address the long-neglected impact of HIV on MSM, formative research must be conducted. This research should include a mapping exercise, an STI/HIV prevalence study (including an assessment of risk behaviors), and qualitative research aimed at better understanding the context of MSM risk-taking behavior in the developing world. Many parts of the world continue to deny the very existence of MSM. This formative research is helpful in gaining insight into who these men are and how they live their lives.

One successful approach to working with MSM has been to create or provide safe spaces where men can talk openly and receive STI care and counseling. Such centers offer a space for men to gather, and may also operate male sexual health projects with medical and psychosocial services for MSM. Another successful approach is integrating safer sex education into existing social activities. It is well accepted that peer-led interventions are most effective in reaching this target group. Peers should be brought into the decision-making process and invited to help develop interventions. These services can be provided through clinics, clubs, drop-in centers or outreach/street-based providers. Peer counselors can provide education and services to MSM and their families and can host regular support group meetings. Here, MSM can explore topics of sexuality and sexual identity, such as safer sex, gay relationships, commercial sex

work, living in a homophobic society, strengthening the gay community, relating to peers, values, attitudes and conduct. In addition, long-term counseling and support services to men living with HIV or AIDS is an important service that should be provided.

### **Some program elements that must also be considered include**

**Ensuring the availability of lubricants** In many settings, the lack of access to water-based lubricants forces men to use oil-based lubricants for sexual activity, jeopardizing the integrity of condoms. For this reason, the myth that condoms easily break strongly persists in some countries.

**Improving access to MSM-friendly STI services** MSM have specific STI-related needs but often feel uncomfortable approaching public-sector health providers with anal and oral STIs. MSM who don't have access to MSM-friendly private-sector providers can face ridicule, violence and even prison.

**Ensuring appropriate segmentation** MSM are not a homogeneous group. In many countries, MSM communities are greatly balkanised. For example, MSM who self-identify as heterosexual do not feel they confront the same issues as those who self-identify as homosexual. Wealthy MSM often move in very different circles than poorer MSM, and MSM sex workers have another set of needs altogether. During the community assessment phase it is important to investigate these differences and to consider them when designing programs.

**Addressing human and legal rights** The marginalization and stigmatization of MSM in many settings is magnified by a lack of human and legal rights. Some countries have severe anti-sodomy laws that drive MSM sexual behavior underground and put men at risk of being imprisoned.

### **Source**

Family Health International. "HIV/AIDS Interventions for Men Who Have Sex With Men (MSM)." <http://www.fhi.org/en/HIVAIDS/pub/fact/intervenmsm.htm> (accessed March 12, 2007).

## Handout E: Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children

The impact of HIV/AIDS on children and their families is not a simple problem with an easy solution. The current situation is complex, interrelated on all levels of life, and cuts across all sectors of development. State-of-the-art components for the care and support of orphans and other vulnerable children have evolved from lessons learned in various countries and experiences from development, child survival, children of war, and other HIV/AIDS-related programs.

### Lessons learned

**Policy and law** Appropriate government policies are essential to protect orphans and other vulnerable children and their families. These policies must contain clauses to prohibit discrimination in access to medical services, education, employment, and housing, and protect the inheritance rights of widows and orphans.

**Medical care** For the maximum well-being of orphans and other vulnerable children, they and their guardians need to have access to complete, relevant information and appropriate health care including clinical and preventive health care services, nutritional support, palliative and home-based care.

**Socioeconomic support** Orphans and other vulnerable children and their families are confronted with severe threats to their well-being including isolation, loss of income, educational access, shelter, nutrition, and other essentials. When families and children are forced to focus on basic daily needs to decrease their suffering, attention is diverted from factors that contribute to long-term health and well-being.

**Psychological support** The psychological needs of children continue to be one of the most neglected areas of support. But the AIDS pandemic has increased the urgency to address the psychological problems of children on a par with other interventions.

**Education** Education plays a vital role in the well-being of children. It offers them a chance for their future as well as developmental stimuli. The impact of HIV/AIDS on the educational system has resulted in a decreasing number of teachers due to mortality, a growing number of children who are not able to attend or stay in school, and rising numbers of pupils whose

ability to take advantage of schooling is undermined by other factors including poor nutrition and psychological stress.

**Human rights** Human rights-based approaches have been increasingly recognized as essential to the success of HIV prevention and care programs, including those working with children and adolescents. Especially important are those tenets outlined in the convention of the rights of the child.

**Community-based programs** There is agreement on the components of community-based programs for orphans and other vulnerable children. Prioritizing program activities will depend upon community needs, abilities, and preferences, as well as on the nature of sponsoring or partner organizations. The community is best able to identify target groups for interventions, although the government may wish to select target regions or communities for program implementation.

The 1997 and 2000 editions of *Children on the Brink* consolidate existing knowledge from a wide range of sources. According to both versions, interventions must include five basic strategies: (1) strengthen the capacity of families to cope with their problems; (2) mobilize and strengthen community-based responses; (3) increase the capacity of children and young people to meet their own needs through access to quality education, protection from exploitation and excessive labor, and building the capacity to care for themselves; (4) create an enabling environment for children and families through such activities as ensuring basic legal protection through laws and policies to protect women and children, decreasing stigma, and behavior change interventions; and (5) ensure that governments protect the most vulnerable and provide essential services.

### The following should also be considered in designing such programs

**Emphasizing community care rather than institutional care** Long-term institutionalization of children in orphanages and other facilities is not a desirable solution to the impacts of HIV/AIDS. Resources expended to fund institutional care for a single child

can assist scores of children if used effectively to support a community-based initiative. The institutionalization of children separates them from families and communities and often delays healthy childhood development.

**Strengthening the care and coping capacities of families and communities** The first line of response to the needs of children affected by HIV/AIDS comes from extended families. Strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost-effective, and sustainable way of assisting orphans and other vulnerable children. Families and communities also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children.

**Involving children and youth as part of the solution, not part of the problem** Children are not simply a passive, powerless target group to be aided, but capable actors and important resources to engage in a community response to HIV/AIDS. Actively involving children in care initiatives can build their sense of self-esteem and efficacy and cultivate skills they can use in the future.

**Building broad collaboration among key stakeholders in all sectors** To meet the needs of children affected by HIV/AIDS, there have to be broad networks and targeted advocacy to involve government, civil society, and nongovernmental organizations in shared initiatives of community action for orphans and other vulnerable children.

**Application of long-term perspective** Children will continue to be affected by AIDS for decades to come. Due to the scope and scale of the pandemic, program design requires sustainable and replicable approaches. Although material assistance is important, it is also important to ensure that community projects are not driven by material support alone but by ownership and responsibility.

**Integration with other services** Since the problems experienced by orphans and other vulnerable children begin well before the death of their parents, care for children affected by HIV/AIDS should start at

the earliest possible point. Services for orphans and other vulnerable children should be integrated with the elements of comprehensive care such as a voluntary counseling and testing for HIV, prevention of mother-to-child-transmission of HIV, and others.

**Linking care and prevention** Orphans and other vulnerable children are themselves at high risk of HIV infection due to economic hardship and loss of parental care and protection. For this reason alone, care programs should include a strong prevention component targeting children and youth.

#### Source

Family Health International. "Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children." <http://www.fhi.org/en/HIVAIDS/pub/fact/carorphans.htm> (accessed March 12, 2007).

## Handout F: HIV Interventions with Youth

Approximately half of HIV infections worldwide are in young people between the ages of 10 and 24. During these years, youth learn, explore, and make decisions that will affect the rest of their lives. If they do not receive the information and services they need to make informed choices, they are more likely to engage in risk behaviors that can have such adverse consequences as high rates of early pregnancy and sexually transmitted infections STIs, including HIV.

### Interventions for youth should be guided by the following principles

**Youth are not one single audience.** Rather, youth are a complex group of people requiring appropriate segmenting based on such factors as age, geographic setting, family, school and civil status, and special needs. It is important to remember that not all youth are equally at risk for HIV/AIDS.

**Start young.** Youth programs often start too late, after many young people have become sexually active and sexual attitudes and behaviors are already well formed. By reaching preteens and older children, programs can affect the emerging norms of young people. For example, the very young (six- to ten-year-olds) can be exposed to messages about healthy body image, body sovereignty (good touches versus bad touches), and support of people living with HIV/AIDS.

**Examine the context of young people's lives.** Interventions must look at the contextual factors in young people's lives, such as their economic status, ability to pay for school, family situation and civil status. Successful interventions will conduct formative research that examines the context of health decision-making behaviors and seeks ways to address them.

**Reach people who influence and control your access to youth.** Prepare the environment. Youth are strongly influenced by the many people and institutions that surround them. It is important to reach the gatekeepers who control access to youth and are key to implementing HIV/AIDS prevention and care programs. Take into account young people's immediate and extended families, teachers, community leaders, religious leaders and media icons. Since youth

interventions are often controversial, it is essential to advocate with community and political leaders.

**Link HIV programs to non-health sectors.** Young people may not be particularly interested in health issues like HIV/AIDS. Young people invest their time and interest in such areas as religion, schools, job training, agriculture, sports and the media. Interventions must take advantage of these sectors and seek to integrate HIV messages into their activities.

**Do not separate HIV from other reproductive health and life issues.** Young people do not compartmentalize their lives. They are often more worried about an unwanted pregnancy than about HIV. A life skills/healthy lifestyle approach will build problem-solving and decision-making skills and help young people assess their risk for STI/HIV and take protective actions.

**Incorporate an age appropriate and balanced "ABC" prevention approach.**<sup>1</sup> Young people are the most important asset to any community or nation, and protecting them from contracting HIV is critical. There is no one right approach to HIV prevention with youth. Young people must be able to choose the healthy behaviors that best fit with their lifestyles—whether abstinence, being in a mutually faithful, stable relationship, or the correct and consistent use of condoms. Youth who have not had their sexual debut should be encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those youth who have initiated sexual activity, returning to abstinence should be a primary message of prevention programs. It must be recognized that certain young people will, either by choice or coercion, engage in sexual activity. In these cases an integrated "ABC" approach is necessary that includes a "C" component, information about correct and consistent use of condoms. This message should be coupled with information about abstinence as the only 100 percent effective method of eliminating risk of sexual HIV infection; and the importance of HIV counseling and testing, partner reduction, and mutual faithfulness as methods of risk reduction.

**Youth are assets.** When programming for youth, approach them as assets to society, not as problems

to be overcome. Youth are resilient in the face of great societal challenges. Look for and seek to expand the reach of the networks and activities that support positive behaviors for youth.

**Involve youth in meaningful ways.** Young people must be involved in every aspect of an intervention program, including its research, design, and implementation. This means that program designers must move beyond consultation to meaningful participation with youth. Doing this requires planners to make changes in their approach—by, for example, using simple concepts, flexible hours and specialized training. It is also important for program planners to seek participation and cultivate the voices of youth who are not usually heard—the youngest, the marginalized, and those directly affected by HIV/AIDS.

**Youth want information from diverse sources.**

For example

- Peer education is an effective strategy. Young people respond best to other young people—where they work, study, and play. This is why peer education/promotion/motivation is a crucial outreach strategy. But because young people move quickly through different phases of life, youth peer education/promotion/motivation programs should expect a high rate of turnover and a constant need for training and re-training.
- Anonymous sources increase access to information. In addition to peer education, youth are interested in seeking information from anonymous sources such as hotlines and the Internet.
- Make it fun! Young people enjoy the media, theater, lively arts and technology. The more fun the means for delivering information, the more likely young people will listen and retain what is being taught.

**Source**

Family Health International. “HIV Interventions with Youth.” <http://www.fhi.org/en/HIVAIDS/pub/fact/hivinterven.htm> (accessed March 12, 2007).

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1 The President’s Emergency Plan for AIDS Relief: Office of the Global AIDS Coordinator. “ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President’s Emergency Plan for AIDS Relief.” <http://www.state.gov/documents/organization/57241.pdf> (accessed March 12, 2007).

# Session Two: The Role of the Volunteer in Development—Combating HIV/AIDS

## Purpose

Peace Corps participants will learn how they fit into the development process, and how to use their role to link capacity-building principles to local, national, and global strategic plans for addressing HIV/AIDS.

## Rationale

The role of the Peace Corps Volunteer is to build capacity by “helping people develop the capacity to improve their own lives.” This session will introduce trainees to the roles they can play as part of the development process and how to link capacity-building principles to local, national, and global Peace Corps’ strategic plans for addressing HIV/AIDS.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours and 35 minutes

## Objectives

By the end of the session, trainees will be able to

1. Identify the roles of the Volunteer in development.
2. Identify global and country-specific strategic plans for addressing HIV/AIDS.
3. Articulate how the Peace Corps, and individual Volunteers, can have an impact on the HIV/AIDS pandemic.

## Session Outline

- 
- I. **Introduction/Opening Activity** (10 minutes)
- 
- II. **The Big Picture: Key Factors Relating to the Pandemic and Organizational Responses** (1 hour, 30 minutes)
    - A. **Overarching Information about HIV/AIDS**
    - B. **Organizational Responses**
- 
- III. **The Roles of the Volunteer in Development** (50 minutes)
- 
- IV. **Closure** (5 minutes)
- 

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Worldwide, regional, and country statistics about HIV/AIDS
- Various agency and country efforts to deal with HIV/AIDS
- Promising practices relating to HIV/AIDS
- Volunteer cross-sectoral roles in the field relating to HIV/AIDS
- Gender and age issues
- Cultural factors related to HIV/AIDS

## Materials and Equipment

Flip charts, markers, tape, or tacks

Prepared flip charts

1. Session Two Outline
2. Overarching Information about HIV/AIDS
3. Organizational Responses
4. Capacity-Building Roles of the Volunteer in Development

Activity Sheet

*Notes on the “Big Picture” of HIV/AIDS*

Handouts

**For Part II A**

A. *The Global HIV/AIDS Epidemic*

- B. *Gender and HIV/AIDS*
- C. *Stigma and Discrimination and HIV/AIDS*
- D. *Reducing HIV in Injection Drug Users*
- E. *HIV Prevention in Mobile Populations*
- F. *HIV/AIDS Interventions with Men Who Have Sex with Men*
- G. *Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children*
- H. *HIV Interventions with Youth*
- I. *Cultural Factors Relevant to Capacity Building and HIV/AIDS*
- J. *Volunteer Success Stories*

#### For Part II B

- K. *UNAIDS and the “Three Ones” Key Principles*
- L. *The Global Fund to Fight AIDS, Tuberculosis and Malaria*
- M. *The World Health Organization*
- N. *The President’s Emergency Plan for AIDS Relief*
- O. *Host Country Strategic Plan for HIV/AIDS (if there is one)*
- P. *The Peace Corps’ Work in HIV/AIDS*

### Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- If you prefer a different opener or closer, or want to add warm ups during sessions, add any materials needed to the materials list.
- Review Handouts D-H. Choose the handouts relevant to the vulnerable populations in the country.
- Update any out-of-date information contained in handouts by visiting websites for UNAIDS, WHO, PEPFAR. Trainers may want to provide information about additional local organizations, particularly if the training group is large.
- Obtain a current Peace Corps Global HIV/AIDS Strategy (if one has been issued).
- Obtain host country strategic plan for HIV/AIDS (if there is one).
- If there is no host country strategic plan, collect information about what is being done nationally, regionally, locally.
- Invite an appropriate representative of the leading agency for the country’s HIV/AIDS strategic plan to address trainees.

- Prepare flip charts and copy handouts.
- You may want to use or reference the Behavior Change module, Session 3, which focuses on stigma and discrimination.

### Methodology

#### I. Introduction/Opening Activity (10 minutes)

**Step 1:** Provide an overview of the session, using the outline on flip chart 1.

<b>Session Two Outline</b>
<b>The Role of the Volunteer in Development: Combating HIV/AIDS</b>
<b>I. Opening Activity</b>
<b>II. The Big Picture: Key Factors Relating to the Pandemic and Organizational Responses</b>
<b>A. Overarching Information about HIV/AIDS</b>
<b>B. Organizational Responses</b>
<b>III. The Roles of the Volunteer in Development</b>

FLIP CHART 1

*Explain: After a brief opening activity, we will spend the first half of the session focusing on the big picture of HIV/AIDS and some of the key factors relating to the pandemic. We will then focus on your role as a Peace Corps Volunteer. We will end with a closing activity.*

*The purpose of this session is to learn how you fit into the development process, and how to use your role to link capacity-building principles to local, national, and global strategic plans for addressing HIV/AIDS.*

**Step 2:** Opening activity.

*Think of a word that starts with the first letter of your first or last name that communicates a concept related to capacity building. Share this word with the group.*

Examples

A—appreciative

B—behavior change



C—community based

D—development

## II. The Big Picture: Key Factors Relating to the Pandemic and Organizational Responses

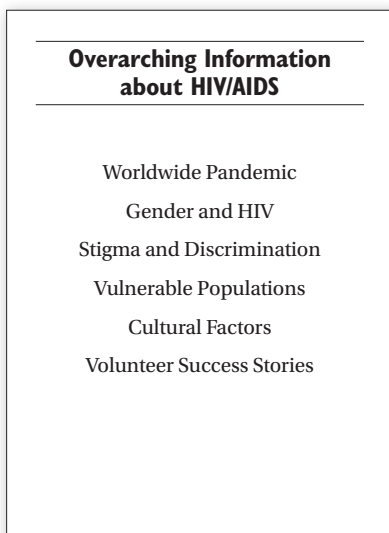
(1 hour, 30 minutes)

### A. Overarching information about HIV/AIDS

(45 minutes)

**Step 1:** Create “expert groups.”

Explain that participants will have the chance to learn a lot of information related to HIV/AIDS quickly by reading about one concept in a small group and presenting information to others. The topics we’ll learn about in the next hour are the following (reveal flip chart 2).



FLIP CHART 2

**Step 2:** Small group work.

Explain that each group will have some resource information about one topic. They are to read the resource information and become “experts” on the subject. Use the flip chart to outline the major points. They will have ten minutes to read and discuss their material, and to select one group member to act as a panel expert representing the group.

Divide into six groups. Provide each group with the handout for one topic, flip chart paper, and markers. (To the group assigned to vulnerable populations, distribute the handouts on vulnerable populations (D-H)

that are relevant for your specific country. If there are enough groups, you may want to divide this piece up and have two or more groups assigned to look at a specific vulnerable population.)

**Step 3:** Panel. (30 minutes)

One person per group sits on a panel. Each panelist has five minutes to present information.

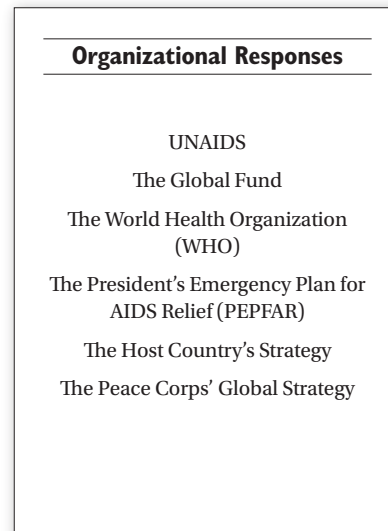
After the panel, let participants know that they will receive copies of all the materials at the end of the session.

### B. Organizational responses (45 minutes)

**Step 1:** New groups and information. (10 minutes)

Explain that they will form six new groups and learn about different initiatives and approaches to working on the HIV/AIDS pandemic. Each person will be responsible for sharing the information he or she learns with another group; so each person should prepare well.

Reveal flip chart 3 and the topics for this round.



FLIP CHART 3

Create six different groups, give each the handouts (K-P) for one topic, and tell them they have 10 minutes to work.

**Step 2:** Each one teach the others. (30 minutes)

Form new groups with one person from each of the former groups in each of the new groups. Each person should teach his or her new group the information about the HIV/AIDS response that he or she read

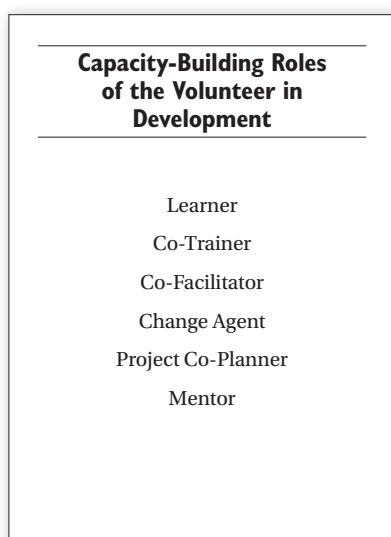
about. Provide the Activity Sheet: *Notes on the 'Big Picture' of HIV/AIDS* as a note-taking aid for trainees.

### III. The Roles of the Volunteer in Development

(50 minutes)

**Step 1:** Small groups. (20 minutes)

Break into six small groups, each with a flip chart. Ask each group to take one of the roles of the Volunteer (see flip chart 4).



FLIP CHART 4

Ask each group to do the following:

Consider some of the HIV/AIDS activities that a Volunteer might conduct in this role. List some of the specific activities you might do that would build capacity that relates to the country strategic plan or local community plan for combating HIV/AIDS. You'll have 20 minutes to work on a list.

**Step 2:** Gallery. (30 minutes)

Have each group post its list of activities on the wall.

Ask groups to circulate around the room, considering each role and the ideas listed. Encourage them to add other activities that they think are relevant.

Bring the group back together to share impressions. Ask for any clarifications, if necessary.

Reinforce the idea that the purpose of this exercise was to expand their vision of the capacity-building roles and potential activities of Volunteers; they shouldn't assume that these are exactly what they should or will be doing. That will depend on further investigation once they get to their communities, as they will learn in the assessment module.

### IV. Closure (5 minutes)

**Trainer's note:** This closure should be done crisply to bring the session to an end in a way that allows trainees to think about the session but without asking for original thinking.

**Step 1:** Ask participants: What has been covered that you particularly connect with?

**Step 2:** When someone contributes something, ask: How many people would say this was something that resonates for them as well? Ask all who agree to stand (with the person who made the suggestion).

**Step 3:** Repeat the process until everyone is standing. If everyone is standing after the first contribution, you can either choose to use this as the closure or go ahead and ask for a few more contributions.

**Step 4:** Provide participants with copies of all the handouts.

### Evaluation

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# Activity Sheet: Notes on the “Big Picture” of HIV/AIDS

## Global Pandemic

Global Responses (organizations)

Global Resources

Capacity-Building Efforts

Volunteer Role(s)

## Regional Pandemic

Regional Responses (organizations)

Regional Resources

Capacity-Building Efforts

Volunteer Roles(s)

**Country Epidemic**

Country Responses (national strategy; Peace Corps strategic plan)

Country Resources

Capacity-Building Efforts

Volunteer Roles(s)

# Handout A: The Global HIV/AIDS Epidemic

The HIV/AIDS epidemic has already claimed more than 25 million lives and another 39.5 million people are currently estimated to be living with HIV/AIDS worldwide.<sup>1,2</sup> HIV/AIDS cases have been reported in all regions of the world, but most people living with HIV/AIDS (95%) reside in low- and middle-income countries, where most new HIV infections and AIDS-related deaths occur.<sup>1,3</sup> The nations of sub-Saharan Africa have been hardest hit, followed by the Caribbean; there is also concern about the epidemic in parts of Eastern Europe and Asia.<sup>4,5</sup> HIV is the leading cause of death worldwide (among those aged 15–59).<sup>6,7</sup> It is considered a threat to the economic well-being, social, and political stability of many nations.<sup>8,9</sup>

## Current Global Snapshot<sup>1</sup>

- There are an estimated 39.5 million people living with HIV/AIDS worldwide, 2.6 million more than in 2004 and twice the number in 1995.<sup>9</sup> The number of people living with HIV/AIDS has increased in every region.
- During 2006, an estimated 4.3 million people became newly infected with HIV, including 530,000 children.<sup>3</sup>
- 2.9 million people died of AIDS-related illnesses in 2006, and deaths have been rising.
- Worldwide, most people living with HIV are unaware that they are infected.<sup>9</sup>

## Impact by Region

The major route of HIV transmission worldwide is heterosexual sex, although risk factors vary within and across populations. In many regions of the world, men who have sex with men, injection drug users, and sex workers account for significant proportions of infections.<sup>1</sup> Several regions and countries have been particularly hard-hit by the HIV/AIDS pandemic (See Figure 1). Even in the United States, where HIV incidence has been level for more than a decade, there are increasing numbers of people living with HIV/AIDS, not everyone has access to care, and HIV/AIDS prevalence is high among some sub-populations.<sup>1,10,11</sup>

The most affected regions around the world are<sup>1</sup>

**Sub-Saharan Africa** Sub-Saharan Africa has been hardest hit and is home to almost two-thirds (62.5%) of people living with HIV/AIDS, or 24.7 million people, but only about 11% of the world's population.<sup>12</sup> The region is also home to most (91%) of the 2.3 million children living with HIV/AIDS globally.<sup>3</sup> Almost all nations in this region have generalized HIV/AIDS epidemics—that is, their national HIV prevalence rate is greater than 1%.<sup>9,13</sup> In several, more than 10% of adults are already estimated to be HIV positive.<sup>9</sup> South Africa has an estimated 5.5 million people living with HIV/AIDS, one of the highest in the world, and almost one in five South African adults are HIV positive.<sup>9</sup> Swaziland has the highest prevalence rate in the world (33%). There is evidence

**Figure 1: HIV Prevalence & Incidence by Region** <sup>1,3</sup>

Region	Total No. (%) Living with HIV/AIDS, end of 2006	Newly Infected in 2006	Adult (aged 15-49) Prevalence Rate, 2006
<b>Global Total</b>	<b>39.5 million (100%)</b>	<b>4.3 million</b>	<b>1.0%</b>
Sub-Saharan Africa	24.7 million (62.5%)	2.8 million	5.9%
South/South-East Asia	7.8 million (19.7%)	860,000	0.6%
Eastern Europe/Central Asia	1.7 million (4.3%)	270,000	0.9%
Latin America	1.7 million (4.3%)	140,000	0.5%
North America	1.4 million (3.5%)	43,000	0.8%
East Asia	750,000 (1.9%)	100,000	0.1%
Western/Central Europe	740,000 (1.9%)	22,000	0.3%
Middle East/North Africa	460,000 (1.2%)	68,000	0.2%
Caribbean	250,000 (0.6%)	27,000	1.2%
Oceania	81,000 (0.2%)	7,100	.4%

that the epidemic may be slowing or stabilizing in eastern and western African countries, but there are signs of growing epidemics in a few countries.<sup>14</sup>

**Latin America & the Caribbean** Nearly 2 million people are estimated to be living with HIV/AIDS in Latin America and the Caribbean combined, 167,000 of whom were newly infected with HIV in 2006. Ten countries in the region have generalized epidemics.<sup>9</sup> The Caribbean has been especially hard hit, with an adult prevalence rate (1.2%) second only to sub-Saharan Africa.

**Eastern Europe & Central Asia** An estimated 1.7 million people are living with HIV/AIDS in this region, which has the fastest growing epidemic in the world and one that is heavily concentrated among young people. Driven initially by injection drug use and increasingly heterosexual transmission, HIV prevalence has risen sharply over the last several years. The Russian Federation has the largest number of people living with HIV/AIDS in the region.

**Asia** An estimated 8.6 million people are living with HIV/AIDS across South/South-East Asia and East Asia. South/South-East Asia has the highest new infection rates in the region. The region is also home to the two most populous nations in the world—China and India—and despite having relatively low prevalence rates today, even small increases translate into large numbers of people. India already has the highest number of people estimated to be living with HIV/AIDS in the world (5.7 million).<sup>9</sup>

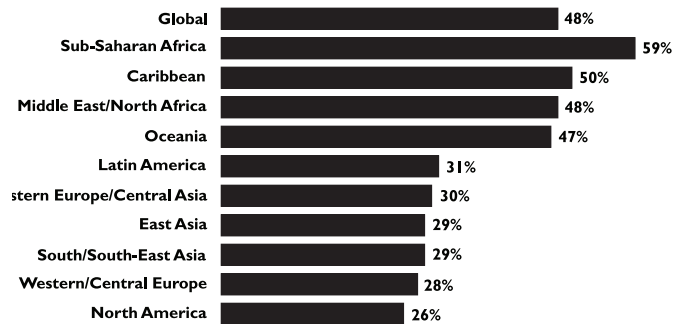
### Impact on Women and Young People

- Today, women represent almost half (48%) of all adults living with HIV/AIDS, and the number of women living with the disease has increased globally and in all regions over time.<sup>1</sup> In sub-Saharan Africa, women represent more than half (59%) of all adults living with HIV/AIDS (See Figure 2).<sup>1</sup> Gender inequalities in social and economic status and in access to prevention and care services increase women's vulnerability to HIV. Sexual violence may also increase women's risk and women, especially young women, are biologically more susceptible to HIV infection than men. The epidemic has multiple effects on women including: added responsibilities of caring for sick family members; loss of property if they become widowed and/or infected; and even, violence when their HIV status is discovered.
- Teens and young adults, particularly girls and young women, continue to be at the center of the

epidemic. Young people aged 15–24 account for about 40% of new HIV infections among those 15 and over.<sup>1,3</sup> Among young people in sub-Saharan Africa, on average, three young women are infected for every young man.<sup>9</sup> A similar pattern is seen in the Caribbean where young women are more than twice as likely to be infected with HIV compared to young men in some countries.<sup>9</sup>

- In 2005, there were an estimated 15.2 million AIDS orphans (children who had lost one or both parents to the epidemic), most of whom (12 million) lived in sub-Saharan Africa.<sup>9</sup>

**Figure 2: Women as a Percent of Adults (aged 15 and over) Living with HIV/AIDS by Region 2006<sup>1</sup>**



### The Multi-Sectoral Impact of AIDS

The global HIV pandemic has had a profound, multi-sectoral impact on the structure of many nations, affecting their development and economic growth, communities, households, and individuals.<sup>6,8,9,15</sup>

- AIDS has been identified as a serious challenge to development, with both short and long-term economic effects.<sup>6,8,9</sup> Because HIV/AIDS often hits working age populations hardest, the workforce of many nations has been affected, as skilled workers are lost to the epidemic. The loss of skilled workers in turn affects nations' ability to respond to the epidemic.<sup>8,9</sup>
- The education sector is also threatened, as AIDS claims the lives of teachers and contributes to serious teacher shortages in several African countries. AIDS also weakens the education sector through its impact on school attendance and enrollment among children affected by HIV/AIDS.<sup>8,9</sup>
- Increasing demand for health care services is overwhelming the public health infrastructure in many developing countries. At the same time, many countries are losing large numbers of health care workers

to AIDS. In some African countries, it is estimated that AIDS causes up to one half of all deaths among employees in the public health sector.<sup>8,9</sup>

- Many of the nations hardest hit by HIV/AIDS also suffer from malnutrition, food insecurity, and famine. These challenges are interrelated with HIV/AIDS, each intensifying and complicating the effects of the other.<sup>8,9</sup>
- The demographic effects of the epidemic are significant, as it alters the population structures of hard hit countries, affecting their growth and mortality rates and, ultimately, their age and sex distributions. Individuals die at prematurely young ages, during their most productive and reproductive years. One consequence of this is that there are fewer working age people to support children and the elderly. And, in some parts of world, there are disproportionately fewer women compared to men, due to HIV mortality.<sup>6,8,16</sup>
- One of the most striking demographic impacts of HIV/AIDS is on life expectancy, reversing steady gains made in many countries during the last century. By 2010, life expectancies in several highly-affected countries could drop to below 40 years, well below what they would have been without HIV/AIDS and even below levels they had reached in the pre-AIDS era.<sup>6,8,16</sup>

## The Global Response

The past few years have brought greater attention by the international community to HIV/AIDS, leading to several important initiatives including: The United Nations General Assembly Special Session on HIV/AIDS and Declaration of Commitment; The Global Fund to Fight AIDS, Tuberculosis and Malaria; The United Nation's Universal Access Campaign; and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Affected country governments and civil society also play critical and increasing roles in many national responses to the epidemic. Global funding for HIV/AIDS has increased over time. Still, resources fall short of projected need and most people at risk for HIV and those living with HIV/AIDS do not have access to prevention, care, and treatment

- UNAIDS estimates that spending on HIV/AIDS rose from US\$300 million in 1996 to \$8.3 billion in 2005, and is projected to reach \$8.9 billion in 2006 and \$10 billion in 2007, but need is much higher. For 2006, UNAIDS estimates that \$15 billion will be needed to effectively respond to the HIV/AIDS epidemic in low- and middle-income countries, rising to \$22 billion by 2008.<sup>5,9</sup>

- The lack of resources has limited many nations' ability to bring prevention and treatment programs to scale, and stem the tide of the epidemic. It is estimated that prevention programs reach fewer than one in five of those who need them and that only 24% of people with HIV/AIDS in need of antiretroviral therapy in low- and middle-income countries have such access.<sup>5,17</sup>
- Most funding for HIV/AIDS is expected to come from international donors, although affected country governments also have an important role to play. In 2005, major donor governments committed \$4.3 billion to global HIV/AIDS efforts in developing countries. The U.S. is a key part of the global response, contributing the highest dollar amount to HIV/AIDS.<sup>18</sup> In its fiscal year (FY) 2006, the U.S. federal funding commitment for global HIV/AIDS, as part of PEPFAR, is expected to total \$3.2 billion, including funding for prevention, care, treatment, and research. This also includes contributions to the Global Fund of \$545 million for FY 2006.<sup>19</sup>

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## Handout B: Gender and HIV/AIDS

**FACT SHEET** *This Fact Sheet is based on information from UNFPA.org (United Nations Population Fund), The Exchange, v. 34 (the Peace Corps' Women in Development Newsletter), and UNAIDS.*

Gender inequalities have been recognized as a major factor driving the HIV/AIDS epidemic and both men and women have a vital role to play in reducing the incidence of HIV. By integrating issues of gender and HIV/AIDS into their work, Peace Corps Volunteers can contribute in direct and indirect ways to reducing the vulnerability of women and girls to HIV infection.

### Why are women and girls more vulnerable to HIV/AIDS?

**Biological factors** Worldwide, more than 90 percent of adolescent and adult HIV infections have resulted from heterosexual intercourse.<sup>1</sup> Biologically, women are particularly vulnerable to heterosexual transmission of HIV due to the large surface area exposure of the vagina to seminal fluids, which contain higher concentrations of virus than female secretions. Additionally, women (especially young girls with underdeveloped reproductive systems) are more likely to develop small rips and tears during sexual intercourse, which give the virus more opportunity to enter and infect the body.

**Social factors** Due to unequal power relationships between men and women, women may not be able to determine whether, and with whom, they have sex, or may be unable to discuss matters of contraception with their partners. Because women may lack access to educational services, they may be unfamiliar with the concept of “safe sex.” There may be cultural practices or beliefs that increase the vulnerability of women and girls. However, there may also be cultural practices or beliefs that protect women, which, for any number of reasons, have been weakened.

**Economic factors** Women and girls often depend on husbands or other male family members for financial security, and so, may be reluctant to introduce sensitive topics, such as the use of condoms, for fear of being ostracized. Additionally, in some societies

widowed women may not have inheritance rights, and may be forced to trade sex for goods or services.

### What role do men play in the epidemic?

Men make many of the decisions that affect how individuals interact in a society, and are more likely to dictate what is expected, accepted and/or required of men and women. Often, these social norms work to consolidate power among men. Gender roles also determine what men and women know about sex, and often women are expected to be relatively ignorant in matters of sex, compared to their male counterparts. As a result, women may not be aware of, nor have access to, reproductive health services and information.

Many of the resources and programs that can help to reduce the vulnerability of women are often in the hands of men. Rather than focusing resources and programs solely on women, strategies to reduce the vulnerability of women and girls must include and encourage the active participation of men. It is important that everyone understand how individual behaviors and practices affect society, and in particular, its vulnerable groups.

### How does the vulnerability of women to HIV/AIDS affect society as a whole?

In many societies, women are the primary caretakers in a household. Women care for the children, provide much of the labor associated with subsistence agriculture, and keep the household stocked with water and fuel. If women are sick, many of these necessary duties are neglected and the household suffers. Several suffering households in a community weakens the entire community.

### How can Volunteers integrate issues of HIV/AIDS and gender into community development work?

It is important for Volunteers to make the issues of HIV/AIDS and gender a philosophical part of the foundation from which they work, even though they may not be explicitly focusing on them in day-to-day activities. Volunteers should learn as much as possible about how gender roles and responsibilities influence

the local HIV/AIDS situation, and work on projects that build skills and self-esteem with vulnerable populations. It is important to avoid polarization of men and women. Blaming any group for the epidemic only increases alienation and stigmatization, which, in turn, drives the epidemic. Work with groups and individuals to strengthen community, and encourage both men and women to take responsibility for their actions and for the health of the community. Explore the repercussions of vulnerability in one group on society as a whole. Also, refer to the *Life Skills Manual* [ICE No. M0063] and *HIV/AIDS: Integrating Prevention and Care into your Sector* [ICE No. M0081].

**Education** Educational status is one of the most powerful determinants of an individual's reproductive health status. Unfortunately, girls may be the first to be pulled out of school to help with household duties if family caretakers fall ill. Therefore, seeking solutions to continue the education of girls automatically reduces their vulnerability to HIV infection. Volunteers are also encouraged to integrate HIV/AIDS issues into school curricula. The *Community Content-Based Instruction (CCBI) Manual* [ICE No. M0073] provides guidance and suggestions.

**Agriculture/Environment** Women are responsible in large part for the labor required to feed the family. The loss or incapacitation of a woman as a result of illness increases the whole family's vulnerability to poverty. Work with women and communities to increase the "safety nets" as they apply to household food security. Some examples might include forming cooperative labor groups and increasing the focus on fruits, vegetables, and small ruminants, which diversifies diet and income opportunities.

**Small business development** Increasing the economic security of women and other vulnerable populations may allow greater independence and the freedom to change the behaviors that make them vulnerable to HIV infection. Volunteers can work in communities affected by HIV/AIDS to build economic and livelihood security through income-generating activities or with community members to develop social marketing campaigns.

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1 National Institute of Allergy and Infectious Diseases. "HIV Infection and Women." <http://www.niaid.nih.gov/factsheets/womenhiv.htm> (accessed March 12, 2007).

# Handout C: Stigma and Discrimination and HIV/AIDS

## FACT SHEET *This Fact Sheet is based on information from UNAIDS and WHO.*

Stigma and discrimination are some of the greatest obstacles to effective HIV/AIDS prevention and care. Fear of discrimination may prevent people from seeking information and/or treatment for HIV, which allows transmission of the virus to continue unchecked. Thus, one component of any effective HIV/AIDS prevention or mitigation activity should be the reduction of stigma and discrimination.

### **What is the link between HIV/AIDS-related stigma/discrimination and poverty and racism?**

HIV-infected people have been subjected to eviction from their homes, firing from their jobs, divorce, violence, and in some cases, murder. The stigma associated with HIV has caused communities, workplaces, health-care providers, immigration officials, friends, and spouses to react in negative ways to people living with HIV. Even those who are not infected by the virus, but who may have a parent or spouse who is HIV-positive, are subject to discrimination and stigma. Millions of people have become impoverished as a result of HIV/AIDS: children have lost parents, families have lost property, communities have lost skilled and educated individuals, along with the social, economic, spiritual and political contributions that they potentially offered. Additionally, those who are most often discriminated against in a society, or who are most at risk economically, are also those who are most at risk to HIV infection.

### **What is the link between HIV/AIDS-related stigma/discrimination and high HIV transmission?**

Stigma and discrimination create conditions that are ripe for transmission of the virus. Because the major mode of HIV transmission is through sex, it is often accompanied by moral judgment and shame. As a result, people often avoid confronting, but do not change, the behavior that facilitates transmission. HIV/AIDS is often connected to practices that are taboo for discussion, and people respond by denying

there is a problem and forcing those infected or at risk for infection underground, which decreases opportunities for public education or treatment and care.

### **What action has been taken to reduce stigma and discrimination?**

Former executive director of UNAIDS, Dr. Peter Piot, named five actions that the world community can take to reduce HIV/AIDS-related stigma and discrimination.

1. Leaders at all levels, from politicians to religious leaders to local heroes, need to visibly challenge HIV-discrimination, spearhead public campaigns, and speak out against the multiple discriminations that poor people, women, ethnic minorities and gay men face in relation to HIV/AIDS.
2. Document HIV-related violations of human rights and conduct public inquiries into them.
3. Support groups of people living with HIV and ensure that they have access to mechanisms to redress discrimination and that they are fully involved in the response to the epidemic.
4. Ensure that a supportive legislative environment exists so that discrimination can be tackled, in relation to both the impact and spread of the epidemic.
5. Ensure that both prevention and care services are accessible to all parts of the population, making particular efforts to overcome the barriers of racial, gender, and other discrimination.

### **What can Peace Corps Volunteers do to address stigma and discrimination?**

#### **Use positive messages in all HIV/AIDS activities.**

Fear-based messages that stress death, or that depict individuals ravaged by disease, serve only to demonize and further alienate HIV-infected or affected individuals.

From early in the AIDS epidemic a series of powerful images were used that reinforced and legitimized stigmatization

- HIV/AIDS as punishment (e.g., for immoral behavior)

- HIV/AIDS as a crime (e.g., in relation to innocent and guilty victims)
- HIV/AIDS as horror (e.g., in which infected people are demonized and feared)
- HIV/AIDS as otherness (in which the disease is an affliction of those set apart)

Together with the widespread belief that HIV/AIDS is shameful, these images represent “ready-made” but inaccurate explanations that provide a powerful basis for both stigma and discrimination. These stereotypes can also enable people to deny their personal risk of being infected or affected.<sup>1</sup>

**Work with people living with HIV/AIDS in as many capacities as possible.** Involve them in the planning and implementation of HIV/AIDS-related activities, and build capacity with organizations that seek to provide social and economic safety nets to those infected and affected by the virus.

**Work with as many different groups of people as possible, and explore how you and your community can facilitate mutual understanding, as well as the idea that HIV/AIDS knows no borders, nor is any ethnic group, sex, gender, or age group immune to infection.**

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<sup>1</sup> AVERTing HIV and AIDS. “HIV and AIDS Discrimination and Stigma.” <http://www.avert.org/aidsstigma.htm> (accessed March 12, 2007).

## Handout D: Reducing HIV in Injection Drug Users

HIV incidence continues to rise among injection drug users (IDUs). Injection drug use accounts for only 5 percent to 10 percent of cumulative HIV infections globally, but in some parts of the world it is the major mode of HIV transmission. For example, it is estimated that in China, Malaysia, and Vietnam at least half of HIV infections are associated with drug injection. In parts of Central and Eastern Europe and the newly independent states of the former Soviet Union, the rapid spread of HIV through shared use of contaminated injection equipment has been observed. In some cities, such as Svetlogorsk in Belarus, HIV prevalence among IDUs rose to more than 55 percent within one year of identifying HIV among the city's IDU population.

HIV epidemics among IDUs are distinguished from those of other populations by their potential for rapid spread of the virus within the IDU community and outward into the general population. In Bangkok, New York and Odessa, experience has shown that once HIV prevalence reaches a threshold of about 10 percent, it can surpass 40 to 50 percent within one to four years. Most of these infections result from sharing or reusing contaminated equipment (mainly needles and syringes) or from injecting tainted drug preparations.

A public health strategy that promotes behavior change through comprehensive HIV prevention and care programs for injection drug users is essential to HIV programming. Using lessons learned internationally, this strategy aims to keep HIV prevalence low in IDU populations by emphasizing that sharing contaminated drug equipment—not drug use itself or even drug injecting carries the greatest risk of HIV infection. A comprehensive approach also addresses issues surrounding sexual transmission.

This approach is compatible with proven public health principles, which view drug use or abuse as a public health issue rather than only as a law-and-order issue. It gives drug users options to reduce their risk at various levels and focuses on supportive rather than punitive strategies. It recognizes that while stopping drug use altogether is the ideal goal, intermediate steps (such as drug substitution and safer injection

techniques) are frequently just as effective in countering the spread of HIV.

These five steps can help implement a comprehensive approach

1. Gain the support of policymakers and stakeholders.
2. Provide options for reducing risk of HIV infection.
3. Establish an effective peer outreach team to access and educate IDUs.
4. Build a peer-driven program in which IDU network leaders help design interventions.
5. Create necessary links between drug treatment and substitution programs, HIV counseling and testing, programs and primary health care services.

### Lessons learned

Evidence indicates that the HIV epidemic associated with injection drug use can be slowed, stopped or even reversed. At least three essential prevention components have been associated with containing the epidemic: implementing prevention initiatives early, while HIV prevalence is less than 5 percent; engaging in community outreach that provides IDUs with HIV information and helps them trust health care providers; and distributing sterile injection equipment widely. Specific lessons that arise from experiences with IDU programming initiatives include

**Law enforcement policies** Police in some countries have devised an approach known as “responsible demand enforcement” in which law enforcement officials work with health care providers to help drug users access services rather than face incarceration. These efforts have helped steer drug users from crime and possible imprisonment. These policies create an environment in which individual drug users can reduce their risk behaviors over the long term.

**Syringe exchange and availability** The rationale behind syringe exchange is that because many IDUs are unable or unwilling to stop injecting, intervention strategies must be used to reduce their risk of HIV

infection and transmission. Providing sterile needles and syringes is a simple, inexpensive way to achieve this goal, and also helps establish contact with drug users through outreach services.

**Education and outreach programs** Drug education materials with a focus on comprehensive HIV prevention and care programs are already available in numerous countries. These materials advise drug users about ways to inject more safely and how to otherwise reduce the risks associated with injecting. They do not promote drug use.

**Methadone programs** Methadone is a synthetic opiate substitute whose long-lasting effects reduce the user's need to resort to street drugs. Numerous studies have shown that methadone can reduce deaths, reduce the drug user's involvement in crime, curb the spread of HIV and hepatitis and help drug users regain control of their lives.

#### **Source**

Family Health International. "Reducing HIV in Injection Drug Users (IDUs)." <http://www.fhi.org/en/HIVAIDS/pub/fact/reducingidus.htm> (accessed March 12, 2007).

## Handout E: HIV Prevention in Mobile Populations

Extended or repeated overnight travel away from home and community is associated with HIV infection. This travel can be divided into three types: voluntary and job-related (truckers, traders, freelance sex workers); legally required (members of the military, deported immigrants); or coerced (political refugees, trafficked sex workers, persons displaced due to war-related population shifts). Work-related mobility often creates an imbalance in the ratio of women to men, which facilitates the sharing of sex partners. Extreme examples are truck stops where female sex workers, vendors and drink shop owners outnumber the men who may be transiting through. The reverse is true in military and mining camps, where men greatly outnumber women.

Mobile populations that regularly cross international borders need access to a complete spectrum of HIV prevention options, including diagnosis and treatment of sexually transmitted infections (STI), affordable condoms and information on assessing, reducing and eliminating one's risk of infection. Many settings with mobile populations especially need policy-focused, contextual interventions to foster individual behavior change. One approach to cross-border HIV prevention is to concentrate interventions at international border crossings because they are high-risk environments where national prevention programming is weak.

The experiences of numerous agencies in cross-border STI/HIV/AIDS prevention activities have produced the following program guidelines

- Link prevention services on both sides of the border.
- Consider communities on opposite sides of the border as a single extended town with heavy interaction between border populations.
- Forewarn mobile populations that there is an unusually high risk for STI/HIV at cross-border areas and that they must anticipate the need for protection when traveling through.
- Produce communication materials in all of the major languages spoken at a border, usually two or more.

### Implementing cross-border interventions requires

**Listing cross-border locations** Cross-border sites are not only contiguous land borders; water transportation can connect “sister” port towns. Compiling a complete list of cross-border crossings is impossible because sites change by the month. With the building or expansion of roads and bridges, new sites open while others may close or temporarily shut down. But it is important to try to establish a working list, mindful that including some unofficial sites may jeopardize refugees' welfare.

**Selecting sites for format assessment** Based on the established list, selecting sites for further intervention requires making an informed judgment on the role of each site as a contributor or potential contributor to the regional HIV epidemic. This judgment is made after considering the population, the historical STI and HIV incidence, the commercial sex industry, the availability of drugs and alcohol, the presence of an established entertainment sector, the number of uniformed service personnel and migrant laborers, and existing coverage with medical and social services.

**Conducting a preliminary rapid assessment and prioritization** Because cross-border areas tend to be remote and receive less coverage than major cities, there are limited resources to support cross-border activities. Identifying priorities based on a quick data collection effort—a “rapid assessment”—is important. The methods used in rapid assessments are most often qualitative, including in-depth focus group discussions, but also can be quantitative. Rapid assessment guidelines can be found in the UNAIDS publication “APICT Task Force on Migrant Labor and HIV Vulnerability and Initiating Cross-Border HIV/AIDS Prevention Programmes: Practical Lessons from Asia.”

**Preparing the intervention program** While the rapid assessment will generate information needed for selecting and prioritizing intervention sites, designing an intervention program requires more detailed information about the cross-border community. In Asia, where the bulk of cross-border HIV implementation activity has occurred, two methods have been used. In one, the Participatory Rural Appraisal and the Par-

ticipatory Learning and Action methodologies have been adapted to allow maximum community input. In the other, multi-disciplinary teams have performed technical assessments of communities, reviewing data with key local informants to design strategies that local groups will implement. In choosing between the two methods, the degree of urgency to implement prevention interventions must be weighed against long-term community development.

**Implementing interventions** The special challenges of cross-border settings require adaptations of state-of-the-art interventions used elsewhere. The most successful projects started locally before gradually sought the support of national governments. As early as possible, identify and engage the key stakeholders in the cross-border areas and forge partnerships among agencies across borders. Establish a project advisory committee whose members—from both sides of the border—can guide and support the implementing agencies.

**Evaluating the program** Evaluation, an essential component of all programs, is particularly difficult in cross-border programs because the populations' high mobility limits contact time for prevention activities. The great number of languages and dialects spoken in border areas is another complicating factor. And the relative absence of social and legal controls in border areas means that interventions designed to modify norms in migrant communities will be especially challenging. Evaluation efforts might be best focused on tracking risk behaviors and STI/HIV prevalence rates in certain community subgroups over time; qualitative methods could be used to assess the risk environment in the community as a whole.

International border trade towns and seaports consistently have the highest HIV prevalence among societies around the world. Epidemics tend to originate in these sites before progressing inland. If effective prevention programs are implemented in these locations, the return on investment (in terms of fewer new infections) should be one of the greatest in the field of prevention.

#### Source

Family Health International. "HIV Prevention in Mobile Populations." <http://www.fhi.org/en/HIVAIDS/pub/fact/mobile-pop.htm> (accessed March 12, 2007).



## Handout F: HIV/AIDS Interventions with Men Who Have Sex with Men

In some parts of the world, men who have sex with men (MSM) have been disproportionately affected by the HIV epidemic. In countries where such information is gathered, HIV infection rates among MSM are often higher than in the general population. Multiple sex partners, unprotected anal sex and the hidden nature of MSM sexual relations in many communities all contribute to the prevalence of HIV among MSM.

Many countries deny the existence of MSM, resulting in an alarming lack of prevention and care services directed at men at risk. This denial and discrimination against MSM feed the secrecy in which many MSM live, increasing their risk taking and making it difficult to reach them with HIV prevention interventions. Developing and implementing interventions for this population is also difficult because of varying definitions and perceptions of gender, sexual roles, stigma, homophobia and internalized homophobia. Due to societal pressure, many MSM have both male and female partners, increasing the HIV risk for their female partners and decreasing the likelihood that MSM self-identify as MSM.

Securing the participation of members of the MSM community is essential for developing and implementing comprehensive interventions. These interventions should address not only personal factors directly related to health (such as risk practices, condom use and sexually transmitted infections) but also personal factors (enhancing self-esteem and empowerment) and structural factors (laws criminalizing homosexual sex and access to non-judgmental STI services).

### Lessons learned

Some important elements for implementing successful MSM programs include

- Making formative assessments to determine the risks and needs of MSM.
- Involving MSM in the design and implementation of interventions.
- Using interpersonal approaches to behavior change communication, such as peer education programs and appropriate community-level interventions to reduce risk through safer sex practices.
- Creating “safe spaces” where MSM can discuss personal issues and access STI care, counseling and referral services.
- Linking interventions to condom distribution and promotion activities.
- Strengthening public and private STI services within health delivery systems used by MSM.
- Ensuring quality HIV voluntary counseling and testing (VCT) services.
- Ensuring care and support services for those affected by HIV, including quality clinical services and support groups for people living with HIV/AIDS.

To address the long-neglected impact of HIV on MSM, formative research must be conducted. This research should include a mapping exercise, an STI/HIV prevalence study (including an assessment of risk behaviors), and qualitative research aimed at better understanding the context of MSM risk-taking behavior in the developing world. Many parts of the world continue to deny the very existence of MSM. This formative research is helpful in gaining insight into who these men are and how they live their lives.

One successful approach to working with MSM has been to create or provide safe spaces where men can talk openly and receive STI care and counseling. Such centers offer a space for men to gather, and may also operate male sexual health projects with medical and psychosocial services for MSM. Another successful approach is integrating safer sex education into existing social activities. It is well accepted that peer-led interventions are most effective in reaching this target group. Peers should be brought into the decision-making process and invited to help develop interventions. These services can be provided through clinics, clubs, drop-in centers or outreach/street-based providers. Peer counselors can provide education and services to MSM and their families and can host regular support group meetings. Here, MSM can explore topics of sexuality and sexual identity, such as safer sex, gay relationships, commercial sex

work, living in a homophobic society, strengthening the gay community, relating to peers, values, attitudes and conduct. In addition, long-term counseling and support services to men living with HIV or AIDS is an important service that should be provided.

### **Some program elements that must also be considered include**

**Ensuring the availability of lubricants** In many settings, the lack of access to water-based lubricants forces men to use oil-based lubricants for sexual activity, jeopardizing the integrity of condoms. For this reason, the myth that condoms easily break strongly persists in some countries.

**Improving access to MSM-friendly STI services** MSM have specific STI-related needs but often feel uncomfortable approaching public-sector health providers with anal and oral STIs. MSM who don't have access to MSM-friendly private-sector providers can face ridicule, violence and even prison.

**Ensuring appropriate segmentation** MSM are not a homogeneous group. In many countries, MSM communities are greatly balkanised. For example, MSM who self-identify as heterosexual do not feel they confront the same issues as those who self-identify as homosexual. Wealthy MSM often move in very different circles than poorer MSM, and MSM sex workers have another set of needs altogether. During the community assessment phase it is important to investigate these differences and to consider them when designing programs.

**Addressing human and legal rights** The marginalization and stigmatization of MSM in many settings is magnified by a lack of human and legal rights. Some countries have severe anti-sodomy laws that drive MSM sexual behavior underground and put men at risk of being imprisoned.

### **Source**

Family Health International. "HIV/AIDS Interventions for Men Who Have Sex With Men (MSM)." <http://www.fhi.org/en/HIVAIDS/pub/fact/intervenmsm.htm> (accessed March 12, 2007).

## Handout G: Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children

The impact of HIV/AIDS on children and their families is not a simple problem with an easy solution. The current situation is complex, interrelated on all levels of life, and cuts across all sectors of development. State-of-the-art components for the care and support of orphans and other vulnerable children have evolved from lessons learned in various countries and experiences from development, child survival, children of war, and other HIV/AIDS-related programs.

### Lessons learned

**Policy and Law** Appropriate government policies are essential to protect orphans and other vulnerable children and their families. These policies must contain clauses to prohibit discrimination in access to medical services, education, employment, and housing, and protect the inheritance rights of widows and orphans.

**Medical care** For the maximum well-being of orphans and other vulnerable children, they and their guardians need to have access to complete, relevant information and appropriate health care including clinical and preventive health care services, nutritional support, palliative and home-based care.

**Socioeconomic support** Orphans and other vulnerable children and their families are confronted with severe threats to their well-being including isolation, loss of income, educational access, shelter, nutrition, and other essentials. When families and children are forced to focus on basic daily needs to decrease their suffering, attention is diverted from factors that contribute to long-term health and well-being.

**Psychological support** The psychological needs of children continue to be one of the most neglected areas of support. But the AIDS pandemic has increased the urgency to address the psychological problems of children on a par with other interventions.

**Education** Education plays a vital role in the well-being of children. It offers them a chance for their future as well as developmental stimuli. The impact of HIV/AIDS on the educational system has resulted in a decreasing number of teachers due to mortality, a growing number of children who are not able to attend or stay in school, and rising numbers of pupils whose

ability to take advantage of schooling is undermined by other factors including poor nutrition and psychological stress.

**Human rights** Human rights-based approaches have been increasingly recognized as essential to the success of HIV prevention and care programs, including those working with children and adolescents. Especially important are those tenets outlined in the convention of the rights of the child.

**Community-based programs** There is agreement on the components of community-based programs for orphans and other vulnerable children. Prioritizing program activities will depend upon community needs, abilities, and preferences, as well as on the nature of sponsoring or partner organizations. The community is best able to identify target groups for interventions, although the government may wish to select target regions or communities for program implementation.

The 1997 and 2000 editions of *Children on the Brink* consolidate existing knowledge from a wide range of sources. According to both versions, interventions must include five basic strategies: (1) strengthen the capacity of families to cope with their problems; (2) mobilize and strengthen community-based responses; (3) increase the capacity of children and young people to meet their own needs through access to quality education, protection from exploitation and excessive labor, and building the capacity to care for themselves; (4) create an enabling environment for children and families through such activities as ensuring basic legal protection through laws and policies to protect women and children, decreasing stigma, and behavior change interventions; and (5) ensure that governments protect the most vulnerable and provide essential services.

### The following should also be considered in designing such programs

**Emphasizing community care rather than institutional care** Long-term institutionalization of children in orphanages and other facilities is not a desirable solution to the impacts of HIV/AIDS. Resources expended to fund institutional care for a single child

can assist scores of children if used effectively to support a community-based initiative. The institutionalization of children separates them from families and communities and often delays healthy childhood development.

**Strengthening the care and coping capacities of families and communities** The first line of response to the needs of children affected by HIV/AIDS comes from extended families. Strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost-effective, and sustainable way of assisting orphans and other vulnerable children. Families and communities also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children.

**Involving children and youth as part of the solution, not part of the problem** Children are not simply a passive, powerless target group to be aided, but capable actors and important resources to engage in a community response to HIV/AIDS. Actively involving children in care initiatives can build their sense of self-esteem and efficacy and cultivate skills they can use in the future.

**Building broad collaboration among key stakeholders in all sectors** To meet the needs of children affected by HIV/AIDS, there have to be broad networks and targeted advocacy to involve government, civil society, and nongovernmental organizations in shared initiatives of community action for orphans and other vulnerable children.

**Application of long-term perspective** Children will continue to be affected by AIDS for decades to come. Due to the scope and scale of the pandemic, program design requires sustainable and replicable approaches. Although material assistance is important, it is also important to ensure that community projects are not driven by material support alone but by ownership and responsibility.

**Integration with other services** Since the problems experienced by orphans and other vulnerable children begin well before the death of their parents, care for children affected by HIV/AIDS should start at

the earliest possible point. Services for orphans and other vulnerable children should be integrated with the elements of comprehensive care such a voluntary counseling and testing for HIV, prevention of mother-to-child-transmission of HIV, and others.

**Linking care and prevention** Orphans and other vulnerable children are themselves at high risk of HIV infection due to economic hardship and loss of parental care and protection. For this reason alone, care programs should include a strong prevention component targeting children and youth.

#### Source

Family Health International. "Care for Orphans, Children Affected by HIV/AIDS, and Other Vulnerable Children." <http://www.fhi.org/en/HIVAIDS/pub/fact/carorphans.htm> (accessed March 12, 2007).

## Handout H: HIV Interventions with Youth

Approximately half of HIV infections worldwide are in young people between the ages of 10 and 24. During these years, youth learn, explore, and make decisions that will affect the rest of their lives. If they do not receive the information and services they need to make informed choices, they are more likely to engage in risk behaviors that can have such adverse consequences as high rates of early pregnancy and sexually transmitted infections STIs, including HIV.

### Interventions for youth should be guided by the following principles

**Youth are not one single audience.** Rather, youth are a complex group of people requiring appropriate segmenting based on such factors as age, geographic setting, family, school and civil status, and special needs. It is important to remember that not all youth are equally at risk for HIV/AIDS.

**Start young.** Youth programs often start too late, after many young people have become sexually active and sexual attitudes and behaviors are already well formed. By reaching preteens and older children, programs can affect the emerging norms of young people. For example, the very young (six- to ten-year-olds) can be exposed to messages about healthy body image, body sovereignty (good touches versus bad touches), and support of people living with HIV/AIDS.

**Examine the context of young people's lives.** Interventions must look at the contextual factors in young people's lives, such as their economic status, ability to pay for school, family situation and civil status. Successful interventions will conduct formative research that examines the context of health decision-making behaviors and seeks ways to address them.

**Reach people who influence and control your access to youth.** Prepare the environment. Youth are strongly influenced by the many people and institutions that surround them. It is important to reach the gatekeepers who control access to youth and are key to implementing HIV/AIDS prevention and care programs. Take into account young people's immediate and extended families, teachers, community leaders, religious leaders and media icons. Since youth

interventions are often controversial, it is essential to advocate with community and political leaders.

**Link HIV programs to non-health sectors.** Young people may not be particularly interested in health issues like HIV/AIDS. Young people invest their time and interest in such areas as religion, schools, job training, agriculture, sports and the media. Interventions must take advantage of these sectors and seek to integrate HIV messages into their activities.

**Do not separate HIV from other reproductive health and life issues.** Young people do not compartmentalize their lives. They are often more worried about an unwanted pregnancy than about HIV. A life skills/healthy lifestyle approach will build problem-solving and decision-making skills and help young people assess their risk for STI/HIV and take protective actions.

**Incorporate an age appropriate and balanced "ABC" prevention approach.<sup>1</sup>** Young people are the most important asset to any community or nation, and protecting them from contracting HIV is critical. There is no one right approach to HIV prevention with youth. Young people must be able to choose the healthy behaviors that best fit with their lifestyles—whether abstinence, being in a mutually faithful, stable relationship, or the correct and consistent use of condoms. Youth who have not had their sexual debut should be encouraged to practice abstinence until they have established a lifetime monogamous relationship. For those youth who have initiated sexual activity, returning to abstinence should be a primary message of prevention programs. It must be recognized that certain young people will, either by choice or coercion, engage in sexual activity. In these cases an integrated "ABC" approach is necessary that includes a "C" component, information about correct and consistent use of condoms. This message should be coupled with information about abstinence as the only 100 percent effective method of eliminating risk of sexual HIV infection; and the importance of HIV counseling and testing, partner reduction, and mutual faithfulness as methods of risk reduction.

**Youth are assets.** When programming for youth, approach them as assets to society, not as problems

to be overcome. Youth are resilient in the face of great societal challenges. Look for and seek to expand the reach of the networks and activities that support positive behaviors for youth.

**Involve youth in meaningful ways.** Young people must be involved in every aspect of an intervention program, including its research, design, and implementation. This means that program designers must move beyond consultation to meaningful participation with youth. Doing this requires planners to make changes in their approach—by, for example, using simple concepts, flexible hours and specialized training. It is also important for program planners to seek participation and cultivate the voices of youth who are not usually heard—the youngest, the marginalized, and those directly affected by HIV/AIDS.

**Youth want information from diverse sources.**

For example

- Peer education is an effective strategy. Young people respond best to other young people—where they work, study, and play. This is why peer education/promotion/motivation is a crucial outreach strategy. But because young people move quickly through different phases of life, youth peer education/promotion/motivation programs should expect a high rate of turnover and a constant need for training and re-training.
- Anonymous sources increase access to information. In addition to peer education, youth are interested in seeking information from anonymous sources such as hotlines and the Internet.
- Make it fun! Young people enjoy the media, theater, lively arts and technology. The more fun the means for delivering information, the more likely young people will listen and retain what is being taught.

**Source**

Family Health International. "HIV Interventions with Youth." <http://www.fhi.org/en/HIVAIDS/pub/fact/hivinterven.htm> (accessed March 12, 2007).

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1 The President's Emergency Plan for AIDS Relief: Office of the Global AIDS Coordinator. "ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief." <http://www.state.gov/documents/organization/57241.pdf> (accessed March 12, 2007).

# Handout I: Cultural Factors Relevant to Capacity Building and HIV/AIDS

Addressing development from a capacity-building perspective implies an understanding of the local culture and the ability to work with it—not against it. While all aspects of the culture need to be understood to the extent possible, some factors that are particularly relevant to capacity building and HIV/AIDS are noted below.

## Status, power, and decision-making authority

Societies have both formal and informal mechanisms through which individuals/groups/ organizations wield status, power, and decision-making authority. In addition, a traditional power structure may exist in tandem with a modern one, or it may operate in a way that an outsider may not be aware of at all. Questions about who has influence over various age groups, how decisions are made in a community, and who is felt to have the power to create social change should be asked often and to a range of people. At the highest levels, the issue of HIV/AIDS has been directly and positively addressed by leaders in some countries; while denial of HIV/AIDS by other national leaders blocked important educational programs to prevent the spread of HIV/AIDS and care for those with the disease. In other countries, local religious leaders (such as Muslim imams) have advocated for community education campaigns.

Formal mechanisms of power and decision-making authority include both modern and traditional political structures. Informal mechanisms include associations, clubs, sports teams, peer groups, and other means of people coming together—both traditional and modern. Those who hold status in a culture may include those from traditional society as well as political leaders, teachers, actors, singers, and so on.

Gender issues, covered in a separate handout, are integral to status, power, and decision-making.

## Beliefs about health

Belief systems include formal religious doctrine, customs and rituals, as well as superstitions and mythology. Belief systems have implications for how health and disease are understood, and how illnesses are treated. Specific beliefs about how HIV/AIDS is spread will affect how it will or will not be addressed.

Illness and disease may be understood as the result of contagion—the spread of germs/viruses/ bacteria—and/ or as a reflection of the general mental, physical, spiritual, and moral health of a person or society. In addition, some believe that witchcraft may be used to cause disease or illness in a person who has wronged another.

## Traditional health care systems

Traditional healers include a wide diversity of diviners, herbalists, and others who diagnose and treat primarily through use of herbs and/or communication with the spirit world. According to UNAIDS: “The majority of populations in developing countries have access to traditional health care and it is widely accepted that about 80 percent of people in Africa rely on traditional medicine for many of their health care needs.”<sup>1</sup>

The World Health Organization has promoted collaboration since the 1970s on a range of health issues and since the 1990s specifically on HIV/AIDS. The level of collaboration, however, varies greatly from country to country. A UNAIDS report states: “. . . it has been found that when there is a mutual willingness on the part of traditional healers and conventional health practitioners to collaborate, and when there is a genuine interest in the beliefs and values of traditional healers, as well as a respect for their practices, a bridge can be built between the two complementary health systems.”<sup>2</sup>

## Beliefs about sexuality

Attitudes about sexuality—including how sexuality is talked about and viewed, and the age and marital status appropriate for first sexual experiences—vary greatly by culture. Learning the appropriate language to talk about sexuality is important, as well as with whom and when, may provide insights into how HIV/AIDS educational programs will best be received.

1 UNAIDS. “Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa—A literature review.” September 2000.

2 UNAIDS. “Ancient Remedies, New Disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa.” UNAIDS Case Study, June 2002.

## Handout J: Volunteer Success Stories

### Honduras: HIV/AIDS prevention and child survival

#### Brian

My name is Brian, and I am a health Volunteer serving in Honduras. Most of my efforts had been focused on HIV/AIDS education and prevention with young children in the city and surrounding communities. About three months ago, however, my work began to change dramatically as I became involved with a men's health initiative for HIV/AIDS education.

In Honduras, men tend to make most of the decisions in the bedroom so women do not have much power to protect themselves from infection. This men's health initiative aims to address the disparity by engaging men in a meaningful and potentially behavior-changing dialogue about their sexual behavior, with the final objective of convincing them to protect themselves while also protecting their sexual partners. We knew from experience that in Honduras discussing sexuality in mixed groups doesn't work, and thus the initiative, known informally as "Men to Men," had males speaking to males about their sexual experiences in an open and trusting environment.

We took some standard but effective HIV/AIDS-prevention activities and tailored them for a male audience and designed new activities that involved elements of competition between the participants. We focused on keeping activities visually interesting and physically engaging, so that they could be used in impromptu educational sessions with, for example, taxi drivers or men waiting around for the bus.

From our experiences we compiled a manual that we are now piloting with Peace Corps Volunteers and their Honduran counterparts in their communities. We will use their feedback and ideas to improve the initiative. This is the first step in what we hope to be a process of integrating the manual, not just among health Volunteers, but as part of the standard Honduran official response to HIV/AIDS-prevention education.

### Malawi: Community forestry extension

#### Meg

Serving in Malawi for more than a year now has made me realize the importance of synergy between the health, environment, and education sectors within the Peace Corps. Being an environment Volunteer does not mean I can disregard the need for both health and educational support with the community. This past year, I have felt a greater sense of success because of my involvement in all three aspects of development, specifically through the organization of a series of community gardens with an eye towards their impact on households affected by HIV.

The major goal of the project was to foster interest in intensive farming techniques while stimulating cooperation at the village level. This alone has great potential but by acknowledging the additional educational opportunities I felt that the project was strengthened even further. While the community was already organized and actively participating in the garden project, I took advantage of the opportunity to teach basic HIV/AIDS-awareness and prevention lessons. Beyond simply educating, we also organized group walks to the nearest volunteer counseling and testing center with any willing community members. It has been a great challenge to motivate people to go for volunteer counseling and testing. At the first organized walk only one woman wanted to go. She and I walked together, she was tested, and we walked back. This was one woman out of 20 but I believe that one woman will serve as an excellent role model that will influence others to do the same.

The community *dimbas* (gardens) were also a great platform for teaching about nutrition, especially for those living with HIV/AIDS. In each *dimba* we planted a variety of nutritious vegetables as well as garlic and ginger for further health benefits. Finally, the *dimbas* also served as a place for collaboration with the local traditional healer, opening discussions about treatment of those living with HIV as well as other diseases in the area.

Improved nutrition, HIV/AIDS prevention, and environmental conservation are all woven with the same thread and the interconnectedness of human health and environment must be recognized and valued in all of our community-based development work.



## **Bangladesh: Teaching English as a foreign language**

### **Sarah**

Sarah served in a business center and transit area near the border crossing to India. A few years earlier, the local brothel was evicted by the administration and now an estimated 600 sex workers operate in the railway station, bus terminals, and other areas of town. The sex workers report an average of 15 to 20 clients per week. Seeing the district's desperate need for HIV/AIDS education, Sarah used the Peace Corps manual Teach English Prevent AIDS as a guide and tailored her own curriculum to teach a three-month course and spread awareness among Bangladeshi youth. In collaboration with a local NGO, Sarah received funding for a week-long awareness program to inform the local population about the imminent dangers of HIV. Sarah gathered resources from Family Health International, students, the NGO, and community members.

Family Health International provided her with the tools, resources, and training she needed to administer effective peer educator training sessions with roughly 100 sex workers. By the end of the sessions the women were educated about condom use and supply and were able to speak knowledgeably about the dangers of HIV. The NGO provided all the necessary arrangements for HIV/AIDS drama theater, folksongs, and cinema shows that were educational, entertaining, and free for anyone interested in watching. They displayed these shows throughout the week in several different areas around the community to ensure access was available to all. Sarah and her students distributed more than 1,000 T-shirts emblazoned with HIV/AIDS transmission and prevention messages on the back to rickshaw pullers, which served as an educational advertisement for anyone riding in the rickshaw. They also distributed red ribbons, leaflets, and caps to many community residents. They organized a rally for 300 people and a panel discussion with influential community representatives. To conclude the week's program there was a five-kilometer race through the town. An outgoing community member announced the week's events in this successful effort to inform the community about how to gain knowledge about HIV/AIDS.

# Handout K: UNAIDS and the “Three Ones”

## Key Principles

### FACT SHEET *This Fact Sheet is based on information from UNAIDS.*

The UNAIDS—Joint United Nations Programme on HIV/AIDS brings together the efforts and resources of ten UN system organizations to help the world prevent new HIV infections, care for those already infected, and mitigate the impact of the epidemic.

The ten UNAIDS co-sponsors are

- The Office of the United Nations High Commissioner for Refugees (UNHCR)
- United Nations Children’s Fund (UNICEF)
- World Food Programme (WFP)
- United Nations Development Programme (UNDP)
- United Nations Population Fund (UNFPA)
- United Nations Office on Drugs and Crime (UNODC)
- International Labour Organization (ILO)
- United Nations Educational, Scientific and Cultural Organization (UNESCO)
- The World Health Organization (WHO)
- The World Bank

UNAIDS was established in 1994 by a resolution of the UN Economic and Social Council, and launched in January 1996. Based in Geneva, with offices in more than 75 countries and co-sponsor representatives in dozens of others, UNAIDS is guided by a Programme Coordinating Board with representatives of 22 governments from all geographic regions, the UNAIDS Co-sponsors, and five representatives of nongovernmental organizations (NGOs), including associations of people living with HIV/AIDS.

One of its major objectives is to support countries in the “development, implementation and scale-up of comprehensive AIDS strategies.” By the end of 2003, more than 100 countries had completed action plans to combat AIDS.

### Principles for the coordination of national AIDS responses

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at

which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves.

They endorsed the “**Three Ones**” principles, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
- **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate.
- **One** agreed country-level Monitoring and Evaluation System.

There has been a marked shift in the global response to the complex AIDS crisis, which continues to worsen. National responses are broader and stronger, and have improved access to financial resources and commodities.

As well as increased commitments by affected countries themselves, the advent of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the new AIDS programmes of the World Bank, expanding commitments from donor countries (especially the United States) and the work of private sector foundations has seen the total amount of funding on AIDS increase from US\$2.8 billion in 2002 to an estimated US\$10 billion available in 2007. While more resources are needed, there is an urgent need for greater support and collaboration with heavily-affected countries and to avoid duplication and fragmentation.

It is this challenge that the “Three Ones” are specifically designed to address. Built on lessons learned over two decades, the “Three Ones” will help improve the ability of donors and developing countries to work more effectively together, on a country-by-country basis.

### Source

<http://search.unaids.org/Results.aspx?q=three+ones&o=html&d=en&l=en&s=false>

### Resource

UNAIDS. “About UNAIDS.” <http://www.unaids.org/en/AboutUNAIDS/default.asp> (accessed May 4, 2007).

# Handout L: The Global Fund to Fight AIDS, Tuberculosis and Malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) was created to dramatically increase resources to fight three of the world's most devastating diseases, and to direct those resources to areas of greatest need.

As a partnership between governments, civil society, the private sector and affected communities, the Global Fund represents an innovative approach to international health financing

## The Global Fund's general principles

The Global Fund was founded on a set of principles (these are fully described in the Global Fund's Framework Document) that guides all processes—from governance to grant-making

- Operate as a financial instrument, not an implementing entity.
- Make available and leverage additional financial resources.
- Support programs that reflect national ownership.
- Operate in a balanced manner in terms of different regions, diseases, and interventions.
- Pursue an integrated and balanced approach to prevention and treatment.
- Evaluate proposals through independent review processes.
- Establish a simplified, rapid and innovative grant-making process and operate transparently, with accountability.

## Operate as a financial instrument, not an implementing entity.

The Global Fund's purpose is to attract, manage, and disburse resources to fight AIDS, TB and malaria. They do not implement programs directly, relying instead on the knowledge of local experts.

As a financing mechanism, the Global Fund works closely with other multilateral and bilateral organizations involved in health and development issues to ensure that newly funded programs are coordinated with existing ones.

## Make available and leverage additional financial resources.

The Global Fund only finances programs when it is assured that its assistance does not replace or reduce other sources of funding, either those for the fight against AIDS, tuberculosis, and malaria or those that support public health more broadly. The Global Fund actively seeks to complement the finance of other donors and to use its own grants to catalyze additional investments by donors and by recipients themselves. In several countries, governments or other organizations have already increased their support to programs that fight these three diseases, validating the Global Fund's ambition to increase overall investment in health.

## Support programs that reflect national ownership.

The Global Fund encourages new alliances among partners within recipient countries and seeks the active participation of local representatives of civil society and the private sector, and encourages local ownership.

This approach serves not only to drive effective disease-specific strategies but also to support efforts to strengthen underlying health systems in recipient countries, consistent with national strategic plans.

## Operate in a balanced manner in terms of different regions, diseases, and interventions.

In awarding grants, the Global Fund gives priority to effective proposals from countries and regions with the greatest need, based on the highest burden of disease and the fewest financial resources available to fight these epidemics. The Global Fund also supports grants in areas of the world with emerging epidemics, in an effort to avert further disaster.

## Pursue an integrated and balanced approach to prevention and treatment.

The Global Fund takes a comprehensive approach to AIDS, TB, and malaria, funding both prevention and treatment based on locally determined needs. Three-

quarters of countries awarded HIV/AIDS funds will use at least a portion of their grants to provide antiretroviral treatment. All HIV grants include prevention activities, most often focusing on young people who comprise half of all new infections worldwide. Grants for malaria will both expand access to insecticide-treated bed nets and give health officials the tools and training to identify, diagnose, and treat people who are ill. In the case of TB, in particular, providing effective treatment has the added benefit of preventing the further spread of the disease.

### **Evaluate proposals through independent review processes.**

The Global Fund's use of an independent technical review panel ensures that limited resources are targeted to technically sound programs with the greatest chances of success. The panel includes disease experts, as well as experts in the field of development who are able to assess how proposed programs complement ongoing health and poverty reduction efforts at the country level.

Proposals are first screened for eligibility by the Secretariat and are then forwarded to the technical review panel which assesses proposals for technical merit and consistency according to proven best practices. The technical review panel, while applying even more rigorous standards in the second round than the first, perceived that proposal quality had improved, following significant investments by countries in the development of proposals, often with important input by technical partners.

### **Establish a simplified, rapid, and innovative grant-making process and operate transparently, with accountability.**

While the concept of performance-based grant making is not new, the Global Fund is pioneering practical systems to implement this approach that balance the need for accountability and efficiency. This includes working with recipient countries to identify a small number of key indicators to be used to measure progress, and ensuring that, where possible, Global Fund reporting requirements rely on existing processes. The use of local fund agents is another accountability mechanism designed to provide appropriate oversight while respecting local implementation.

All approved proposals and signed grant agreements are available on the Global Fund's website for review in unedited form, as are documents discussed at board meetings.

### **Source**

The Global Fund. <http://www.theglobalfund.org/en/> (accessed May 4, 2007).

## Handout M: The World Health Organization

The World Health Organization (WHO) is the United Nations specialized agency for health. It was established on April 7, 1948. WHO's objective, as set out in its Constitution, is the attainment by all peoples of the highest possible level of health. Health is defined in WHO's Constitution as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

All countries which are members of the United Nations may become members of WHO by accepting its Constitution. Other countries may be admitted as members when their application has been approved by a simple majority vote of the World Health Assembly. WHO is governed by 193 Member States through the World Health Assembly. The Health Assembly is composed of representatives from WHO's Member States. The main tasks of the World Health Assembly are to approve the WHO program and the budget for the following biennium and to decide major policy questions.

As the directing and coordinating authority on international health, WHO takes the lead within the UN system in the global health sector response to HIV/AIDS. The HIV/AIDS Department provides evidence-based, technical support to WHO Member States to help them scale up treatment, care, and prevention services with a broad health sector approach and ensure a comprehensive and sustainable response to HIV/AIDS.

The WHO HIV/AIDS department comprises of following teams: Prevention in the Health Sector (PHS), Antiretroviral Treatment and HIV Care (ATC), Operational and Technical Support (OTS), Health Systems Strengthening (HSS), Strategic Information and Research (SIR) and the Office of the Director (ODH) that responds on policy coordination, advocacy communications, resource mobilization and program management. The department is located in the Cluster for HIV/AIDS, TB and Malaria (HTM).

While partnering with global institutions within and outside of the United Nations, the WHO HIV/AIDS Department works in the following areas

- Policy development, and normative and technical guidance to help countries scale up HIV/AIDS interventions in the health sector
- Country support, including capacity building and training for health workers
- Securing an adequate supply of HIV medicines, diagnostics, and other tools
- Monitoring the global spread of HIV/AIDS and the availability of treatment and prevention services, and;
- Advocating for greater global attention and commitment to HIV/AIDS.

### Source

World Health Organization. <http://www.who.int/en/> (accessed May 4, 2007).

# Handout N: The President's Emergency Plan for AIDS Relief

## FACT SHEET This Fact Sheet is based on information from the U.S. Department of State

In his State of the Union address on January 28, 2003, President Bush announced the \$15 billion President's Emergency Plan for AIDS Relief (known as PEPFAR or the Emergency Plan), the largest commitment ever by a single nation for an international health initiative.

On May 27, 2003, President Bush signed P.L. 108-25, the United States Leadership Against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003, the legislative authorization for the Emergency Plan.

On February 23, 2004, one month after the first congressional appropriation of resources for the Emergency Plan, the Coordinator submitted to Congress the U.S. Five-Year Global HIV/AIDS Strategy (Five-Year Strategy). The Five-Year Strategy identifies the vision of the Emergency Plan as turning the tide against the global HIV/AIDS pandemic. To achieve this vision, the mission of the Emergency Plan is

*To work with leaders throughout the world to combat HIV/AIDS, promoting integrated prevention, treatment, and care interventions, with an urgent focus on countries that are among the most afflicted nations of the world.*

## Goals of the U.S. five-year global HIV/AIDS strategy

Across the world, the Emergency Plan will

- Encourage bold leadership at every level to fight HIV/AIDS
- Apply best practices within our bilateral programs in concert with host governments' national HIV/AIDS strategies
- Encourage all partners to coordinate, adhere to sound management practices, and harmonize monitoring and evaluation efforts

In 15 of the most afflicted nations of the world, the Emergency Plan goals include support for

- The prevention of 7 million new HIV infections
- Antiretroviral treatment for 2 million HIV-infected people
- Care for 10 million people infected and affected by HIV/AIDS, including orphans and vulnerable children

At the inception of PEPFAR, the U.S. developed a five-year strategy that devoted \$15 billion in the following way

- \$10 billion for the 15 focus countries;
- \$4 billion for other PEPFAR countries and for additional activities including HIV/AIDS research; and
- \$1 billion over five years for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

## Source

U.S. Department of State. "Emergency Plan Basics." <http://www.state.gov/s/gac/plan> (accessed March 12, 2007).

# Handout 0: Host Country Strategic Plan for HIV/AIDS

Supply best source available in your country.

# Handout P: The Peace Corps' Work in HIV/AIDS

## Health and HIV/AIDS

Worldwide, 20 percent of all Peace Corps Volunteers are assigned to health and HIV/AIDS projects, and 60 percent of all Peace Corps projects incorporate some HIV/AIDS activities. In addition to the HIV/AIDS pandemic, more than 1 billion people around the world cannot obtain safe drinking water and more than 2 billion lack access to adequate sanitation facilities. To address these worldwide health problems, Volunteers serving in the health and HIV/AIDS sector promote

- Increased HIV/AIDS prevention, treatment, and care;
- Expanded peer education to urge youth and other groups to reduce risky behavior;
- Expanded maternal and child health;
- Enhanced health, nutrition, and hygiene education at the individual, family, and
- Community level; and
- Improved infectious disease prevention through improved water and sanitation services.

Volunteers urge the participation of individuals, families, and communities in activities to improve health. Examples of this Peace Corps work include

- Teaching, formally and informally, about HIV/AIDS prevention and care;
- Promoting healthy lifestyles, especially for youth;
- Supporting youth and orphan activities and care;
- Providing nutrition and hygiene education classes in the community;
- Assisting in maternal and child health clinics;
- Strengthening NGO health delivery systems;
- Constructing and managing water systems; and
- Supporting community sanitation efforts.

No area of development remains safe from the impact of HIV/AIDS. The spreading pandemic has indelibly impacted individuals, families, communities, countries, and regions. Its long-term effects can already be seen in many developing countries. Schools have closed because teachers have died or are too sick to continue working. Traditional agriculture methodology cannot be passed from one generation to the next because parents die before their children are old enough to grasp the technical intricacies. Small businesses have failed and whole industries are suffering. Scarce health resources have been exhausted as AIDS patients occupy most of the beds.

Peace Corps Volunteers have been responding to HIV- and AIDS-related issues since the 1980s. None of the Peace Corps sectors have remained untouched by the far-reaching implications of HIV/AIDS. Volunteers are uniquely suited to work in HIV/AIDS prevention and education because they live and work in local communities and can present information in culturally sensitive ways. In addition, the Peace Corps is an implementing partner of the President's Emergency Plan for AIDS Relief (PEPFAR), the U.S. government's worldwide HIV/AIDS care, prevention, and treatment commitment.

Each year, an increasing number of Volunteers are joining the fight against HIV/AIDS, and the Peace Corps plans to continue expanding its commitment to HIV/AIDS programs.





# Behavior Change

## HIV/AIDS TRAINING RESOURCE KIT

- Session 1: Behavior Change Theory**
- Session 2: The Bridge Model of Behavior Change**
- Session 3: Understanding Stigma and Discrimination Relating to HIV/AIDS**
- Session 4: Behavior Change Toolkit Sampler**
- Session 5: Facts and Myths about HIV/AIDS (optional)**



# Session One: Behavior Change Theory

## Purpose

To provide Peace Corps participants (trainees and/or Volunteers) an understanding of behavior change theory.

## Rationale

The role of the Volunteer as an agent of change is an integral part of every Volunteer's experience, and particularly relating to work addressing HIV/AIDS. It is useful for Volunteers to understand the theories behind behavior change models and strategies they will be using. At the same time, it is important to demystify behavior change, to understand that it is not complicated, that it has phases and steps that are related to real life. The behavior change goal with HIV/AIDS is to get people to live healthy lifestyles by: reducing risky behaviors that transmit HIV/AIDS; knowing their HIV status (testing); keeping their bodies as healthy as possible through good nutrition and safe water; and seeking treatment when needed.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours to 2 hours and 35 minutes (optional case study activity is 35 minutes)

## Objectives

By the end of the session participants will be able to

1. Articulate the "Stages of Change Theory" of behavior change.
2. Explain the relevance of behavior change theories to their work relating to HIV/AIDS.

## Session Outline

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**I. Introduction and Help and Hinder Exercise**  
(30 minutes)

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**II. Behavior Change Theory and HIV/AIDS**  
(45 minutes)

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**III. Optional Behavior Change Case Study Activity**  
(35 minutes)

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**IV. Thinking about Strategies** (30 minutes)

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**V. Wrap up** (10 minutes)

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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Behavior change theory
- Behavior change communication strategies
- Peace Corps' Life Skills program

## Materials and Equipment

Blank flip chart, markers, tape, or tacks

For optional behavior change activity: Copies of Parts A and B of the behavior change case studies for small group work (activity sheet at the end of the session)

Make goal and strategy cards for section IV (activity sheet at the end of session). Copy onto colored paper and cut apart, or copy and cut and paste on colored cards, one color for goals, a second color for strategies.

Prepare flip charts or overhead presentation

1. Help/Hinder Chart
2. Traditional Information, Education, and Communication (IEC) Approach
3. Behavior Change Communication Approach
4. Model of Community-Level Determinants of Individual Behavior
5. Health Belief Model/Social Cognitive Theory
6. Stages of Change

7. Behavior Change and Communication Strategies
8. Reflection Questions (for optional activity)
9. Small Group Task

#### Handouts

- A. *From Information to Behavior Change: Trends in HIV Prevention*
- B. *Behavior Change and Communication Strategies*

### Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Locate any behavior change strategic policies and practices documents available in the host country. Incorporate them into the session.
- If using the optional activity, review the behavior change case studies. You may wish to develop additional case studies to more closely reflect the realities of your post.
- Prepare goal and strategy cards.

### Methodology

#### I. Introduction and Help and Hinder Exercise (30 minutes)

##### Introduction

**Step 1:** Provide an overview of the session. (5 minutes)

Session goal: To help participants understand the theories behind the behavior change models and strategies Volunteers use to encourage behavior change relating to HIV/AIDS.

To understand behavior change theory we will use

- Personal reflection
- Behavior change case study activity (optional)
- Discussion about theory
- Practice matching goals and strategies

**Step 2:** Personal reflection (5 minutes)

Ask participants to think about a behavior they have changed at some time in their lives. Perhaps they started recycling, wearing a seat belt, or exercising on a regular basis or maybe they stopped smoking. Reflect for a minute about the process undertaken to

make the change. What influenced the decision to make the change? Did the change occur immediately or what happened? How long did it take to sustain the change?

Allow five minutes for individuals to reflect.

**Step 3:** Sharing experiences (10 minutes)

**Step 4:** Help and hinder chart (10 minutes)

With whole group, ask them to call out examples of things that helped or enabled them to make the behavior change, if they were able to do so. List on flip chart 1, "Help/Hinder Chart."

<b>Help/Hinder Chart</b>	
Helped	Hindered

FLIP CHART 1

Items may include: tired of negative consequences, family wanted and encouraged the change, fear, self-imposed goal, reward, change in the environment, having a role model, disassociate/stay away from negative influences

What things hurt and/or hindered the behavior change? List on the chart.

Items may include: laziness—it takes a lot of work to change, fear of change, instant gratification, peer pressure, environment, loneliness—no one to share change with, poor self-image

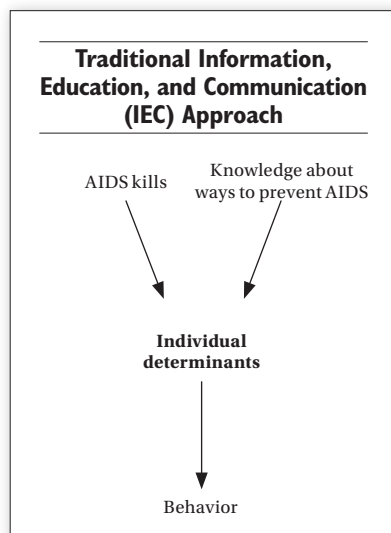
Note that they will come back to this chart later and learn more about behavior change theory.

## II. Behavior Change Theory and HIV/AIDS

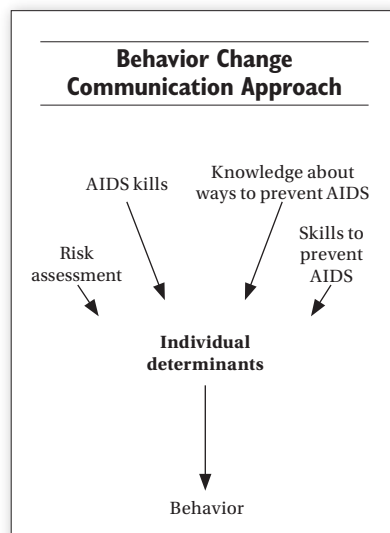
(45 minutes)

The following can be a flip chart or overhead presentation. Also, it's not as important that participants know every detail of the following theories. It is important that participants are aware of the theories of behavior change and can access them when they are ready to do so in the field.

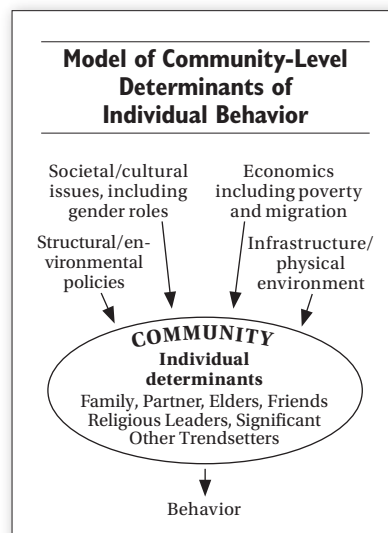
**Step 3:** Behavior change communication (BCC) (flip chart 3), is an approach that begins to look at more of the reasons individuals are at risk and the skills they need in order to begin to change behavior that puts them at risk. For example, rather than just providing informational pamphlets, consider also providing peer counselors who will help develop risk-assessment skills and self-esteem. The more interactive the approach, the more likely the change in behavior.



FLIP CHART 2



FLIP CHART 3



FLIP CHART 4

### Lecturette—Overview (20 minutes)

**Step 1:** Introduce flip chart 2 or overhead presentation, “Traditional Information, Education, and Communication (IEC) Approach.” Explain that you will spend a few minutes looking at the evolution of behavior change approaches and methods.

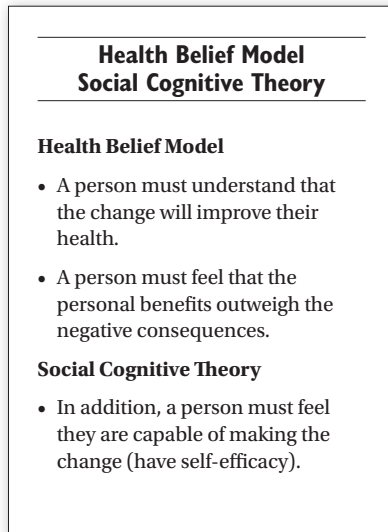
**Step 2:** Distribute *Handout A: From Information to Behavior Change: Trends in HIV Prevention* so participants can follow along and take notes.

In the past, we might have talked about changing behavior through information, education, and communication—called the IEC approach (flip chart 2). The assumption behind this approach is that through information and education people will be motivated to change their behavior. One of the assumptions of this approach is that people don't know enough about the impact of their behavior to see a need for change without additional information. This example focuses on the individual level of behavior change. With this level of information alone, only about two to five percent of the population will change their behavior on their own.

**Step 4:** A more comprehensive behavior change approach (flip chart 4) also looks at community level determinants of individual behavior—including things such as: community infrastructure and physical environment, including access to services; economics, including poverty and migration; societal/cultural issues, including gender roles; and structural/environmental policies. Many of these things that are outside of the individual may profoundly impact individual behavior change. The individual is a member of a community with social norms.

We will continue to talk about this as we go through the workshop. For example, we may provide life skills training, but this may not be enough to change behavior. People have to have sufficient power to make decisions about their behavior. In addition, we know that there has to be an infrastructure to support certain behavior changes. For example, HIV counseling and testing has to be available in a community and set up in a way that truly is confidential to support an individual's decision to be tested.

**Step 5:** Other approaches include the “Health Belief Model” (flip chart 5) or may incorporate social cognitive theory—which would also look at a person’s self-efficacy as a factor in behavior change.



FLIP CHART 5

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. The key variables of the HBM are as follows<sup>1</sup>

- **Perceived threat** Consists of two parts: perceived susceptibility and perceived severity of a health condition.
- **Perceived susceptibility** One’s subjective perception of the risk of contracting a health condition.
- **Perceived severity** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- **Perceived benefits** The believed effectiveness of strategies designed to reduce the threat of illness.
- **Perceived barriers** The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
- **Cues to action** Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to action is an aspect of the HBM that has not been systematically studied.

- **Other variables** Diverse demographic, sociopsychological, and structural variables that affect an individual’s perceptions and thus indirectly influence health-related behavior.
- **Self-efficacy** The belief in being able to successfully execute the behavior required to produce the desired outcomes.<sup>2</sup>

Implications for health behaviors: HBM research has been used to explore a variety of health behaviors in diverse populations. In a literature review of all HBM studies published from 1974-1984, the authors identified, across study designs and populations, perceived barriers as the most influential variable for predicting and explaining health-related behaviors.<sup>3</sup> More recently, though, researchers are suggesting that an individual’s perceived ability to successfully carry out a “health” strategy, such as using a condom consistently, greatly influences his/her decision and ability to enact and sustain a changed behavior.<sup>4</sup>

**Step 6:** Summarize: All of these approaches are part of a larger concept, behavior change interventions (BCI). BCI includes all information, education, and communication and behavior change communication (BCC) approaches and adds components outside the community as additional methods. The Volunteer’s role is in BCC.

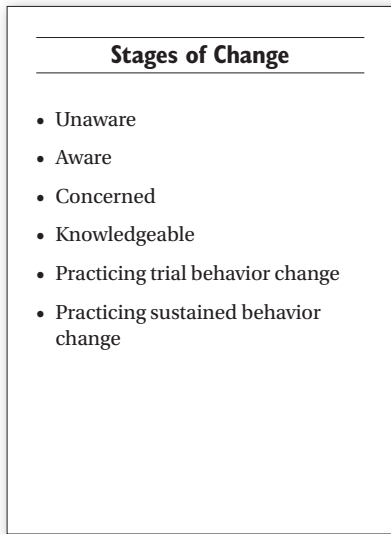
### Introduce Stages of Change Theory<sup>5</sup> (10 minutes)

#### Step 1: Explain Behavior Change Theories

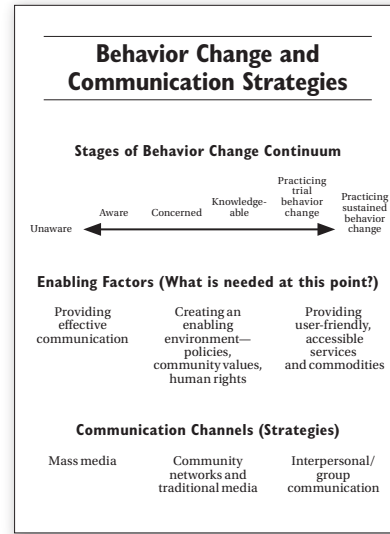
There are many behavior change theories that have been used to develop projects targeting different kinds of issues, including HIV/AIDS.

Many of these have a lot in common—notably that behavior change takes place through a series of steps that move people from a stage of being unaware or unconscious of their behavior, through various stages of increasing knowledge and understanding, until there is a behavior change that through practice becomes habitual.

**Step 2:** Explain Stages of Change Theory. Reveal flip chart 6, “Stages of Change”.



FLIP CHART 6



FLIP CHART 7

- **Unaware** Individual has the problem (whether he or she recognizes it or not) and has no intention of changing.
- **Aware** Individual recognizes the problem.
- **Concerned** Individual is concerned about the problem and is seriously thinking about changing.
- **Knowledgeable** Individual recognizes the problem and intends to change the behavior within the next month. Some behavior change efforts may be reported, such as inconsistent condom usage. However, the defined behavior change criterion has not been reached (e.g., consistent condom usage).
- **Practicing trial behavior change** Individual has enacted consistent behavior change (e.g., consistent condom usage) for less than six months.
- **Practicing sustained behavior change** Individual maintains new behavior for six months or more.

**Step 3:** Explain: In all Stages of Change Theory there is a back and forth that occurs. Someone may make great progress and move two steps forward only to backslide and take a step or two back later on. Sometimes steps can even be skipped altogether.

**Family Health International's application (15 minutes)**

FHI has developed a behavior change communication strategy based on this theory. Reveal flip chart 7 and distribute *Handout B: Behavior Change and Communication Strategies*.

Different strategies may be more effective at different stages of the behavior change continuum. For example, providing services and commodities before people are contemplating change may not be as effective as introducing these later. The more you know about where a community is in the process of adopting changes the more effectively you can design activities with community members or organizations. As we talk about some of the tools available to you as Volunteers to work with others to create behavior change we will talk about how your knowledge of the community will help you select the most effective strategies.

As part of this theory, there are different **enabling factors** that can affect behavior change in different ways at different stages of the continuum and we would want to use different **channels of communication**—at different stages of the continuum. To identify the appropriate enabling factors we can ask: “What is needed at this point?”

For example: When an individual/community is at the beginning of the continuum—the unaware stage—what is needed at this point is effective communication and this would be an appropriate time to develop communication strategy.

A communication campaign can provide information to a specific population but once the individual or community has moved further along the continuum of change and is prepared for action, then policies, community values, and human rights become more important.

Point further along the continuum of change: once an individual or community is ready for action you must have services available.

Spend a few minutes thinking of specific examples.

### III. Optional Behavior Change Case Study Activity

(35 minutes)

#### Introduction (5 minutes)

**Step 1:** Introduce the activity. This activity will demonstrate some of the stages that people typically go through to change behavior.

**Step 2:** Break into as many groups as you have prepared case studies, perhaps five or six people per group. (If you have a large group, you can give more than one group the same case study; it might be interesting to see if different groups reach different conclusions about the same case study.)

**Step 3:** Explain that you will give each group a case study of one person and the circumstances he or she currently finds him or herself. Each group should read the case study and discuss and decide which stage (according to FHI's Stages of Change Theory) the group feels that the person in the case study is.

#### Read and discuss case studies (20 minutes)

**Step 1:** Each group reads Part A and discusses the case study. Each group should come to a consensus.

**Step 2:** After the first 10 minute read and discussion period, hand out Part B to each group. Ask each group to read Part B, and, based on this additional information about the person in the case study, discuss and determine if the person has advanced along the continuum of the stages or regressed. Ask groups to be prepared to present a synopsis of their discussion to the whole group after another 10-minute period.

#### Debrief (10 minutes)

At the end of the activity ask each group to spend a few minutes presenting its case study and a brief review of its discussion to the whole group. Post the questions (flip chart 8) to think about

Reflection Questions
1. Briefly describe the situation presented in Part A of your case study.
2. How (and why) did you decide where to place your character along the continuum. Was it an easy decision or was there debate?
3. After reading Part B, how did the character move along the continuum? Again, was it an easy decision within the group, or was there debate?
4. What do you think might help this character make positive movement along the continuum? Or, what needs to happen to keep this person moving in the right direction along the continuum?

FLIP CHART 8

**Step 1:** Briefly describe the situation presented in Part A of your case study.

*How (and why) did you decide where to place your character along the continuum? Was it an easy decision or was there debate?*

After reading Part B, how did the character move along the continuum? Again, was it an easy decision within the group, or was there debate?

*What do you think might help this character make positive movement along the continuum? Or, what needs to happen to keep this person moving in the right direction along the continuum?*

**Step 2:** Ask entire group, "What did you learn about behavior change by discussing these case studies?"

### IV. Thinking about Strategies (30 minutes)

#### Introduction (5 minutes)

**Step 1:** Explain that participants will look at some behavior change goals and strategies. Working in small groups, each group will have a card with a goal and a card with a strategy of a behavior change project listed with a brief explanation (use all the cards or combine concepts).



**Step 2:** Reveal flip chart 9, “Small Group Task”. Your task will be to read and discuss the goal. (Flesh out some ideas around the goal: What is the situation? What else might they know about it? How is it relevant to an HIV/AIDS campaign?)

**Small Group Task**

1. Read and discuss the goal.  
(Flesh out some ideas around the goal: What is the situation? What else might they know about it? How is it relevant to an HIV/AIDS campaign?)
2. Read the strategy.  
(How would that strategy work in a behavior change project? Is it a part of a larger strategy?)
3. Briefly outline the steps of behavior change strategy for the goal. Be ready to report out.

FLIP CHART 9

Read the strategy. (How would that strategy work in a behavior change project? Is it a part of a larger strategy?)

Briefly outline the steps of behavior change strategy for the goal. Be ready to report out.

**Small groups (15 minutes)**

**Step 1:** Break participants into small groups. Provide each with a goal card, a strategy card, a flip chart, and a pen.

**Step 2:** After 15 minutes, ask the small groups to reassemble in a whole group. Have each group present its goal and its outline.

**Step 3:** Ask for comments and suggestions from the others.

**Debrief (10 minutes)**

Ask some summarizing questions, such as

*How easy was it to match the strategy to the goal? What would have made it easier?*

*Did you know as much as you needed about the goal? How could you have found out more if this was a goal in your community?*

*Was it hard to incorporate the strategy you were given? How would it have been easier to determine the strategy(ies) to use?*

**V. Wrap up (10 minutes)**

**Reflections**

Let’s go back to your personal reflections about changing a behavior. *How does the theory we just talked about relate to your personal experience?*

Ask for a few people to share their thoughts. *How far along are you? What strategies did/or would have helped? What did you learn in this session that helps you understand your own attempts at behavior change?*

**Debrief**

*What does behavior change theory tell you about working with HIV/AIDS? What do you need to learn to be effective in working with people about HIV/AIDS?*

**Evaluation**

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**References or Resources**

*Behavior Change Communication (BCC) for HIV/AIDS: A Strategic Framework.* Arlington, VA: Family Health International, Institute for HIV/AIDS, September 2002. Available for download at: [www.fhi.org](http://www.fhi.org) (accessed March 28, 2007).

- 1. Rosenstock, Strecher & Becker, 1994.
- 2. This concept was introduced by Bandura in 1977.
- 3. Janz & Becker, 1984.
- 4. Bandura, 1989.
- 5. For our purposes, we are using the Stages of Change Theory adapted by Family Health International from Prochaska, DiClemente, and Norcross (1992).

**Notes**

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# Activity Sheet: Behavior Change Scenarios for Discussion of Stages

*Make enough copies for each person in each group. Cut Part A from Part B.*

*Use Part A for the first round of reading and discussing, and then pass out Part B for more discussion.*

## **Annette, Part A**

Annette is beginning her fourth month of pregnancy and has just begun attending prenatal consultations at the local health center. Pregnancy is not openly discussed in her culture, therefore only a few of her close friends and relatives are aware that she is pregnant. While awaiting today's consultation, the head nurse spoke with the attending women about the importance of HIV testing and risks associated with being HIV-positive or contracting HIV during pregnancy. She encouraged all pregnant women to get an HIV test at the testing center at the departmental hospital (approximately 40 km away). Annette was not previously aware that a mother could transmit the HIV infection to her unborn child. The health of her baby is of utmost importance to Annette. She realizes, however, that she will need to discuss the issue with her husband if she is to seek his support to travel to the departmental capital for testing.

## **Claudette, Part A**

Claudette is a bright student in middle school. Her peers tease that she will become the community's first woman doctor. She is naturally gifted in science but is also intimately involved with her teacher—the relationship allows her special privileges at school that permit her to continue her education. She knows that her parents do not have the means to finance her three brothers' studies as well as her own and feels fortunate that they have allowed her to remain in school rather than pressuring her to get married, a destiny several of her former classmates have faced. She appreciates the support that her science teacher gives but is concerned about his insistence on unprotected sexual relations. She has repeatedly heard messages about the dangers of unprotected sex and the importance of protecting her future. She does not want to offend her sponsor but also values her health and future.

## **Annette, Part B**

That evening, Annette timidly tells her husband about her visit to the local health center. When she shares with him the nurse's advice about HIV testing, he immediately becomes defensive and suggests that she is accusing him of infidelity. She attempts to explain the effects to their unborn child but he is no longer listening to her and instead angrily questions her trust in him. Not wanting to upset him, she quickly brings the discussion to a close and moves on to another topic.

## **Claudette, Part B**

Later in the week when Claudette's teacher asks to see her after school she agrees and informs him that there is something she would like to discuss. He smiles and agrees. When she sees him later, however, he compliments her beauty and suggests that they first enjoy themselves and talk later. She insists upon talking first and he senses the urgency of the topic. After much determination and persuasion, she eventually convinces him that she will only continue having sexual relations if he uses a condom. He agrees to use a condom this time but insists that she will eventually get tired of using a condom and will change her mind.

**Marie, Part A**

Marie has not been feeling well and has been struggling to care for her four children and mother-in-law single-handedly while her husband is away in the neighboring country for work. She does not want to appear weak in her mother-in-law's eyes and therefore does her best to conceal her fatigue, persistent cough, and frequent fever. She has worked for months to build her confidence and doesn't want to compromise her status now.

**Hassan, Part A**

Hassan is a well respected man in his community and is true to the Muslim faith. Given his status and influence in society, he has been asked to assist the local health team with their campaign to fight AIDS. Through this process Hassan learns that an essential means of HIV prevention is being in a mutually faithful relationship with a partner who has been tested for HIV and is not infected, and the consistent use of condoms with all partners who have not been tested for HIV. He realizes this includes his three wives. He had never considered this before as he is a good husband who is faithful to his wives. But the doctor shared statistics from the local testing center showing that two out of ten women attending prenatal consultations test positive for HIV. To his knowledge, his wives have not been tested.

**Marie, Part B**

Several days later while working in the field, Marie collapses. Her comrade comes to her aid and persuades her to rest. She notes that Marie has been working very hard and encourages her to take better care of herself. She knows that Marie is working hard for her family but reminds Marie that she will be of no good to them if she pushes herself too far. Later when the two women are walking back from the field, Marie's friend remarks that Marie's husband is often away and leaves her for extended periods. She jokes that men take care of their "needs" and hopes that Marie is taking sufficient care of herself. Marie frequently avoided thinking about her husband's extended time away but now questions the implications of her friend's words.

**Hassan, Part B**

Later that week Hassan discusses the information he learned with his first wife. She is the oldest and wisest of his wives and they have spent 12 positive years of marriage together. She listens carefully to what Hassan tells her and appears concerned. She reassures him that he has no need to worry with her, she has always been faithful, but she warns him to be careful with his youngest wife. She reminds him that the generations of today are not like his own and suggests that the youngest wife may have had sexual relations with other men

**Yohance, Part A**

Yohance recently entered high school and is popular with the boys, girls, and teachers in his class. He is smart, athletic, and admired by his peers. He is also a bright student. Aware of the risk of STIs including HIV, Yohance made an oath last year to remain abstinent from sex until marriage. He has upheld the decision without a problem, until recently. He began seeing a new girl in his class at the onset of the school year. Since that time the relationship has become more serious. She has not directly raised the issue of sexual relations though Yohance senses that she questions their lack of intimacy. At the same time his sexual desires are becoming stronger and his friends mock his practice of abstinence. They imply that Yohance's girlfriend will soon get tired of being with a boy and will leave him for a real man.

**Yohance, Part B**

Later, when Yohance is alone with his girlfriend he tells her that he would like to talk. Their communication has always been open but they have never discussed their relationship directly. Yohance tells her about his oath, his concerns, and stresses his commitment to her. She thanks him for his honesty and expresses great relief. She explains that she was concerned about the lack of intimacy because she feared that it meant he did not like her as much as she likes him. She agrees to join him in his oath to abstinence but asks that he come to her if he ever changes his mind.

**Vitalie, Part A**

Vitalie is a 22-year-old male living in a regional capital city. He lives with seven other young men who are all looking for work. Originally from a close-knit, but economically depressed rural community, Vitalie moved to the city with the hope of finding viable employment. Unfortunately, he is still jobless and spends most of his time looking for work or hanging out with his friends, watching MTV, and drinking vodka. But the last four months he has experimented with heroin and become addicted, shooting up almost daily. He says that the escape he feels while high helps him better forget the difficulties in finding a job. Additionally, he cites that the relationships he fostered with his drug buddies helps ease the emotional burden of missing his family. Sharing needles is common since injection drug use is illegal in this country.

**Vitalie, Part B**

Vitalie finally receives an offer of employment, working as a waiter at a local restaurant. The wages are fair and consistent. He continues his drug use though. For a few weeks, he manages to conceal his drug use from the restaurant manager; but is eventually found out and is fired. After another six months of heroin use and working odd jobs, Vitalie notices that he has lost weight, is often tired and fatigued, and does not enjoy the heroin high as much as he once did. Additionally, one of his flatmates and drug buddies was recently diagnosed with HIV, overdosed, and died. Vitalie is confused—he does not want to die and is unsure of what he should do.

## Activity Sheet: Behavior Change Goals

Cut the situations below apart. Use those you feel are most appropriate to your country to this point in the training. Feel free to combine. Provide each group with one goal.

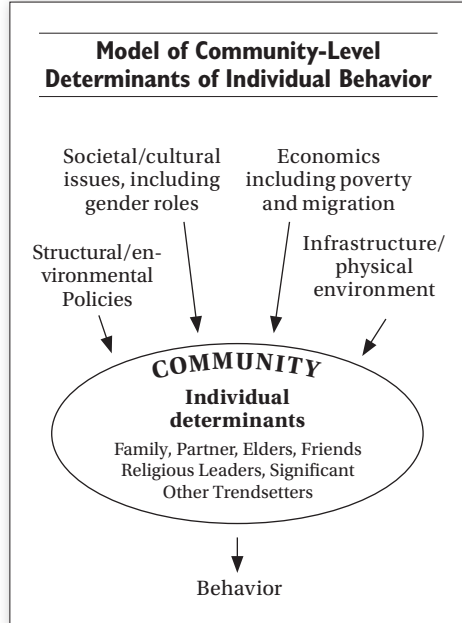
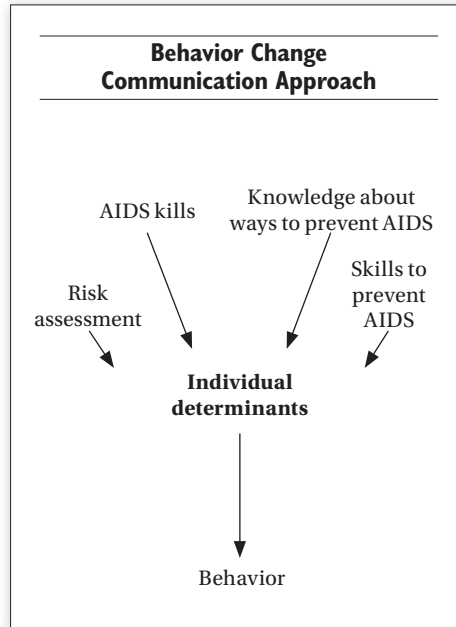
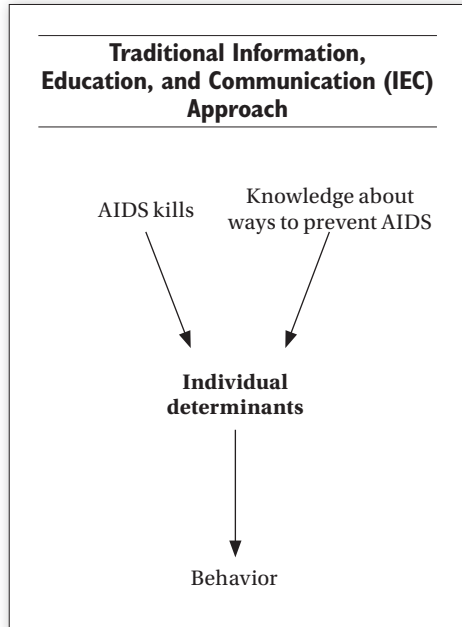
<p>Prevention through a combined “ABC” approach of “A: promoting abstinence or delayed onset of sexual activity for youth”; “B: being faithful to one partner”; and “C: correct and consistent condom use, particularly for high risk sexual activity,” plus other strategies that address gender inequality and violence against women</p>	<p>Increased numbers of people seeking care and support, including treatment for sexually transmitted infections, opportunistic infections, including tuberculosis, and antiretroviral treatment; and services for orphans and vulnerable children and high-risk populations such as injection drug users.</p>
<p>Empowerment of girls, women, and youth, including strategies to ensure economic security.</p>	<p>Public awareness of human rights for girls, women, and youth, including the right to control over their bodies.</p>
<p>Increased voluntary counseling and testing.</p>	<p>Increased demands for information.</p>
<p>Education for boys and men focused on developing positive values and behavior relating to human rights of girls and women.</p>	<p>Reduced stigmatization/discrimination against people living with HIV/AIDS.</p>

## Activity Sheet: Behavior Change Strategies

Cut the sentences below apart. Use those you feel appropriate to your country this point in the training. Feel free to combine. Randomly provide one of these strategies with one of the goals (previous page) to each group.

Assess HIV/AIDS-related strengths, assets, and barriers to change in the community.	Build individual, organizational, and community capacity.
Assess gender roles as a central factor in determining appropriate activities.	Develop culturally appropriate communication strategies.
Involve key stakeholder groups across different sectors (agriculture, education, health, etc.), including people living with HIV/AIDS.	Engage community leaders at the highest levels including political, civic, religious, and informal leaders.
Work with traditional belief systems about health and illness.	Include people living with HIV/AIDS into the planning and implementation of activities.
Identify role models in the community.	Use appreciative and participatory approaches.
Develop communication strategies that use a variety of channels, including: Mass media Person-to-person exchanges of information	Use positive messages in communication strategies.

# Handout A: From Information to Behavior Change, Trends in HIV Prevention



Information, education, and communication (IEC) focuses on the knowledge individuals and communities need in order to create behavior change.

Behavior change communication looks at the reasons people are at risk and the skills they need to change behavior that puts them at risk.

A more comprehensive behavior change approach also looks at community-level determinants of individual behavior—including things such as: community infrastructure and physical environment, including access to services; economics—including poverty and migration; societal/cultural issues, including gender roles; and structural/environmental policies.

Different approaches include the health belief model or may incorporate social cognitive theory—which would also look at a person’s self-efficacy as a factor in behavior change.



The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. The key variables of the HBM are as follows (Rosenstock, Strecher & Becker, 1994)

- **Perceived threat** Consists of two parts: perceived susceptibility and perceived severity of a health condition.
- **Perceived susceptibility** One's subjective perception of the risk of contracting a health condition.

<b>Health Belief Model Social Cognitive Theory</b>
<p><b>Health Belief Model</b></p> <ul style="list-style-type: none"> <li>• A person must understand that the change will improve their health.</li> <li>• A person must feel that the personal benefits outweigh the negative consequences.</li> </ul> <p><b>Social Cognitive Theory</b></p> <ul style="list-style-type: none"> <li>• In addition, a person must feel they are capable of making the change (have self-efficacy).</li> </ul>

- **Perceived severity** Feelings concerning the seriousness of contracting an illness or of leaving it untreated (including evaluations of both medical and clinical consequences and possible social consequences).
- **Perceived benefits** The believed effectiveness of strategies designed to reduce the threat of illness.
- **Perceived barriers** The potential negative consequences that may result from taking particular health actions, including physical, psychological, and financial demands.
- **Cues to action** Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Cues to actions is an aspect of the HBM that has not been systematically studied.
- **Other variables** Diverse demographic, sociopsychological, and structural variables that affect an individual's perceptions and thus indirectly influence health-related behavior.
- **Self-efficacy** The belief in being able to successfully execute the behavior required to produce the desired outcomes. (This concept was introduced by Bandura in 1977.)

HBM research has been used to explore a variety of health behaviors in diverse populations. In a literature review of all HBM studies published from 1974-1984, the authors identified, across study designs and populations, perceived barriers as the most influential variable for predicting and explaining health-related behaviors (Janz & Becker, 1984). More recently, though, researchers are suggesting that an individual's perceived ability to successfully carry out a "health" strategy, such as using a condom consistently, greatly influences his or her decision and ability to enact and sustain a changed behavior (Bandura, 1989).

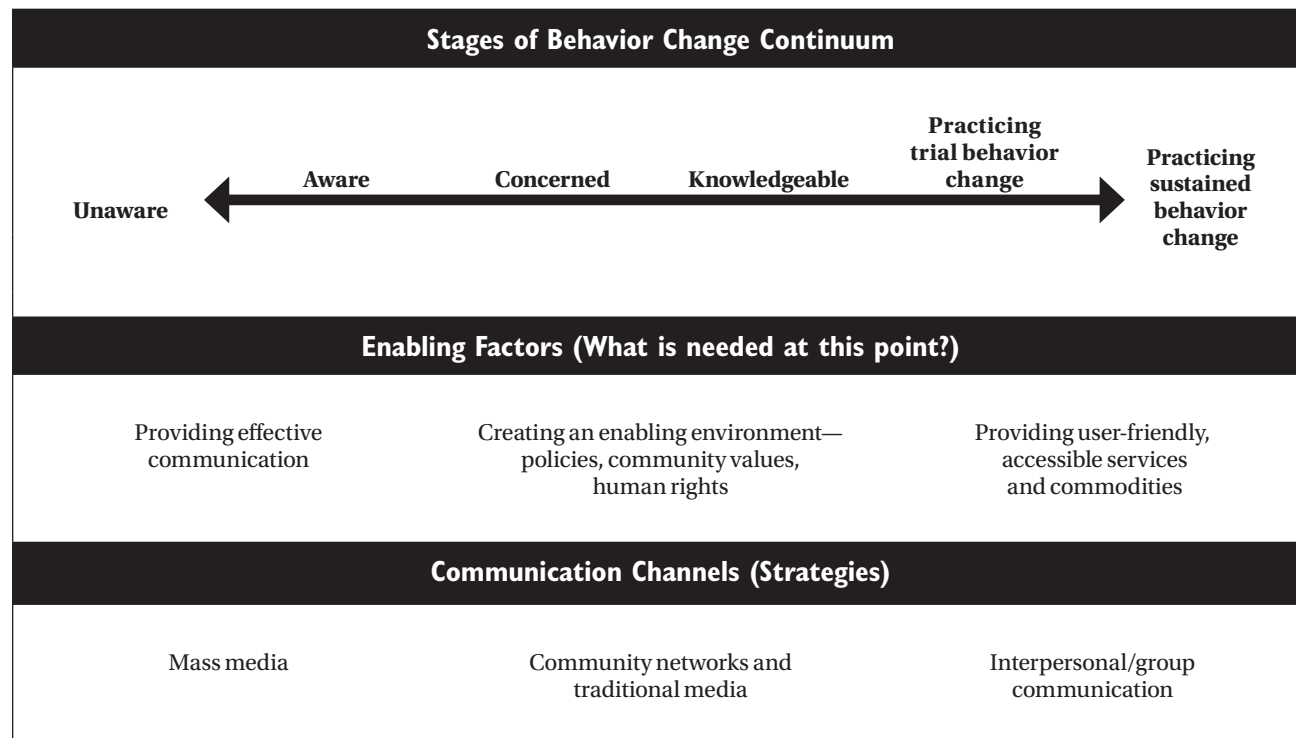
### Behavior Change Interventions

All of these approaches are part of a larger concept of behavior change interventions (BCI).

BCI includes all information, education, and communication (IEC) and behavior change communication (BCC) approaches and adds components outside the community as additional methods.

The Volunteer's role is in behavior change communication.

## Handout B: Behavior Change and Communication Strategies



# Session Two:

## The Bridge Model of Behavior Change

### Purpose

To introduce how the life skills program provides context for and skills to change behavior.

### Rationale

This session demonstrates the kind of knowledge, skills, and attitudes people need to promote behavior change that will prevent HIV/AIDS. By using the bridge model, participants can visualize what is needed to link knowledge to healthy, positive behavior.

### Target Audience

Peace Corps participants (trainees and/or Volunteers)

### Duration

1 hour to 1 hour, 30 minutes

### Objectives

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

1. Identify the skills and attitudes people need to link knowledge to healthy, positive behavior.
2. Describe how the Bridge Model from the *Life Skills Manual* provides sessions related to behavior change.
3. Visualize their own role in helping individuals develop healthy, positive behavior that will promote prevention of HIV/AIDS.

### Session Outline

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**I. Introduction** (5 minutes)

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**II. Optional Bridge Model Role Play** (20 minutes)

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**III. The Bridge Model** (45 minutes)

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**IV. Debrief—Life Skills and Social Change**  
(20 minutes)

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### Facilitators/Technical Expertise

Facilitator\* must be knowledgeable about

- Promising practices relating to behavior change programs focused on HIV/AIDS
- Peace Corps life skills program
- Gender-based violence
- Understanding of cultural issues relating to HIV/AIDS
- Volunteer cross-sector roles in the field relating to HIV/AIDS
- Facilitating discussion of sensitive information with a mixed-gender and mixed-age group
- Knowledge of American gender and diversity issues

\*May be able to use second-year Volunteers

### Materials and Equipment

Flip charts, tape, or tacks

Markers or chalk

Copy of the *Life Skills Manual* [ICE No. M0063]

Prepared flip chart, “Bridge Model”

Props for the role play (if using this option)

Activity Sheet

*Role Play Scenario (if using this option)*

Handouts

A. *Principles of Behavior Change and How the Life Skills Program Mirrors These Principles*

### Preparation Checklist

- Read the section on the bridge model (pgs. 27-37) in the *Life Skills Manual* (Part III, pg. 3-18 in previous three-ring binder version)
- Read the entire session and modify the session according to the time you have available.
- Prepare and post the Bridge Model flip chart on a prominent wall; roll it or cover it up.
- Arrange the chairs around the Bridge Model flip chart in a half-circle.

- ❑ If you want to use a role play (Part II, Step 2), choose the role play best suited to your trainees' situations and make copies for the actors. Options include the role play in the *Life Skills Manual* and three additional role play scenarios provided at the end of the session. If none of these is appropriate to your region, create one of your own.
- ❑ Prepare and rehearse the role play in advance. Ask two volunteers to be the actors and prepare the role play. It is much more effective to choose two people from the training participant group rather than using fellow facilitators or peer educators. This role play will be the basis for your discussion of the Bridge Model, so it is essential that it is performed well and covers the topics you wish to highlight.
- ❑ Determine if you will distribute copies of the *Life Skills Manual* to all participants. If so, order sufficient quantities from ICE well in advance of your training session.

## Methodology

### I. Introduction (5 minutes)

Hold up a copy of the *Life Skills Manual* and tell participants that this session will provide some of the highlights of the Bridge Model that is the basic concept in the manual. It is a model that they may want to introduce to their counterparts, students, fellow community members or whomever they work with on HIV/AIDS activities. The manual has sessions that build skills to change behaviors that will lead to healthy lifestyles and prevent HIV/AIDS. All participants should have a copy of the manual.

### II. Optional Bridge Model Role Play (20 minutes)

**Step 1:** Introduce the role play as an example of what could be a real situation.

**Step 2:** Invite the actors to perform the role play. Stop the role play when the point has been made.

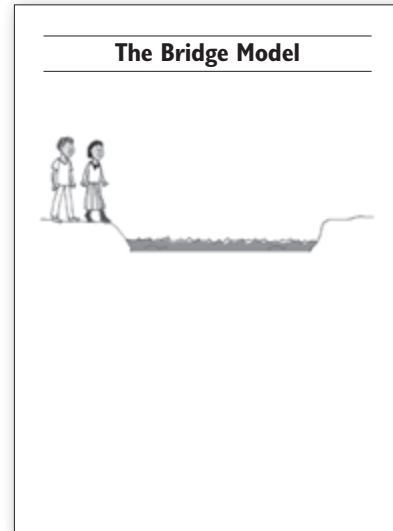
**Step 3:** State and discuss

*The person in the role play had a lot of information to stay safe, yet contracts HIV anyway. Why?*

### III. The Bridge Model (45 minutes)

#### Step 1: Bridge Model. (5 minutes)

Reveal the Bridge Model flip chart.



FLIP CHART 1

Point out that, as demonstrated in the role play, people, particularly young people, generally have some knowledge about the risks of sexual activity. However, even though people have the knowledge that does not mean that they will not engage in risky behaviors.

#### Step 2: Explaining the model. (5 minutes)

Draw attention to the other side of the bridge. The goal is to have people move to the “positive, healthy life” side of the bridge.

Equipped with nothing but knowledge, young people face the risk of falling into a sea of problems (point to the sea) like HIV infection, alcohol and drug addiction, unwanted pregnancy, etc.

#### Step 3: Brainstorm. (20 minutes)

*So, what is missing? What does it take to help people to use their knowledge to lead a better life?*

Lead a group brainstorming session about what it takes to get across the bridge. (You might continue to refer to the role play during this brainstorming session.)

Guide the group to explore all angles of the situation so that you can get as many different suggestions as

possible. Be sure to talk about situations where boys/men/adults hold the power in a relationship and girls/women/youth do not have the choice to negotiate, make decisions, etc.

Each time someone gives a suggestion, it becomes a “plank” in the bridge. Write it on the chart above the sea between the two hills. Keep brainstorming until the entire bridge is completed. There should be many, many ideas.

The list may include

- Communication skills
- Understanding consequences
- Resistance to peer pressure
- Positive role models
- Empowerment for girls, women, and youth
- Values for boys and men that promote human rights/gender equality for girls and women
- Goals for the future
- Decision-making skills
- Negotiation skills
- Strength
- Gender equality
- Youth empowerment
- Assertiveness
- Sense of responsibility
- Confidence
- Self-respect
- Opportunities for the future
- Self-esteem

Be sure that empowerment of girls, women, and youth and the need for boys/men to have values relating to human rights and gender equality for girls and women is addressed.

**Step 4:** Relate to behavior change models. (10 minutes)

*Think about the Stages of Change Theory referred to in Session One. As we discussed, there are many thoughts about what creates behavior change. We know that knowledge is needed for someone to move from unaware to aware. But this is not enough.*

The Health Belief Model says that a person has to be motivated to change. Motivation includes understanding that change will prevent illness or improve one’s health. A person has to feel that the personal benefits outweigh the negative consequences.

Social cognitive theory adds that people must feel that they are capable of making the change (have self-efficacy).

However, it is important to remember that there may be other factors—political, gender restraints, economic—that make people incapable of changing their behavior.

Distribute *Handout A: Principles of Behavior Change and How the Life Skills Program Mirrors These Principles*. Go around the room having one person read a principle and another how the life skills program addresses that principle.

**Step 5:** Summarize (5 minutes)

Pointing to the left side of the bridge, say

*We have to provide accurate information to people about HIV/AIDS but we also have to help them get from this side of the bridge to the other side.*

Continue

*These planks in the bridge are the components needed to help translate knowledge into healthier behavior. Some of these are the life skills a person needs, such as communication and decision-making skills; others are tools to address those issues that stand in the way of people using life skills, such as empowerment and values relating to the human rights and gender equality of women, girls, and youth.*

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#### IV. Debrief—Life Skills and Social Change

(20 minutes)

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**Step 1:** Life skills categories (15 minutes)

Write the three categories of life skills on a flip chart or on the board.

##### Life Skills

Communication skills  
Decision-making skills  
Relationship skills

Explain that we can group the life skills into a few categories to make it easier to think about working with them.

Go over each category, and ask the group to suggest which of the life skills written on the Bridge Model flip chart might fit into each category (for example, relationship skills might include good role models, gender issues, communication skills, self-esteem, and resistance to peer pressure).

Many of the life skills will fit into more than one category. Do not spend too much time on this topic. Just make sure that the participants understand that these are just groupings for the sake of convenience. All of the life skills are important, and some fit in more than one category.

In addition, individuals must have sufficient power and control over their own lives to use these skills successfully. That is why the life skills program tries to develop values among boys and men that promote human rights and gender equality for girls and women.

**Step 2:** Conclusion (5 minutes)

Volunteers, regardless of the sector their work is in, can be instrumental in helping people of all ages, but particularly youth, develop better life skills relating to communication, decision-making and relationship skills.

Pay attention to the need for empowerment of girls, women, and youth, while helping boys and men develop values that promote the human rights and equality of girls and women.

The Peace Corps and many other agencies have materials already developed that can be used in many community settings. We will explore some of these and resources to help you continue to identify sources that will be useful in your community.

Optional—distribute a copy of the *Life Skills Manual* to each participant.

**Evaluation**

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**References or Resources**

*Life Skills Manual*. Washington, DC: Peace Corps, 2001. [ICE No. M0063]

**Notes**

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**Changes to Session**

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## Activity Sheet: Role Play Scenarios

### The Characters

**Rita**, a teenager, had to drop out of her final year of secondary school when she became pregnant. She has been advising her friend, Lucy, to stay in school and to avoid boyfriends, sex, and so forth, until she completes her education.

**Lucy** is in her first year at secondary school, and she has been doing very well in her classes. Despite her friend's warning, she has become pregnant and has come to break the news to her friend.

### The Role Play

Rita is sitting outside her house. She is rocking her baby in her arms. As she sits alone with the baby, she talks about how tired she has been and how much work the baby turned out to be. She might say things like: "Oh, my baby—how troublesome you are! Keeping me up all night like that! Won't you ever settle down?"

Lucy walks up and shouts "Hello, is anybody home?" She is welcomed warmly by Rita. Lucy sits down and greets her friend. She inquires after the health of the baby, and Rita tells her that the baby has been sick and has yet to sleep through the night. The friends chat for a moment before Rita comments on how odd it is to see Lucy like this during a school day. Rita asks Lucy why she is not in school, but Lucy changes the subject by talking about the baby. Rita asks Lucy again, and she again avoids the topic by asking Rita about Rita's boyfriend, James. Rita responds by saying that she has not heard from James since the birth of their baby. She has heard that he is now studying in the U.K., but he has never come to see her or the baby. Rita reminisces that she, too, could have gone to the U.K. for studies—her scores were so high—and she reminds Lucy of how important it is to avoid these boys and stay in school.

Rita asks again why Lucy is here on a school day. Lucy says something like this—"My friend, do you remember the advice that you are always giving me?" Rita responds—"Of course I do—I told you! Don't make the same mistakes I made—forget these boys until you are finished with your studies. Abstaining from sex is the best way to avoid getting pregnant or getting diseases—even AIDS!" Lucy probes further. "What else have you advised me?"

Rita says, "I told you that if you and that boyfriend of yours, Richard, cannot abstain, then remember to use a condom. You remember! I even gave you some condoms! Ah! But come on, my friend, what are you really doing here? Are you in trouble? What is it?"

Lucy, now in tears, confesses that she is pregnant with Richard's baby. Rita becomes angry. She reminds Lucy of all the advice she has given her; she reminds Lucy of the example of her own life. Lucy protests with ideas like, "But he loves me! He has promised to marry me!" Rita reminds Lucy that James promised her the same thing. Rita asks why Lucy had sex with Richard after all her warnings. Lucy says that Richard threatened to leave her if she did not have sex with him. He said it was the only way to show him that she loved him, that everyone was having sex, etc. Rita asks why Lucy didn't use any of the condoms she gave her. Lucy says that her church is against condom use, and besides—Richard refused to use them.

Finally, defending herself, Lucy says, "Well, why wait? Why not have a baby now? Richard is going to be a doctor. I want to be his wife! What is the difference if I finish school? Look at Marie—she finished school and she is just staying at home. There are no jobs anyway!"

## Alternative Role Play Scenarios

### Role Play One

**Maria** and **Ricardo**, both 18 years old, have been seeing each other for several weeks. Ricardo is pressuring Maria to have sex with him. Maria is from a traditional religious family and has been seeing Ricardo without the permission of her parents. She tells Ricardo that she really does want to have sex with him but she is worried enough about her parents finding out they are seeing one another. In addition, what about pregnancy and HIV?

Ricardo tells Maria that since neither of them have had sex with many people the chances of getting HIV are very small and the chances she would get pregnant if they do it just this time are also small. She can get on the pill before they have sex again. Maria finally relents.

The role play stops and then starts again—six months later. Ricardo finds out he is HIV-positive. He tells Maria.

### Role Play Two

**Misha** is at a party with his friend **Uri**. They talk about how bored they are and how depressing it is to think about the future. Both have degrees from college but no job prospects. They agree that there is little hope of a good future.

They go to a party and talk about trying new drugs. While they both have used drugs in the past neither of them has ever injected drugs. They talk about the risks of needles—getting addicted and contracting HIV. However, after a few more minutes they both decide to ignore their fears and agree to try the drugs being offered by a third person.

### Role Play Three

**Svetlana** works as a prostitute to earn money to support her three children. **Alexander** gives her money for sex. When they get into a room he insists on having sex without a condom. Svetlana resists but Alexander shoves her roughly and tells her that if she doesn't shut up he will tell her pimp and he is sure that will be the end of her resistance. She has no choice.



## Handout A: Principles of Behavior Change and How the Life Skills Program Mirrors These Principles

Principles of Behavior Change	How the Life Skills Program Mirrors These Principles
<p><b>1 Providing information is the logical starting point in any behavior change effort.</b> Information, although necessary, is rarely enough by itself to produce behavior change in most people. The information must be easily understood and relevant to the individuals you are trying to reach.</p>	<p>The Life Skills program assumes that you will begin by teaching basic information about HIV/AIDS, STIs, unwanted pregnancy, drugs or alcohol, violence, or other pressing community problems. [Extensive information about HIV/AIDS is provided in this manual in “Part III: Facing Facts about HIV/AIDS and STIs.” (Part II, in previous 3 ring binder version)]</p>
<p><b>2 Fear messages have limited use in motivating behavioral change.</b> If fear is overwhelming it can hinder, rather than help, efforts to change. Too much fear may cause people to deny they are at risk, to rationalize by pointing to others who have practiced similar behaviors and survived, sometimes avoiding seeking medical care altogether. Using words like “scourge” or “plague” or showing pictures of emaciated “AIDS victims” may cause people not only to ostracize those infected, but to deny their own risks for contracting the infection.</p>	<p>Life Skills avoids fear and negativity, and instead focuses on positive messages—creating, maintaining, and reinforcing healthy behaviors, and working towards a better life for everyone in the community—young people, women, men, and people living with HIV/AIDS.</p>
<p><b>3 People are more likely to try behaviors they feel capable of performing.</b> It is important to teach people the skills for engaging in the desired behaviors. Seeing examples of people engaging in the healthy behavior will help a person believe that he or she too can engage in that behavior.</p>	<p>Life Skills systematically attempts to build skills for healthy behavior. This is the crux of the Bridge Model of behavior change (see pg 27, or Part III, pg. 3 in previous 3 ring binder version). Many programs provide “one shot” information to large numbers of people. A Life Skills program works with a small group of people over a longer period of time to motivate participants to adopt a new behavior, to teach and model the skills necessary to successfully adopt that behavior, and to continually reinforce those new skills, until participants “feel capable of performing” healthier behavior. Peer educators can further reinforce this, as they provide a positive example of healthy behavior.</p>

<p><b>4 Individuals are more likely to adopt a new behavior if they are offered choices among alternatives.</b> For example, rather than just promoting abstinence or condoms, give ranges of possible behaviors that reduce risk, like practicing less risky sexual behaviors, getting an HIV test with your partner, and so on.</p>	<p>Life Skills helps develop critical thinking skills so participants learn a number of alternatives in dealing with a difficult situation. Participants are thus exposed to many choices in terms of negotiating healthier behavior.</p>
<p><b>5 Campaigns should create environments that encourage change.</b> Work to change social norms in favor of healthy behavior. Peer education programs provide a support base for change, as accepted peers model behaviors. Working with community leaders or a people living with HIV/AIDS group around an HIV/AIDS program can reduce the stigma of the disease and create an environment that encourages change.</p>	<p>Because change is easier if one's environment encourages it, Life Skills programs emphasize working with a community holistically. For example, if you are interested in working with young people, first provide a training-of-trainers (TOT) to community leaders such as mayors or chiefs, headmasters, government officials and parents. Then have a TOT for teachers in the school in which you work, or if you are working with young people outside the school system, consider training the nearest adult role models in that community. These workshops introduce the entire community to the program, provide the possibility that those trained will begin programs of their own with their new skills, and will serve as a powerful support to the program that you begin with young people. You may also wish to consider training youth peer educators before moving to the target of your program, the youth in a particular school or area. If a group of people living with HIV/AIDS operates in your community, be sure to include it in every aspect of your project.</p>
<p><b>6 Change is more likely in a community if influential people adopt the change.</b></p>	<p>Since it is clear that influential people can drive change, peer educators can be an effective addition to your Life Skills program. Young people often seek health or sex-related information from their peers before discussing these issues with adults. Training influential young people to serve as role models in their peer group can thus dramatically increase the impact of your program. Some advice on working with peer educators can be found in "Part II: Peer Education."</p>
<p><b>7 Relapse is expected.</b> Therefore, any program that seeks to change behaviors over time needs to build in ways to maintain those behaviors and to help bring people "back on the path" to positive behaviors after they have relapsed.</p>	<p>Because relapse is expected, it is important to continually re-create the Bridge Model to assist those who have already fallen into damaging behaviors. You may need to design a slightly different approach to the "planks" in the bridge for young women who have gotten pregnant and expelled from school, for drug-addicted youth, or for people living with HIV/AIDS, for example.</p>

*Life Skills Manual*, Washington, DC: Peace Corps, 2001. [ICE No. M0063] Pages 10-12. Adapted with permission from "Principles of Behavior Change," an article by Thomas Coates, Ph.D., Center for AIDS Prevention Studies at the University of California, San Francisco.

# Session Three: Understanding Stigma and Discrimination Relating to HIV/AIDS

## Purpose

To help Peace Corps participants understand stigma (feeling) and discrimination (action)—two of the major barriers to behavior change relating to HIV/AIDS prevention, treatment, support, and care.

## Rationale

Stigma about HIV/AIDS and discrimination of people living with HIV/AIDS are major issues to be addressed in behavior change projects. These exercises provide: a look at the roots of stigma and how it affects people living with HIV/AIDS, families, children, and communities; a safe space for participants to consider how stigma and discrimination about AIDS can affect them and their performance; and an opportunity to develop strategies and skills to confront stigma and discrimination.

## Target Audience

Peace Corps participants (trainees and Volunteers)

## Duration

2 hours, 45 minutes to 3 hours

## Objectives

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

1. Describe some of the root causes of stigma, according to recent research.
2. Identify some of the feelings involved in being stigmatized and in stigmatizing others.
3. List several expressions and forms of stigma that are physical, social, language/verbal, and institutional.
4. Describe the influence of stigma on communities and some of the reactions of Volunteers working in those environments.
5. Describe various strategies for addressing stigma and discrimination that are particularly suited to roles Volunteers play.

## Session Outline

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- I. **Introduction** (30 minutes)
  - II. **Panel of People Living with HIV/AIDS** (45-60 minutes)
  - III. **Causes and Forms of Stigma** (45 minutes)
  - IV. **Stigma, Communities, and Unproductive Volunteer Behavior** (20 minutes)
  - V. **Wrap up** (10 minutes)
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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Promising practices relating to behavior change programs focused on HIV/AIDS.
- Peace Corps Life Skills program.
- Cultural issues relating to HIV/AIDS.
- Causes and forms of stigma and discrimination related to HIV/AIDS.
- Volunteer cross-sector roles in the field relating to HIV/AIDS.
- Facilitating discussion of sensitive information with a mixed-gender and mixed-age group.

## Materials and Equipment

Blank flip chart paper

Markers

Tape

Trainer Reference: Volunteers Working in High Stigma Communities (at end of session; modified version for participant handout)

Small gifts for panelists, if culturally appropriate

Prepared large labels for wall

Knowledge as a Root Cause of Stigma  
Role of Values, Norms, and Moral Judgment  
Shame, Blame, and the Role of Gender

## Prepared flip chart

Dysfunctional Communication or Interpersonal Systems (Section IV, Introduction)

## Tip Sheet

*Preparing for Guest Speakers Who Are People Living with AIDS*

## Activity Sheet

*Examples of Knowledge as Root Causes of Stigma*

## Handouts

- A. *Expressions and Forms of Stigma*
- B. *Volunteers Working in High Stigma Communities*
- C. *Recommendations for Combating Stigma*

## Preparation Checklist

- Read the entire session and modify the session according to the time you have available.
- Read Tip Sheet on people living with HIV/AIDS panels. Invite and prepare panelists. Provide panelists with written guidelines relating to the goal of the panel (to help new Volunteers understand the lives of people living with HIV/AIDS in this country) and what you want them to talk about (such as their personal experiences relating to stigma and discrimination, how stigma and discrimination relate to voluntary counseling and testing).
- Make two extra copies of *Handout A: Examples of Knowledge as Root Causes of Stigma*. Keep one for your reference, and cut the other into numbered slips, eliminating the sections without numbers.
- If possible, download and read *Common at its Core: HIV/AIDS Related Stigma Across Contexts* by the International Center for the Research on Women (ICRW) ([www.icrw.org](http://www.icrw.org)). At a minimum, read Handouts A and C which are taken from that report.

## Methodology

## I. Introduction (30 minutes)

## Feelings of being stigmatized (15 minutes)

Guided visualization can be a powerful technique. If participants visualize particularly painful memories, they may get emotional—unable or unwilling to speak about the experience, or they may cry. The trainer should feel confident that he or she can handle these situations, allowing people to work through their own experiences in the room or leaving the room, assuring everyone that powerful feelings are OK, and, if appropriate, putting a hand on someone's shoulder for comfort. Only those participants who want to share should share. The trainer needs to follow up individually with anyone who has strong emotions outside/after the session to make sure he or she is OK.

*To open our session on stigma and discrimination we are going to spend a few minutes exploring some of our own experiences and feelings concerning stigma. We'll do this through a guided visualization.*

**Step 1:** Ask participants to sit quietly, to close their eyes, if they wish. Say the following, pausing for about 15-20 seconds where indicated to let them think.

1. Think about a time in your life when you felt isolated or rejected for being seen as different from others—or when you saw other people treated this way. It does not need to be because of HIV or AIDS—it could be any form of isolation or rejection for being seen as different. (pause)
2. Visualize what happened. Who was there? What did people say/not say to you? What did people do, or perhaps not do that you expected? (pause)
3. How did you feel at that moment in time? Or, how did it feel to watch someone else who was isolated or rejected? (pause)
4. What did you do? (pause)
5. What affect did it have on you . . . at that particular time? Since that incident? (pause)
6. Sit quietly for a moment with your thoughts, and then bring yourself back to our training room.

**Step 2:** Ask participants to write down any thoughts, feelings, or words that they associate with being isolated or rejected.

**Step 3:** Ask participants to share any of what they wrote down that they would like to—list these on a flip chart.

### Definitions and significance (5 minutes)

**Step 1:** Define stigma.

Stigma means to mark or devalue someone based on specific factors. With HIV/AIDS it is described as a “process of devaluation” of people either living with or associated with HIV and AIDS.

**Step 2:** Ask

*How does it lead to discrimination?*

It leads to unfair and unjust treatment of an individual based on his or her real or perceived HIV status.

HIV and AIDS-related stigma and discrimination together have long been recognized as one of the main obstacles to the prevention, care, and treatment of HIV and AIDS.

In this session we are going to use recent research to explore stigma and discrimination in detail, and consider its effects on individuals, communities, and you as Volunteers. We are also going to look at specific ways that Volunteers are well-suited to combating stigma and discrimination.

### Preparation for panel of people living with HIV/AIDS (10 minutes)

**Step 1:** Explain that during the next activity we will be hearing from several people who are living with HIV/AIDS.

**Step 2:** Ask participants what feelings this brings up for them. Allow a few minutes to hear what they have to say.

**Step 3:** Ask them to think for a minute about what they expect to see or hear from people living with HIV/AIDS. They might want to write down their expectations, so they can review them later.

Note that the panelists have agreed to come tell their stories to help participants understand people in their situation in this culture, to learn about their experiences with contracting and living with HIV/AIDS, and how people living with HIV/AIDS can be supported. It

takes a great deal of courage to tell one’s story, but this is one way to fight stigma and discrimination.

There will be time for some questions and answers after their presentations. If participants want to ask a question, they should put it in writing. Submit questions after the panel, before the question and answer period begins.

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## II. Panel of People Living with HIV/AIDS

(45-60 minutes)

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Give participants a few minutes break so you can greet your visitors and bring them to seats in front of the room.

### Facilitated panel presentations (45 minutes)

**Step 1:** Introduce panel members. Ask each panelist to tell his or her story. (*Maximum of 10 minutes each.*)

**Step 2:** When everyone has spoken, thank them all.

**Step 3:** Ask participants to provide any written questions they have. Select some key questions and pose them to the panel.

**Step 4:** Close the panel. If culturally appropriate, have participants present small gifts to each panelist, and perhaps stand and shake their hands as they leave.

### Debrief (5-15 minutes)

**Step 1:** Ask participants to sit and relax for a moment to gather their thoughts.

**Step 2:** Ask them to look back at the expectations they wrote down, and consider whether they were met—why or why not?

*Did anyone have false expectations? Would you be willing to share them? Where did those expectations come from?*

*Which of your expectations were met?*

*What did you learn from the panel?*

*What did the panel’s presentations inspire you to learn more about?*

*What do you think are the strengths and weaknesses of doing panels of people living with HIV/AIDS?*

**Step 3:** Indicate that there is a tip sheet for preparing panels of people living with HIV/AIDS that they can get at the end of the session.

### III. Causes and Forms of Stigma (45 minutes)

#### Recent research

**Step 1:** Explain that this portion of the session is based on findings of research conducted in three countries in Africa (Ethiopia, Tanzania, and Zambia) and Vietnam by the International Center for Research on Women and reported in their publication, *Common at Its Core: HIV-Related Stigma Across Contexts*. (Hold up a copy, if you have one.)

**Step 2:** Read aloud this introductory piece

*“HIV and AIDS-related stigma and discrimination together have long been recognized as one of the main obstacles to the prevention, care, and treatment of HIV and AIDS. Yet little has been done on a large scale to combat them.*

*“There are many reasons for this inaction, including the belief of many policymakers that stigma is hard to define and measure, making it difficult to design and implement interventions.*

*“Stigma, it is believed, is too cultural, too context-specific, and too sensitive to be addressed meaningfully.*

*This report, a synthesis of findings from research in four countries, presents evidence suggesting that HIV and AIDS-related stigma is far less varied and context-specific than may have been imagined. In fact, there are many more similarities than differences across these contexts in the key causes of stigma, the forms stigma takes, and the consequences of stigma. This finding opens a number of important avenues for intervention. . . .” (page 7).*

We are going to learn about these findings in two ways

First, I am going to distribute to each of you an example the study found of root causes of stigma. These are important—and perhaps surprising—but provide important implications for how to combat stigma. Each person will have a turn to share what his or her example is, and we will categorize them on the wall.

Secondly, we’ll study and discuss the chart that shows common expressions and forms stigma takes.

#### Root causes of stigma

**Step 1:** Distribute all of the numbered Activity Sheet slips of *Examples of Knowledge as Root Causes of Stigma* to individual participants. (Some can work

together on longer pieces, or some can take two shorter ones, as necessary.) Give about five minutes to study slips, and ask them to prepare either to read it or paraphrase it. While they are doing this, put the labels on different sections of the wall.

Begin by pointing to the label, “Examples of Root Cause of Stigma.”

Read Part A on the Activity Sheet

*These findings explore the root causes of stigma related to knowledge or understanding of HIV and fear of HIV transmission through routine, noninvasive daily interactions (casual contact) with those living with HIV and AIDS, and how these lead to stigma.*

Have participants with slips from #1 through #13 come to the front to read or paraphrase their finding. Place them on the board under the heading.

**Step 2:** Move to the label “Role of Values, Norms, and Moral Judgments.”

Read Part B on the Activity Sheet

*These findings explore the intersection between HIV and AIDS-related stigma and the values and norms that frame any moral community, but in particular those of our study sites. Three common elements are discussed: (1) the ways in which HIV and AIDS-related stigma functions to sharpen the boundaries of the moral community—creating a clear division between “us” (the presumably uninfected), and “them” (those known or presumed to be living with HIV and AIDS); (2) the tendency in all sites for members of the wider community to assign degrees of “guilt” or “innocence” to HIV-positive people according to assumptions about how that person acquired his or her infection; and (3) the role of gender in these processes.*

Have participants with slips from #14 through #21 come to the front to read or paraphrase their finding. Place them on the wall under the heading.

**Step 3:** Move to the label “Shame, Blame, and the Role of Gender.”

Read Part C on the Activity Sheet

*A key similarity across all research sites was the role that gender plays in the nexus between HIV-related stigma, moral judgment, shame, and blame. Although this interface was complex, it is clear that women generally bear the strongest brunt of this type of stigma. The reason underlying this seems to be that women in all of these settings are expected to uphold the moral tradi-*

tions of their societies. HIV is regarded as evidence that they have failed to fulfill this important social function.

Have participants with slips from #22 through #24 come to the front to read or paraphrase their findings. Place them on the wall under the heading.

**Step 4:** Ask participants to name the one most startling or new fact to them.

**Step 5:** Ask what they heard that was similar to what the people living with HIV/AIDS panel members related.

### Expressions and forms of stigma

**Step 1:** Distribute *Handout A: Expressions and Forms of Stigma*.

**Step 2:** Ask participants to read each column and consider which of the root causes of stigma seem to be influencing those forms of discrimination.

**Step 3:** Ask what they see happening as a result of stigma—to individuals, to families, to the workforce, to communities.

**Step 4:** Ask how they think HIV stigma might affect the implementation of HIV and AIDS services or programs? (Make sure that it is clear that stigma blocks both prevention and treatment of HIV and AIDS.) Some points that should be made:

Stigma keeps people from learning their HIV status through testing and discourages them from telling their partners. As a result, HIV-positive people may infect their partners.

Stigma keeps people who suspect they are positive from accessing treatment and counseling services. For example, a TB patient hides his diagnosis.

Stigma discourages people from using other services (e.g., a pregnant woman might not take ARVs).

Stigma prevents people from caring for people living with HIV and AIDS.

## IV. Stigma, Communities, and Unproductive Volunteer Behavior (20 minutes)

### Introduction (5 minutes)

In communities affected by HIV/AIDS, stigma, shame, and guilt can lead to dysfunctional communication or interpersonal systems which make confrontation of the problem extremely difficult.

“Dysfunctional” has a very specific meaning in this context. Customary ways of resolving community challenges are replaced by three **rules** (reveal flip chart).

**Dysfunctional Communication  
or Interpersonal Systems**

1. Do not **talk** to or tell anyone about the problem.
2. Do not **trust** anyone to respond compassionately.
3. Do not let anyone know how you **feel**.

HIV/AIDS becomes the proverbial “elephant in the living room.” We go about our routines without ever talking about this thing that is taking up so much space in our lives and harming our family and friends. While the disease is infectious, the silence is contagious. Everyone is vulnerable and Volunteers and workers in the field may unconsciously develop coping strategies which can lead to burnout or early termination.

### Unproductive Volunteer roles (15 minutes)

**Step 1:** Distribute *Handout B: Volunteers Working in High Stigma Communities* and ask participants to read the three roles Volunteers may take when living in such a community.

**Step 2:** Ask if they can imagine playing such a role for **two years?**

**Step 3:** Have them look back at the three points on the chart and note that these Volunteer roles reflect the issues there.

**Step 4:** Ask what would help them have ways to

- 1. talk about their experiences?
- 2. manage feelings?
- 3. develop trust in the systems that are there to support them?

Note ideas on a flip chart.

**Transition**

State that given all the information participants have learned, it is clear that working in communities affected by HIV/AIDS will be difficult. In addition to taking care of their mental and physical health, they can look for realistic opportunities to make a difference. Next we'll look at the recommendations from the study we have been using and see what roles participants might be able to play in combating stigma.

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**V. Wrap up (10 minutes)**

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**Recommendations**

**Step 1:** Distribute *Handout C: Recommendations for Combating Stigma* and ask participants to read it, and select a few specific suggestions that look like things they might reasonably be able to do in their communities.

**Step 2:** Ask a few to share what they picked and explain why.

**Step 3:** Ask their general reactions to the recommendations, and if they seem to be the kinds of educational activities that could build capacity at the community level.

**Where are we now?**

**Step 1:** Ask for a couple participants to recap the different segments of this training session.

**Step 2:** Ask for some reactions to what they have learned—hard and hopeful.

**Step 3:** Ask for a few participants to give some hopeful statements based on what they learned.

**Handouts**

Distribute any of the handouts they have not received (including the entire Activity Sheet) for future reference.

**Evaluation**

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## References or Resources

The Change Project. "Understanding and Challenging HIV Stigma: Toolkit for Action," <http://www.changeproject.org/technical/hivaids/stigma/StigmaToolkit.pdf> (accessed March 26, 2007). See: *Module A: Naming the Problem and Module B: More Understanding and Less Fear*.

Jessica Ogden and Laura Nyblade, *Common at its Core: HIV-Related Stigma Across Contexts*, Washington, DC: ICRW, 2005.

## Notes

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## Changes to Session

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# Trainer Reference: Volunteers Working in High Stigma Communities

## HIV/AIDS and stigma

In communities affected by HIV/AIDS, stigma, shame, and guilt can lead to dysfunctional communication or interpersonal systems which make confrontation of the problem extremely difficult.

“Dysfunctional” has a very specific meaning in this context. Customary ways of resolving community challenges are replaced by three rules

1. Do not **talk** to or tell anyone about the problem;
2. Do not **trust** anyone to respond compassionately; and
3. Do not let anyone know how you **feel**.

As such, HIV/AIDS becomes the proverbial “elephant in the living room.” We go about our routines without ever talking about what is taking up so much space in our lives and harming our family and friends. While the disease is infectious, the silence is contagious. Volunteers and workers in the field may unconsciously develop coping strategies which can lead to burnout or early termination. Those discouraged strategies can include

**Overfunctioning** These Volunteers are seen as models for everyone else. As such they may not give themselves needed breaks or rest. They may never feel satisfied with their efforts as they know just how much more could be done. Praise falls on deaf ears. It only proves that others are out of touch. They may feel guilty for not doing more.

**Unfunctioning** These workers know at some level that the work is overwhelming. They sense that they will never live up to the standards set by the “super” worker. As a result, they may turn to more negative strategies for coping with shame/guilt such as high-risk behaviors, misuse of alcohol/drugs, unexplained absences from work, etc. They may feel angry at those that put them in this impossible situation, shame the morning after, and guilt at not doing the right thing.

**Underfunctioning** These Volunteers may develop a strategy which seeks anonymity. All they want to do is get through the next couple of years without allowing their feelings to become too intense. They may fear that if they really let anyone know how they are doing that others will make a decision about whether or not they should stay. They may feel shame at not being

more proactive or assertive, at not voicing their concerns, and not doing as much as others.

In effect, these Volunteers have internalized the stigma prevalent in their communities. Strategies to help them remain resilient throughout their service must include

- Ways of helping them **talk** about their experience,
- Find ways to manage **feelings**, and
- Develop **trust** of the systems in place to support them.

Ideas include

- Peer support training which encourages finding words which help explain unfamiliar and disquieting thoughts or emotions
- Strategies which help “diversify” projects/programs that are highly intense, e.g., teaching children expressive arts
- Developing strategies for bringing workers together with others to build a community of connection—buddy systems, regular time off, in-service training debriefings
- Promotion of mental health resources at post—counselors, libraries, etc.
- Recruit programming and training officers who can facilitate group debriefings and brainstorm strategies for staying resilient
- Develop pre-staging materials that provide applicants with more realistic understanding of the challenges ahead
- Provide ongoing training/debriefing throughout the life cycle of the Volunteer to deal with such topics as grief and loss, stress management, peer helping, etc.

Enhanced approaches to support workers in areas affected by HIV/AIDS will contribute to minimizing the impact of the three rules found in dysfunctional systems

1. Does the idea help increase a Volunteer’s ability to communicate freely with staff and/or others;
2. Does the approach help develop a community of connection and trust; and/or
3. Does this training or effort promote an environment where strong feelings can be expressed safely.

Sanders, Jon. Peace Corps, Office of Special Services, 10/28/04.

# Tip Sheet: Preparing for Guest Speakers Who Are People Living with AIDS

## Why invite people living with AIDS?

One strategy to encourage behavior change, create awareness, and fight the spread of HIV/AIDS is to invite people living with AIDS to share their personal experiences. In Tanzania, due to the fear and blame unjustly surrounding people living with HIV/AIDS, it is crucial to prepare and train both the people living with HIV/AIDS as well as the audience before the session takes place.

In order to prepare, it is important for the Volunteer first to clearly identify her or his session objectives. Some possible objectives may include

- To help participants face their own prejudices about people living with HIV/AIDS
- To erase the stigma surrounding people living with HIV/AIDS
- To emphasize the fact that people living with HIV/AIDS cannot always be identified on sight
- To personalize HIV/AIDS
- To provide concrete examples of the impact of HIV/AIDS
- To personify the courage and fortitude of people living with HIV/AIDS
- To show support and discuss ways to support and care for people living with HIV/AIDS
- To test the participants' ability to put HIV/AIDS education into practice
- To reinforce lessons of behavior change

## People living with HIV/AIDS preparation

Training for people living with HIV/AIDS should include a clear description of the information they are expected to present. Some discussion topics may include

- Birth location
- Testing method used
- Family history
- Reaction of family and friends
- Educational background
- Current situation
- Employment history

- Strategies for a healthy lifestyle
- Family life (marriage, children)
- Suggestions for how to support people living with HIV/AIDS
- Description of HIV contraction

The topics should be agreed upon, making sure that people living with HIV/AIDS are comfortable with the Volunteer's expectations.

In addition to the discussion topics, the Volunteer and people living with HIV/AIDS guests should agree on how the session will be facilitated. It may be helpful to invite several people living with HIV/AIDS, as well as an HIV/AIDS counselor to help facilitate the session. Experience has shown that the best method for a question and answer session is to have the participants write anonymous questions on blank slips of paper, to be collected and given to the guests (or panel moderator). Open question and answer sessions may be difficult, and even painful, as the questions cannot be screened in advance.

One possible session to hold with people living with HIV/AIDS prior to the workshop is "Answering Difficult Questions" (see notes below). This session will help prepare the guests to face/address the possible prejudices of the participants.

## Audience preparation

It is important to prepare the audience for the people living with HIV/AIDS session to make the guest speakers as comfortable as possible. In general, it is beneficial to teach the participants the basic facts about HIV/AIDS, especially points concerning transmission. One suggested session from the *Life Skills Manual* is "How HIV is Transmitted", pg. 63 (Part II, pg. 51 in previous 3 ring binder version)

In addition, some sessions about living with HIV/AIDS should be included in preparation for people living with HIV/AIDS guests. Some possible activities from the *Life Skills Manual* may include

- The Loss Game
- Case Studies
- The Wheel of Care

- True/False Game
- “I Have AIDS” role play
- Statement of Faith
- “HIV/AIDS and You” small group discussions

In general, inviting people living with HIV/AIDS guest speakers can be the highlight of any workshop or seminar, if handled correctly. It is one significant way to allow participants to experience the reality of HIV/AIDS, and often serves as a catalyst for our main goal: behavior change.

### Answering difficult questions

It may be helpful to people living with HIV/AIDS to discuss how they can handle questions they may receive during a panel, individual talk, or just in conversation. It will be less stressful, perhaps, to do this in a small group, where no one is singled out and they can help each other strategize.

Start by asking what kinds of questions they would find difficult. Make a list.

Then try to group and label the questions, using categories such as

#### Hostile questions

Examples: *Isn't it your fault you have AIDS?*  
*Why do you always have to talk about sex?*

#### Questions that have no answer

Example: *Where did AIDS come from?*  
When you don't know the answer.  
Example: *How many people in this town have AIDS?*

#### Personal questions

Example: *Do you use condoms?*

#### Controversial questions

Example: *My pastor says condoms have holes in them. Are you saying he's lying?*

Talk about strategies for handling difficult questions. Some ideas include

- Repeat the question to make sure you understood it and to give yourself some time to think.
- Open up the question to the whole group (panel and/or audience).
- Admit it if you don't know the answer. If you have suggestions how people can find out the answers, provide them.
- Don't feel you have to speak for everyone. Use a phrase such as, “In my experience . . .” or “From what I have heard from others . . .”
- Appeal to universals, such as “We all make mistakes, and mine was . . .” or “Doing risky things is not uncommon, but unfortunately . . .”
- Diffuse hostile or controversial questions by turning away from the questioner and addressing the whole group.
- Preface opinion as such, “In my opinion . . .”
- Know that you don't have to answer questions that are offensive or too personal. “I just don't feel I can talk about that.”

Based on work by school health education Volunteers, Tanzania, July 2000.

Additional resource: *Using Participatory Analysis for Community Action: PACA Idea Book Manual* [ICE No. M0086]. See Chapter 4: “Preparing for PACA” which includes a section on facilitation and dealing with difficult group members.

## Activity Sheet: Examples of Knowledge as a Root Cause of Stigma

PART A explores the root causes of stigma related to knowledge or understanding of HIV and fear of HIV transmission through routine, noninvasive daily interactions (casual contact) with those living with HIV and AIDS, and how these lead to stigma. [Chapter 3: Findings, excepts from Section 3.1]

**1.** Fear that HIV could be transmitted through ordinary, daily interactions with people living with HIV and AIDS that involve *no* exchange of body fluids was common. Examples include contact with an HIV-positive person through simple touch (shaking hands, kiss on the cheek, sitting next to); eating food prepared by or which may have come in contact with those living with HIV and AIDS; breathing infected air; or using objects that someone living with HIV and AIDS had touched (e.g., clothing, bedding, or eating utensils).

**2.** Fear of and preoccupation with transmission through everyday casual contact leads directly to stigma in the form of isolation of persons living with HIV and AIDS in all aspects of daily life. It occurs everywhere, from within the home, to social gathering places in the neighborhood, to the market place, health facilities, and even sometimes in places of worship.

**3.** The common fear across all countries of modes of casual transmission that carry extremely low, if any risk, is striking. In particular, many fear even the most peripheral contact with blood (e.g., left on nail clippers or hair cutting scissors or through mosquitoes), and other nonsexual body fluid (saliva, sweat).

**4.** Standard HIV and AIDS messages often focus solely on how HIV is transmitted, that it has no cure, and that it kills. Such messages tend to convey the incorrect impression that HIV is highly infectious. Rarely do HIV and AIDS messages focus on explaining how HIV is *not* transmitted, the relative infectiousness of HIV, and the fact that HIV is *not* easily viable outside the human body.

**5.** This fear of and preoccupation with contracting HIV through impossible or highly unlikely routes persists across all four countries despite high levels of knowledge about how HIV is transmitted. The data suggests that the persistence of doubts about how HIV is transmitted despite knowing otherwise and the fixation on the least likely modes of transmission could be the result of several interacting factors.

- Lack of specific, in-depth information about HIV transmission
- Fear-based public messaging
- Evolving knowledge on HIV and AIDS

**6.** Ambiguous or vague messages about transmission also can perpetuate the incorrect assumption that daily interactions with people living with HIV and AIDS pose a serious risk of infection. This is particularly the case for the blood mode of transmission . . . Because of the lack of clarity in standard messages about how much, and through what means, blood poses a transmission risk, people do not have the information they need to accurately assess the transmission risk of coming into contact with blood from an HIV-positive person by touching an object or brushing up against someone living with HIV or AIDS.

**7.** Given the narrow and often incomplete or ambiguous knowledge about how HIV is, or is not, transmitted, it is not surprising that the common conclusion to a *what if* scenario is that it could potentially pose a significant risk of transmission and therefore should be avoided. This, in turn, may lead to actions that, while perceived simply as preventive, in fact result in stigmatizing behaviors, such as minimizing or restricting contact with people living with HIV and AIDS. For example, many people refuse to sit next to infected people on a bus, eat food they have cooked, buy produce from them, or share objects with them.

**8.** Adding to the confusion, doubt, and fear over whether, and how much, daily activities pose a risk for HIV transmission is the widespread and well-established knowledge about how other viral and bacterial diseases are transmitted, particularly those commonly associated with HIV (like tuberculosis and diarrhea), and other diseases that have a transmission cycle that includes blood and biting insects, in particular malaria. Given this knowledge, doubt and fear creeps in that HIV might be transmitted this way, too. Knowing that TB is airborne, diarrhea contracted through contaminated food and water, and infected body fluids or objects, and malaria through mosquitoes, people often reason that perhaps HIV could be transmitted these ways too.

**9.** Another factor that adds to the fear and desire to avoid any situation that might pose a potential transmission risk is the legacy of fear and panic created by fear-based messages about HIV coupled with sensationalized reporting around HIV. Fear-based messages in health campaigns focused heavily not only on death as the outcome of HIV, but also on the depiction of a painful, disfiguring, and sometimes shameful death (through linking HIV to socially unacceptable behaviors).

**10.** The sensationalization of alleged cases of vindictive and purposeful infection of others by people living with HIV and AIDS (for example by injecting their blood into others or having premeditated unprotected sex); and lack of positive images of the more prevalent reality of people with HIV and AIDS who are productive and responsible members of society ratchets up the fear and panic of contracting HIV, hence creating stigma toward those living with HIV and AIDS.

**11.** The creation of this fear has affects on public health. For example, people may avoid getting tested for HIV. People may also believe that only sick-looking people have HIV, and so deny their own potential risks and any need for behavior change.

**12.** The continued fear of casual transmission indicates that individuals are not receiving information in an interactive format that allows people to think through the information received, discuss it, and then raise questions with an informed, trusted moderator to provide answers.

**13.** Adding additional doubt to the mix is the relative newness of the HIV epidemic and the constantly evolving, sometimes contradictory, scientific and medical knowledge about HIV and AIDS. Because knowledge continues to grow on all aspects of HIV, including transmission, people begin (or continue) to doubt the validity of existing information, causing fear that current information about transmission might be wrong.

## The Role of Values, Norms, and Moral Judgment

The moral dimensions of stigma are well known and indeed can be traced back to the original meaning of the word itself, which according to Goffman relates to “bodily signs designated to expose something unusual and bad about the moral status of the signifier” (Goffman 1963). [Chapter 4: Findings, Section 3.1.2]

PART B explores the intersection between HIV and AIDS-related stigma and the values and norms that frame any moral community, but in particular those of our study sites. Three common elements are discussed: (1) the ways in which HIV and AIDS-related stigma functions to sharpen the boundaries of the moral community—creating a clear division between “us” (the presumably uninfected), and “them” (those known or presumed to be living with HIV and AIDS); (2) the tendency in all sites for members of the wider community to assign degrees of “guilt” or “innocence” to HIV-positive people according to assumptions about how that person acquired his or her infection; and (3) the role of gender in these processes.

**14.** The tendency to link HIV and morality might be related to the fact that affliction is often perceived as an outward manifestation of a moral transgression. In some Asian cultures, these perceptions might be couched in terms of *karma*. In a number of African societies, specific illnesses or sets of symptoms are associated with having broken one or more social prohibitions. Elsewhere, including the Judeo-Christian traditions of North America and Europe, it is not uncommon for people to believe that illness is a punishment for one’s sins.

**15.** Whatever its roots, the tendency to associate illness with moral impropriety is a central contributing factor to HIV and AIDS-related stigma. This stigma is exacerbated by the seriousness of the illness, its mysterious nature, and its association with behaviors that are either illegal or socially sensitive (e.g., sex, prostitution, and drug use). Also relevant is the perception that HIV infection is the product of personal choice: that one *chooses* to engage in “bad” behaviors that put one at risk and so it is “one’s own fault” if HIV infection ensues.

**16.** The Vietnamese refer to people with HIV as having contracted the virus through a lack of self-discipline—through “indulging in play” and engaging in “social evils.” Lack of seriousness, discipline, and personal integrity contravenes many of the core tenets of Vietnamese society, which stem ultimately from Confucianism. Notably similar findings have been identified elsewhere, for example in Thailand.

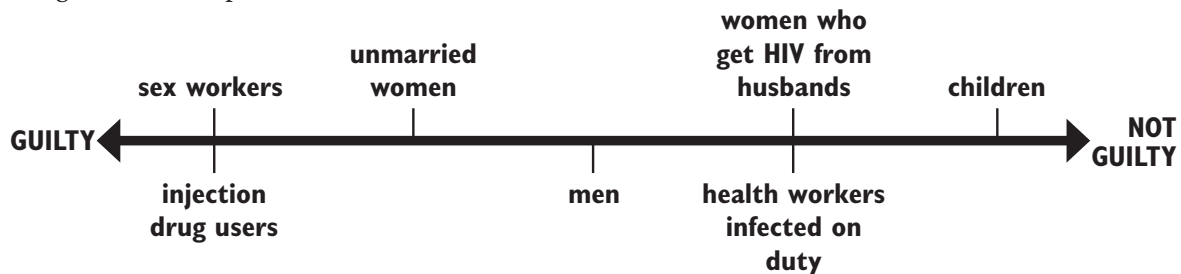
**17.** The presence of HIV also enhances pre-existing stigmas and serves to retrench social values and norms about correct, normal, or appropriate behavior. In Vietnam this takes the form of a discourse of social evils. In the African settings it tended to be couched in religious terms—especially reinforcing the pre-existing stigma against sex workers and youth.

**18.** Stigma reinforces previously defined boundaries between “us” (the normal/righteous/upstanding citizens) and “them” (the deviant/bad/“fallen” ones). The fact that one has become infected with HIV is used to distance that person from the mainstream community, to set him or her apart, marked out as having transgressed or sinned against god and/or society. This mark (or literally, “stigma”) is a cause for opprobrium in and of itself—but all the more so because of the perception that he or she has become infected by *choosing* to do things (such as inject drugs or have unsanctioned sex) that he or she *knows* are wrong.

This boundary-making serves at least two purposes: it enables the (apparently) uninfected to reinforce their notions of themselves as being morally right and upstanding citizens, while also allowing this group to deny its own level of risk, thereby enabling them to believe they have no need to contemplate any changes to their own behavior.

**19.** Clear distinctions were made between those who became (or were presumed to have become) infected through such “improper” behaviors, and those who were deemed “innocent victims”—such as sexually faithful married women (or men) who became infected because of their spouse’s philandering; health care workers or police infected in the course of their work; or children infected through vertical transmission. Thus, there exists in people’s minds a kind of continuum from presumed “guilt” to presumed “innocence.” Although all people with HIV experience some degree of stigmatization, where one falls along this continuum will determine, to a significant extent, the type and degree of stigmatization received from one’s family and the wider community.

This schematic broadly generalizes a complex picture into a few categories plotted in a very simplistic and linear way. In real life, the specific placement of any individual in any single circumstance will vary considerably, sometimes from one person to the next. The category broadly labeled “women who get HIV from their husbands” is a good example. The extent to which such a woman is considered more “guilty” or “innocent” will depend on a range of factors. For example, is she considered by the community to be a “proper woman”? If so, she is likely to be deemed “innocent,” an unwitting victim of her husband’s bad behavior. However, if such a woman has been in conflict with any of her neighbors or if for some other reason the community wants to cast her out, then people will find reason to question her moral integrity and guilt will be imputed.



**20.** The continuum also indicates the ways in which HIV and AIDS-related stigma interacts with pre-existing stigmas; in addition to creating stigma where none previously existed, HIV and AIDS create *double* stigma—the pre-existing stigma associated with an unapproved behavior (such as injection drug use or “immoral” sex), in combination with the stigma of living with HIV. In Vietnam, injection drug use and prostitution are widely regarded as social evils, an association entrenched in the minds of the public as well as in legislation and policy. Because HIV often is associated with these pre-existing stigmatized groups, HIV itself has started to be referred to as a social evil. Because HIV often is associated with these pre-existing stigmatized groups, HIV itself has started to be referred to as a social evil. This linkage between HIV, drug use/sex work, and social evils therefore not only affects those who do engage in these behaviors, but all people living with HIV, serving to magnify HIV and AIDS-related stigma and the misery it creates. A parallel example from the African settings relates to the close association made between HIV and AIDS and promiscuity.

**21.** Given the close associations between HIV and moral impropriety, the harshest stigma is reserved for those expected to uphold moral laws and the moral fabric of society should not be surprising. For example, HIV-positive women tended to be more highly stigmatized than men. In Africa, those in the clergy who became infected with HIV were the object of particular opprobrium, while the equivalent in Vietnam was members of the Communist Party. Because these are the social roles specifically designated as moral and social role models, their “fall from grace” is particularly heavily stigmatized.



## Shame, blame, and the role of gender

**PART C:** A key similarity across all research sites was the role that gender plays in the nexus between HIV-related stigma, moral judgment, shame, and blame. Although this interface was complex, it is clear that women generally bear the strongest brunt of this type of stigma. The underlying reason seems to be that women in all of these settings are expected to uphold the moral traditions of their societies. HIV is regarded as evidence that they have failed to fulfill this important social function.

**22.** A fundamental double-standard exists in all study settings, whereby men are generally expected to be reckless, adventurous and more likely exposed to a whole host of sexually transmitted infections (STIs) (including HIV), and women are expected to be sexually faithful, chaste, and morally upstanding. Again, the specific ways in which these values are expressed may differ from one setting to the next, but the core underlying issues remain startlingly consistent.

**23.** Although HIV-positive women in general may be more reviled than HIV-positive men in Vietnam, as a whole they are not generally blamed directly for bringing HIV into a family (although they may be in specific instances), as this is often known to have happened through the husband's injection practices.

**24.** In Tanzania, Zambia, and Ethiopia, more women than men are living with HIV (UNAIDS 2004). Findings in all three of these country studies show that women tend to be *both* more heavily stigmatized than men for having “failed as proper woman” *and* blamed more often for “bringing” HIV into a family or marriage. In Ethiopia, for example, although some people are sympathetic to women exposed to HIV for reasons beyond their control, women are nevertheless more likely to be viewed as the source of HIV and blamed.

Excerpted from *Common at Its Core: HIV-Related Stigma* by Jessica Ogden, Laura Nyblade, ICRW, 2005. Data in this report comes from four studies: Ethiopia, Tanzania, Vietnam, and Zambia.

# Handout A: Expressions and Forms of Stigma

Physical	Social	Language/Verbal	Institutional
<p><b>Isolation</b></p> <p>Separating sleeping quarters</p> <p>Marking and separating eating utensils</p> <p>Separating clothing and bed linens</p> <p>No longer allowing person to eat meals with family</p> <p>Confinement to certain rooms of house</p> <p>No longer allowing person to participate in housework (e.g., cooking food)</p> <p>Public rejection (refuse to sit next to person on bus, bench, at church, tea shops or in bars)</p> <p>Separation from children</p> <p>Abandonment by family</p> <p><b>Violence</b></p> <p>Beatings</p> <p>Being kicked</p> <p>Throwing stones</p> <p>Arrests</p>	<p><b>Isolation</b></p> <p>Reduction of daily interactions with family and community</p> <p>Exclusion from and shunning at family and community events</p> <p>Loss of social networks</p> <p>Decreased visits from neighbors</p> <p><b>Voyeurism</b></p> <p>Increased visits from neighbors, not out of concern but to mock individual or report back to community</p> <p><b>Loss of identity/role</b></p> <p>Viewed and treated by community as having no future</p> <p>No longer considered productive member of society</p> <p>Automatically associated with “social evils” (e.g., drug use, sex work)</p> <p>Expected to adopt new role of teaching others about HIV and disclosing status</p> <p>Loss of power, respect, and standing in community</p> <p>Loss of right to make decisions about own life</p> <p>Loss of marriage and childbearing opportunities</p>	<p><b>Gossip</b></p> <p>Speculation on how person acquired virus</p> <p>Spreading rumors</p> <p>Whispering behind back</p> <p><b>Taunting</b></p> <p>Insults</p> <p>Mocking</p> <p>Finger-pointing</p> <p>Threats</p> <p><b>Expressions of blame and shame</b></p> <p>Scolding (e.g., blamed for not listening to elders)</p> <p>Blamed for bringing “bad luck” to whole family</p> <p><b>Labeling and use of derogatory words to describe people living with HIV or AIDS</b></p> <p>In Africa: “moving skeleton,” “walking corpse,” “keys to the mortuary”</p> <p>In Vietnam: “they are social evils,” “scum of society,” “deserves to die”</p>	<p><b>Loss of livelihood/future</b></p> <p>Loss of employment</p> <p>Loss of customers/business</p> <p>Denial of loans, scholarships, visas</p> <p><b>Loss of housing</b></p> <p>Denied housing</p> <p>Eviction by landlord</p> <p><b>Differential treatment in schools</b></p> <p>Teachers supporting the idea of separating children of HIV+</p> <p>People to “protect” other students</p> <p><b>Differential treatment in health care settings</b></p> <p>Excessive and unnecessary precautions by health-care staff</p> <p>Shuffled between providers to avoid caring for HIV+ patient</p> <p>Denial of health services</p> <p>Provision of substandard treatment</p> <p>Use of separate medical tools for people with HIV or AIDS</p> <p>Place patients with HIV in separate rooms</p> <p><b>Differential treatment in public spaces</b></p> <p>Refusal of services (e.g., will not be served food by vendors, or not served in shared containers)</p> <p><b>Media and public health messages and campaigns</b></p> <p>Posters and news stories emphasizing negative images of people with HIV and AIDS and employing fear tactics to warn about HIV and AIDS</p> <p>Posters and news stories presenting factual information about HIV and AIDS with a moral and judgmental tone</p> <p>Inflammatory news stories about HIV-positive individuals purposefully infecting others</p>

Reproduced from *Common at Its Core: HIV-Related Stigma* by Jessica Ogden and Laura Nyblade, ICRW 2005, page 26.  
Based on studies in Ethiopia, Tanzania, Vietnam, and Zambia.

## Handout B: Volunteers Working in High Stigma Communities

### HIV/AIDS and stigma

In communities affected by HIV/AIDS, stigma, shame, and guilt can lead to dysfunctional communication or interpersonal systems which make confrontation of the problem extremely difficult.

“Dysfunctional” has a very specific meaning in this context. Customary ways of resolving community challenges are replaced by three rules

1. Do not **talk** to or tell anyone about the problem;
2. Do not **trust** anyone to respond compassionately; and
3. Do not let anyone know how you **feel**.

As such, HIV/AIDS becomes the proverbial “elephant in the living room.” We go about our routines without ever talking about this thing that is taking up so much space in our lives and harming our family and friends. While the disease is infectious, the silence is contagious. Everyone is vulnerable and Volunteers and workers in the field may unconsciously develop coping strategies which can lead to burnout or early termination. Those discouraged strategies can include

**Overfunctioning** These Volunteers are seen as models for everyone else. As such they may not give themselves needed breaks or rest. They may never feel satisfied with their efforts as they know just how much more could be done. Praise falls on deaf ears. It only proves that others are out of touch. They may feel guilty for not doing more.

**Unfunctioning** These workers know at some level that the work is overwhelming. They sense that they will never live up to the standards set by the “super” worker. As a result, they may turn to more negative strategies for coping with shame/guilt such as high risk behaviors, misuse of alcohol/drugs, unexplained absences from work, etc. They may feel angry at those that put them in this impossible situation, shame the morning after, and guilt at not doing the right thing.

**Underfunctioning** These Volunteers are aware that the other two are grabbing all the attention and may develop a strategy which seeks anonymity. All they want to do is get through the next couple of years without allowing their feelings to become too intense. They may fear that if they really let anyone know how they are doing that others will make a decision about whether or not they should stay. They may feel shame at not being more proactive or assertive, at not voicing their concerns, and not doing as much as others.

In effect, these Volunteers have internalized the stigma prevalent in their communities. Strategies to help them remain resilient throughout their service must include

- Ways of helping them **talk** about their experience,
- Find ways to manage **feelings**, and
- Develop **trust** of the systems in place to support them.

Sanders, Jon. Peace Corps, Office of Special Services, 10/28/04.

## Handout C: Recommendations for Combating Stigma

... We thus call for an approach to intervention that starts with the conviction that individual attitudes can and do make a difference, and that long-term and far-reaching stigma reduction can start with individuals. Depending on the context, it may be necessary to intervene with people in positions of power and influence; people who determine to a large extent what messages are delivered and how; people who have the power to institute anti-discrimination laws and policies; and people who are charged to carry out these laws and policies. **In all contexts, it will be appropriate and necessary to intervene at the community level with community members, including health-care workers, people working with faith-based and community-based organizations, and people living with HIV and AIDS and their families.**

### Knowledge and fear about HIV and AIDS

The persistence across diverse settings of the “*knowing, but not quite believing*” that HIV can only be transmitted through three specific routes indicates that overcoming these doubts and fears is one of the key steps for any program working to reduce HIV-related stigma. The continuation of stigma driven by these fears, despite years of information, education, and communication (IEC) and more recently behavior change communication (BCC) efforts, indicates that current strategies for imparting an understanding of HIV transmission, and AIDS more generally, are not completely effective, and in some cases may be contributing to fear and stigma. More specifically, the findings suggest that programs need to focus on the substantive content of messages pertaining to HIV as well as the style and method of delivery, paying attention to the following

### Substantive content of messages

Persistent fears about HIV transmission through improbable means, and the “what if” scenarios people create in the face of these fears, indicate that many people dwell on and worry about HIV transmission through casual encounters in daily life. These unfounded fears clearly suggest that partial or ambiguous (and often negative) information contained in HIV and AIDS-related messaging can have

unintended, and undesirable, consequences. Thus, programs and policies need to broaden, deepen, and sharpen HIV messages by

- Providing information not only on how HIV is transmitted, but also how it is *not* transmitted. This includes identifying the most commonly feared “casual” contact situations in a community (e.g., contact with blood, sweat, and saliva where no fluids are exchanged, or mosquitoes) and explaining *why* HIV transmission is highly unlikely or impossible through these situations.
- Ensuring that people have a deep enough understanding of what HIV is and how it is transmitted so that they are equipped to make correct assessments of actual HIV risk in any given life situation they encounter. For example, understanding that HIV is unable to survive for long outside the body will help reassure people that HIV cannot be transmitted through various modes of casual contact experienced on a routine basis, such as sitting next to a person with HIV on a bus or sharing utensils with a person with HIV. This is an especially important message to get across because people in all four studies expressed fear of transmission through casual contact, and many forms of stigma are directly related to that fear.
- Delivering clear and unambiguous information by explaining exactly how HIV is transmitted through blood and sex, or from mother-to-child, to ensure a clear understanding of risky exposures and the relative risks of different exposures. The ways in which HIV can be transmitted are often presented in ambiguous terms (sex, blood, mother-to-child), with little distinction made between the relative risks of the three modes or of the relative risks of different kinds of contact within a given mode (e.g., blood exposure through injection or transfusion versus blood left on a nail clipper).
- Broadening the content of HIV messages to include information on HIV and AIDS beyond transmission, in particular, what it means to live with HIV; the skills needed to help individuals prevent its transmission; and if infected, how to live healthy and productive lives. For example, messages could inform about the longevity of

a person living with HIV or that opportunistic infections are treatable in HIV-positive persons. Messages also could offer practical tips on different strategies for bringing up the issue of HIV and condom use with sexual partners, both in steady partnerships and casual relationships.

- Creating recognition and understanding of HIV stigma, including what it is; how it is harmful to ourselves, our families, and our communities; and the role each individual has to play in reducing it. While not dealt with in depth in this report, the data from all countries shows a gap between people's stated intentions *not* to stigmatize and their actions, which are stigmatizing. This indicates a lack of recognition of what stigma actually is. Creation of improved awareness of what stigma is and fostering an understanding of how stigma is harmful would help stop this inadvertent stigma from occurring. At the same time, addressing each individual's role in creating or reducing stigma would generate the necessary will to do something about it.

### Style and delivery of messages

In addition to the content of HIV and AIDS information, the style and delivery of messages also potentially creates and perpetuates stigma. In this respect, the following are critical areas to address in working toward reducing HIV-related stigma

- Provide HIV and AIDS information in an interactive format, moderated by a knowledgeable and trusted facilitator. This will encourage discussion, questions, and feedback on the hypothetical scenarios that people worry about. Such a format allows the facilitator to address all individual concerns and unambiguously dispel the notion that HIV can be transmitted through casual contact. Once people truly understand and believe this, they will be less likely to stigmatize people with HIV through avoidance and isolation. Messages delivered in a unidirectional mode (e.g., through billboards, fliers, posters, radio, etc.) are important but need to be complemented by opportunities to ask questions about the information to dispel any misunderstandings the information creates about casual transmission.
- Gather data on how people understand the messages they receive, whether from specific IEC or BCC campaigns or from the growing global flow of information through the Internet and other

communication outlets. A regular process of collecting this kind of information is critical so that misconceptions can be dealt with quickly, before harm is done.

- Use more positive images of people living with HIV, rather than fear-based messages and negative images. The findings confirm that the use of fear-based messages that equate HIV infection with disfigurement, suffering, and death, and images of sick and dying people with AIDS only serve to increase the fear of HIV and people with HIV. Eliminating fear-based and negative imagery will increase positive images of persons living with HIV and combat the fear that drives stigma, as well as the stigmatizing beliefs that HIV equals immediate disability and death, and that persons with HIV are nonproductive members of society.

### Values, norms, and moral judgments

To effectively address stigma, programs and policy also must attempt to disassociate HIV from the sensitive and often taboo social issues that are associated with its transmission, in particular sex and injection drug use. This can be done without sacrificing effective communication of information about prevention. For example

- Explain how HIV is (and is not) transmitted in a fact-based, neutral, and non value-laden format.
- Messages, programs, and policies need to discuss the behaviors that can lead to HIV transmission without direct reference to particular individuals or groups to ensure that specific groups (e.g., young girls, MSM, sex workers, injection drug users) are not singled out as vectors of transmission. Messages about HIV that include implicit value judgments about a behavior legitimize stigma by implying that HIV is a matter of personal choice.
- Create safe, facilitated spaces to discuss the values and beliefs that underlie stigma. The values, norms, and moral judgments that create and justify stigma are ingrained and often unconscious. Tackling stigma requires facing these issues, including reflecting on

*Why we hold these judgments and their negative effects;*

*How judgments keep us from accepting and caring for people with HIV, even those close to us;*

*The fact that the nature of HIV puts us all at risk,*

*and that making morality-based distinctions of “us” versus “them” does not protect us, but instead puts us at greater risk by creating a false sense of distance; and*

*How the position of women in society, particularly the double standards for men and women, lead to increased stigma (and vulnerability) for women.*

- Key institutions and opinion leaders shaping and reinforcing societies’ values must take the lead in reducing stigma. They can do this by

*Promoting non-stigmatizing principles like compassion and nondiscriminatory and equal treatment for all;*

*Carefully examining content and style of messages (as described above) to ensure that they are non-stigmatizing; and*

*Training leaders to improve their understanding of HIV and overcome fears of casual transmission, recognize stigma, and become motivated to tackle it, and begin the process of self-reflection on values, morals, and judgment.*

### **Involve people with HIV and AIDS as integral members of all programs**

People with HIV and AIDS have a central role in stigma reduction at any level of intervention and provide a strong basis on which to build successful programs. Bearing the brunt of stigma, those living with HIV have the life experience and knowledge needed to design and implement appropriate stigma-reduction responses. Where appropriate, with training (where needed) and support, and as paid staff members or consultants, people with HIV should form the core of stigma-reduction programs. As detailed in a recent review (Brown et al. 2003), interventions which involved direct interaction between people with HIV and AIDS and “stigmatizers” indicate some success in lowering stigma. Several of the underlying causes of stigma identified in this report point to the critical role people living with HIV have in dispelling the myths that allow stigma to persist. In particular, they can help combat the fear of casual transmission of HIV, the belief that HIV means immediate disability and death, and that people living with HIV are somehow different from everyone else. In addition, working to fight HIV and stigma is an empowering activity that gives hope to people with HIV, which also helps people overcome internalized stigma.

### **The way forward**

The research evidence presented in this report indicates that it is time to stop making excuses for not addressing HIV and AIDS-related stigma and discrimination. Stigma is certainly complex and affected by context. However, as these studies show, there are more commonalities than differences in the causes, forms, and consequences of HIV and AIDS-related stigma across countries and continents. Taking the opportunity to design and implement interventions that address these common issues and understandings is the first step in reversing the devastating impact that stigma is having on those infected with and affected by HIV and AIDS. The time to act is now.

Excerpted from chapter 5, “Recommendations,” of *Common at Its Core: HIV-Related Stigma Across Contexts*, by Jessica Ogden and Laura Nyblade, ICRW, 2005.

## Session Four: Behavior Change Toolkit Sampler

### Purpose

To have Volunteers plan a behavior change training activity for a specific audience, through use or modification of existing activities and materials.

### Rationale

Many excellent training materials have been carefully developed but are never used. For Peace Corps trainees, Volunteers, and staff to understand the value of existing materials they need to see them in use. This session provides an opportunity to bring to life a sample of the training materials that are available and to encourage the modification of well-grounded materials for various uses. (Volunteers are not encouraged to create their own materials without first looking for appropriate materials in existing sources.)

### Target Audience

Peace Corps participants (trainees and/or Volunteers)

### Duration

2 hours—in session

Plus: 1 hour for each small group to present to its peers at some other time **and**

1 hour presentation by each group to a target audience/group at some other time.

### Objectives

By the end of the session participants will be able to

1. Explain how to use a variety of existing materials from the Peace Corps and other agencies.
2. Adapt materials for use in their communities.
3. With others, present an HIV session.

### Session Outline

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**I. Introduction to Available Community Activity/ Training Materials** (15 minutes)

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**II. Small Group Planning** (45 minutes)

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**III. Presentations** (10 minutes per group—approximately 50 minutes)

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**IV. Scheduling Full Presentations** (10 minutes)

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### Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Promising practices relating to behavior change programs focused on HIV/AIDS
- Peace Corps *Life Skills Manual*
- Gender-based violence
- Understanding of cultural issues relating to HIV/AIDS
- Volunteer cross-sectoral roles in the field relating to HIV/AIDS
- Facilitating discussion of intimate information with a mixed-gender and mixed-age group
- Materials available to the Peace Corps for use in the field
- Knowledge of how to make presentations, assist in preparing presentations, and critiquing training design and delivery

### Materials

Sample training materials including: (several copies of each)

Peace Corps' *Life Skills Manual* [ICE No. M0063]  
*Games for Adolescent Reproductive Health: An International Handbook*, by Path, [www.path.org](http://www.path.org). (Download a copy from the Web.)

CEDPA's *Choose a Future: Issues and Options for Adolescent Boys* (ICE No. YD032) and *Choose a Future: Issues and Options for Adolescent Girls* (ICE No. WD127)

Common materials for activities: blank flip chart paper, markers, tape, colored paper, note cards, etc.

Blank flip chart

Markers

Prepared flip chart, "Group Assignment"

## Preparation Checklist

- Read the entire session and modify the session according to the time you have available.
- Borrow copies of the ICE publications from your IRC or order any books not on hand from ICE.
- Download *Games for Adolescent Reproductive Health* (see above) from the Web.
- Identify target groups for whom participants can plan activities.
- Have common training materials available.

## Methodology

### I. Introduction to Available Community Activity/ Training Materials (15 minutes)

**Step 1:** Introduce session by telling participants that there many excellent training materials available to them. These materials have been carefully written, reviewed, and tested by experts in the field. Volunteers should always look for prepared materials they can adapt, if necessary, rather than create their own. This is because it is difficult to create good training materials from scratch and easy to make errors in content and methodology. In this session participants will learn about several resources available to them and have a chance to work with some of the prepared training sessions.

**Step 2:** Hold up each of the resources you have. Give a brief overview of the content of each.

**Step 3:** Provide time for trainees to browse the materials.

### II. Small Group Planning (45 minutes)

**Step 1:** Provide target groups/topics. (5 minutes)

Provide a list of target audiences such as class of children (junior high age), boys and/or men, girls and/or women, etc., and topics, if you wish, such as life skills, empowerment community meeting, HIV/AIDS awareness.

**Step 2:** Form groups. (5 minutes)

Ask participants to form groups of three or four and select one of the target groups/topics.

**Step 3:** Small group planning. (35 minutes)

Explain the task (reveal flip chart).

**Group Assignment**

1. Select a resource that has training materials for your target group.
2. Select an activity from one of the resources; modify if you need to/want to.
3. Plan how you will deliver the activity to the rest of the training group.
4. Plan an overview of the activity and information about
  - Under what situations would this activity be appropriate?
  - What role could it play in an overall strategy to address HIV/AIDS?

### III. Presentations (50 minutes)

**Group reports** (10 minutes/per group) (50 minutes total)

**Step 1:** Explain that each group should present a description of their target group, selection of activity and why, role it would play in an overall strategy to address HIV/AIDS, when it would be appropriate. The larger group can make suggestions/ask questions.

**Step 2:** Each group makes presentation.

**Step 3:** Once all groups have delivered their activities, evaluate the materials available. Discussion points can include

*What is useful?*

*What is still needed?*

*How can existing materials spark ideas for modifying activities for local use?*



**V. Scheduling Full Presentations** (10 minutes)

**Step 1:** Schedule full presentations to training group. (5 minutes)

Determine when each group can deliver its full training to the rest of the group over the next few days.

**Step 2:** Schedule community presentations. (5 minutes)

Discuss when/how they might be able to actually practice the activity in the community.

**Evaluation**

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**References or Resources**

*Choose a Future: Issues and Options for Adolescent Boys*, The Centre for Development and Population Activities: Washington, DC, 1998. [ICE No. YD032]

*Choose a Future: Issues and Options for Adolescent Girls*. The Centre for Development and Population Activities: Washington, DC. [ICE No. WD127]

*Gender and Relationships: A Practical Action Kit for Young People*, The Commonwealth Secretariat, London, in collaboration with Healthlink Worldwide, London, 2001. See the Introduction, Parts 1, 2, 3, and 4.

*Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual*, EngenderHealth: Washington, DC, 2002.

*Life Skills Manual*. Washington, DC: Peace Corps, 2001. [ICE No. M0063]

*Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers*, Participant’s Handbook, EngenderHealth: New York, NY, 2004.

**Notes**

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**Changes to Session**

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# Optional Session Five: Facts and Myths About HIV/AIDS

## Purpose

To help participants understand how different beliefs affect attitudes about HIV/AIDS, and how these impact behavior change.

## Rationale

A first step in creating a behavior change program is to assess knowledge, beliefs, and attitudes about HIV/AIDS and related issues. This session will provide participants insight into some of the beliefs and attitudes people hold and help them understand the need to explore these questions in their own communities. Sessions 1-3 of this module must be trained before this session.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

1 hour to 1 hour and 30 minutes

## Objectives

By the end of the session participants will be able to

1. Describe beliefs that affect people's attitudes towards HIV/AIDS.
2. Discuss the significance of understanding beliefs and attitudes as a first step in designing an initiative focused on behavior change.

## Session Outline

- I. **Introduction** (5 minutes)
- II. **Beliefs about HIV/AIDS** (20 minutes)
- III. **Factors Affecting Our Beliefs** (20 minutes)
- IV. **Facts We Don't Believe** (30 minutes)
- V. **Wrap up** (10 minutes)

## Facilitators/Technical Expertise

Facilitator\* must be knowledgeable about

- American and host country beliefs and attitudes about HIV/AIDS.
- Cultural and cross-cultural issues relating to HIV/AIDS and Volunteers.
- Behavior change theory.

\*The cross-cultural coordinator should be part of the training team.

## Materials and Equipment

Cards for cardstorming (approximately five per participant)

Tape or push pins and large corkboard/soft wall

Handouts, if available, relating to local beliefs relating to disease and HIV/AIDS

Blank flip chart

Markers

Prepared flip charts

1. Small group task on beliefs about HIV/AIDS
2. Pair task on facts they don't believe

## Preparation Checklist

- Read the entire session and modify the session according to the time you have available.
- Ask the cross-cultural coordinator for materials to create handouts about traditional beliefs relating to disease and HIV/AIDS.

## Methodology

Trainer's note: Cardstorming is a quick way of getting out ideas and getting everyone involved. Participants, working individually or in pairs, write single points on cards and tape them on the wall, creating a quick brainstorm of ideas. Once everyone is finished, the cards are organized into categories and discussed.

### I. Introduction (5 minutes)

**Step 1:** Explain the purpose and rationale for the session.

**Step 2:** Explain the concept of cardstorming if this method of brainstorming has not been used before. Distribute blank cards.

### II. Beliefs about HIV/AIDS (20 minutes)

#### Pairs (10 minutes)

Divide the group into pairs. Ask pairs to cardstorm beliefs around HIV/AIDS and post their cards on the wall.

#### Small Groups (10 minutes)

**Step 1:** Ask participants to divide themselves into groups of three or four.

**Step 2:** Ask each group to select one of the beliefs and discuss it. Groups should be prepared to share (reveal flip chart 1).

**Beliefs about HIV/AIDS**

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**Small Group Task**

1. Pick one belief from the cards and discuss it.
2. Be prepared to share your ideas about
  - Where might this belief originate? (origin)*
  - What could be some of the reasons or thinking behind the belief?*

FLIP CHART 1

#### Examples of popular beliefs

- Condoms transmit HIV
- Using contraceptives such as the pill or diaphragm can prevent a woman from getting HIV
- HIV is caused by sleeping with a woman who has had a miscarriage
- HIV is caused by witchcraft
- The partner who falls sick first is the person who became infected with HIV first—who “brought HIV into the family”
- Sex with a virgin/young girl cleanses you of HIV
- Every time you have sex with another person your viral load goes down
- If one partner is HIV-positive, the other must also be HIV-positive
- Holy water can cure you of AIDS

**Step 3:** Ask each group to quickly read its belief out loud and share its ideas of where the belief may have come from and what some of the reasons for it might be.

### III. Factors Affecting Our Beliefs (20 minutes)

#### Brainstorm

**Step 1:** Ask participants to call out factors that influence what we believe about diseases such as HIV/AIDS. List them on a flip chart without discussion.

**Step 2:** Discuss any items that are not clear.

#### Examples of responses

- Day-to-day experience and survival learning
- Understanding of other illnesses
- Religious and spiritual beliefs
- Ideas learned from our family members, clan, tribe, community
- Ideas from our peers
- Facts learned at school
- HIV/AIDS messages
- Popular beliefs and sayings/folklore
- Level of trust in AIDS educators or health workers

**Step 3:** Discuss whether there are some common themes. Note them.

Examples may be

- Medical knowledge or lack thereof of any illnesses, modes of transmission
- Religious or spiritual beliefs—moral judgments
- Media
- Family, peer values/influence

**Step 4:** If there is time, the cards on the wall from the first exercise could be categorized according to the themes.

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#### IV. Facts We Don't Believe (30 minutes)

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**Step 1:** Explain that there are “facts” or information we hear that we don't believe. We are going to explore that a little bit.

**Step 2:** Divide into pairs to discuss the following questions (post flip chart 2).

**Facts We Don't Believe**

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**Pair Task:** Discuss the following questions and be prepared to share what you discussed.

*What do you know already about how HIV is transmitted?*

*Which of those facts don't you believe and why?*

*Do you trust people who give you information on AIDS? Do you trust their information? If not, why not? (What makes people distrust what they get through AIDS educators or health workers?)*

FLIP CHART 2

Examples of responses

#### Reasons people may not trust factual information provided on AIDS

- Educators give contradictory, confusing, or incomplete information.
- Information changes.
- Audience may not believe educator because of own beliefs, life experience, knowledge.

#### Traditional beliefs which make people distrust facts on HIV/AIDS

- HIV is the result of sin.
- Foreigners brought AIDS to Africa.
- HIV is in the condom.
- God/ancestors/spirits are punishing you so there is no cure.
- Muslims don't get HIV.

**Step 3:** Ask a few pairs to give an example of something they don't believe and why. Any other pair with a different reason can add their ideas.

**Step 4:** Ask cross-cultural coordinator to comment on the ideas generated, from the point of view of the host country. If handouts have been prepared on local beliefs, distribute them now.

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#### V. Wrap up (10 minutes)

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Ask some summary and application questions, such as

- What surprised you about what you heard in this session?
- What is the significance of beliefs and attitudes for your work relating to behavior change and HIV/AIDS?
- What more do you need to know about local beliefs and attitudes relating to disease and HIV/AIDS and how can you find out?

#### Evaluation

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### References or Resources

Adapted from: The Change Project. “Understanding and Challenging HIV Stigma: Toolkit for Action,” <http://www.changeproject.org/technical/hivaids/stigma/StigmaToolkit.pdf> (accessed March 26, 2007). See: *Module A: Naming the Problem* and *Module B: More Understanding and Less Fear*.

### Notes

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# Assessment Analysis & Prioritizing Activities

## HIV/AIDS TRAINING RESOURCE KIT

**Session 1:** Assessment and Prioritizing Basics for HIV/AIDS Prevention/Intervention

**Session 2:** Culture, Assessment, and HIV/AIDS

**Session 3:** Using Assessment Data for Targeted Interventions

**Session 4:** An Appreciative Approach (optional)





# Session One: Assessment and Prioritizing Basics for HIV/AIDS Prevention/Intervention

## Purpose

To provide an understanding of the role of assessment in designing and prioritizing projects addressing HIV/AIDS and in the value of appreciative and participatory approaches to assessment.

This session assumes that participants have had an introduction to an appreciative approach and training in participatory analysis for community action (PACA) tools.

Additional sessions for more training

- **Appreciative Approach** Optional activity (20 minutes) at end of this session.
- **Appreciative Approach** See optional Session Four in this module.
- **PACA tools** See the *PACA Idea Book: Using Participatory Analysis for Community Action* [ICE No. M0086].
- To review and/or practice PACA tools: Session 4, “Participatory Analysis and Priority-Setting with the Community,” in *The New Project Design and Management Workshop Training Manual* [ICE No. T0107], pages 44-56.

## Rationale

Assessment is the first step in designing an effective strategy to address HIV/AIDS. This session will provide participants with an understanding of the role of assessment in HIV/AIDS project design, how to access, evaluate, and utilize existing assessment data, and the value of appreciative and participatory approaches to assessment.

## Target Audience

Peace Corps participants (trainees and Volunteers)

## Duration

3 hours

## Objectives

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

1. Identify sources of assessment information for their community and how to access, evaluate, and use this information.
2. Identify the kind of information needed from assessments to inform project planning.
3. Describe how an appreciative approach informs asset-based assessment.
4. Identify gaps in information available for their community.
5. Utilize asset-based and participatory approaches to assessment.

## Session Outline

- I. **Introduction and Opening Activity** (15 minutes)
- II. **The Role of Assessment in Addressing HIV/AIDS** (25 minutes)
- III. **Review: Community Assessment Concepts** (55 minutes)
- IV. **Practicum** (75 minutes)
- V. **Wrap up** (10 minutes)

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Sources of assessments by government and non-governmental organizations, how to access and read them
- Appreciative approach
- Asset-based assessment
- Participatory analysis methods including Peace Corps’ methods presented in the *PACA Idea Book: Using Participatory Analysis for Community Action* [ICE No. M0086], and *HIV/AIDS Idea Book: Integrating Prevention and Care into Your Sector* [ICE No. M0081]

- HIV/AIDS-related assessment strategies and best practices

## Materials and Equipment

Small stones (25 or so, for introductory exercise)

Blindfold

Blank flip charts

Markers

Prepared flip charts

1. Project Design Cycle
2. Appreciative Approach
3. One page each with title at top: Individuals and Groups; Roles in the Community; Job Categories

Handouts

- A. *Sources for HIV/AIDS Assessment Information*
- B. *Interpreting Surveillance Data*
- C. *Local community scenario (to be prepared by trainers) with assessment information relating to host country/community*

## Preparation Checklist

- Read the entire session and decide if any optional activities need to be added, depending on previous training experience of the group.
- Prepare a scenario/case study representing a typical Volunteer site placement; identify and make copies of national/regional/local assessment information relating to the scenario/case study—from websites and the Ministry of Health. *Handout A: Sources for HIV/AIDS Assessment Information* can be used as a research guide.
- If not already at your post, order copies of the *HIV/AIDS Idea Book: Integrating Prevention and Care into Your Sector* [ICE No. M0081] from ICE for participants. This should be done well in advance of the session.
- Prepare flip charts and handouts.

## Methodology

### I. Introduction and Opening Activity (15 minutes)

#### Welcome and introduce participants to assessment module

#### The Stone Game

**Step 1:** Have the participants form a large circle. Ask for a volunteer. Explain that the volunteer represents “a program” and that the circle represents “the community.”

**Step 2:** At one side of the circle, explain to the volunteer that his or her objective is to start at point A and make a straight line by placing stones on the ground and across the circle to point B at the other side of the circle. Clearly designate point A and point B with objects or signs.

**Step 3:** Before the volunteer begins, blindfold and spin him or her around several times. Explain that when doing some activities we often cannot see where we are going and we can become disoriented.

**Step 4:** The volunteer should then try to place the stones in as straight a line as possible from point A to point B.

**Step 5:** Discuss these questions with the group

*What happened? Why did it happen?*

*What was the objective of the volunteer?*

*Was the volunteer able to make a straight line? Why not?*

*How does this exercise relate to assessment and planning our activities?*

*Does this happen in this community? If so, why?*

*What can we do to try and avoid this kind of situation with our activities?*

### II. The Role of Assessment in Addressing HIV/AIDS (25 minutes)

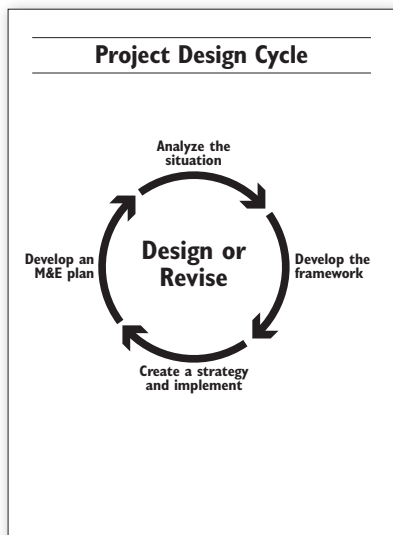
For more background see *Programming and Training Booklet 2: How to Design or Revise a Project* [ICE No. T0114] and *Roles of the Volunteer in Development* [ICE No. T0005] “*The Volunteer as Project Co-Planner.*”

### Review the role of assessment in the project cycle

(5 minutes)

The first step in designing a project is to assess and analyze what is currently happening. Although this seems obvious, many times in development history, well-meaning development organizations have charged ahead, implementing their own ideas of how to help.

Reveal flip chart 1, “Project Design Cycle.”



FLIP CHART 1

The project cycle is an ongoing process of analyzing, designing, implementing, assessing, and revising a project while at the same time developing and delivering training that supports the goals of the project.

Information about the current situation can be collected from many sources, including reviewing assessments done by other organizations and you and your counterpart’s own interviews, participatory activities, and observations.

#### Assessment relating to HIV/AIDS (10 minutes)

**Step 1:** Ask, “What are some of the things you would want to know from a community assessment before starting to address HIV/AIDS in a particular community?” (You can make references to some of the conclusions from the opening activity.)

**Step 2:** Let participants brainstorm and list on a flip chart. The list should include

- The prevalence of HIV/AIDS: The number of people in a particular population living with HIV/

AIDS at any one time. (Total number of cases of a disease, both new and old, in a population. For more information, see Biology Module: Session 2.)

- The incidence of HIV/AIDS: The rate at which new cases of disease are occurring in a population. (For more information, see Biology Module: Session 2.)
- Who is affected.
- Which populations are most at risk.
- How HIV is transmitted in the community.
- Existing initiatives, services, etc.
- Organizations working on HIV/AIDS issues, and what each does.
- Existing information about HIV/AIDS in the community, if it exists—assessments, surveys, etc.
- Barriers such as stigma, discrimination, attitudes and policies, etc.

**Step 3:** Refer participants to the *HIV/AIDS Idea Book: Integrating Prevention and Care into Your Sector* [ICE No. M0081] and walk them through the assessment questions in the “Questions to Explore” section, which are organized by sector.

Environment: pgs. 18-19

Small enterprise development: pg. 25

Health: pgs. 35-37

Youth: pgs. 46-48

Education: pgs. 54-55

**Step 4:** Post this list on a wall for later activities.

#### Make several key points relating to assessment

(5 minutes)

Assessment is a first step in planning an effective HIV/AIDS strategy.

Assessment provides information about the social, cultural, and economic context of HIV/AIDS, including (point to the list and comment on key items)

- Providing an understanding of community members
- Identifying who is at risk
- Identifying how various segments of the population are infected and affected
- Providing information about a community’s strengths and assets (individuals, families, organizations/institutions, etc.) for addressing HIV/AIDS and information about barriers (stigma, discrimination, etc.)

**Transition** (5 minutes)

Ask: *Why is this information important?*

Encourage comments from participants. If not mentioned, highlight

- The specific cultural and behavioral factors that are driving HIV/AIDS transmission will determine the types of prevention and intervention strategies that will be employed.
- High-prevalence countries/communities require different strategies than those with low-prevalence.
- Prevalence data does not provide enough information to be able to determine appropriate prevention and intervention initiatives.
- It is important to notice that the methods used in gathering data will determine much of what the assessment says about a community.

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### III. Review Community Assessment Concepts

(55 minutes)

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**Introduction**

The Peace Corps approach to development is participatory, gender-sensitive, and appreciative. Review these recurring themes in training as key aspects of the approach to assessment.

**Compare and contrast two approaches**

(15 minutes)

**Step 1:** Ask participants to get into pairs. Provide each with a question on a card that each should use to interview his or her partner. Ask pairs to spend five minutes interviewing each other—using the questions provided.

First interviewer's question:

*Tell me about your strengths and what you bring to your role as a Volunteer.*

Second interviewer's question:

*Tell me what you lack in terms of skills and what you need from training to resolve any deficits you have in knowledge/skills?*

**Step 2:** After each has had a turn, have partners spend five minutes talking about the difference in how the two interviews felt.

**An appreciative approach** (10-15 minutes)

See optional activity provided at the end of this session, if additional experience with an appreciative approach is desired.

**Step 1:** Ask participants to explain their understanding of the asset-based and/or appreciative approaches to development. If any participants have had experience with these approaches, especially in HIV/AIDS work, encourage them to share with the group.

**Step 2:** Introduce or review the following representation of the appreciative approach, using flip chart 2.

**Appreciative Approach**

**One Goal**  
To seek the root causes of success  
(not the root causes of failure)

**Two Laws**  
What you look for is what you find  
(the questions you ask determine the answers you get).  
Where you think you are going is where you end up (images are powerful and they create the future).

**Three Principles**  
If you look for problems, you find more problems.  
If you look for success, you find more success.  
If you have faith in your visions, you can achieve important things!

FLIP CHART 2

**Participatory approaches** (20 minutes)

**Step 1:** Review of participatory tools (5 minutes)

Various methods of engaging community members in assessing their own priorities/needs have been introduced during training. Name some of these.

List on flip chart and allow participants to provide a very brief summary of what the approach accomplishes, indicated in brackets

- Community mapping [a PACA tool—maps physical landmarks, frequency of activities, institutions, etc., and demonstrates gender differences relating to these]
- Seasonal calendar activity [a PACA tool—identifies gender seasonal variations relating to household activities, including those relating to labor, income, and expenditure]

- Daily activity schedule [a PACA tool—identifies gender variations in daily schedules relating to household activities, labor, expenditure, etc.]
- Gender analysis matrix (GAM) [in *The New Project Design and Management Workshop Training Manual*, Session 4—analyzes the potential affect of an activity or project on various community groups]

**Step 2:** Viewpoints in the community (15 minutes)

Keeping in mind participatory processes and gender-sensitive approaches, consider the many different viewpoints to cover in a community assessment.

Reveal the three flip charts previously prepared with the titles: Individuals and Groups, Roles in the Community, Job Categories.

**Individuals and Groups**

FLIP CHART 3

**Roles in the Community**

FLIP CHART 4

**Job Categories**

FLIP CHART 5

Form small groups around the flip charts and brainstorm for five minutes on the individuals who might be included in the category on your chart.

Have all groups bring their charts to the front and post. Allow time for everyone to read the charts. Ask for clarifications or additions.

**Transition** (5 minutes)

Say: *Let's think back to our opening exercise. When you go to your site you will feel blindfolded in a way. You have to find your way to be able to figure out how to approach your work. We have just talked about and reviewed some of the key principles relating to assessment and how you will approach this task. Now we are going to spend time focusing on the actual kinds of things you will do when you get to your site.*

**IV. Practicum** (75 minutes)

**Existing assessment data** (5 minutes)

Because of the importance of assessment data, many governmental and nongovernmental agencies have done extensive assessment relating to prevalence and other aspects of the affects of HIV/AIDS on the community, country, and regional level. The first step in an assessment is to identify, access, and evaluate existing data.

**Step 1:** Distribute *Handout A: Sources for HIV/AIDS Assessment Information*. Briefly review together this list of sources that Volunteers should be familiar with and from whom information can be requested.

**Step 2:** If possible, lead a discussion about what information is relevant/available for the host country.

**Interpreting surveillance data** (10 minutes)

Provide *Handout B: Interpreting Surveillance Data*. Go through the handout together, along with the sample behavioral surveillance survey (BSS) or use local behavioral surveillance survey data, or some similar data set.

**Group work** (30 minutes)

**Step 1:** Explain that participants will have an opportunity to learn specifically about their host country/community using available assessment data (or another country as a sample case study).

**Step 2:** Divide participants into small groups of 6-7 people.

**Step 3:** Provide each group with Handout C, the country or community scenario and assessment information available from various sources for the host country.

**Step 4:** Ask groups to review the information provided and highlight or make a list of important information they find that provides insight into prevalence, vulnerable groups, and other details that would be critical to working on any HIV/AIDS activities.

**Step 5:** Ask groups to highlight for the others the most important things they learned from studying the assessments.

**Flow chart** (20 minutes)

**Step 1:** Ask groups to reconvene and to create a hierarchical chart showing the information they have for the region as a whole, the host country, and regions and/or specific communities. Based on the information they have, what HIV/AIDS activities are being done and are appropriate at each level?

**Step 2:** Post charts and share information. Emphasize the need to get more information and clarify before jumping into activities.

**V. Wrap up** (10 minutes)

**Step 1:** Note that a lot of information has been covered in this session. Return to the opening exercise.

**Step 2:** Ask for participants to once again form a circle and ask for one volunteer.

This time, instead of blindfolding the volunteer, help the volunteer navigate his or her way through the community.

**Step 3:** Ask participants to call out (one at a time) strategies for assessing and understanding the community. Ask for consensus about whether or not the strategy mentioned would be helpful. If there is consensus the volunteer can take three steps across the circle. When the volunteer gets to the other side everyone can applaud!

**Evaluation**

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**References or Resources**

EMA Sub-Regional Workshop: HIV/AIDS Education and Training Strategies: Tashkent, Uzbekistan, 2003, "Appreciative Inquiry in Addressing HIV/AIDS," Maura J. Fulton, PTO PC/Thailand (also attached with slight modifications as optional additional session).  
*HIV/AIDS Idea Book: Integrating Prevention and Care into Your Sector*, Peace Corps, Washington, DC, 2000. [ICE No. M0081]  
*PACA Idea Book: Using Participatory Analysis for Community Action*, Peace Corps: Washington, DC, 2005. [ICE No. M0086]  
*Programming and Training Booklet 2: How to Design or Revise a Project*, Peace Corps: Washington, DC, 2001. [ICE No. T0114]  
*The New Project Design and Management Workshop Training Manual*, Peace Corps: Washington, DC, 2000. [ICE No. T0107]  
*The Roles of the Volunteer in Development*, Peace Corps: Washington, DC, 2002. [ICE No. T0005]  
*The Synergy HIV/AIDS APDIME Programming Toolkit V1.0*, Assessment Module, [www.SynergyAIDS.com](http://www.SynergyAIDS.com).

**Notes**

The Stone Game was adapted from TASO Community Initiatives Trainer’s Manual, printed in Planning, Monitoring and Evaluation Training Exercises and Activities—Draft, by Ana Coghlan, Evaluation Specialist, Program Learning Unit, Peace Corps, June, 2003.

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**Optional Activity**

**An Asset-Based Approach to Assessment (20 minutes)**

**Step 1:** Small group discussion. (10 minutes)

Break into small groups. Provide the following statements to each group. Ask them to discuss the question on the paper, as well as other feelings they have about the statements.

Statement 1: An appreciative approach to assessment focuses on a community’s assets and strengths rather than its deficits and problems, even though analyzing barriers to addressing issues is part of a total assessment.

*Does the word “barrier” connote something different than “deficit” or “problem”? What is the difference?*

Statement 2: An appreciative, or asset, approach to development considers community members and the organizations and associations they create key development resources—some call these the social capital of a community.

*What is the difference in considering the resources of a community to be its members rather than experts from outside?*

**Step 2:** Reconvene and ask groups to share comments. (10 minutes)

# Handout A: Sources for HIV/AIDS Assessment Information

## Center for Disease Control (CDC)

[www.cdc.gov](http://www.cdc.gov)

Global AIDS Program (GAP): Currently the CDC works in 25 countries and has four regional offices around the world. To find country-specific fact sheets, including available assessment information, go to GAP's homepage of CDC's website (<http://www.cdc.gov/nchstp/od/gap/default.htm>) and follow links to country and regional programs, and then to specific countries/regions.

## Family Health International (FHI)

[www.fhi.org](http://www.fhi.org)

Produces surveillance and assessment reports, including Behavioral Surveillance Surveys (BSS), for some countries. BSS track HIV risk behaviors over time as part of an integrated surveillance system which monitors various aspects of the HIV/AIDS epidemic. They are especially useful in providing information on behaviors among subpopulations who may be difficult to reach through traditional household surveys, but who may be at especially high risk for contracting or transmitting HIV.

Produces numerous publications and tools related to assessment.

To find country-specific information, go to the HIV/AIDS section: <http://www.fhi.org/en/HIVAIDS/index.htm> and follow links to countries.

## MEASURE DHS

[www.measuredhs.com](http://www.measuredhs.com)

MEASURE DHS (demographic and health surveys), is part of USAID's MEASURE effort to assist developing countries collect and use data to monitor and evaluate population, health, and nutrition programs, including HIV/AIDS. MEASURE DHS surveys are large, nationally representative efforts, using questionnaires targeting households and women, on a large range of topics. They utilize innovative technology for data collection and analysis. To find reports on specific countries, go to: <http://www.measuredhs.com/hiv-data/reports/start.cfm>.

## Ministry of Health (MOH)—Host Country

Demographic and health surveys, conducted in most countries every five years by CDC and MACRO International in conjunction with the MOH.

National AIDS Control Program data.

Assessment, census, and other data collected by agencies working in-country.

## Population Services International (PSI)

[www.psi.org](http://www.psi.org)

Manages AIDSMARK, funded by USAID, that generates information related to HIV/AIDS behavior change programs, published as country profiles in HIV/AIDS Behavior Change Communications (BCC) Catalogue: [www.aidsmark.org/catalogue/catalogue.html](http://www.aidsmark.org/catalogue/catalogue.html).

In Central America known as Pan American Social Marketing Organization (PASMO): [www.psi.org/where\\_we\\_work/central\\_america.html](http://www.psi.org/where_we_work/central_america.html).

## Joint United Nations Program on HIV/AIDS (UNAIDS)

[www.unaids.org](http://www.unaids.org)

Provides country-specific information, including

- Overviews of HIV/AIDS prevalence rates by age and gender.
- Overview of UNAIDS support to the National HIV/AIDS Response.
- Country situation analysis.
- Link to country-by-country epidemiological information developed in collaboration with World Health Organization (WHO): epidemiological fact sheets on HIV/AIDS and sexually transmitted infections.

For UNAIDS country level information, go to [http://www.unaids.org/en/Regions\\_Countries/Countries/default.asp](http://www.unaids.org/en/Regions_Countries/Countries/default.asp).



## **United States Agency for International Development (USAID)**

**[www.usaid.gov](http://www.usaid.gov)**

Provides country profiles, including an overview of the country situation, national response, and programs supported by USAID.

Provides links to various publications with relevant information related to assessment.

To find country-specific information relating to HIV/AIDS: From home page, click on “HIV/AIDS”, in red box under “Health” look under “HIV/AIDS” for countries, scroll to country you are seeking and click for list of reports and other information available.

## **World Health Organization (WHO)**

**[www.who.int/en](http://www.who.int/en)**

For country-specific information on HIV/AIDS treatment and prevention scale-up, and epidemiological fact sheets with the latest statistics on HIV/AIDS and STIs visit <http://www.who.int/hiv/countries/en/>

## Handout B: Interpreting Surveillance Data

The first step in working with HIV/AIDS is assessment and analysis. This step involves finding, reading, and interpreting various kinds of data collected by the numerous agencies and governments working on HIV/AIDS projects. It is important to be able to transfer the information from research and assessment documents into meaningful activities in programs, being able to use that data to target or direct the intervention activities to specific populations.

The information below is an example of a behavioral surveillance survey. The surveys include many different target groups including youth in and out of school, men in the categories listed in the table, female sex workers and female factory workers.

The excerpt from the data includes information from the Behavior Surveillance Survey for adult male populations.

**Columns** are the categories of men interviewed.

**Rows** are the survey questions asked.

**Top number** is the percentage of respondents in the sample who responded positively to the indicator listed in that column.

**Bottom number** is the ratio of the number of positive responses over the total number surveyed in that category, and corresponds to the percentage listed.

## Behavior Surveillance Survey (BSS) Adult Male Populations

BSS Indicators	Military	Police	Seasonal Workers	Watchmen	Local Drivers	Long Distance
<b>Knowledge of HIV prevention method</b>	72.4% 280/387	69.7% 129/185	60.2% 151/251	69.5% 116/167	63.5% 219/345	67.5% 83/123
<b>No incorrect beliefs about AIDS</b>	58.9% 228/387	71.4% 132/185	48.6% 122/251	55.1% 92/167	51.0% 176/345	54.5% 67/123
<b>Sex with non-regular sexual partner(s) in the last 12 months</b>	57.7% 212/387	38.4% 71/185	30.7% 77/251	49.1% 82/167	57.7% 199/345	28.5% 35/123
<b>Condom use at last sex with a non-regular partner</b>	59.4% 126/212	73.2% 52/71	29.9% 23/77	59.8% 49/82	59.8% 119/199	57.1% 20/35
<b>Sex with commercial sex worker(s) in the last 12 months</b>	0.8% 3/387	-	0.4% 1/251	0.6% 1/167	2.3% 8/345	4.8% 6/123
<b>Condom use at last sex with a commercial partner*</b>	- 0/3	- 0/0	-	- 1/1	- 6/8	- 4/6
<b>Reported episode of STIs in the last 12 months</b>	12.1% 47/387	6.5% 12/185	10.0% 32/251	4.8% 23/167	4.3% 15/345	5.7% 33/123
<b>Ever tested for HIV</b>	25.0% 96/387	19.5% 36/185	12.7% 32/251	13.8% 23/167	11.6% 40/345	26.8% 33/123
<b>Accepting attitude towards people living with HIV/AIDS**</b>	34.0% 128/376	36.6% 67/183	23.9% 59/246	41.5% 68/164	29.7% 102/345	26.8% 33/123

\*Sample size too small for any meaningful inferences to be made

\*\*No stigmatizing attitude

### What other information can you surmise from the table?

*What does it tell you about adult male behavior? How would it help to design an intervention for this population?*

*Is the date of this survey relevant to current information of the same indicators?*

*Do you need more up-to-date data? Where could you look for it?*

*How will this data affect your ideas for HIV/AIDS activities?*

*Who might you target?*

*What types of activities might you plan?*

*What other information do you need before you develop any activities?*

*Where can you get that additional information?*

*If no other agency or group is doing an activity that seems promising, who might help you further develop the activity?*

## Handout C: Local Community Scenario

This handout should be prepared at post using assessment information relating to the host country/community.

# Session Two: Culture, Assessment, and HIV/AIDS

## Purpose

To provide an understanding of the significance of “culture” in how a community thinks about, and ultimately addresses, HIV/AIDS.

## Rationale

Culture plays a significant role in determining values, attitudes, and behavior. This session provides an opportunity to explore how culture and other aspects of individual identity affect how individuals and communities think about and address HIV/AIDS, and introduces ideas about how to use the information gained in assessment.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours

## Objectives

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

1. Identify how culture and other aspects of one’s identity affect values, attitudes, and behavior relating to HIV/AIDS.
2. Identify how his/her own values, attitudes, and behavior relating to HIV/AIDS need to be considered in working in a community with a different culture.
3. Outline an approach for learning how individuals, institutions, and other stakeholders in their new community view issues relating to HIV/AIDS.
4. Understand how to take cultural information into consideration when planning an intervention/activity to address HIV/AIDS.

## Session Outline

### I. Cultural Aspects of HIV/AIDS (30 minutes)

### II. Exploring Values, Attitudes, and Behavior Relating to HIV/AIDS across Cultures

(50 minutes)

### III. Listening Skills (20 minutes)

### IV. Application (20 minutes)

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Cross-cultural aspects of HIV/AIDS (must include at least one host country national, preferably as a co-facilitator; others who are appropriate to content, such as a Peace Corps medical officer, or language staff).
- Appreciative approach.
- Asset-based assessment.
- Participatory analysis methods including the Peace Corps’ methods presented in the *PACA Idea Book: Using Participatory Analysis for Community Action* [ICE No. M0086].
- HIV/AIDS-related assessment strategies and best practices.

## Materials and Equipment

Blank flip charts

Markers

Prepared flip chart, “Small Group Task” (for Part II, Small group work)

Handouts

A: *Effects of Culture On My Views*

B: *Culture Matters, Appendix*

C: *Excerpt from: “Empowering People and Strengthening Organizations Through Asset-Based Approaches” from An NGO Training Guide for Peace Corps Volunteers, pg. 51-57 (relating to interviewing skills with an emphasis on appreciative inquiry techniques)*

## Preparation Checklist

- Read the entire session and decide if any optional activities need to be added, depending on previous training experience of the group.
- Select host country co-facilitator; discuss session and together identify other host country nationals who can participate. Brief all of them on the session contents and provide them with *Handout A: Effects of Culture On My Views* prior to the session.
- Copy handouts.
- Provide *Handout A: Effects of Culture on My Views* to all participants, including host country national and American staff at least one day prior to the session.**

## Methodology

### I. Cultural Aspects of HIV/AIDS (30 minutes)

#### Introduction

Understanding the culture and appropriate ways of working in a community are important for any type of work Volunteers do. Working on issues relating to HIV/AIDS requires sensitivity to beliefs and behavior relating to sexuality, disease, and death—topics that can be difficult to talk about even in one's own culture.

This session will introduce the knowledge, skills, and attitudes to help address HIV/AIDS in a cross-cultural setting.

#### Small groups (20 minutes)

*Determine with the host country national co-facilitator what would be the most productive small groups' arrangement. If there are any doubts about the depth of conversation possible in mixed groups, have female Americans/male Americans/female host country nationals/male host country nationals in separate groups. Their small group discussions can be very open and rich, and they can choose what and how to share their conclusions in culturally appropriate ways.*

**Step 1:** Ask participants to take out *Handout A: Effects of Culture On My Views* distributed earlier. Explain that they will be discussing their reactions to these questions in small groups.

**Step 2:** Have groups form according to the decisions made by co-facilitators. Give participants 20 minutes to discuss their handout and prepare to share some of their findings with the whole group.

#### Questions on Handout A

*How is sexuality taught and talked about in your culture—in school, in your family, with friends?*

*How do you talk about HIV/AIDS?*

*In your experience, do people have different feelings about people who contract HIV from needles, sex, or blood transfusions? If so, why?*

*In your experience, do people have different feelings about women, men, or children with HIV? If so, why?*

*How were your responses to these questions formed by family? Religion? Other cultural values?*

**Step 3:** Remind groups when they have five minutes left to prepare to share what they have discussed. They can share general responses, individual ideas that are different—whatever they feel is appropriate to share with the whole group.

#### Debrief (10 minutes)

Have groups come back together. Ask each group to address the following questions

*What did you learn about how your particular backgrounds, cultures, or individual personalities affect the values, attitudes, and behavior you have relating to HIV/AIDS?*

*In working with HIV/AIDS, you may work with people who have different values, attitudes, and behavior than your own. How easy is it to put beliefs and values aside? Can you think of times you did it successfully?*

### II. Exploring Values, Attitudes, and Behavior Relating to HIV/AIDS across Cultures

(50 minutes)

#### Introduction

Explain: *Now that we have explored some of our own attitudes, beliefs, and behaviors you will have an opportunity to plan how you will go about learning what you need to know about the community where you will be living and working. An important thing to*

*remember is that while we can make some generalizations about what a particular “culture” believes, every culture is diverse, and there will be a range of beliefs, attitudes, and behavior you will need to learn about relating to the people living in any given community. During the next 45 minutes or so you will be exploring more techniques for learning and creating some concrete plans for how to gain the knowledge you need once at your site.*

### **Small group work** (30 minutes)

These groups do not need to be the same as those in part I. Consider mixing groups to have a wider variety of perspectives. If possible, have one or more host country national in each group.

**Step 1:** Reveal the flip chart, “Small Group Task.”

**Small Group Task**

Review the resources provided to consider how you will approach learning culturally appropriate ways to talk and learn about HIV/AIDS in your community.

Create a plan of how you will approach this task during the first three months of being on-site.

Remember to consider how you will learn from and about the various individuals, organizations, institutions, health-care providers (traditional and Western), religious/ritual/spiritual practitioners and traditions, etc.

**Step 2:** Provide the following handouts, along with any other materials you have identified

*Handout B: Excerpt from “Culture Matters”*

*Handout C: Excerpts from “Empowering People and Strengthening Organizations Through Asset-Based Approaches”*

**Step 3:** Check in with groups as they work. If there is time, ask each group to come up with some kind of dramatization of at least one approach to share with the group—this can be through art, song, skit, role play, etc.

### **Reports to whole group** (20 minutes)

Ask each group to share its plan and dramatization. If doing dramatizations, present these first, asking the audience to identify the important aspects.

Be sure that plans include

- Learning appropriate language and terminology.
- Identifying and using key cultural “informants.”
- Reviewing all existing assessment information.

### **III. Listening Skills** (20 minutes)

For additional activities related to listening and other communication issues see: *Culture Matters*, Chapter Three, Styles of Communication, pages 75-102.

#### **Why is it important to be a good listener?** (10 minutes)

**Step 1:** Discuss and list (5 minutes)

Ask the group, “Why is it important to be a good listener?”

Possible answers could be: to show someone you care, to be able to understand information, to help people solve their problems, to understand and sort out their feelings, and to sort out what they are going to do about a particular issue or situation.

**Step 2:** Summarize (5 minutes)

Point out that sharing one’s feelings is a normal human way of processing an experience. Humans need to be listened to as they sort through feelings and move forward to trying to resolve them. Listening for and encouraging sharing of feelings is key.

#### **How do you know someone is listening to you?**

(10 minutes)

**Step 1:** Randomly choose a person in the group and ask him or her to make up an issue to talk about. One of the trainers should be the “listener.” While listening, display bad listening skills, e.g., look around, interrupt, change the subject, act in a hurry and/or talk about yourself.

**Step 2:** Ask the group what they saw, whether there had been good listening, and why or why not.

**Step 3:** Brainstorm the characteristics of a good listener. The list may include

- Eye contact
- Nonverbal communication
- Asking questions for clarification
- Taking the time to listen
- Sitting/standing close (if appropriate with culture/gender)
- Touching shoulder/hug only (if appropriate with culture/gender)
- Empathetic voice
- Reinforcing the feelings
- Repeating/paraphrasing the person’s statements to show you understand/care
- Not interrupting or talking about oneself
- Focused only on that person
- Not giving information or advice unless requested
- Help the person solve his or her own issues once the issues have been sorted out
- Encourage the person to feel the feelings so that they can then sort through their options for solving the issue
- Not getting involved/emotional

**Cross-cultural listening**

**Step 1:** Ask, “What are some of the challenges of cross-cultural listening?” Start them on the list above. Examples may include: differences relating to eye contact, gender, age, space, timing, formalities, etc.

**Step 2:** Summarize. Listening is an important aspect of assessment. It is one component of how we communicate. We need to be aware of our own behaviors and of how those behaviors are seen in a different culture, as well as learn about the appropriate way to listen and respond in our host culture.

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**IV. Application (20 minutes)**

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**Whole group discussion (15 minutes)**

*What ways might a Volunteer have difficulty understanding how to have an affect on behavior change in an unfamiliar culture?*

*How do participatory processes of assessment and project planning help mitigate these issues?*

*What consideration might you want to give to participatory types of educational programs such as participatory theater?*

*How will information about cultural perceptions relating to HIV/AIDS influence the way you might design a public awareness or educational campaign?*

**Wrap up (5 minutes)**

**Step 1:** Ask participants to reflect for a minute and write down on paper

- Anything they learned about their own attitudes or behavior relating to HIV/AIDS.
- Anything they learned about the host country culture.
- Gaps in knowledge they hope to learn more about.

**Step 2:** Ask if anyone would like to share one or two key observations.

**Evaluation**

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**References or Resources**

An NGO Training Guide for Peace Corps Volunteers, Module 2: “Empowering People and Strengthening Organizations Through Asset-Based Approaches,” pages 37-61, Peace Corps: Washington, DC, 2003. [ICE No. M0070]

Culture Matters: The Peace Corps Cross-Cultural Workbook, Peace Corps: Washington, DC, 1997. [ICE No. T0087]

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*PACA Idea Book: Using Participatory Analysis for Community Action*, Peace Corps: Washington, DC, 2005. [ICE No. M0086]

## Handout A: Effects of Culture on My Views

This handout is for your individual use, to help you think about each of these questions on your own before participating in a group discussion in a training session. This handout will not be collected; feel free to make notes on it.

1. *How is sexuality taught and talked about in your culture—in school, in your family, with friends?*
2. *How do you talk about HIV/AIDS?*
3. *In your experience, do people have different feelings about people who contract HIV from needles, sex, or blood transfusions? If so, why?*
4. *In your experience, do people have different feelings about women, men, or children with HIV? If so, why?*
5. *How were your responses to these questions formed by family? Religion? Other cultural values?*

## Handout B: Excerpt from “Culture Matters”

### Continuing your learning

The exercises in this handout are meant for Volunteers to do after you finish your training and go out to your site. Once there, you become immersed in the culture, living and working in it, puzzling everyday with some cultural enigma or other. These activities encourage you to step back for a moment and once more study the culture deliberately and systematically. They complement the workbook exercises and provide you with techniques for studying culture that can be repeated and referred to often during your service and when you return home.

### Using cultural informants

One way to continue learning about your host culture is to identify people who understand it and can explain it to you. In general, you look for information of three kinds

1. Important facts or textbook information about the culture;
2. Ways to behave and not behave in various situations; and
3. Reasons for host country people’s behavior or reactions.

You may need to approach different informants for these different kinds of information. In most Peace Corps posts, you have your choice of four types of potential informants

1. Host country nationals;
2. Other Peace Corps Volunteers;
3. Other Americans (not Volunteers); and
4. Third-country nationals.

You might assume that host country nationals will always be your best resources, but this may not necessarily be true. They may know the do’s and don’ts of host country behavior, but not all may know many facts about their culture, nor *why* host country people behave the way they do. For this information, you may be better off asking foreigners or that handful of host country people who have studied their culture.

### Guidelines

In dealing with informants, keep the following general guidelines in mind

- Critically evaluate the opinions of Volunteers, other Americans, and third-country nationals who seem especially negative or bitter about the host culture.
- Select people who have been in the country long enough to have successfully built relationships and have some perspective.
- Select host country people who are somewhat representative of their country

Avoid those who may be too Westernized, or at least consider their Western bias in evaluating their comments.

Remember that people who speak English may not be representative of the general population.

Your Peace Corps trainers or other host country national staff also may not be especially representative (though they may be knowledgeable and understand your perspective).

- Talk to a variety of informants, a cross section, so you don’t get the views of just one social class, one ethnic group, only men, the college educated, etc.
- Try to corroborate what you’ve heard from one informant with the views of at least one other person.
- Try to select informants who are objective, able to distinguish between their own personal experience and what is true of the culture in general. Otherwise, *you* have to do the distinguishing.

It may be interesting for you to see how the views of the four types of informants compare by asking each of them the same question. These are some suggestions

*Why do host country people \_\_\_\_\_?*

*How should I treat counterparts at work?*

*Someone asked me to lend him money. What should I do?*

*Is it okay in this culture to \_\_\_\_\_?*

## Joining in

Perhaps the most natural way of learning about the culture around you is to actively participate in it, to become involved in the life of your community and its people. Much of this involvement happens automatically as you go about living and working in your village or city, but you can also make a conscious effort to become involved in community activities outside your work and meet people you ordinarily would not. The easiest way to become involved is through a friend or host family member who is already engaged in an activity that might interest you. Below are some suggestions

- Donate your time and services as a volunteer to any organization, public service, or institution that accepts volunteers, such as a hospital or clinic; nursing home; or a local charity.
- Offer to teach English in any venue where it seems appropriate.
- Offer to teach any other skill you have that people might be interested in learning.
- Become a member of the congregation of a local church.
- Join a church group in that church.
- Join or start a choir or some other singing group that meets regularly.
- Join or start a group that plays music.
- Offer to tutor students at the local school, or start a tutoring program.
- Join an existing women or men's club, or start one.
- Join a local sports team.
- Join any interest group that meets regularly—a sewing class, pottery class, poetry group, self-defense class, bird-watching club, video club—or help to start one.
- Help to organize a special event such as a fund raiser; a craft fair; a beautification project; a painting project; a construction project; a local library cleanup; or an environmental cleanup.
- Offer to help out with a local boys' or girls' club.
- Join an organization affiliated with your workplace.
- Help to organize field trips for school children, people in a nursing home, or a boys' or girls' club.

If you're at a loss about getting started, ask other people how they did it.

## Keeping a journal

Many of the other techniques for continued learning presented in this module imply the regular use of a journal. Keeping a journal provides you the opportunity to reflect on your experience and to stay in tune with your emotions and feelings, and to refer back to when you decide to explain your experience to an audience back home. A journal illustrates the work-in-progress that is your Peace Corps experience, recording your deepening understanding of the culture around you and the changes that are taking place in you as you adjust to your host country. It is a record of your struggle to come to grips and make your peace with the strange, foreign reality that slowly becomes your home.

Most Volunteers find they use journals for a number of different purposes

- To make random notes;
- To think out loud (on paper);
- To record the events of the day;
- To record a conversation;
- To record observations, random or targeted;
- To record impressions and reactions;
- To relate events and experiences (to tell a story);
- To record thoughts and emotions;
- To record realizations and conclusions;
- To write poetry or fiction;
- To talk to themselves.

## Three common mistakes

1. If you associate writing in your journal with an hour of serious thinking and literate prose, chances are you'll be too daunted to ever begin. Start simple, recording a few thoughts, ideas, or questions in a 10-to-15-minute respite at the end of the day.
2. Don't think of your reader or your writing style. Write for yourself, not posterity; otherwise, you edit too much and stop the free flow of your thoughts and emotions while they're happening.
3. Don't delay your writing for more than a day. It's only when you haven't written for two weeks or so that you find yourself spending two hours, feeling exhausted and negative towards what has become a chore. It's also better to write when things are fresh in

your mind, and you can recall details. If you haven't started already, in a notebook where you write nothing else, begin writing. For the first few weeks, just describe what's been happening. It's automatic and customary to interpret and categorize, but that can come later as you reflect on what you've written in light of what you now know about the culture. By their very nature, frustrating experiences are only understood in retrospect, upon reflection and analysis—and cultural adjustment is full of just such experiences.

You may want to organize your journal in this way

**Observation/Description** On left-hand pages of the journal, describe what you saw. Anything that strikes you as different, funny, weird, sad, etc. is appropriate. Feelings, emotions, judgments should not be expressed on this side. Just stick to the facts.

**Opinion/Analysis/Judgment** On right-hand pages of the journal, describe your thoughts, feelings, etc. about the event. Then try to analyze why you feel this way. What in your cultural makeup may be affecting how you feel? How is it different from whatever values or assumptions may be at work in the new culture?

### Learning from the media and the arts

In every country, a great deal about the culture is revealed by the media, which includes the following

- Books/Poetry;
- Newspapers;
- Magazines;
- Radio;
- Television;
- Movies/Theater;
- Songs and Music.

Your ability to use the media to learn about the culture depends on how well you speak and read the language, but even if your local language skills are minimal, you have some options.

#### Books/Poetry

Try to find English translations of the most famous works of the best known authors in your country. You may be able to find a translation locally, or ask your family back home to look for one.

If no translations are available, ask an informant to tell you about some of the great works of literature in

his or her country, including the plot and important themes of these works.

Go to the local bookstore (ideally with an informant) and look over the selection. What books are the most popular? Which subjects have the most books devoted to them? What subjects aren't covered or are barely covered?

#### Newspapers

Does the country have an English language paper? If so, read it regularly for insight into numerous aspects of the country and culture.

If no local English language paper exists, look with an informant at other newspapers and see which stories get the most space and what is relegated to the inside. What different sections does the newspaper have, and who is the intended audience for each one?

#### Magazines

Read any local English language magazines you can find.

If none exist, sit down with an informant and "read" a host country magazine from time to time to find out what topics are discussed and what is said.

On your own, study the advertisements and pictures in magazines.

Go to the magazine section of your local newsstand or bookstore and see what kinds of magazines are there. Which topics or areas of interest have the most magazines devoted to them? What topics are missing?

#### Radio

Listen to any locally or regionally produced programs in English.

Listen to the radio with an informant. Select different types of programs—news broadcasts, public affairs programs, dramas, interviews, etc.—and ask your informant to relate the content. Ask him or her which are the most popular programs and why. Ask who listens to the radio and when they listen.

#### Television

Watch locally or regionally produced television, whether you understand the language or not. (It's an excellent way to improve your language skills.) What kind of shows are the most common? What kinds of stories, people, events are depicted?

Watch TV with an informant and ask questions about what you're seeing. In dramas, how can you tell who are the good guys and the bad guys?

If American shows are shown in-country, watch them with host country people and notice their reactions. Ask them why they like these shows.

Notice who watches which shows. Does the family watch any shows together? Which do they never watch together? Who decides what to watch?

### **Movies and theater productions**

Go to any locally or regionally made movies or theater production and notice the stories and themes. Notice audience reactions. Which scenes do they enjoy the most? Which scenes get the biggest reactions from them? What qualities do the heroes or the villains have? Who makes up the audience?

Go to American or other foreign-made films and notice audience reactions. Ask people why they come to these films. Ask them which films they like better: American/western-made or locally made. Why?

### **Songs and music**

Listen to local or regionally produced songs with an informant and ask him or her to tell you what the lyrics are about. What kind of music and songs are the most popular?

Listen to American or foreign music with your informant and ask what he or she thinks of it. Who are the most popular local and foreign singers? Why? Is American music popular? Which artists?

### **Critical incidents**

Another way to learn about culture is through your own critical incidents, moments you remember because of their emotional intensity. You may have gotten furious at the post office, for example, because people kept cutting in line, or maybe you were shouted at on the bus for something you still don't understand. On their own, these incidents don't necessarily teach you anything about the country or culture, but if you reflect on and analyze them, you almost always learn something from them. Here is a four-step method for deconstructing a critical incident.

1. Recollect the incident after you have calmed down, but not so long afterwards that you forget the details.
2. Write down all you can remember about it: what you did and said; what others did and said.
3. Get more information. The easiest way is to relate the incident to anyone you think can

help you understand it better, including, if possible, anyone else who was involved in it. Another way is to revisit the scene where the incident occurred, in an observer role, and see if you can find clues to explain what happened.

4. Review the incident from the perspective of this new knowledge and see if you now understand it. You may not understand it completely, but you may understand it better or understand parts of it. And record this entire process in your journal.

### **Studying an institution**

An excellent way to learn about a culture is to study a specific institution, whether a private, commercial, educational, charitable, or government enterprise. A sample of institutions in different fields are listed below; you may be able to identify still others in your community:

**Agriculture** an animal farm; produce farm; banana, cocoa, or coffee plantation; ag extension office; a retailer or wholesaler of agricultural supplies; distributor of meat or produce.

**Arts** a theater company; community theater; an art gallery; a museum of art; an orchestra or some other professional music ensemble; art or textile coop.

**Communications** a radio or TV station; newspaper plant; magazine publisher; movie theater.

**Educational** a day-care center; nursery; kindergarten; primary school; middle school; high school; vocational school; private academy.

**Government** an agency or department; a court; the office of a legislator or government official; any part of the military; any public works department or branch.

**Health and Welfare** a hospital; clinic; home for the aged; drug rehabilitation center; physician's office; health education center; an AIDS clinic.

**Manufacturing** an assembly plant; a manufacturing plant or factory; food or mineral processing plant.

**Public Services** a library; recreational center; police station; public park.

**Religion** a church; mosque; temple; monastery; convent; seminary; church run orphanage, co-op, or recreation center or school.

**Retailing** a department store; pharmacy; bookstore; newsstand; grocery store; restaurant; cafe; corner store; shoe store; office supply store; furniture store; etc.

It's best to choose an institution with which someone you know is connected. You need the institution's cooperation for a study that may take several weeks. Once you begin, try to be as systematic as possible, recording your results in a notebook set up for this purpose. Expect to do both interviewing and observing. The topics and sample questions on the next page may help get you started.

**Purpose** Why was the institution created? What purposes does it serve?

**Ownership** Who owns the institution? How did they get to be owners? Why do they want to own such an institution? What impact does their ownership have on the product or service?

**Clients** Who are the clients? How does the institution get clients? Does it have enough, too many, too few?

**Management** Who runs the institution? How did this person get this position? How is the institution organized for management purposes? Who reports to whom (request or draw an organizational chart)?

**Capital** How much money does the institution have?

**Resources** What are its annual expenses? What reserves, debts does it have? What is its annual revenue, profit or loss?

**Raw Materials** What raw materials does it need? Where does it get them? How does it get them to the facility, store, or plant? What do they cost? What does transportation cost? Does it keep a large inventory? Where? How does the institution select its suppliers?

**Building/Plant Office** Where is the institution housed? How much does this place cost to lease, or what did it cost to buy? Who maintains it? What does it cost for upkeep, for insurance? How was the location chosen?

**Equipment** What equipment does the institution have? How was it obtained? How much did it cost? How is it kept in working order? How much does it cost to maintain?

**Supplies** What supplies does the institution need to operate? What do these cost? What's the source? Do other suppliers exist? How is the decision made as to whom to buy from?

**Workers** How many people work here? What qualifications do they need? How big is the payroll (weekly, monthly)? How did most of these people get their jobs? What benefits do they get? What do these benefits cost the institution per employee?

**Procedures** How do people learn what they have to do? Are procedures many or few? Who sets the procedures?

**Distributors** How does the institution handle distribution? What are the costs? How does it select a distributor?

**Licenses and Permits** Does this institution need official approval to operate? How is it obtained? How much do these permits, etc., cost? How often do they have to be renewed? Who decides whether an institution gets one and on what basis is this decision made?

**Competitors** Who are the competitors? What does the institution do to stay competitive or be ahead of the competition?

*J. Daniel Hess. The Whole World Guide to Cultural Learning, reprinted with permission of Intercultural Press, Inc., Yarmouth, ME. Copyright 1994.*

*Culture Matters: The Peace Corps Cross-Cultural Workbook, Peace Corps: Washington, DC, 1997, [ICE No. T0087]. (Pages 219-232)*

# Handout C: Excerpts from “Empowering People and Strengthening Organizations through Asset-Based Approaches”

## Interviewing skills

Asking the right questions is magic. Who answers the questions, when they are asked, how they are asked, how the answers are listened to, and how answers are collected, interpreted, and used makes a difference.

At the heart of all good appreciative and participatory approaches is sensitive interviewing—listening to others “generously.” Without it, no matter which methods and approaches we use, the conversations and discussions will yield poor information and limited understanding. Strong interviewing skills largely depend on self-awareness, perceptive listening, and careful observation. These qualities take time to develop and refine. Interviewing in a culture and/or language different from your own presents additional challenges. We suggest that you identify and train local individuals with good “people skills” who want to improve their interviewing skills. This way you transfer skills and increase local capacity. Below is a set of interviewing tips you may want to share.

## Interviewing tips

The interviewing planning process should be a team effort.

- Identify the major topics/issues.
- Determine what the team thinks is important to understand more about.
- Decide who will be interviewed, where, when, and how.
- Plan how interviews will be conducted and information recorded.
- Assign roles and responsibilities and promote good group dynamics.
- Carefully formulate open-ended and nondirective questions, using  
*Who? . . . Where? . . . When? . . . What? . . . Why? . . . How? . . .*

Raise awareness on the importance of setting, timing, body language, seating arrangements, biases. Encourage sensitive listening and an open attitude among all participants.

Develop an “opening statement” on who the information is for, why the information is being collected, how the information will be handled, and confidentiality. (One AI practitioner found that attributing quotes on appreciative dream statements substantially increased positive conversations throughout the organization.)

Sequence the questions to achieve a conversational rhythm. Start with descriptive questions about present behaviors, activities, and experience. Later, move to tougher questions about interpretations, opinions, or feelings about behaviors and activities described. Ask questions about knowledge and skills bearing on the issue at hand. Ask questions about past activities first, then about the present, then the future—do they see applications for the future?

Be quiet and let the person talk—do not be afraid of a bit of silence. If you ask a question that demands some thought, give your respondents a moment to collect their thoughts before answering. Ask questions one at a time; avoid double questions that require respondents to figure out your meaning before answering the question. Avoid asking “why” too often. Use questions that are neutral (nonjudgmental). Consider asking people to respond via role-playing or ask simulation questions (e.g., “Suppose . . .”).

Preface questions when required. Do so to focus people’s attention and to give them time to prepare to change the subject. Make transitions easy: Announce the beginning of the next section of an interview.

Summarize to bring closure to a section. Ask if the respondent has anything to add. You can also make a direct announcement: “What I’m going to ask next . . .”

Ask probing and follow-up questions if required. Ask these kinds of questions to obtain additional detail, to fill in information that seems to be partial, and when you think the answer could use elaboration or clarification.

Support and recognize your interviewee’s responses. Make sure you give cross-culturally appropriate verbal and nonverbal support. Your interview has to be two-sided, not an interrogation.

Facilitate obtaining the information you need. Listen carefully to make sure the interview is working. Adjust



your questions, your approach, your style, or your focus if you are not getting the information you need. This is distinct from the fact that data may simply not exist—make sure you know the difference. Give signals to encourage the respondents, redirect, and move on as required. As the interview winds down, let respondents know how long you think the interview will take. If it is taking much longer than anticipated, negotiate additional time or schedule an additional visit.

**Record data.** Before you begin, ask permission to record. Tape-record the interview and transcribe it; to do this you will need reliable recording equipment and a person who knows the issues well enough to faithfully transcribe. Or you can take notes during an interview (and, rarely, after the interview), which is a much more common way to record the data.

“The important thing is not to stop questioning. Curiosity has its own reason for existing. One cannot help but be in awe when one contemplates the mysteries of eternity, of life, of the marvelous structure of reality.”

—Albert Einstein

*An NGO Training Guide for Volunteers* pages 51-57, [ICE No. M0070]

## Key terms

Key terms are defined as they are used in the module. A space is provided to write the translation of the word or phrase into the local language. Work with your language teachers to find the right translations and build your technical vocabulary as you study this module.

**Appreciative** refers to the act of recognizing the best in people or the world around us; affirming past and present strengths, best practices, success, and potentials; to perceive those things that give life (health, vitality, excellence) to living systems.

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**Appreciative Inquiry** “refers to both a search for knowledge and a theory of intentional collective actions which are designed to help evolve the normative vision and will of a group, organization or society as a whole” (Cooperrider, D.L., and S. Sirvastra, *Collaborating for Change: Appreciative Inquiry*. Berrett-Koehler, San Francisco. 2000. p. 159).

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**Asset** refers to something that has a future value. An NGO’s assets are not limited to money, buildings, and equipment; they include committed people, a respected organization, and the capacity to put ideas into action.

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**Inquire** is the act of exploration and discovery: to ask questions, to be open, and to see new potentials and possibilities. Synonyms: discovery, search, systematic exploration, and study.

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**Stakeholders** are those who work with, benefit from, and/or care about an organization.

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**Vision** refers to a shared idea of the results to be achieved.

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## Activity

### Try out your questioning skills

Work in groups of two or three to reword/rearrange the following “yes-no” questions to be affirmative and open-ended. What problems arise from each of the “yes-no” versions?

- Talking with a person who looks disappointed:  
“So you didn’t like that, huh?”
- A pilot to a new copilot:  
“Do you know how to fly this thing?”
- A nurse to a patient:  
“Have you been taking your medication?”
- Parent to teen:  
“Don’t you think it would be better if you did your homework first?”
- One colleague to another:  
“Do you think that plan will work?”

Note: Sample answers are found at the end of the module.

Can you think of ways to use open-ended appreciative questions in your daily Volunteer life? How might the ability to ask open-ended appreciative questions affect your ability to work with nongovernmental organization stakeholders?

### Examples of powerful questions to ask

- *Why do you feel this is important?*
- *How does it feel when you achieve a personal goal?*
- *How would you describe your success?*
- *What can you do to replicate your success?*
- *How would you describe the path to the future?*
- *What do you see as your role in the future?*
- *What has worked? Describe what you have learned.*
- *Have you experienced anything like this before? What did you do?*
- *What can you do yourself? With others?*
- *What do you hope for?*
- *If you could make one change, what would it be?*
- *Imagine a successful point in the future. What does it look like?*
- *What part would you want to play in the future?*
- *What would you want to share?*

Appreciative interviewing is not limited to the discovery phase of the AI process. Use these interview techniques anytime you need to gather information. As a Volunteer you are constantly asking questions to learn about the culture, how the local economy functions, how your host agency works, etc. Ask your questions appreciatively.

Over and over again counterparts and host country nongovernmental organization partners express their appreciation for Volunteers’ enthusiasm, optimism, and “can-do” attitude. AI and other asset-based approaches compliment these Volunteer strengths. Use your personal strengths and the asset approaches when building individual, organizational, and community capacity—they will serve you well.

One last thought as you use asset approaches. It is essential to consciously seek to involve those who are often ignored—the poor, women, minorities, the very young, and the very old. They too bring unique assets to the development process.

# Session Three: Using Assessment Data for Targeted Interventions

## Purpose

To provide an understanding of how assessment data is used to design HIV/AIDS interventions for specific populations.

## Rationale

This session builds on material presented in Session One to provide a more in-depth understanding of how to use assessment information to guide project design.

## Target Audience

Peace Corps participants (trainees and Volunteers)

## Duration

1 hour 45 minutes

## Objectives

By the end of the session, participants will describe how to utilize assessment information in project design, including

1. The importance of knowing the type of epidemic in a country when developing HIV/AIDS activities.
2. How to use assessment data to develop targeted HIV/AIDS interventions.

## Session Outline

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### I. Introduction (5 minutes)

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### II. Impact Assessment and Project Planning (20 minutes)

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### III. Targeted Project Design (70 minutes)

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### IV. Wrap up (10 minutes)

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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Appreciative approach
- Asset-based assessment
- Participatory analysis methods including Peace Corps' methods presented in the *PACA Idea Book: Using Participatory Analysis for Community Action* [ICE No. M0086]
- HIV/AIDS-related assessment strategies and best practices
- Project design

## Materials and Equipment

Blank flip charts

Markers

Prepared cards for activity Part I "Impact Assessment" (see end of session)

Prepared flip charts

1-3: Types of HIV Epidemics (1 level per chart)

4: Small Group Task for Part III, Step 2

Copy for each participant of *HIV/AIDS: Integrating Prevention and Care into Your Sector Idea Book* [ICE No. M0081]

If available, copy of *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International (FHI), 2001, for each participant. If not available, use Handouts C, D and E below. (This resource is available for free download at: <http://www.fhi.org/en/HIVAIDS/pub/guide/ecrhndbk/index.htm>)

Handouts

- A. *An Effective HIV/AIDS Strategy*
- B. *Considerations for Varying HIV Epidemics*
- C. *Key Partners for Strategic Planning* (from FHI's *Expanded and Comprehensive Response* publication)

- D. *Roles for Community Participation in Strategic Planning* (from FHI's *Expanded and Comprehensive Response* publication)
- E. *Integration of Targeted Prevention Into Other Services and Sectors*
- F. *Local scenario/case study used in Session One* (prepared by trainers)

## Preparation Checklist

- Read the entire session and make decisions about optional activities.
- Prepare cards for impact assessment activity if using this activity option.
- Make copies of handouts.
- Access copies of publication(s) for distribution to trainees.

## Methodology

### I. Introduction (5 minutes)

#### Session introduction

This session will build on material presented in Session One to provide a more in-depth understanding of the role of assessment information in project design.

Using the information obtained or gleaned from the assessment process, how do we take advantage of this information to design effective HIV/AIDS interventions? How do we turn “research information” into practice? Our goal is to be sure there is a link between the assessment information and the intervention planned to target specific groups.

#### An effective HIV/AIDS strategy

Distribute *Handout A: An Effective HIV/AIDS Strategy*. Explain that this is an overview of a strategy that will be addressed through the training they receive on HIV/AIDS. Read through the first seven points.

Ask participants to keep this as a reference.

### II. Impact Assessment and Project Planning

(20 minutes)

#### Review characteristics of an HIV epidemic

(5 minutes)

This information was covered in the Biology Module: Session 2.

**Incidence:** the rate at which new cases of disease are occurring in a population

**Prevalence:** the total number of cases of a disease, both new and old, in a population

Remind participants that prevalence data does not always reveal increasing HIV rates in subpopulations. Also, heavily populated countries may have a low HIV prevalence, but a significant number of people will be infected.

Review the types of epidemics. (Show flip charts.)

#### Low Level Epidemic

HIV prevalence is less than one percent in the general population and in all subpopulations practicing high risk behavior.

HIV infection may have existed for many years, but it has never spread to significant levels in any groups with high-risk behavior.

FLIP CHART 1

### Concentrated Epidemic

HIV prevalence is less than one percent in the general population, but more than five percent in any sub-population practicing high risk behavior.

HIV has spread in one or more groups with high-risk behavior (CSWs, IDUs, MSMs, etc.) but has not become well established in the general population.

The future of the epidemic is determined by the frequency and nature of links between the highly infected sub-populations and the general public.

FLIP CHART 2

### Generalized Epidemic

HIV prevalence is more than one percent in the general population.

HIV is firmly established in the general population.

Although some high-risk groups may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic.

FLIP CHART 3

## Activities and interventions for different HIV epidemics (15 minutes)

As we have discussed, some activities/interventions may be more appropriate given the type of epidemic and the populations that practice high risk behavior.

**Step 1:** Distribute *Handout B: Considerations for Varying HIV Epidemics*. Explain that these are general guidelines, and remind participants that any intervention should be based on a full assessment of the country and community.

**Step 2:** Choose one of the options.

**Option A** After reviewing Handout B, name one of the interventions listed below and have participants suggest the type of epidemic for which it would be most

appropriate. Talk about why an activity might be more appropriate for different kinds of epidemics, or could be appropriate for all kinds of epidemics. Mix up the order. Other activities can be added.

**Option B** After reviewing Handout B, hand out cards (at least one to each person) with one intervention written on it. Ask people to tape the card to the flip chart with the phase most appropriate for the activity's introduction. Once done, ask if there is consensus about where each card is placed and discuss why it is correct or not. Be clear that some interventions are appropriate for all kinds of epidemics.

### Interventions/Activities

This list is not meant to be exhaustive, but rather to illustrate the types of interventions appropriate for different epidemics, particularly in low-resource settings. Remember that the activity categories are just guidelines; participants should be encouraged to include country and community specific assessment information in their discussions.

*Appropriate for ALL epidemics: Low, Concentrated, and Generalized*

- Provide youth with life skills education
- Engage community leaders to help disseminate HIV prevention messages
- Develop peer education groups for youth and groups practicing high risk behaviors
- Develop sustainable community activities to follow up on mass awareness campaigns
- Disseminate a balanced prevention message
- Encourage early treatment of STIs
- Target populations practicing high risk behavior with behavior change communication strategies
- Involve people living with HIV/AIDS in support groups, program planning, and HIV educational presentations
- Give messages that reduce discrimination and stigmatization of people living with HIV/AIDS
- Incorporate effective behavioral change theory into interventions

*Appropriate for Concentrated Epidemic and Generalized Epidemics (in addition to the activities listed above).*

- Promote HIV counseling and testing
- Capacity building of organizations focused on HIV/AIDS

*Appropriate for Generalized Epidemics (in addition to the activities listed above)*

- Provide people living with HIV/AIDS and their families (including orphans and widows) with income-generating skills and training on growing sustainable food sources.
- Train family members in home-based care
- Educate pregnant women and new mothers to make informed and appropriate choices for breastfeeding.

### III. Targeted Project Design (70 minutes)

#### Materials (15 minutes)

**Step 1:** Explain: Important aspects of an effective HIV/AIDS strategy are engaging key stakeholder groups across different sectors, including people living with HIV/AIDS, and using participatory approaches for both assessment and project design.

**Step 2:** Distribute to each participant

*Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International, 2002

**OR** Handouts

- C. *Key Partners for Expanded and Comprehensive Response (ECR) Strategic Planning*
- D. *Roles for Community Participation in ECR Strategic Planning*
- E. *Integration of Targeted Prevention Into Other Services and Sectors*

**AND**

*HIV/AIDS: Integrating Prevention and Care into Your Sector*, Idea Book [ICE No. M0081]

**Step 3:** Review contents of materials.

If FHI publication is available: The manual provides detailed strategies for designing and implementing HIV/AIDS programs. This manual gives you key questions and guidelines to follow for each step of the project cycle. Pages 11 and 12 give you an outline of key partners for a community-based comprehensive response to HIV and roles for community participation. These charts plus the *Idea Book* provide

materials and resources to help you plan a project that engages broad participation and crosses sectors.

Spend a few minutes pointing out other aspects of the manual that can be helpful: The manual provides key implementation questions for dozens of different interventions (point these out). Module 2, starting on page 21, focuses on prevention with a chart on page 27 of how prevention can be integrated into other services and sectors.

If FHI publication is not available: The Handouts C, D, and E are charts from a Family Health International handbook for designing and implementing HIV/AIDS programs. These charts give you an outline of key partners for a community-based comprehensive response to HIV, roles for community participation and how prevention can be integrated into other services and sectors. These charts plus the *Idea Book* provide materials and resources to help you plan a project that engages broad participation and crosses sectors.

#### Small group work with resources (45 minutes)

**Step 1:** Explain that they will work in small groups for 45 minutes, using the materials just provided, plus the case study from Assessment Analysis & Prioritizing Activities Module: Session One, to do the following:

**Step 2:** Reveal flip chart 4, “Small Group Task”.

**Small Group Task**

What additional questions would you ask? (That is, what additional information is needed to design an appropriate intervention?)

Outline an activity you think would be useful based on the data available:

- Who would be involved?
- What are the implications of the activity for women, men, and youth?
- How does it build on the community's strengths and assets?

Justify your responses based on the data to target the activity(ies) to specific populations.

Sketch out your activity on a flip chart, including hoped for effect.

FLIP CHART 4

**Step 3:** Break into groups of 4-5 people. Provide copies of case study from Session One if they don't have it (Handout F).

**Step 4:** Warn groups when they have 15 minutes left, so they can prepare their flip charts.

**Report back** (10 minutes)

**Step 1:** Have each group report back to the large group, specifically linking its activity to assessment data it had.

**Step 2:** Ask other groups to ask questions or share observations.

**Step 3:** Thank all participants for their thoughtful work.

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**IV. Wrap up** (10 minutes)

Ask participants to review the session by answering questions, such as

*What is prevalence?*

*What are the three kinds of HIV epidemics?*

*Name an appropriate activity for each type of epidemic.*

*Describe the connection between assessment data and activity design.*

*What are some of the resources that can help with activity design?*

*What are some of the obstacles to designing appropriate activities?*

*Who should be involved in designing activities in your community?*

**Evaluation**

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**References or Resources**

*HIV/AIDS: Integrating Prevention and Care into Your Sector Idea Book*, Peace Corps: Washington, DC, 2000. [ICE No. M0081]

*Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International: Arlington, VA, 2001.

**Notes**

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**Changes to Session**

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## Activity Sheet: Interventions

Copy the sheet and cut out the individual cards. Additional interventions can be added.

Disseminate a balanced prevention message	Encourage early treatment of STIs
Incorporate effective behavioral change theory into interventions	Promote HIV counseling and testing
Involve people living with HIV/AIDS in support groups, program planning, and HIV educational presentations	Give messages that reduce discrimination and stigmatization of people living with HIV/AIDS
Target populations practicing high-risk behavior with behavior change communication strategies	Capacity building of organizations focused on HIV/AIDS
Provide people living with HIV/AIDS and their families (including orphans and widows) with income-generating skills and training on growing sustainable food sources	Educate pregnant women and new mothers to make informed and appropriate choices for breastfeeding
Train family members in home-based care	Develop sustainable community activities to follow up on mass awareness campaigns
Develop peer education groups for youth and for groups practicing high risk behavior	Provide youth with life skills education
Engage community leaders to help disseminate HIV prevention messages	



# Handout A: An Effective HIV/AIDS Strategy

## An effective HIV/AIDS strategy

- Begins by assessing HIV/AIDS-related strengths, assets, and barriers to change in the community
- Considers gender roles as a central factor in determining appropriate activities
- Uses appreciative and participatory approaches
- Engages community leaders at the highest levels including political, civic, religious, and informal leaders
- Involves key stakeholder groups across different sectors (agriculture, education, health, etc.) and includes people living with HIV/AIDS
- Builds individual, organizational, and community capacity
- Works with traditional belief systems about health and illness
- Identifies behavior change goals at the individual and community levels that include (as appropriate)
  - Reduced stigmatization/discrimination against people living with HIV/AIDS
  - Uses communication strategies that
    - Are culturally appropriate
    - Use a variety of channels, but focus on person-to-person exchanges of information
    - Deliver positive messages
    - Includes monitoring and evaluation throughout the life of the project in order to adjust implementation

**A balanced prevention approach** of “A” promoting abstinence or delayed onset of sexual activity for youth; “B” being faithful to one partner; and “C” correct and consistent condom use particularly for high-risk sexual activity; plus other strategies that address gender inequality and violence against women

**Empowerment** of girls, women, and youth, including strategies to ensure economic security

**Public awareness** of human rights for girls, women, and youth, including the right to control over their bodies

**Education for boys and men** focused on developing positive values and behavior relating to human rights of girls and women

**Increased demands for information**

**Increased voluntary counseling and testing**

**Increased numbers of people seeking care and support**, including treatment for sexually transmitted infections, opportunistic infections, including tuberculosis, and antiretroviral treatment; and services for orphans and vulnerable children and high-risk populations such as intravenous drug users

## Resources

*HIV/AIDS: Integrating Prevention and Care into Your Sector Idea Book*, Peace Corps: Washington, DC, 2000.

USAID Issue Brief, HIV/AIDS, “Behavior Change Communication Programs.”

USAID. “The ABCs of HIV Prevention.”

UNAIDS. Fact Sheet, “ABC Plus: Preventing HIV Infection Amongst Women and Girls in Southern Africa,” August 2004.

Family Health International, *Behavior Change Communication for HIV/AIDS: A Strategic Framework*, Arlington, VA, 2002.

The United States President’s Plan for Emergency AIDS Relief, Office of the U.S. Global AIDS Coordinator. “ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually Transmitted HIV Infections Within The President’s Emergency Plan for AIDS Relief.” <http://www.state.gov/documents/organization/57241.pdf> (accessed May 25, 2007).

# Handout B: Considerations for Varying Types of HIV Epidemics

## Low level epidemic

- HIV prevalence is less than one percent in the general population and in all subpopulations practicing high risk behavior.
- HIV infection may have existed for many years, but it has never spread to significant levels in any groups with high-risk behavior.

When HIV prevalence is low in high-risk groups, other sexually transmitted infections may be high, signaling that HIV may enter in the future. Interventions that target individuals at especially high risk of becoming infected or of transmitting the virus should be emphasized.

In low-level epidemics, high-risk groups might include commercial sex workers (CSWs) and their clients, injections drug users (IDUs) or men who have sex with men (MSM). But because risky behavior also may exist in the general population, the links between higher- and lower-risk populations are avenues in which the epidemic can grow. Activities focused on empowering youth to practice healthy lifestyles, such as life skills and income-generation training, help to mitigate such linkages.

In some countries with a low-level epidemic, people erroneously assume that the behaviors that promote HIV transmission do not exist in the country. HIV-prevention awareness messages targeted at the general population in a culturally appropriate fashion are important.

## Concentrated epidemic

- HIV prevalence is less than one percent in the general population, but more than five percent in any subpopulation practicing high-risk behavior.
- HIV has spread in one or more groups with high-risk behavior (CSWs, IDUs, MSMs, etc.) but has not become well established in the general population.
- The future of the epidemic is determined by the frequency and nature of links between the highly infected subpopulations and the general public.

A concentrated epidemic may remain so because there is little risk behavior in the general population. Or, HIV may not have yet infected a sufficient number of individuals to cause explosive growth. Interventions that target individuals at especially high risk of becoming infected or of transmitting the virus

## Other Resources

Family Health International. "Effective Prevention Strategies in Low HIV Prevalence Settings." <http://www.fhi.org/en/HIVAIDS/pub/guide/effectiveprevention.htm> (accessed March 26, 2007).

*HIV/AIDS Prevention and Care in Resource-Constrained Settings: A Handbook for the Design and Management of Programs*, Family Health International: Arlington, VA, 2001. Available to download: <http://www.fhi.org/en/HIVAIDS/pub/guide/HIVAIDSPreventionCare.htm> (accessed March 25, 2007).

PEPFAR. "ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief." <http://www.state.gov/documents/organization/57241.pdf> (accessed March 26, 2007).

should be emphasized. For example, peer education programs for high-risk populations (such as IDUs, migrant workers, MSM) to promote safer behaviors would be an effective intervention.

A concentrated epidemic has the potential to increase and spread to the general population. Prevention and awareness messages targeted to the general population, particularly with youth (gender empowerment, life skills education, etc.) are important.

In countries with concentrated epidemics, HIV/AIDS is typically intensified in socially or economically marginalized populations. Hence, attention to socio-economic factors and to the stigmatization of key populations is vital to an effective response.

## Generalized epidemic

- HIV prevalence is more than one percent in the general population.
- HIV is firmly established in the general population.
- Although some high-risk groups may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain the epidemic.

Groups with particularly high levels of risky behavior may continue to drive new infections in a general-

ized epidemic, but the pattern of HIV spread goes far beyond high-risk groups and their immediate partners. Interventions that target entire populations and population subgroups are necessary.

Contextual factors such as poverty and the stability of the health-care system will affect service provision at every level. Building linkages between home-based care providers, community-based organizations (including people living with HIV/AIDS support groups), local clinics, and larger health-care institutions will help to provide a continuum of care and support for people living with HIV and AIDS.

The status of women, an important factor in all epidemics, becomes an overriding concern in a generalized epidemic, and necessitates interventions that reduce the economic, social, legal, and physical vulnerability of girls and women.

## Handout C: Key Partners for Strategic Planning

Sector	Partners
<b>Private sector/ Not for profit</b>	People living with HIV/AIDS Political, religious and traditional leaders Traditional healers Unions and their members Professional associations Nongovernmental organization networking (Apex) organizations Faith-based organizations and networks
<b>Private sector/ Businesses</b>	Organized private sector coalitions for HIV/AIDS Workplace HIV/AIDS programs
<b>Public sector</b>	Ministry of Finance Health sector Education sector Agriculture sector Mining sector Community development sector Social services sector Youth and sports sector Uniformed services Information and communications sector Housing sector Justice and human rights sector

Adapted from: Lamptey, Peter R., MD, DrPH, Paul Zeitz, DO, MPH and Carol Larivee, MA, editors, *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International: Arlington, VA, 2001, p. 11.

## Handout D: Roles for Community Participation in Strategic Planning

<b>Defining the Planning Process</b>
<p>Identifying key stakeholders, including people living with HIV/AIDS</p> <p>Navigating political obstacles to HIV/AIDS program planning</p> <p>Engaging in community advocacy for acceptability of planning process</p> <p>Contributing to design of the planning process</p>
<b>Implementing the Planning Process</b>
<p>Mobilizing resources</p> <p>Transferring resources to implementers</p> <p>Accessing special stakeholders</p> <p>Collecting information and data</p> <p>Contributing experience and information</p> <p>Analyzing information</p> <p>Validating information</p> <p>Identifying culturally acceptable strategies</p> <p>Setting priorities</p> <p>Identifying potential partners</p> <p>Keeping the public informed of planning progress</p> <p>Being accountable for resources and results</p>
<b>Launching and Supporting the Plan</b>
<p>Advocating for plan acceptability by broader community</p> <p>Identifying, raising and providing resources</p> <p>Active partnering in implementation</p> <p>Overseeing plan implementation</p>

Adapted from: Lamptey, Peter R., MD, DrPH, Paul Zeitz, DO, MPH and Carol Larivee, MA, editors, *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International: Arlington, VA, 2001, p. 12.

## Handout E: Integration of Targeted Prevention Into Other Services and Sectors

Program/System	HIV/AIDS-Related Activities
<b>Education</b>	HIV/AIDS in the curriculum, co-curricular activities, outreach to the community, AIDS clubs, incorporating a balanced and age-appropriate “ABC” approach into prevention messages
<b>Uniformed services</b>	Integration into basic and in-service training, peer education, sexually transmitted infection (STI) services, condom distribution, outreach to the community, voluntary counseling and testing (VCT)
<b>Agriculture</b>	Integration into training of agricultural extension workers, revision of agriculture policy, peer education, food security issues
<b>Unions/Associations</b>	Peer education activities, referral to services
<b>Workplace</b>	Local behavior change communication, policy advocacy, STI services, care and support services, voluntary counseling and testing (VCT)
<b>Labor</b>	Revised training programs, integration of HIV/AIDS into existing training initiatives, policy
<b>Health</b>	Reproductive health, primary health-care system, training of health care providers
<b>Women’s organizations</b>	BCC, training programs, care and support, VCT
<b>Youth organizations</b>	BCC, training programs, care and support, referral to services

Adapted from: Lamptey, Peter R., MD, DrPh, Paul Zeitz, DO, MPH and Carol Larivee, MA, editors, *Strategies for an Expanded and Comprehensive Response (ECR) to a National HIV/AIDS Epidemic: A Handbook for Designing and Implementing HIV/AIDS Programs*, Family Health International: Arlington, VA, 2001, p. 27.

## Handout F: Local Community Scenario

This handout should be prepared at post using assessment information relating to the host country/community.





# Optional Session Four: An Appreciative Approach

## Purpose

To provide an understanding of the appreciative approach.

*It is possible for Volunteers to be too optimistic about the affect they may have on HIV/AIDS. While it is important to be positive and have high aspirations, helping Volunteers focus on capacity building rather than what “they” can do will be a helpful balance.*

## Rationale

An appreciation of a host country organization/community groups’ assets, strengths, and successes is an important first step to collectively developing a “common vision for the future” and initiating activities to achieve it. Appreciative inquiry (AI) is an approach that allows Volunteers and their host country partners to do just that. This session on AI provides participants with a basic understanding of the 4-D AI model and ways in which they can use it in their work with HIV/AIDS.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

1 hour, 45 minutes

## Objectives

By the end of the session, participants will

1. Create a dream or vision of their work in the area of HIV/AIDS education and training.
2. Articulate the principles of the appreciative approach to development and how they can guide work in HIV/AIDS.
3. Understand AI and participate in the 4-D AI cycle.
4. Contribute ideas for effective strategies of using AI in their work in the field.
5. Design a basic AI interview guide for HIV/AIDS activities that can be used with various target populations.

## Session Outline

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**I. Introduction** (20 minutes)

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**II. The Appreciative Approach** (10 minutes)

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**III. The 4-D Model of Appreciative Inquiry**  
(40 minutes)

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**IV. The Appreciative Inquiry Framework**  
(10 minutes)

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**V. Application** (20 minutes)

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**VI. Wrap up** (5 minutes)

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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- Appreciative approach
- Asset-based assessment
- Participatory analysis methods including Peace Corps’ methods in participatory analysis for community action (PACA)
- HIV/AIDS-related assessment strategies and best practices

## Materials and Equipment

Blank flip charts

Markers

Candy (used to divide participants into groups, so need as many colors or kinds as the number of groups you want to make)

Prepared flip charts

1. The Appreciative Approach
2. Small Group Task
3. Appreciative Inquiry

Handouts (from *Roles of the Volunteer in Development*)

- A. *The Appreciative Interview Guide*
- B. *The Appreciative Approach*
- C. *The 4-D Cycle of Appreciative Inquiry*

## Preparation Checklist

- Read the entire session and plan according to the time available
- Prepare flip charts
- Make copies of handouts

## Methodology

### I. Introduction (20 minutes)

#### Rocking chair activity

**Step 1:** Ask several participants to come up to the front of the room and sit in “rocking chairs.”

**Step 2:** Ask them to imagine that they are sitting in front of the group in three years’ time, describing the work that they did with counterparts in HIV/AIDS education and awareness. Mention all of the positive and successful activities and endeavors they undertook with host country partners during those three years. Encourage creativity and imagination.

**Step 3:** Take turns in the rocking chair.

**Step 4:** Application: Point out that such visions/dreams have the power to inspire terrific and innovative activities. Exploring and discovering these dreams will help while working with counterparts and community members to identify priorities and design projects that help address needs. The starting

point will be on past successes, strengths, and assets (not problems).

### II. The Appreciative Approach (10 minutes)

**Step 1:** Ask participants to explain their understanding of the asset-based and/or appreciative approaches to development. If any participants have had experience implementing these approaches, especially in HIV/AIDS work, encourage them to share with the group.

**Step 2:** Reveal flip chart 1 and introduce participants to the following representation of the **appreciative approach** that will guide the session and perhaps inspire in them a new way to carry out their work.

**The Appreciative Approach**

**One Goal**  
To seek the root causes of success  
(not the root causes of failure)

**Two Laws**  
What you look for is what you find  
(the questions you ask determine the answers you get)  
Where you think you are going is where you end up (images are powerful and they create the future)

**Three Principles**  
If you look for problems, you find more problems.  
If you look for success, you find more success.  
If you have faith in your visions, you can achieve important things!

FLIP CHART 1

### III. The 4-D Model of Appreciative Inquiry (AI)

(40 minutes)

Before defining AI, take participants through a brief 4-D cycle of Discover, Dream, Design, and Deliver (see handout), using their previous experience in HIV/AIDS education and awareness as a starting point.

**Step 1:** Ask participants to indulge in an activity before knowing what new approach they’re learning.

**Step 2:** DISCOVER

Divide participants into pairs and distribute *Handout A: The Appreciative Interview Guide*. Have each person take a few minutes to ask his or her partner the questions.

**Best Experience** Tell about a time in the past when you felt excited about work you have been involved in with HIV/AIDS awareness, prevention, or intervention. Who was involved? What qualities made it a positive experience? (If you've never been involved in this area, share a time when you felt you had a positive experience in any awareness activity.)

**Values** What personal values and past experiences can you bring to HIV/AIDS strategies? What sources of creativity and energy can you draw on?

**Promising practices and core values** At this point in the workshop, what do you understand to be promising practices and core values of the HIV/AIDS activities you might be engaged in as a Volunteer?

**Three wishes** If you had three wishes for the involvement of the Peace Corps in your country in addressing HIV/AIDS, what would they be?

### Step 3: DREAM

Ask participants to close their eyes and reflect on their answers. Have them imagine that they are sitting in that rocking chair and ask them to dream/envision the HIV/AIDS activities and projects they will have undertaken with their counterparts in three years' time. After one minute, ask pairs to share with each other one to three wishes for how their dream might be realized.

### Step 4: DESIGN

Divide participants into (three) groups by passing out candy and having everyone with the same color or same kind form a group. Tell them they will have 10-15 minutes to discuss their dreams and come up with a consensus dream. Reveal task on flip chart 2.

#### Small Group Task

1. Discuss their dreams and come up with a consensus dream.
2. On flip chart paper, draw or write a picture of steps to be made during the next three years to achieve their consensus dream.
3. Each participant pledges one specific action to the group that he or she will take to get there.
4. Be prepared to present flip charts briefly to the larger group.

FLIP CHART 2

### Step 5: DELIVER

Have all participants brainstorm simple activities that they might undertake **now** to start to realize these dreams.

Have the group choose one action, symbolic or practical, to do by the end of the session to start the process. (It is hoped this will involve a pledge to network and share resources among the group.)

Make sure it is clear that this was an activity to learn about the process—not that they are determining what they will really be doing by just sitting in a classroom and dreaming something up!

## IV. The Appreciative Inquiry Framework

*(10 minutes)*

### Step 1: Definition of appreciative inquiry

Inform participants that they have just successfully taken part in the 4-D cycle of appreciative inquiry.

Define AI as a capacity-building approach that builds on strengths and assets to create an empowering vision of the future that leads to action. Reveal Appreciative Inquiry on flip chart 3. Review.

Appreciative	Inquiry
Values	Find out
Assets	Inquire
Strengths	Ask questions
Best practices	Discover

FLIP CHART 3

**Step 2:** Distribute the handouts.

*Handout B: The Appreciative Approach.*

*Handout C: The 4-D Cycle of Appreciative Inquiry.*

Briefly review the four steps, and point out the hints for each step.

**V. Application (20 minutes)**

**Step 1:** How might they use AI? Why?

Challenge participants to consider how they might be able to utilize AI in their work with HIV/AIDS in their respective sites. What might be the benefits of such an approach? What do they foresee as being the greatest challenge? What ideas do they have for applying the 4-D model?

**Step 2:** Revise the interview questions.

The important first step for you will be to develop and adapt a series of questions for your AI interview guide.

Using the questions from this session as a guide, consider ways in which you might adapt them for your work at post. Create a short appreciative interview guide for a targeted group (colleagues, students, educators, health-care providers, etc.). Spend about five minutes—modify the one used today.

**Step 3:** Share interview questions.

Ask several participants to share some sample questions that they developed.

Were there questions you wanted to ask, but could not formulate them appreciatively? (See if the group can help.)

**VI. Wrap up (5 minutes)**

End with a proverb and then ask participants to contribute a proverb or motto that captures the appreciative focus of the work that Peace Corps staff, Volunteers, and counterparts carry out at post.

**Evaluation**

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## References or Resources

Appreciative Inquiry Workshop: Sharing Our Strengths—Creating Our Dreams, Peace Corps/South Africa and the GEM Initiative, 1998.

EMA Subregional Workshop: HIV/Aids Education and Training Strategies, Tashkent, Uzbekistan, 2003. *Appreciative Inquiry in Addressing HIV/AIDS*, Maura J. Fulton, programming and training officer, Peace Corps/Thailand.

Hammond, Sue, *The Thin Book of Appreciative Inquiry*, Thin Book Publishing: Bend, OR, 1998.

*Roles of the Volunteer in Development*, Volunteer as Change Agent—Appreciate Inquiry section, pp. 24-27, Peace Corps: Washington, DC, 2002. [ICE No. T0005]

## Notes

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## Changes to Session

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## Handout A: The Appreciative Interview Guide

**Best experience** Tell about a time in the past when you felt excited about work you have been involved in with HIV/AIDS awareness or prevention. Who was involved? What qualities made it a positive experience? (If you've never been involved in this area, tell about a time when you felt you had a positive experience in any awareness activity.)

**Values** What personal values and past experiences can you bring to HIV/AIDS awareness and prevention strategies? What sources of creativity and energy can you draw on?

**Best practices and core values** At this point in the workshop, what do you understand to be promising practices and core values of HIV/AIDS prevention activities?

**Three wishes** If you had three wishes for the involvement of the Peace Corps in your country in HIV/AIDS prevention, what would they be?

# Handout B: The Appreciative Approach

## **One Goal**

To seek the root causes of success  
(not the root causes of failure)

## **Two Laws**

What you look for is what you find  
(the questions you ask determine the answers you get)

Where you think you are going is where you end up  
(images are powerful and they create the future)

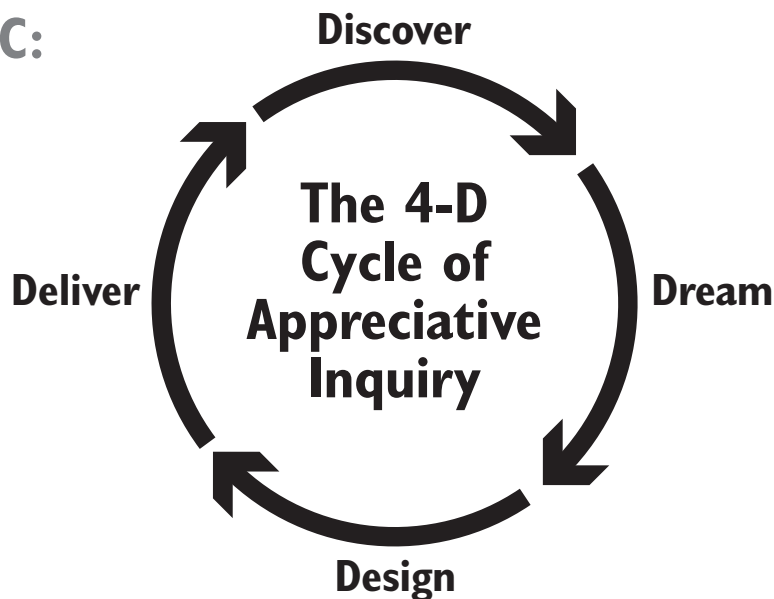
## **Three Principles**

If you look for problems, you find more problems.

If you look for success, you find more success.

If you have faith in your visions, you can achieve important things!

# Handout C:



Discover	Dream	Design	Deliver
<p>Asking positive questions, seeking what works, what empowers, what gives life to the community or organization, when has a community felt particularly excited, energized</p> <p><b>Activity</b> Participants are asked to share their 'best moments' during the past year in their work; times when they felt successful, valued, empowered.</p>	<p>Visioning of what could be, where to go</p> <p><b>Activity</b> Participants close their eyes for one minute, dream of how they envision their organization being within five years, share their dreams and one to three wishes for how that might be realized.</p>	<p>Making an action plan and personal commitments</p> <p><b>Activity</b> Participants discuss their dreams, in small groups if appropriate, and draw or write a consensus picture of steps that will be made during next year to achieve their consensus dream; each participant makes a public pledge of one action he or she will undertake as part of the process.</p>	<p>Start taking action, now!</p> <p><b>Activity</b> Participants brainstorm simple activities that might be undertaken, NOW, to start process of implementation of the dream; group discusses options and chooses by consensus one action, symbolic and/or practical, to do now, within next 5-10 minutes to start the process.</p>
Hints for Each Step of the 4-D Cycle			
<p>Appreciative questions</p> <ul style="list-style-type: none"> <li>• Are positive</li> <li>• Get people to think creatively about themselves and their future</li> <li>• Identify: strengths, assets, talents, skills, hopes for the future, things the school and community have done that are good</li> <li>• Allow you to have interesting and meaningful conversations</li> </ul>	<p>“How can dreams of the future influence behavior in the present?” Suggest</p> <ul style="list-style-type: none"> <li>• They help us to choose among several courses of action</li> <li>• They guide our vision of the future</li> <li>• They shape the direction in which we go</li> <li>• They can motivate us today</li> <li>• They can be a powerful platform for action</li> </ul>	<p>What part of the dream does the group have the most enthusiasm for?</p> <p>How can you get others excited about your dream?</p> <p>How can you best use all the resources of your team?</p> <p>What ideas, approaches, tools, tasks, plans can you use?</p> <p>How could you begin implementation?</p> <p>What are some strategies that will help the group move closer to the dream?</p>	<p>Just do it!</p> <p>“Motivation follows action!”</p>





# Awareness Raising & Extension Activities

## HIV/AIDS TRAINING RESOURCE KIT

**Session 1: Identifying Awareness Raising Opportunities and Targets**

**Session 2: Creating Messages for Target Audiences**

**Session 3: Pre-testing, Disseminating, and Evaluating Awareness and Extension Activities**



# Session One: Identifying Awareness-Raising Opportunities and Targets

## Purpose

This session brings together earlier information on behavior change stages and country-specific assessment information, to help participants identify gaps or needs for specific awareness-raising opportunities in their communities.

*The Behavior Change and Assessment Analysis modules must be trained before this module.*

## Rationale

Most Peace Corps Volunteers will have some opportunities to be involved in raising awareness about HIV/AIDS prevention, testing, or treatment. This module helps participants learn how to be strategic in their investigation of needs for awareness-training activities; look for areas where current awareness raising is not complete, does not address specific audiences, or needs reinforcement; understand how awareness raising is just the first component of behavior change; and locate appropriate partners for conducting awareness-raising activities.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours

## Objectives

By the end of the session participants will be able to

1. Recall the stages of behavior change, and state several ways to raise awareness for various audiences.
2. Using a case study, determine what target group might benefit from specific awareness raising, given the cultural context of the country.
3. Use local and national statistics and HIV/AIDS-prevalence information and current local efforts at awareness to identify and analyze gaps in reaching audiences or lack of comprehension of awareness messages.
4. Discuss at least three potential unwanted results from some HIV/AIDS-awareness campaigns and how to address them.

## Session Outline

- I. **Introduction** (10 minutes)
- II. **Review Behavior Change Model** (10 minutes)
- III. **Identify and Analyze Your Target Audience—Case Study** (80 minutes)
- IV. **Conclusion: Issues with Awareness-Raising Campaigns** (20 minutes)

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- HIV/AIDS prevention strategies.
- Strategic communication approaches.
- Targeted prevention and social marketing.
- Behavior change theory and behavior change communication projects.

## Materials and Equipment

Flip charts, markers, tape or tacks

Prepared flip charts

1. Small Group Task Instructions
2. Contextual Analysis Chart

Handouts

- A. *Behavior Change and Communication Strategies*
- B. *Case Study*  
*B-1 Ethiopia*  
*B-2 Vietnam*
- C. *Small Group Task Instructions*

- D. *Contextual Analysis Chart*
- E. *Recommendations for Awareness-Raising Activities*
- F. *Sources for HIV/AIDS Assessment Information (from Assessment Module: Session One)*
- G. *The ABC Approach*

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Either choose one of the attached case studies or prepare a case study using local information. See *Handout F: Sources for HIV/AIDS Assessment Information*.
- Prepare flip charts or other drawings.
- Make copies of handouts.

## Methodology

### I. Introduction (10 minutes)

#### Experiences with awareness campaigns

**Step 1:** Ask participants to think about awareness campaigns they have been exposed to, perhaps related to things like safe sex, smoking, drugs, drinking and driving, etc. What were some of the least effective messages? What were some of the most effective?

**Step 2:** As people share, ask if others agree—encouraging discussion about the fact that some messages work well for some people, and not well for others. Encourage discussion about the many different factors relating to why messages are effective or not.

#### Bring in relevance of other modules

This module brings together what has been learned so far about behavior change theory, the biology of HIV/AIDS, assessment, and capacity building.

### II. Review of Behavior Change Model

(10 minutes)

**Step 1:** Distribute *Handout A: Behavior Change and Communications Strategies* and review the behavior change principles from the Behavior Change Module.

#### Stages of Behavior Change Continuum

Unaware  
 Aware  
 Concerned  
 Knowledgeable  
 Practicing trial behavior change  
 Practicing sustained behavior change

#### Enabling Factors

Providing effective communications  
 Creating an enabling environment  
 Providing user friendly accessible services and commodities

#### Communication Channels (Strategies)

Mass media  
 Community networks and traditional media  
 Interpersonal/group communication

**Step 2:** Review points discussed in the behavior change module. Change takes time—people go back and forth between steps.

- Changing behavior begins with awareness.
- Awareness activities need to target specific audiences and their behaviors that need to change.

### III. Identify and Analyze Your Target Audience—Case Study (80 minutes)

#### Identify a target audience

**Step 1:** Participants read a case study that describes a particular country and the HIV/AIDS situation there. They read the case study individually and determine what group might be a good target for some type of awareness-raising activity.

**Step 2:** Distribute the case study (Handout B-1 or B-2) and allow about 10 minutes to read and select a target audience.

**Analyze the context and possibilities for the target audience**

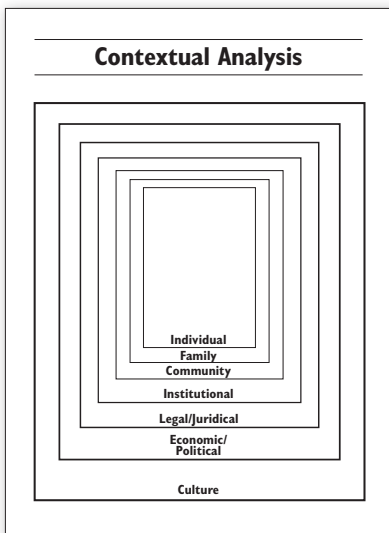
**Step 1:** Ask individuals to call out their target groups; list all the target groups identified on a flip chart.

**Step 2:** Groups work together according to the target audiences they picked. Reveal flip chart 1 with the small group task instructions.

**Small Group Task Instructions**

1. Discuss the contexts presented in the case (see flip chart 2).
2. Identify specifically what awareness raising your target group needs and what might realistically be accomplished, given their situation. What would you hope to accomplish?
3. Discuss what agencies, nongovernmental organizations, or other groups might 1) already be involved in such activities; 2) be interested or logical partners in the types of awareness raising you are proposing.
4. Prepare to share your analysis and decisions with the whole group.

FLIP CHART 1



FLIP CHART 2

**Step 3:** Explain the contextual analysis chart (flip chart 2).

Individuals do not function alone. They are encased in a number of levels of context, as shown in the chart.

The case study presented information about most of these levels.

Discuss what you know about each level and how it influences the target group you are interested in. What things make some behavior changes more difficult? What behavior changes might you/your partners realistically hope for?

**Step 3:** Have participants form small groups around target audiences. Give them Handouts C and D and a piece of flip chart paper and markers. Allow 15 minutes to work.

**Plenary session with report outs**

**Step 1:** Ask groups to report out their discussions, including their target audience, awareness activity, and with whom they would explore partnering.

**Step 2:** Ask other groups for questions, clarifications.

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**IV. Conclusion: Issues with Awareness-Raising Campaigns (20 minutes)**

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**Discussion**

*What unexpected results did earlier awareness campaigns have in this country? How might those results be changed?*

*What cultural aspects of this country have influenced how individuals deal with HIV and AIDS, either in themselves or family members, or in others?*

*What similarities and differences do you see in this case study with awareness campaigns you have experienced? What do you think accounts for some of the differences?*

**Recommendations from current research findings**

As discussed in the Behavior Change Module, research by the International Center for Research on Women (ICRW) has indicated that a lack of specific, in-depth information about HIV transmission is a major cause of stigma, which in turn is a major barrier to behavior change. The study by ICRW in four countries produced several important recommendations relating to how awareness messages should be framed and delivered to be effective. (*Distribute Handout E: Recommendations for Awareness-Raising Activities and go through the recommendations together.*)

**Recalling the ABC approach**

In addition to the recommendations from the study, Volunteers should include in their awareness activities a balanced, culturally and age-appropriate prevention message that incorporates abstinence, faithfulness, and correct and consistent use of condoms as a means to reduce the risk of HIV infection.

Refer to *Handout G: The ABC Approach*.

**Review awareness-raising activities ideas you considered**

*How did the ideas you had for awareness-raising activities compare with these lists? Which, if any, of these recommendations do you need to consider again?*

**Sources for HIV/AIDS assessment information**

Distribute *Handout F: Sources for HIV/AIDS Assessment Information* if participants have not worked on data from their own country in the case study. The handout provides sources of information they can access.

**Evaluation**

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**References or Resources**

*Behavior Change Communication (BCC) for HIV/AIDS: A Strategic Framework*, Family Health International, Institute for HIV/AIDS, Arlington, VA, 2002.

Jessica Ogden and Laura Nyblade, *Common at its Core: HIV-Related Stigma Across Contexts*, International Center for Research on Women (ICRW): Washington, DC, 2005.

Mahler, Hally and Donna Flanagan, *How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions*. The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA. [ICE No. HE369]

**Notes**

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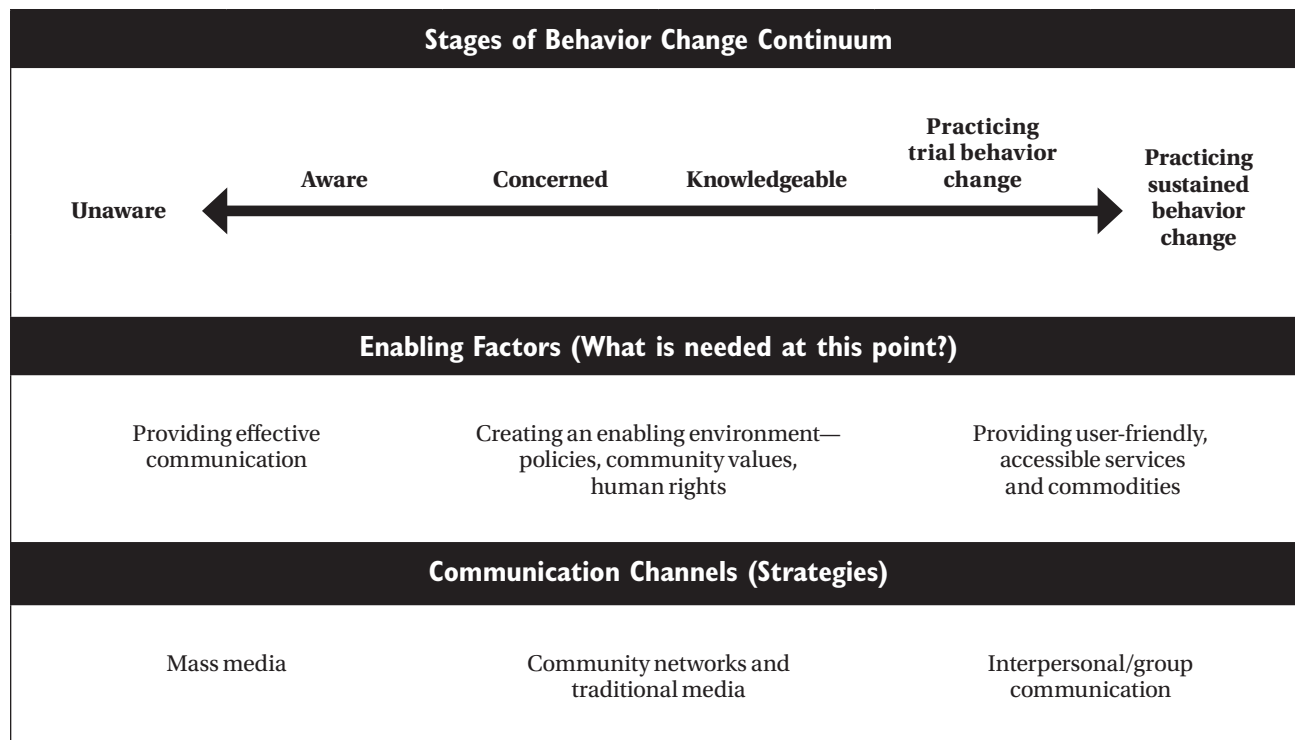
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# Handout A: Behavior Change and Communication Strategies



## Handout B-I: Case Study, Ethiopia

The following represents a synthesis of assessments conducted by multiple partner institutions and individuals with the International Center for Research on Women.

### Partners

In Ethiopia, the research was led by the Miz-Hasab Research Center (MHRC).

### Objectives

The objectives of the studies were to

1. Untangle the underlying factors that perpetuate or mitigate stigma;
2. Document how stigma is influenced by the context in which it occurs;
3. Analyze how stigma and discrimination is experienced by people with HIV and others who are affected by the disease;
4. Understand how stigma and discrimination affects access to HIV prevention, testing, disclosure, care, and support efforts; and
5. Recommend interventions.

### Methods and sampling

An urban and a rural site were selected for the community based exploration of HIV and AIDS-related stigma and discrimination. The communities selected are poor with high population density in urban areas and limited access to services, especially in rural areas. Employment is dominated by the informal sector in urban areas and subsistence farming in rural areas.

Data collection techniques were both qualitative and quantitative. Qualitative research methods included key informant interviews, focus group discussions (FGDs), diaries, content review, and semi-structured interviews. At the onset of the study, participatory techniques (such as transect walks, community mapping, listing of health problems, and timelines) were conducted in each of the communities to build rapport and gain insight into the general community layout and structure. Respondents included community members, people living with HIV and AIDS, youth, religious leaders, health professionals, caregivers, educators, employers, and nongovernmental

organization (NGO) staff. The researchers purposively sampled all interview and focus group discussion respondents by sex and socio-economic status.

Researchers also administered a survey questionnaire on knowledge, attitudes and behaviors around HIV to 202 rural residents and 200 urban residents who were systematically selected from existing official household lists. More details are available in Nyblade et al. (2003) and the country research reports (Bond, Chilikwela et al. 2003; Banteyerga, Kidanu et al. 2004; Mbwambo, Kilonzo et al. 2004).

In addition to the core community studies, additional topics for sub-studies were chosen to reflect issues of immediate concern in their communities. Men and women living with HIV and AIDS who belong to a NGO offering support to people with HIV and AIDS wrote diaries for six months, documenting their experiences of living with HIV, including disclosure, interactions with family, community, peers, and colleagues, and how they coped with stigma.

### The HIV/AIDS pandemic

Ethiopia is experiencing a generalized HIV epidemic. HIV and AIDS are no longer confined to specific risk groups, but are being experienced by the population as a whole. As a consequence, transmission is primarily through heterosexual penetrative intercourse. Prevalence rate is relatively high, at 4.4 percent.

### Economic situation: the relationship between poverty and stigma

Some statistics from 1999-2000

- Percentage of population below \$1.00/day: 26.3
- Percentage of population below National Poverty Line: 45.0
- Gini index:\* 30.0

\* The Gini Index is a measure of inequality. The closer the number is to 0, the more equally distributed income is among individuals or households. The closer the number is to 100, the more unequal this distribution is.

In sub-Saharan African generally, and in Ethiopia, woman experience more than 50 percent of all HIV infections. Poverty plays a role in driving people (especially women) to engage in behaviors (such as sex work) that make them vulnerable to infection. Generally,



the rich were more likely to be stigmatized than the poor because it was felt that they deserved their fate for indulging themselves in sinful and/or pleasurable behaviors “just for fun.” However, this tendency to stigmatize the rich was mitigated by the fact that the wealthy could more easily hide their HIV-positive status from the general public. In addition, the poor were more likely to experience stigma at home due to the greater strain that caring for someone with HIV and AIDS imposes on a poor household economy than on a rich one.

Many families may have multiple members infected—if not within their immediate household, then within their extended families. The costs of caring for even one person who is sick or dying with AIDS can be devastating for any poor family, but when these costs are multiplied, the weight of the cost burden can become unbearable—driving some families to stigmatize, even neglect, their members living with HIV and AIDS.

### **The importance of religion**

Ethiopia, like many African countries, is characterized by a profusion of religious orders and sects, most relating either to Christianity or Islam, nearly all of which are layered over pre-existing (traditional) belief systems. The living retain a strong connection to the dead through the respect given to ancestors and this continuity also has implications for HIV and AIDS-related stigma experienced by families of people living with HIV.

### **The role of knowledge about HIV and AIDS and fear**

The fear that HIV could be transmitted through ordinary, daily interactions with people living with HIV and AIDS that involve *no* exchange of body fluids was common. Examples include contact with an HIV-positive person through simple touch (shaking hands, kiss on the cheek, sitting next to); eating food prepared by or which may have come in contact with those living with HIV and AIDS; breathing infected air; or using objects that someone living with HIV and AIDS had touched (e.g. clothing, bedding, or eating utensils).

*It [HIV] might be transmitted through breathing, we do not know. So being careful is necessary: avoiding eating food coming from the patient's home, not sharing clothes and not drinking with the glass that the patient used. This is what I think.* (Ethiopian man)

Fear of and preoccupation with transmission through everyday casual contact leads directly to stigma in the form of isolation of persons living with HIV and AIDS in all aspects of daily life. It occurs everywhere, from within the home, to social gathering places in the

neighborhood, to the market place, health facilities and even sometimes in places of worship.

*Some people in this community believe that HIV/AIDS transmits through kissing, shaking hands, sleeping together [in the same room], and eating together with an infected person. Due to this they isolate the person from the community. For example, if they see him passing the same way they are passing, they change their way not to kiss and shake hands with him . . . because they are assuming that it is transmitted through breath, shaking hands, eating together with an infected person.* (Ethiopian woman)

The common fear of modes of casual transmission that carry extremely low, if any risk, is striking. In particular, many fear even the most peripheral contact with blood (e.g., left on nail clippers or hair cutting scissors or through mosquitoes), and other nonsexual body fluid (saliva, sweat).

*I fear people living with HIV and AIDS because AIDS might be transmitted through clothes and shaking hands. . . . We fear it might be transmitted to us through touching their clothes and through sweat.* (Ethiopian man)

This fear of and preoccupation with contracting HIV through impossible or highly unlikely routes persists despite high levels of knowledge about how HIV is transmitted. Respondents know, or at least can easily recite, the three correct modes of HIV transmission (sex, blood, and mother-to-child). However, correct knowledge does sometimes coexist with incorrect beliefs about transmission, and there is often a lack of confidence about how HIV is *not* transmitted. The doubts and concerns that exist despite “knowing” that HIV is only transmitted in three ways.

### **Persistent focus on casual transmission**

The data suggests that the persistence of doubts about how HIV is transmitted despite knowing otherwise and the fixation on the least likely modes of transmission could be the result of several interacting factors

#### **Lack of specific, in-depth information about HIV transmission**

The first is the narrowness and lack of depth and specificity in much HIV and AIDS information. Standard HIV and AIDS messages often focus solely on how HIV is transmitted, that it has no cure, and that it kills. Such messages tend to convey the incorrect impression that HIV is highly infectious. Rarely do HIV and AIDS messages focus on explaining how HIV is *not* transmitted, the relative infectiousness of HIV, and the fact that HIV

is *not* easily viable outside the human body. These messages, therefore, allow fears of casual transmission to go unchallenged and to persist. By not specifically addressing the risk of HIV transmission through routes that are of common concern in people's daily lives (e.g., noninvasive contact with blood, sweat, saliva, and mosquitoes), the possibility is left open that these are indeed risk situations to avoid.

- What if I'm sitting on a bus next to someone with HIV or AIDS and the bus crashes, that person bleeds and I'm cut, and some of his or her blood gets on my open wound?
- What if an HIV-positive person cooking food cuts him/herself and blood drips into the food, which I then eat?
- What if an HIV-positive person drips sweat into the food they are handling or I use a bed sheet or article of clothing a person with HIV and AIDS has sweated on?
- What if a fingernail clipper was used by a person with HIV and AIDS, they cut themselves with it, some dried blood remains and then I use it and cut myself in the process?
- What if the person has diarrhea and when washing the messed clothes you have a cut and are not wearing your gloves for protection, you may [contract HIV] as well.

The following quote captures how people's doubts about HIV transmission can have an impact on daily life:

*They say eggs transmit the infection. They say do not eat eggs since they can be infected. ...Hens are everywhere in town, hotel, bars, restaurants. The people working there use condoms and throw it in the open field. Hens eat this. If the condom has the virus the hens get infected because they swallow it with this thing [sperm]. The virus goes to the egg, and if we eat raw eggs we get infected. So people say do not eat raw eggs. (Ethiopian man)*

Given the narrow and often incomplete or ambiguous knowledge about how HIV is, or is not, transmitted, it is not surprising that the common conclusion to a *what if* scenario is that it could potentially pose a significant risk of transmission and therefore should be avoided

Adding to the confusion, doubt, and fear over whether, and how much, daily activities pose a risk for HIV transmission is the widespread and well-established knowledge about how other viral and bacterial diseases are transmitted, particularly those commonly associated with HIV (like tuberculosis and

diarrhea), and other diseases that have a transmission cycle that includes blood and biting insects, in particular malaria. Given this knowledge, doubt and fear creeps in that HIV might be transmitted this way too. Knowing that TB is airborne, diarrhea contracted through contaminated food and water, and infected body fluids or objects, and malaria through mosquitoes, people often reason that perhaps HIV could be transmitted these ways too.

### **Fear-based public messaging**

Another factor that adds to the fear and desire to avoid any situation that might pose a potential transmission risk is the legacy of fear and panic created by fear-based messages about HIV, coupled with sensationalized reporting around HIV. Fear-based messages in health campaigns focused heavily not only on death as the outcome of HIV, but also on the depiction of a painful, disfiguring, and sometimes shameful death (through linking HIV to socially unacceptable behaviors).

The focus, both in public health campaigns and the media, on negative images of sick, dying, and disfigured persons; the sensationalization of alleged cases of vindictive and purposeful infection of others by people living with HIV and AIDS (for example by injecting their blood into others or having premeditated unprotected sex); and lack of positive images of the more prevalent reality of people with HIV and AIDS who are productive and responsible members of society ratchets up the fear and panic of contracting HIV, hence creating stigma toward those living with HIV and AIDS. As a woman explained:

*When I watch TV and listen to the radio HIV/AIDS program presented in the form of drama, the message of the drama scares me and makes me cry. ... In the drama they show how the disease makes people suffer and change their physical appearance and look. It disfigures the face of the patient, changes the color from dark to pale. This makes me worry much.*

In addition to perpetuating stigma, the creation of this fear has public health impacts. For example, people may avoid getting tested for HIV. The impact on testing has been described as follows: "Respondents also discussed how fear of testing is related to images people have of a grossly disfiguring disease as shown on billboards and that a positive finding of a test implies a sentence of death." People may also believe that only sick-looking people have HIV, and so deny their own potential risks and any need for behavior change. A woman explained how images of thin, sick people with HIV and AIDS

create fear and stigma, as well as feeding the misconception that only sick-looking people have HIV.

*Advertisements and dramas [that show only thin people with AIDS] encourage people to fear HIV and AIDS and people with HIV and AIDS very much. Moreover, they make people think that a healthy-looking person doesn't have HIV and they isolate thin people.*

### **Evolving knowledge on HIV and AIDS**

Adding additional doubt to the mix is the relative newness of the HIV epidemic and the constantly evolving, sometimes contradictory, scientific and medical knowledge about HIV and AIDS. Because knowledge continues to grow on all aspects of HIV, including transmission, people begin (or continue) to doubt the validity of existing information, causing fear that current information about transmission might be wrong.

### **The role of values, norms, and moral judgment**

Assumptions made about the moral integrity of people living with AIDS is a central cause of stigma, and these assumptions underpin the tendency to blame people for their HIV infection—as well as the shame felt at some stage almost universally by those living with HIV and AIDS and those associated with them. The tendency to link HIV and morality might be related to the fact that affliction is often perceived as an outward manifestation of a moral transgression.

In a number of African societies, specific illnesses or sets of symptoms are associated with having broken one or more social prohibitions. In some locations, including the Judeo-Christian traditions of North America and Europe, it is not uncommon for people to believe that illness is a punishment for one's sins. Whatever its roots, the tendency to associate illness with moral impropriety is a central contributing factor to HIV and AIDS-related stigma. This stigma is exacerbated by the seriousness of the illness, its mysterious nature, and its association with behaviors that are either illegal or socially sensitive (e.g., sex, prostitution, and drug use). Also relevant is the perception that HIV infection is the product of personal choice: that one *chooses* to engage in “bad” behaviors that put one at risk and so it is “one's own fault” if HIV infection ensues. A woman explained

*Those who go out of God's permission will be infected. I always advise my children to be loyal to God and respect his rules. Thus, I won't mind if they refuse to be loyal to God and die [of AIDS].*

HIV and AIDS-related stigma has become a mechanism for sharpening the boundaries of the “moral community.” In other words, stigma reinforces previously defined boundaries between “us” (the normal/righteous/upstanding citizens) and “them” (the deviant/bad/fallen ones). The fact that one has become infected with HIV is used to distance that person from the mainstream community, to set him or her apart, marked out as having transgressed or sinned against god and/or society. This mark (or literally, “stigma”) is a cause for opprobrium in and of itself—but all the more so because of the perception that he or she has become infected by *choosing* to do things (such as inject drugs or have unsanctioned sex) that he or she *knows* are wrong.

This boundary-making serves at least two purposes: it enables the (apparently) uninfected to reinforce their notions of themselves as being morally right and upstanding citizens, while also allowing this group to deny its own level of risk, thereby enabling them to believe they have no need to contemplate any changes to their own behavior.

Clear distinctions were made between those who became (or were presumed to have become) infected through such “improper” behaviors, and those who were deemed “innocent victims”—such as sexually faithful married women (or men) who became infected because of their spouse's philandering; health care workers or police infected in the course of their work; or children infected through vertical transmission. Thus, in all sites there exists in people's minds a kind of continuum from presumed “guilt” to presumed “innocence.” Although all people with HIV experience some degree of stigmatization, where one falls along this continuum will determine, to a significant extent, the type and degree of stigmatization received from one's family and the wider community.

*The community believes that people get infected [with HIV] due to their deviant behaviors when they are having sexual contact with different partners. They think that a person who is infected is a promiscuous person.*

### **Shame, blame, and the role of gender**

Gender plays an important role in the nexus between HIV-related stigma, moral judgment, shame, and blame. Although this interface was complex, it is clear that women generally bear the strongest brunt of this type of stigma. The reason underlying this seems to be that women are expected to uphold the moral traditions of their societies. HIV is regarded as evidence that they have failed to fulfill this important social function. To

phrase the problem otherwise: Women living with HIV and AIDS (or more often, suspected to be living with HIV and AIDS) are regarded as everything they should not be—sick and slim when they should be healthy; being cared for when they should be caring for others; sexually deviant when they should be sexually righteous. To be HIV-positive is not to be a proper woman.

A fundamental double-standard exists, whereby men are generally expected to be reckless, adventuresome and more likely exposed to a whole host of sexually transmitted infections (STIs) (including HIV), and women are expected to be sexually faithful, chaste, and morally upstanding.

In many African countries including Ethiopia, more women than men are living with HIV. Women tend to be *both* more heavily stigmatized than men for having “failed as proper woman” *and* blamed more often for “bringing” HIV into a family or marriage. In Ethiopia although some people are sympathetic to women exposed to HIV for reasons beyond their control, women are nevertheless more likely to be viewed as the source of HIV and blamed. As a woman explained, “[Women] would be blamed more than men for being promiscuous and contracting the virus.” Similarly, a man made the following comment:

*A man would receive more respect than a woman because he is a man. And if a man gets infected, it will be said, “He got infected accidentally.” But if the woman gets infected, the gossip about her will be more exaggerated. People say she brought the disease by going out with different men.*

## Types of stigma

### Physical stigma

The forms of physical stigma can be grouped into isolation and violence, with the former being widespread and the latter less common. Physical isolation of people living with HIV and AIDS occurs in all locations, from the home to community gathering or public spaces (like tea shops, markets, sports grounds, buses, places of worship), to within workplaces, schools and hospitals. Common expressions within the home include marking and separating out typically shared objects like eating utensils, clothes, and bed linens and making those with HIV and AIDS sleep in separate quarters and eat alone, highly unusual actions where space is limited and eating together is the norm. Less common, but still present, are more extreme manifestations of physical isolation including complete abandonment by family, divorce, or separation from children. Women

are more likely to experience, and therefore fear, this kind of stigma. Women’s lack of access to resources and dependence on husbands and families leaves them particularly vulnerable to abandonment, divorce, and separation from their children, and with little recourse to challenge these actions.

In the urban settings, abandonment often took the form of sending a person with AIDS back to the village to “die,” thereby often transferring the responsibility of care to usually poorer, rural relatives with less access to health care and other support services.

### Social stigma

The manifestations of social stigma can be grouped into social isolation, loss of identity and role, and voyeurism. Isolation comes in various forms both in relation to important family and community events, as well as in daily life. It takes the very visible form of the disappearance of invitations to significant family and community events such as weddings, or outright orders to stay away. This woman living with HIV in Ethiopia described her experience: “I have a problem with my family, especially my father. He does not want me to participate in any kind of social life. . . . He always tells me, ‘Please do not show your face to others and do not be close to our relatives.’ I think he says this for the sake of his family reputation.” Perhaps a less blatant, but equally damaging expression of social stigma is no longer being asked to participate in the planning or hosting of events. In the diaries kept by people living with HIV in Ethiopia, women were more likely than men to document experiencing this type of stigma. According to this woman living with HIV:

*Last time a ceremony was conducted in the neighboring home and I went to help the women who were peeling and chopping onions and doing other things. However, they did not want me to participate and one of them told that I should get rest and the onion would burn my eyes.*

In the realm of daily life, the most common forms of social stigma were the waning or disappearance of existing friendships and the reluctance of neighbors, friends, and relatives to visit or lend or borrow common household implements and food items, important actions for survival in poor communities

People living with HIV and AIDS reported, and community members noted, that visits by family, friends, and neighbors tapered off, as did requests for assistance with daily needs (e.g., borrowing some salt, cooking oil, a hoe, money to get a sick child to a hospital). A man in Ethiopia explained:

*They try to avoid the person by not shaking hands, turning [their] face, and showing their back and even do not exchange verbal greetings and would not sit with him in places where they go for relaxing. They will not share knives, cooking utensils, and other tools like sickle, axe.*

Another form of stigma is voyeurism. This is most frequently described in the African countries as an increase in visits to people living with HIV, particularly once AIDS has set in, where the specific intent is to see how the person is progressing in their illness and report back to the community. As a female respondent in Ethiopia explained: “When I was ill, my neighbors came and visited me, but from behind they were [talking about] me.” This voyeurism, and the fear of it by people living with HIV and AIDS and their families, can lead to increased physical and social isolation of the person, as the protective or coping reaction becomes to keep all visitors away.

In addition to isolation, social stigma is also expressed through the taking away or diminishing of the roles, responsibilities, and social standing of those living with HIV and AIDS within the family and larger community. As a result, HIV positive people lose power, respect, and identity. This expression of stigma is a result of both how people living with HIV and AIDS are assumed to have contracted HIV, as well as the belief that HIV means immediate disability and death

### **Verbal stigma**

A third form of stigma is verbal. This can be direct (pointing fingers, insulting, taunting, or blaming), or more indirect (gossip and rumors). Gossip and rumors focus on speculation about whether a person has HIV, usually because of visible signs, illness, behavior, or association with groups seen as “high risk.” Once a person is assumed to be HIV-positive, people often speculate about how he or she contracted HIV. Gossip was reported to be one the most significant forms of stigma, particularly for women. As this woman living with HIV noted:

*Let me tell you from my experience. In our village I am the only woman who is suspected for having the virus. However, many men are suspected and known for having the virus. But nobody seems concerned and talks about the men. They spread gossip about me.*

More direct forms of verbal stigma were expressed through insulting, mocking, taunting, cursing, and threatening those living with HIV and AIDS. They also included the expression of blame and shame, often

through scolding or judgmental statements indicating people with HIV and AIDS “got what they deserved.” People living with HIV and AIDS are blamed for becoming infected with HIV through their “irresponsible” and “selfish” behavior, and for bringing shame to themselves, their families and the community as well as becoming a burden to the family.

An integral and hurtful expression of the verbal stigma is the use of derogatory, demeaning and pessimistic or despairing language to talk about or label people with HIV and AIDS. Terms commonly used to describe HIV and AIDS assume the outcome is death (*makizi yaku mochari*, or “keys to the mortuary” in Zambia); the physical appearance of a person with advanced AIDS (*maiti inayotembea*, or “walking corpse” in Tanzania); and the behaviors associated with infection and judgment of the person (*anawila posa gwila*, or “laid your hands where you shouldn’t,” in Zambia).

### **Institutional stigma**

Institutional stigma refers here to differential treatment within any broadly defined institutional setting that leads to a negative outcome for the person living with HIV. The main areas documented in the study had to do with loss of or inability to secure livelihoods, housing, health care, and education. It also includes losing access to new or future opportunities because an HIV test is required to qualify for a job, loan, scholarship, or visa for travel; differential treatment within an institution that leads to poorer outcomes (for example having to wait longer for health services); and the way those with HIV are depicted in the media. Not only do all of these forms of stigma lead to reduced life chances for people living with HIV and AIDS, but they also often serve to visibly mark a person as having HIV, exposing him or her to all the other forms of stigma discussed above.

### **Consequences and impact of stigma**

This section explores both the impact of stigma and its consequences for individuals living with HIV and AIDS, their family members and HIV/AIDS programs. There are differences in impact from one context to the next. These differences relate to individual personality and circumstance (everyone’s experience of stigma is somewhat different, even within a given social setting); the nature and duration of the epidemic; and social, health care, and cultural contexts.

Given the tremendous impact a disclosed HIV diagnosis can have on the life of a person living with HIV because of stigma, it is not surprising that so few

people choose to be tested for HIV, and that so many of those who do test, and do test positive, try by any means to prevent their HIV status from becoming known to people around them.

The most profound consequences of stigma was the impact it had on their ability to earn a living. People in formal employment found themselves being dismissed upon disclosure (whether voluntary or not) of their HIV status, and those selling goods or cooked food found their client base dropping off—particularly once they began to show symptoms of HIV related diseases. Domestic workers with HIV were almost always dismissed.

Another disturbingly common consequence of HIV and AIDS-related stigma relates to marriage and child-bearing. Spouses—particularly wives—were frequently deserted upon disclosure of their HIV status. Often this desertion was accompanied by blaming—the first person to become tested in the relationship being considered as the one who brought the disease into the home (by being unfaithful or “indulging in play”).

Unmarried HIV-positive people may find marriage no longer is an option available to them. People living with HIV may find that they are strongly discouraged from having children.

HIV positive people receive inferior care or are denied care altogether. For example, a nurse explained:

*The wards don't have gloves, so how would you expect a nurse to go and attend to a HIV/AIDS patient? That's why you can find a patient lying in a pool of diarrhea for many hours.*

A person living with HIV recounted the following experience:

*I went to a dentist . . . [and] told him I am HIV positive. When he heard this he told me that he cannot help me and asked me to leave his clinic.*

As a result, the bulk of the care is given within the context of the household, generally by family members and most often by a woman. However, HIV and AIDS-related stigma can result in the refusal of family members to provide this care—whether out of fear of transmission, out of anger, judgment and moral condemnation, fear of experiencing the stigma of others, or a combination of these factors. Intertwined with this is the impact of poverty and resource constraints, which can significantly limit the amount of care any given family is able—or willing—to provide to someone who is anyway believed to be “a hopeless case.” A further factor is the burn-out often experienced by

caregivers, particularly as HIV-disease advances and the burden of care becomes increasingly demanding.

*She was seriously ill and asked her brother to take her to hospital. He refused by telling her that she was hopeless. He told her not to bother people and he does not want to waste money on her. (Ethiopian woman)*

Perhaps one of the most profound consequences of HIV and AIDS-related stigma for people living with the condition is the phenomenon sometimes referred to as “self-stigma” or “internalized stigma,” which occurs when a person living with HIV and AIDS imposes stigmatizing beliefs and actions on themselves. It should not be surprising that this occurs: people living with HIV are, after all, members of the same cultural, social, and moral communities as many of their “stigmatizers.” They will largely ascribe to the same values and norms, and so have the same ideas about the nature of HIV and what it means about people living with it. However, they additionally have to deal with being the object of the cruel, thoughtless, and hurtful actions of others.

It is clear that many people living with HIV and AIDS go through a process, from the initial feelings of shock, despair, shame, and grief—sometimes accompanied by denial—to (particularly if well supported) an eventual acceptance and understanding that there remains much to live for. The internalization of the stigmatizing attitudes of one's own moral community, often at their worst during the early stages, can remain with one throughout life.

A consequence of internalized stigma can be profound depression. Upon receipt of a positive test result, and often before any symptoms appear, people may drop out of school or discontinue employment, and/or may choose to isolate themselves from their families and communities. This self-imposed isolation can be a product of the shame they are feeling, and/or out of fear of further spreading the virus through casual contact. As one woman explained:

*I do not want to have close contact with people because I know that I have HIV. . . . I am the one who should isolate myself from others. Some people who know me well want to have a good relationship with me, but I do not want to be close to them.*

Ultimately, HIV and AIDS-related stigma results in a loss to families and society of the unique and valuable contributions of people living with HIV and AIDS. Self-stigma thus exacerbates the serious human

resource drain caused by HIV related morbidity and mortality in high prevalence countries, where there are dramatic reductions in the number of essential workers such as teachers and nurses.

The consequences of HIV and AIDS-related stigma do not begin and end with the HIV positive person, but extend to include their families, children, and even friends and caregivers. This phenomenon is generally referred to as “secondary stigma,” or stigma by association. The parents of the person with HIV were often held responsible for the “bad” behavior, which led to the HIV infection of their children.

Because of this attribution of blame, as well as the close shared physical proximity, family members of people living with HIV and AIDS experience many of the same expressions of stigma as do the those living with HIV and AIDS themselves, including being the subject of gossip, being socially ostracized and isolated, and even losing income, employment, or housing. The children of people living with HIV and AIDS may bear the worst impact of stigma, sometimes being denied a place in school or being taunted, teased, and rejected by peers.

### **Consequences of stigma for HIV and AIDS treatment and prevention efforts**

The presence of stigma and the fear of experiencing its effects has a profound impact on the ability and willingness of people to access and utilize the services that are available for controlling the further development of the epidemic. HIV and AIDS-related stigma inhibits people from seeking treatment for infections that are closely associated with HIV, such as TB, skin rashes, and certain types of diarrhea, whether or not they have tested positive for HIV

Perhaps even more worrying, however, is the impact stigma has on the willingness of people to implement prevention measures and come forward for testing.

Fear of casual transmission and the moral dimensions of stigma serve to distance the (presumably) non-infected from people living with HIV. Fear of casual transmission has the effect of shifting the focus on to mechanisms of transmission that are largely impossible and/or those modes that are the *least* risky, but over which people have the least perceived control. The moral judgment aspect of stigma allows the (presumably) non-infected to deny their risk because “I am not like that”—as an upstanding member of the “moral community,” I could never get an infection like HIV, which only “bad” people get. If someone perceives

him or herself to be at the greatest risk through means over which he or she has no control, or if a person perceives no risk, then he or she probably will not take the measures necessary to protect against acquiring HIV. Stigma, therefore, operates in a number of ways to distance people from a sense of risk. From that vantage point, stigma creates an obstacle to prevention.

Stigma gets in the way of prevention in other ways as well. Even where there is a fairly high sense of vulnerability to HIV, stigma seems to interfere with the ability of individuals or couples to discuss condom use and use condoms regularly and correctly. Condoms themselves have acquired a strong stigma through their close association with HIV in the press and health promotion campaigns. Thus, the mere suggestion of using a condom in any given sexual encounter can be interpreted as tantamount to admitting one’s own infidelity, or that one suspects one’s partner has not been faithful.

HIV and AIDS-related stigma also prevents people from coming forward for testing, or when they do get tested, from returning for their test results. This relates in part to the way services are designed. For example, many people will avoid going to clinics known as HIV testing sites for fear of being seen there by others and thus suspected as having HIV. Another fear is that test results will not be kept confidential.

People also avoid testing out of fear of getting a positive result—with the stigma and other repercussions that would ensue. As one man explained:

*People fear to take the blood test because if their results [are] positive, they think that people will isolate and segregate them.*

People living with HIV struggled with the issue of disclosure. In some cases people live with the knowledge that they have HIV for years without telling even their most intimate partners for fear of stigma and its consequences, which can include physical violence and/or abandonment. As was the case for one woman, who continued to have sexual relations with her husband without condoms, and who had another child without availing herself of mother-to-child transmission prevention services, this can mean that the necessary measures are not taken to prevent the further transmission of the virus.

#### **Source**

Ogden, Jessica and Laura Nyblade, *Common at Its Core: HIV-Related Stigma Across Contexts*, International Center for Research on Women: Washington, DC, 2005.

## Handout B-2: Case Study, Vietnam

The following represents a synthesis of assessments conducted by multiple partner institutions and individuals with the International Center for Research on Women.

### Partners

The Institute for Social Development Studies (ISDS), based in Hanoi, conducted the research with technical support from ICRW. ( See Hong et al. 2004 for a full report on this study.)

### Objectives

The objectives of the Vietnam study were to

1. Document the experiences of people living with HIV and AIDS;
2. Explore how HIV and AIDS-related stigma interacts with other stigmas; and
3. Investigate the role of gender in the causes and consequences of stigma.

### Methods and sampling

The study was conducted in two Vietnamese cities, both relatively badly affected by the epidemic: Hai Phong in the north of the country, and Can Tho in the south. One ward was selected for each city. Due to the sensitivity of the topic, a qualitative approach was deemed most appropriate. The primary methods used to collect data were in-depth interview and focus group discussions (FGDs). Other methods included observation, photography, and the use of participatory techniques such as matrix mapping and brainstorming. Secondary sources were also consulted widely. Additional information was obtained from key informants who were members of the project's Leadership Advisory Group.

In each research site, the study sample consisted of people living with HIV and AIDS, their family members, and people living in their communities. In selecting participants living with HIV and AIDS, attention was given to whether they were likely to have acquired their infection through injection drug use, involvement in sex work, or by other means. In each site, the research sample included

- Fifteen people living with HIV and AIDS who participated in in-depth interviews;
- Fifteen male and female family members of people living with HIV and AIDS who participated in in-depth interviews;
- Sixty-four community members from each ward who participated in FGDs; and
- Thirty-two local leaders from each ward who participated in FGDs.

Local leaders in each ward also participated in in-depth interviews. Additional key informant interviews were conducted with local health workers, teachers, and other members of the community.

### The HIV/AIDS pandemic

Vietnam is still experiencing what is known as a “concentrated” epidemic: HIV infections occur primarily among a few select population groups, the most important of which is injection drug users (IDU), who bear nearly 60 percent of all HIV infections. Sex workers (3.1 percent), TB patients (4.4 percent), and people attending clinics for sexually transmitted infections (1.8 percent) are also experiencing relatively high prevalence rates, and youth are heavily infected (10 percent of those living with HIV and AIDS are between 10 and 19 years old, and 55 percent are between 20 and 29 years old). The overall prevalence rate in Vietnam, however, remains relatively low at around 0.4 percent. Women make up around one-third of those living with HIV.

The presence of stigma is perhaps not surprising in a country like Vietnam where the epidemic is concentrated among those already stigmatized and marginalized (injection drug users and sex workers). Yet as these studies clearly indicate, whether the epidemic is contained within subgroups or has spread more broadly to the general population, there is little difference in the ways stigma is expressed.

One key feature distinguishing the context in Vietnam is the way in which HIV and AIDS have so strongly been linked, in policy and programs, with illegal drug use and prostitution—both of which fall under the general rubric of “social evils.” In 2000, the government of Vietnam merged its National AIDS



Committee with its committees on the control of illicit drugs and prostitution to create the National Committee for AIDS, Drugs and Prostitution. This committee included members from the National Drug Standing Bureau and the Department for Social Evil Prevention. Although this structure changed in 2003, the act of combining these three social issues under one program umbrella firmly established the link between HIV and social evils in the public imagination.

### **Economic situation: the relationship between poverty and stigma**

Statistics on poverty (World Development Report 2005)

- Percent of Population Below \$1/day: 17.7 (1998)
- Percent of Population Below National Poverty Line: 57.2 (1998)
- Gini Index\*: 36.1 (1998)

\*The Gini Index is a measure on inequality. The closer the number to 0, the more equally distributed income is among individuals or households. The closer the number is to 100, the more unequal this distribution is.

It was acknowledged that poverty plays a role in driving people (especially women) to engage in behaviors (such as sex work) that make them vulnerable to infection. Generally, the rich were more likely to be stigmatized than the poor because it was felt that they deserved their fate for indulging themselves in sinful and/or pleasurable behaviors “just for fun.” However, this tendency to stigmatize the rich was mitigated by the fact that the wealthy could more easily hide their HIV-positive status from the general public. In addition, the poor were more likely to experience stigma at home due to the greater strain that caring for someone with HIV and AIDS imposes on a poor household economy than on a rich one.

In Vietnam, families may have one or at most two members living with HIV, whereas in many African countries many families will have multiple members infected—if not within their immediate household, then within their extended families. The costs of caring for even one person who is sick or dying with AIDS can be devastating for any poor family, but when these costs are multiplied, the weight of the cost burden can become unbearable—driving some families to stigmatize, even neglect, their members living with HIV and AIDS.

### **The importance of religion**

Vietnam is a predominantly secular society, grounded in Confucianism in combination in recent decades with a strong commitment to socialist doctrine. The living retain a strong connection to the dead through

the respect given to ancestors. Ancestor veneration in Vietnam is much more formalized than in other countries, but this continuity still has implications for HIV and AIDS-related stigma experienced by families of people living with HIV.

### **The role of knowledge about HIV and AIDS and fear**

The fear that HIV could be transmitted through ordinary, daily interactions with people living with HIV and AIDS that involve *no* exchange of body fluids was common. Examples include contact with an HIV-positive person through simple touch (shaking hands, kiss on the cheek, sitting next to); eating food prepared by or which may have come in contact with those living with HIV and AIDS; breathing infected air; or using objects that someone living with HIV and AIDS had touched (e.g. clothing, bedding, or eating utensils).

*People are also afraid whenever he [the person living with HIV] cooks or cleans the rice . . . During meals, they also fear sharing things. The family is so fearful. Of course, the family does love him, but . . . (wife of a person living with HIV and AIDS)*

Fear of and preoccupation with transmission through everyday casual contact leads directly to stigma in the form of isolation of persons living with HIV and AIDS in all aspects of daily life. It occurs everywhere, from within the home, to social gathering places in the neighborhood, to the market place, health facilities and even sometimes in places of worship

*For self-prevention of the disease, I think I should keep far from PLHA because those persons [can infect me]. As we know for prevention of disease, to keep away is best. (woman)*

The common fear of modes of casual transmission that carry extremely low, if any risk, is striking. In particular, many fear even the most peripheral contact with blood (e.g., left on nail clippers or hair cutting scissors or through mosquitoes), and other nonsexual body fluid (saliva, sweat).

*. . . [HIV] is transmitted through blood and unsafe sexual relationships only . . . but in case we are grazed, it can be transmitted through blood—even if it is a small scratch only . . . Cutting hair may also cause the disease. For example, if we hold the scissors that makes our skin grazed, another person who holds it later could be infected, too. (woman)*

This fear of and preoccupation with contracting HIV through impossible or highly unlikely routes persists

despite high levels of knowledge about how HIV is transmitted. Respondents know, or at least can easily recite, the three correct modes of HIV transmission (sex, blood, and mother-to-child). However, correct knowledge does sometimes coexist with incorrect beliefs about transmission, and there is often a lack of confidence about how HIV is *not* transmitted. The doubts and concerns that exist despite “knowing” that HIV is only transmitted in three ways.

### **Persistent focus on casual transmission**

The data suggests that the persistence of doubts about how HIV is transmitted despite knowing otherwise and the fixation on the least likely modes of transmission could be the result of several interacting factors.

### **Lack of specific, in-depth information about HIV transmission**

The first is the narrowness and lack of depth and specificity in much HIV and AIDS information. Standard HIV and AIDS messages often focus solely on how HIV is transmitted, that it has no cure, and that it kills. Such messages tend to convey the incorrect impression that HIV is highly infectious. Rarely do HIV and AIDS messages focus on explaining how HIV is *not* transmitted, the relative infectiousness of HIV, and the fact that HIV is *not* easily viable outside the human body. These messages, therefore, allow fears of casual transmission to go unchallenged and to persist. By not specifically addressing the risk of HIV transmission through routes that are of common concern in people’s daily lives (e.g., noninvasive contact with blood, sweat, saliva, and mosquitoes), the possibility is left open that these are indeed risk situations to avoid.

- What if I’m sitting on a bus next to someone with HIV or AIDS and the bus crashes, that person bleeds and I’m cut, and some of his or her blood gets on my open wound?
- What if an HIV-positive person cooking food cuts themselves and blood drips into the food, which I then eat?
- What if an HIV-positive person drips sweat into the food they are handling or I use a bed sheet or article of clothing a person with HIV and AIDS has sweated on?
- What if a fingernail clipper was used by a person with HIV and AIDS, they cut themselves with it, some dried blood remains and then I use it and cut myself in the process?
- What if the person has diarrhea and when washing the messed clothes you have a cut and are not wearing your gloves for protection, you may [contract HIV] as well.

Given the narrow and often incomplete or ambiguous knowledge about how HIV is, or is not, transmitted, it is not surprising that the common conclusion to a *what if* scenario is that it could potentially pose a significant risk of transmission and therefore should be avoided

Adding to the confusion, doubt, and fear over whether, and how much, daily activities pose a risk for HIV transmission is the widespread and well-established knowledge about how other viral and bacterial diseases are transmitted, particularly those commonly associated with HIV (like tuberculosis and diarrhea), and other diseases that have a transmission cycle that includes blood and biting insects, in particular malaria. Given this knowledge, doubt and fear creeps in that HIV might be transmitted this way too. Knowing that TB is airborne, diarrhea contracted through contaminated food and water, and infected body fluids or objects, and malaria through mosquitoes, people often reason that perhaps HIV could be transmitted these ways too.

### **Fear-based public messaging**

Another factor that adds to the fear and desire to avoid any situation that might pose a potential transmission risk is the legacy of fear and panic created by fear-based messages about HIV, coupled with sensationalized reporting around HIV. Fear-based messages in health campaigns focused heavily not only on death as the outcome of HIV, but also on the depiction of a painful, disfiguring, and sometimes shameful death (through linking HIV to socially unacceptable behaviors).

The focus, both in public health campaigns and the media, on negative images of sick, dying, and disfigured persons; the sensationalization of alleged cases of vindictive and purposeful infection of others by people living with HIV and AIDS (for example by injecting their blood into others or having premeditated unprotected sex); and lack of positive images of the more prevalent reality of people with HIV and AIDS who are productive and responsible members of society ratchets up the fear and panic of contracting HIV, hence creating stigma toward those living with HIV and AIDS.

In addition to perpetuating stigma, the creation of this fear has public health impacts. For example, people may avoid getting tested for HIV. The impact on testing has been described as follows: “Respondents also discussed

how fear of testing is related to images people have of a grossly disfiguring disease as shown on billboards and that a positive finding of a test implies a sentence of death.” People may also believe that only sick-looking people have HIV, and so deny their own potential risks and any need for behavior change. A woman explained how images of thin, sick people with HIV and AIDS create fear and stigma, as well as feeding the misconception that only sick-looking people have HIV.

### **Evolving knowledge on HIV and AIDS**

Adding additional doubt to the mix is the relative newness of the HIV epidemic and the constantly evolving, sometimes contradictory, scientific and medical knowledge about HIV and AIDS. Because knowledge continues to grow on all aspects of HIV, including transmission, people begin (or continue) to doubt the validity of existing information, causing fear that current information about transmission might be wrong.

### **The role of values, norms, and moral judgment**

Assumptions made about the moral integrity of people living with AIDS is a central cause of stigma, and these assumptions underpin the tendency to blame people for their HIV infection—as well as the shame felt at some stage almost universally by those living with HIV and AIDS and those associated with them. The tendency to link HIV and morality might be related to the fact that affliction is often perceived as an outward manifestation of a moral transgression.

The tendency to link HIV and morality might be related to the fact that affliction is often perceived as an outward manifestation of a moral transgression. In some Asian cultures, these perceptions might be couched in terms of *karma*.

Whatever its roots, the tendency to associate illness with moral impropriety is a central contributing factor to HIV and AIDS-related stigma. This stigma is exacerbated by the seriousness of the illness, its mysterious nature, and its association with behaviors that are either illegal or socially sensitive (e.g., sex, prostitution, and drug use). Also relevant is the perception that HIV infection is the product of personal choice: that one *chooses* to engage in “bad” behaviors that put one at risk and so it is “one’s own fault” if HIV infection ensues.

All of these elements have strong resonance with the moral dogmas of many religious texts as well as with the form of socialism practiced in Vietnam. ” In Vietnam the same types of sentiments were expressed, but

couched in different terms. Rather than the explicit religious references, the Vietnamese refer to people with HIV as having contracted the virus through a lack of self-discipline—through “indulging in play” and engaging in “social evils.” Lack of seriousness, discipline, and personal integrity contravenes many of the core tenets of Vietnamese society, which stem ultimately from Confucianism.

### **Creating a divide between “us” and “them”**

HIV and AIDS-related stigma has become a mechanism for sharpening the boundaries of the “moral community.” In other words, stigma reinforces previously defined boundaries between “us” (the normal/righteous/upstanding citizens) and “them” (the deviant/bad/“fallen” ones). The fact that one has become infected with HIV is used to distance that person from the mainstream community, to set him or her apart, marked out as having transgressed or sinned against god and/or society. This mark (or literally, “stigma”) is a cause for opprobrium in and of itself—but all the more so because of the perception that he or she has become infected by *choosing* to do things (such as inject drugs or have unsanctioned sex) that he or she *knows* are wrong.

Clear distinctions were made between those who became (or were presumed to have become) infected through such “improper” behaviors, and those who were deemed “innocent victims”— such as sexually faithful married women (or men) who became infected because of their spouse’s philandering; health care workers or police infected in the course of their work; or children infected through vertical transmission. Thus, there exists in people’s minds a kind of continuum from presumed “guilt” to presumed “innocence.” Although all people with HIV experience some degree of stigmatization, where one falls along this continuum will determine, to a significant extent, the type and degree of stigmatization received from one’s family and the wider community.

This boundary-making serves at least two purposes: it enables the (apparently) uninfected to reinforce their notions of themselves as being morally right and upstanding citizens, while also allowing this group to deny its own level of risk, thereby enabling them to believe they have no need to contemplate any changes to their own behavior.

In Vietnam this separation can be quite explicit, as the following quotes indicate. Many people disguise their contempt for people living with HIV and AIDS by

expressing their sentiments as “legitimate” concerns about prevention. This 65-year-old father of an HIV-positive man believes the government should put all those living with HIV on an island to live and work together. He explained further that:

*The government should not let PLHA wander in the community and in the society. They should be split off. I say this not because I hate them, but because I am thinking of the protection of the community.*

In another city, Hai Phong, a 50-year-old woman participating in a focus group discussion expressed a similar opinion:

*. . . the government should create a separate area in order to limit them [PLHA]. . . . If there is no separate place and we let them [intermingle] like now, people will be afraid.*

The presence of HIV also enhances pre-existing stigmas and serves to retrench social values and norms about correct, normal, or appropriate behavior. In Vietnam this takes the form of a discourse of social evils.

### **The continuum between “innocence” and “guilt”**

Because of the clear associations that exist in peoples’ minds between HIV infection and morally incorrect behaviors, and as a way to distance oneself from any possibility of HIV risk, the first question invariably in peoples’ minds when they discover someone is living with HIV is: *How did he/she get it?* Often the asker will answer the question simply through assumptions made about the person’s character or known behaviors.

In Vietnam, if the person in question was a man, especially a young man, it was generally assumed that he became infected through injection drug use, sex with prostitutes, or generally “indulging in play.”

*In the case of women who unfortunately get infected, we should give them support and educate them so that they can avoid transmitting to others. Regarding the case of drug injectors, the damage is already done and they cannot be educated. We should definitely put them in a separate place because we cannot educate those people. The other group—they deserve our pity and we should protect them (participant in FGD of women over 50 years old).*

### **Shame, blame, and the role of gender**

Gender plays an important role in the nexus between HIV-related stigma, moral judgment, shame, and blame. Although this interface was complex, it is clear that women generally bear the strongest brunt of this type

of stigma. The reason underlying this seems to be that women are expected to uphold the moral traditions of their societies. HIV is regarded as evidence that they have failed to fulfill this important social function. To phrase the problem otherwise: Women living with HIV and AIDS (or more often, suspected to be living with HIV and AIDS) are regarded as everything they should not be—sick and slim when they should be healthy; being cared for when they should be caring for others; sexually deviant when they should be sexually righteous. To be HIV-positive is not to be a proper woman.

A fundamental double-standard exists, whereby men are generally expected to be reckless, adventuresome and more likely exposed to a whole host of sexually transmitted infections (STIs) (including HIV), and women are expected to be sexually faithful, chaste, and morally upstanding.

In Vietnam, the family is at the center of society. Women, more than men, are expected to put their families first, to support and reinforce the family in all their actions and deeds. Although the socialist ideology of the country promotes and supports equal rights for women in all aspects of social life, both government and society in general continue to embrace traditional Confucian values, including those that apply to gender. So, while Vietnamese women are on the one hand encouraged to participate fully in employment, politics, and social life, they are nevertheless expected to prioritize their roles as wives and mothers. A woman engaging in “social evils” such as drug use (which undermines both the reputation and economic well-being of families) or sex work (said to “break the family’s happiness”), therefore, is strongly judged and simply not tolerated; and HIV infection is considered *de facto* evidence of such involvement. This sentiment is expressed in the following quotes:

*People do not hate a drug-addicted man nearly as much as a drug-addicted woman. (participant in FGD of women 18-24 years old,)*

*To say frankly, if men are still young and they indulge in play and get [HIV] infected, that’s the general story of society. If a girl gets this disease, no one would like to get close to her, because it is a problem of her conduct and her morality. It is not tolerated in females compared to males. (female community counselor)*

Although HIV-positive women in general may be more reviled than HIV-positive men in Vietnam, as a whole they are not generally blamed directly for bringing HIV into a family (although they may be in

specific instances), as this is often known to have happened through the husband's injection practices.

## Types of stigma

### Physical stigma

The forms of physical stigma can be grouped into isolation and violence, with the former being widespread and the latter less common. Physical isolation of people living with HIV and AIDS occurs in all locations, from the home to community gathering or public spaces (like tea shops, markets, sports grounds, buses, places of worship), to within workplaces, schools and hospitals. Common expressions within the home include marking and separating out typically shared objects like eating utensils, clothes, and bed linens and making those with HIV and AIDS sleep in separate quarters and eat alone, highly unusual actions where space is limited and eating together is the norm. More extreme manifestations of physical isolation include complete abandonment by family, divorce, or separation from children.

In the urban settings, abandonment often took the form of sending a person with AIDS back to the village to "die," thereby often transferring the responsibility of care to usually poorer, rural relatives with less access to health care and other support services.

Expressions in public spaces include not sitting next to or moving away from a person with HIV in public transport, in places of worship, while waiting in a queue or on a bench, or at a tea shop or bar. In places where eating together from a shared platter, sharing a communal drinking container or even sharing washed cups (e.g., tea shops in Vietnam) is common, people living with HIV and AIDS may be publicly excluded, or the usual customs visibly altered when an infected person is present. For example, suddenly individual plates or spoons and forks appear, where eating with hands from a common platter is the norm. Some actions may be very subtle, but clearly recognizable to all as being out of the ordinary.

*I asked, "Please give me a cup of sugar cane drink" and the vendor said: "If you drink in the cup, other persons will see you drink from that cup and they won't dare to use it. So take the drink in a [plastic] bag. (man living with HIV)*

*When we watched TV with them they put mosquito-killing incense beside them. Do you see? Nothing happened when others were sitting there but when we*

*came they took the incense and put it beside them. This made us feel ashamed. (mother of person living with HIV/AIDS)*

Less common, but still present, are more extreme manifestations of physical isolation including complete abandonment by family, divorce, or separation from children. Women are more likely to experience, and therefore fear, this kind of stigma. Women's lack of access to resources and dependence on husbands and families leaves them particularly vulnerable to abandonment, divorce, and separation from their children, and with little recourse to challenge these actions. This father of a woman with HIV in Vietnam explained that her son was taken from her in order to "protect" him from contracting the virus:

*The child is living here to avoid being infected. I let him live with us because I am frightened [that he may become infected]. It is better to make disease prevention. Supposing a mosquito stings his mother? That mosquito will continue to sting my grandchild [and so infect him]. What if there are some marks or traces of scabies and itches on my grandchild's body and his mother scratches for him? He can be infected when the place bleeds.*

### Social stigma

The manifestations of social stigma can be grouped into social isolation, loss of identity and role, and voyeurism. Isolation comes in various forms both in relation to important family and community events, as well as in daily life. It takes the very visible form of the disappearance of invitations to significant family and community events such as weddings, or outright orders to stay away.

In the realm of daily life, the most common forms of social stigma were the waning or disappearance of existing friendships and the reluctance of neighbors, friends, and relatives to visit or lend or borrow common household implements and food items, important actions for survival in poor communities. A woman in Vietnam explained that she terminated all contact with a childhood friend because "people told me I should stop spending time with her. They said things like, 'I know you have been close with her from childhood, but now she goes on that track [sex work] so don't play with her.'" People living with HIV and AIDS reported, and community members noted, that visits by family, friends, and neighbors tapered off, as did requests for assistance with daily needs (e.g., borrowing some salt, cooking oil, a hoe, money to get a sick child to a hospital).

In addition to isolation, social stigma is also expressed through the taking away or diminishing of the roles, responsibilities, and social standing of those living with HIV and AIDS within the family and larger community. As a result, HIV positive people lose power, respect, and identity. This expression of stigma is a result of both how people living with HIV and AIDS are assumed to have contracted HIV, as well as the belief that HIV means immediate disability and death.

### Verbal stigma

A third form of stigma is verbal. This can be direct (pointing fingers, insulting, taunting, or blaming), or more indirect (gossip and rumors). Gossip and rumors focus on speculation about whether a person has HIV, usually because of visible signs, illness, behavior, or association with groups seen as “high risk.” Once a person is assumed to be HIV-positive, people often speculate about how he or she contracted HIV. Gossip was reported to be one the most significant forms of stigma, particularly for women.

More direct forms of verbal stigma were expressed through insulting, mocking, taunting, cursing, and threatening those living with HIV and AIDS. They also included the expression of blame and shame, often through scolding or judgmental statements indicating people with HIV and AIDS “got what they deserved.” People living with HIV and AIDS are blamed for becoming infected with HIV through their “irresponsible” and “selfish” behavior, and for bringing shame to themselves, their families and the community as well as becoming a burden to the family.

An integral and hurtful expression of the verbal stigma is the use of derogatory, demeaning and pessimistic or despairing language to talk about or label people with HIV and AIDS. In Vietnam, where the epidemic has been concentrated among injection drug users and sex workers, the language used focuses less on describing the physical attributes of people with AIDS and the outcome of death, and more on the behavioral aspects of HIV and judgment, using phrases like “he got his just desserts.”

### Institutional stigma

Institutional stigma refers here to differential treatment within any broadly defined institutional setting that leads to a negative outcome for the person living with HIV. The main areas documented in the study had to do with loss of or inability to secure livelihoods, housing, health care, and education. It also includes

losing access to new or future opportunities because an HIV test is required to qualify for a job, loan, scholarship, or visa for travel; differential treatment within an institution that leads to poorer outcomes (for example having to wait longer for health services); and the way those with HIV are depicted in the media. Not only do all of these forms of stigma lead to reduced life chances for people living with HIV and AIDS, but they also often serve to visibly mark a person as having HIV, exposing him or her to all the other forms of stigma discussed above.

### Consequences and impact of stigma

This section explores both the impact of stigma and its consequences for individuals living with HIV and AIDS, their family members and HIV/AIDS programs. There are differences in impact from one context to the next. These differences relate to individual personality and circumstance (everyone’s experience of stigma is somewhat different, even within a given social setting); the nature and duration of the epidemic; and social, health care, and cultural contexts.

Given the tremendous impact a disclosed HIV diagnosis can have on the life of a person living with HIV because of stigma, it is not surprising that so few people choose to be tested for HIV, and that so many of those who do test, and do test positive, try by any means to prevent their HIV status from becoming known to people around them.

The most profound consequences of stigma was the impact it had on their ability to earn a living. People in formal employment found themselves being dismissed upon disclosure (whether voluntary or not) of their HIV status, and those selling goods or cooked food found their client base dropping off—particularly once they began to show symptoms of HIV related diseases. Domestic workers with HIV were almost always dismissed.

*Now they are afraid of me so they do not hire me [to wash clothes]. People like me cannot ask for any job. Now I do only some agricultural laboring—that is all I am doing for my living now. (woman living with HIV)*

Another disturbingly common consequence of HIV and AIDS-related stigma relates to marriage and childbearing. Spouses—particularly wives—were frequently deserted upon disclosure of their HIV status. Often this desertion was accompanied by blaming—the first person to become tested in the relationship being considered as the one who brought the disease

into the home (by being unfaithful or “indulging in play”).

Unmarried HIV-positive people may find marriage no longer is an option available to them. People living with HIV may find that they are strongly discouraged from having children.

HIV positive people receive inferior care or are denied care altogether. And a health worker in Vietnam admitted:

*We absolutely never inject [HIV] infected persons. We just give them medicines . . . We also treat small children here, so we give [HIV] infected people no injections at all.*

As a result, the bulk of the care is given within the context of the household, generally by family members and most often by a woman. However, HIV and AIDS-related stigma can result in the refusal of family members to provide this care—whether out of fear of transmission, out of anger, judgment and moral condemnation, fear of experiencing the stigma of others, or a combination of these factors. Intertwined with this is the impact of poverty and resource constraints, which can significantly limit the amount of care any given family is able—or willing—to provide to someone who is anyway believed to be “a hopeless case.” A further factor is the burn-out often experienced by caregivers, particularly as HIV-disease advances and the burden of care becomes increasingly demanding.

*Many families, although they love the child, still keep away, they are so afraid. They hire [others living with HIV] to provide care for him at the last stage, but they do not dare to provide care directly themselves.* (woman FGD participant).

Perhaps one of the most profound consequences of HIV and AIDS-related stigma for people living with the condition is the phenomenon sometimes referred to as “self-stigma” or “internalized stigma,” which occurs when a person living with HIV and AIDS imposes stigmatizing beliefs and actions on themselves. It should not be surprising that this occurs: people living with HIV are, after all, members of the same cultural, social, and moral communities as many of their “stigmatizers.” They will largely ascribe to the same values and norms, and so have the same ideas about the nature of HIV and what it means about people living with it. However, they additionally have to deal with being the object of the cruel, thoughtless, and hurtful actions of others.

It is clear that many people living with HIV and AIDS go through a process, from the initial feelings of

shock, despair, shame, and grief—sometimes accompanied by denial—to (particularly if well supported) an eventual acceptance and understanding that there remains much to live for. The internalization of the stigmatizing attitudes of one’s own moral community, often at their worst during the early stages, can remain with one throughout life: loss of hope, feelings of worthlessness (even suicidal feelings) and inferiority, believing oneself to be a person with no future.

*I am in such a state—how could I get married? If I could begin my life again, nothing would make me happier. As it is, I cannot marry a wife, my economic situation cannot be regained, and my body is not healthy. So, as far as I can afford to, I just play [i.e. inject drugs].* (young man living with HIV)

A woman living with HIV in Vietnam said *I am afraid of giving my disease to my family members—especially my youngest brother who is so small. It would be so pitiful if he got the disease. I am aware that I have the disease so I do not touch him—I talk with him only. I don’t hold him in my arms now.*

#### **Consequences of stigma for the families of people living with HIV and AIDS (secondary stigma)**

The consequences of HIV and AIDS-related stigma do not begin and end with the HIV positive person, but extend to include their families, children, and even friends and caregivers. This phenomenon is generally referred to as “secondary stigma,” or stigma by association. The parents of the person with HIV were often held responsible for the “bad” behavior, which led to the HIV infection of their children.

*People tend to think that children get this disease when they become spoiled. It’s clear that the family does not know how to educate their children. People say that the family is to blame, not the infected one.* (man living with HIV)

Because of this attribution of blame, as well as the close shared physical proximity, family members of people living with HIV and AIDS experience many of the same expressions of stigma as do the those living with HIV and AIDS themselves, including being the subject of gossip, being socially ostracized and isolated, and even losing income, employment, or housing. The children of people living with HIV and AIDS may bear the worst impact of stigma, sometimes being denied a place in school or being taunted, teased, and rejected by peers. Two major effects are loss of livelihood and loss of reputation.

The mother of a woman living with HIV in Vietnam used to take in neighborhood children as a day care provider. Once the news of her daughter's HIV status became the subject of gossip, all the children were withdrawn from her care, and she had to seek alternative (and far less lucrative) employment selling lottery tickets in the city center.

### Consequences of stigma for HIV and AIDS treatment and prevention efforts

The presence of stigma and the fear of experiencing its effects has a profound impact on the ability and willingness of people to access and utilize the services that are available for controlling the further development of the epidemic. HIV and AIDS-related stigma inhibits people from seeking treatment for infections that are closely associated with HIV, such as TB, skin rashes, and certain types of diarrhea, whether or not they have tested positive for HIV.

Perhaps even more worrying, however, is the impact stigma has on the willingness of people to implement prevention measures and come forward for testing.

Fear of casual transmission and the moral dimensions of stigma serve to distance the (presumably) non-infected from people living with HIV. Fear of casual transmission has the effect of shifting the focus on to mechanisms of transmission that are largely impossible and/or those modes that are the *least* risky, but over which people have the least perceived control. The moral judgment aspect of stigma allows the (presumably) non-infected to deny their risk because “I am not like that”—as an upstanding member of the “moral community,” I could never get an infection like HIV, which only “bad” people get. If someone perceives him or herself to be at the greatest risk through means over which he or she has no control, or if a person perceives no risk, then he or she probably will not take the measures necessary to protect against acquiring HIV. Stigma, therefore, operates in a number of ways to distance people from a sense of risk. From that vantage point, stigma creates an obstacle to prevention.

Stigma gets in the way of prevention in other ways as well. Even where there is a fairly high sense of vulnerability to HIV, stigma seems to interfere with the ability of individuals or couples to discuss condom use and use condoms regularly and correctly. Condoms themselves have acquired a strong stigma through their close association with HIV in the press

and health promotion campaigns. Thus, the mere suggestion of using a condom in any given sexual encounter can be interpreted as tantamount to admitting one's own infidelity, or that one suspects one's partner has not been faithful.

HIV and AIDS-related stigma also prevents people from coming forward for testing, or when they do get tested, from returning for their test results. This relates in part to the way services are designed. For example, many people will avoid going to clinics known as HIV testing sites for fear of being seen there by others and thus suspected as having HIV. Another fear is that test results will not be kept confidential.

People also avoid testing out of fear of getting a positive result—with the stigma and other repercussions that would ensue.

People living with HIV struggled with the issue of disclosure. In some cases people live with the knowledge that they have HIV for years without telling even their most intimate partners for fear of stigma and its consequences, which can include physical violence and/or abandonment. As was the case for one woman, who continued to have sexual relations with her husband without condoms, and who had another child without availing herself of mother-to-child transmission prevention services, this can mean that the necessary measures are not taken to prevent the further transmission of the virus.

One man living with HIV observed that “Because our community does not have good feelings toward infected persons, they keep away from them. This makes me feel inferior. That's why I would like to hide [my HIV status].” In some cases, people with HIV avoid making use of available support services out of fear that using those services would result in public disclosure of their status. As one woman living with HIV reported:

The ward invited me [for counseling] several times but I did not go because I am reluctant to meet people there. . . . It is normal for a drug addicted person to be infected. But for me, people tell each other, “Look, such a girl but yet infected.” So I feel reluctant. I do not want to go [to the ward's activities for those living with HIV].

### Source

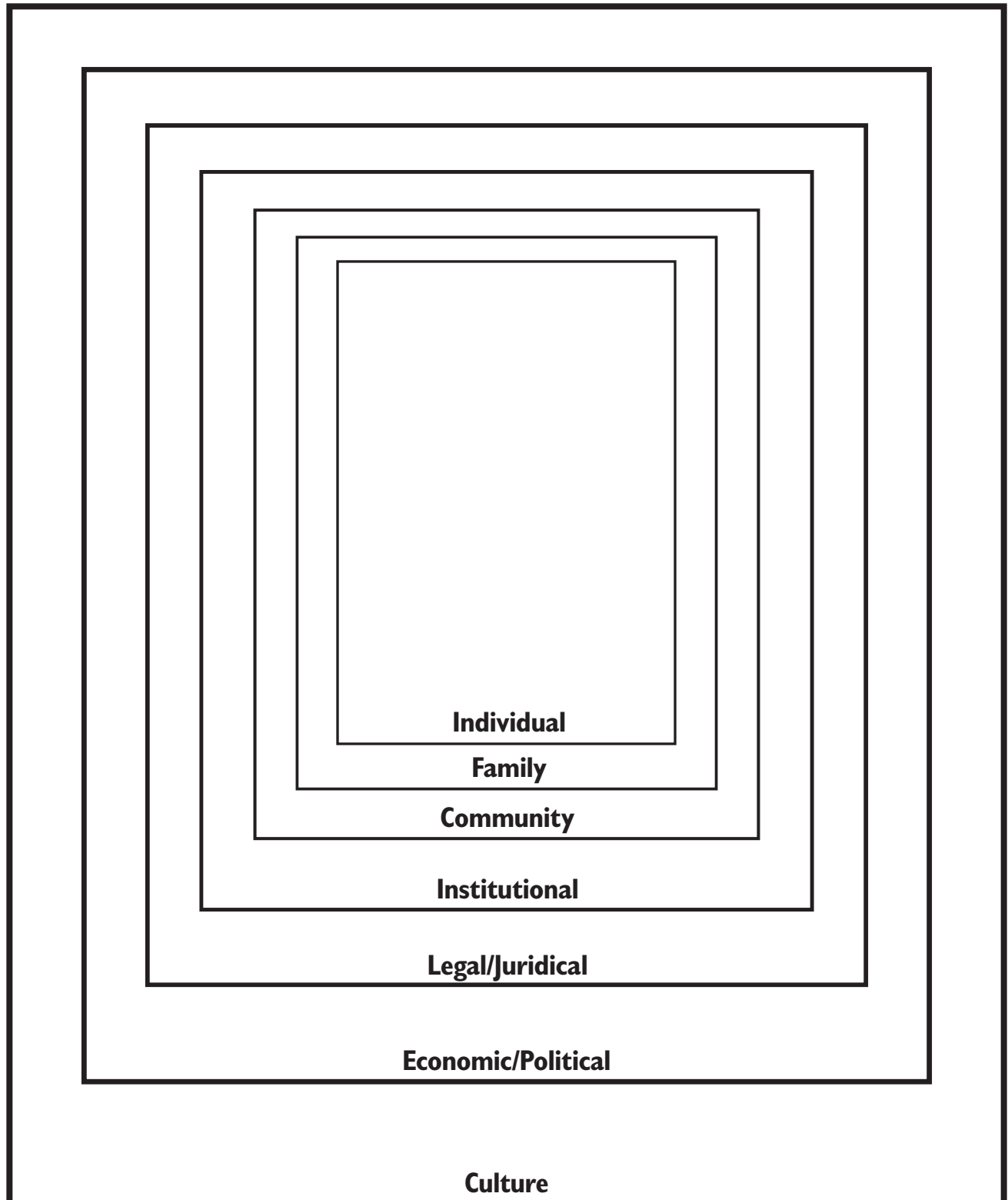
Ogden, Jessica and Laura Nyblade, *Common at Its Core: HIV-Related Stigma Across Contexts*, International Center for Research on Women: Washington, DC, 2005, pps. 38-40.



## Handout C: Small Group Task Instructions

1. Discuss the contexts presented in the case (see handout D).
2. Identify specifically what awareness raising your target group needs and what might realistically be accomplished, given their situation. What would you hope to accomplish?
3. Discuss what agencies, nongovernmental organizations, or other groups might  
1) already be involved in such activities; 2) be interested or logical partners in the types of awareness raising you are proposing.
4. Be prepared to share your findings.

## Handout D: Contextual Analysis



# Handout E: Recommendations for Awareness-Raising Activities

Research by the International Center for Research on Women (ICRW), which is where the case study was extracted, has indicated that a lack of specific, in-depth information about HIV transmission is a major cause of stigma, which in turn is a major barrier to behavior change. The study by ICRW in four countries produced several important recommendations relating to how awareness messages should be framed and delivered to be effective.

## Recommendations relating to content

- Provide information not only about how HIV is transmitted, but also about how it is not transmitted. Address concerns about casual contact situations with blood, sweat, saliva, and mosquitoes, or common situations such as sitting next to someone in a bus, eating/drinking from the same bowl/cup, sharing utensils.
- Provide clear and unambiguous information by explaining exactly how HIV is transmitted through each mode—enabling a person to distinguish relative risk. For example, the risk of transmission through IV drug use vs. sharing a nail clipper that has blood left on it.
- Provide information about living with HIV, including skills relating to living healthy and productive lives and practical tips for things like bringing up condom use.
- Create recognition and understanding of HIV stigma so that people can recognize their own behavior.

## Recommendations relating to style and delivery of messages

- Use an interactive format, facilitated by someone trusted and knowledgeable to encourage discussion, questions, and feedback about people's real concerns. Once people truly believe that HIV cannot be transmitted through casual contact they will be less likely to stigmatize people with HIV.
- Use positive images of people living with HIV/AIDS to combat the fear that drives stigma.
- Continually evaluate how people understand the messages they receive and address misconceptions quickly.

## Source

Ogden, Jessica and Laura Nyblade, *Common at Its Core: HIV-Related Stigma Across Contexts*, International Center for Research on Women: Washington, DC, 2005, pps. 38-40.

# Handout F: Sources for HIV/AIDS Assessment Information

## Center for Disease Control (CDC)

[www.cdc.gov](http://www.cdc.gov)

Global AIDS Program (GAP): Currently the CDC works in 25 countries and has four regional offices around the world. To find country-specific fact sheets, including available assessment information, go to GAP's homepage of CDC's website (<http://www.cdc.gov/nchstp/od/gap/default.htm>) and follow links to country and regional programs, and then to specific countries/regions.

## Family Health International (FHI)

[www.fhi.org](http://www.fhi.org)

Produces surveillance and assessment reports, including Behavioral Surveillance Surveys (BSS), for some countries. BSS track HIV risk behaviors over time as part of an integrated surveillance system which monitors various aspects of the HIV/AIDS epidemic. They are especially useful in providing information on behaviors among subpopulations who may be difficult to reach through traditional household surveys, but who may be at especially high risk for contracting or transmitting HIV.

Produces numerous publications and tools related to assessment.

To find country-specific information, go to the HIV/AIDS section: <http://www.fhi.org/en/HIVAIDS/index.htm> and follow links to countries.

## MEASURE DHS

[www.measuredhs.com](http://www.measuredhs.com)

MEASURE DHS (demographic and health surveys), is part of USAID's MEASURE effort to assist developing countries collect and use data to monitor and evaluate population, health, and nutrition programs, including HIV/AIDS. MEASURE DHS surveys are large, nationally representative efforts, using questionnaires targeting households and women, on a large range of topics. They utilize innovative technology for data collection and analysis. To find reports on specific countries, go to: <http://www.measuredhs.com/hiv-data/reports/start.cfm>.

## Ministry of Health (MOH)—Host Country

Demographic and health surveys, conducted in most countries every five years by CDC and MACRO International in conjunction with the MOH.

National AIDS Control Program data.

Assessment, census, and other data collected by agencies working in-country.

## Population Services International (PSI)

[www.psi.org](http://www.psi.org)

Manages AIDSMark, funded by USAID, that generates information related to HIV/AIDS behavior change programs, published as country profiles in HIV/AIDS Behavior Change Communications (BCC) Catalogue: [www.aidsmark.org/catalogue/catalogue.html](http://www.aidsmark.org/catalogue/catalogue.html).

In Central America known as Pan American Social Marketing Organization (PASMO): [www.psi.org/where\\_we\\_work/central\\_america.html](http://www.psi.org/where_we_work/central_america.html).

## Joint United Nations Program on HIV/AIDS (UNAIDS)

[www.unaids.org](http://www.unaids.org)

Provides country-specific information, including

- Overviews of HIV/AIDS prevalence rates by age and gender.
- Overview of UNAIDS support to the National HIV/AIDS Response.
- Country situation analysis.
- Link to country-by-country epidemiological information developed in collaboration with World Health Organization (WHO): epidemiological fact sheets on HIV/AIDS and sexually transmitted infections.

For UNAIDS country level information, go to [http://www.unaids.org/en/Regions\\_Countries/Countries/default.asp](http://www.unaids.org/en/Regions_Countries/Countries/default.asp).

**United States Agency for International Development (USAID)**

[www.usaid.gov](http://www.usaid.gov)

Provides country profiles, including an overview of the country situation, national response, and programs supported by USAID.

Provides links to various publications with relevant information related to assessment.

To find country-specific information relating to HIV/AIDS: From home page, click on “HIV/AIDS”, in red box under “Health” look under “HIV/AIDS” for countries, scroll to country you are seeking and click for list of reports and other information available.

**World Health Organization (WHO)**

[www.who.int/en](http://www.who.int/en)

For country-specific information on HIV/AIDS treatment and prevention scale-up, and epidemiological fact sheets with the latest statistics on HIV/AIDS and STIs visit <http://www.who.int/hiv/countries/en/>

## Handout G: The ABC Approach

**FACT SHEET** *This Fact Sheet is based on information from the President's Emergency Plan for AIDS Relief (PEPFAR).*

### Defining the ABC approach

The “ABC Approach” (**A**bstinence, **B**e Faithful, and correct and consistent **C**ondom use) employs population-specific interventions that emphasize abstinence for youth and other unmarried persons, including delay of sexual debut; mutual faithfulness; partner reduction for sexually active adults; and correct and consistent use of condoms. It is important to note that ABC is not a program; it is an approach to infuse throughout prevention programs. The ABC approach is distinctive in its targeting of specific populations, the circumstances they face, and behaviors within those populations for change. This targeted approach results in a comprehensive and effective prevention strategy that helps individuals personalize risk and develop tools to avoid risky behaviors under their control.

**Abstinence** programs encourage unmarried individuals to abstain from sexual activity as the best and only certain way to protect themselves from exposure to HIV and other sexually transmitted infections. Abstinence until marriage programs are particularly important for young people, as approximately half of all new infections occur in the 15- to 24-year-old age group. Delaying the first sexual encounter can have a significant impact on the health and well-being of adolescents and on the progress of the epidemic in communities. Internationally, a number of programs have proven successful in increasing abstinence until marriage, delaying first sex, and achieving “secondary abstinence” (returning to abstinence) among sexually experienced youth. These programs promote the following

- Abstaining from sexual activity as the most effective and only certain way to avoid HIV infection.
- The development of skills for practicing abstinence.
- The importance of abstinence in eliminating the risk of HIV transmission among unmarried individuals.
- The decision of unmarried individuals to delay sexual debut until marriage.

- The adoption of social and community norms that support delaying sex until marriage and that denounce cross-generational sex, transactional sex and rape, incest, and other forced sexual activity.

**Be faithful** programs encourage individuals to practice fidelity in marriage and other sexual relationships as a critical way to reduce risk of exposure to HIV. Once a person begins to have sex, the fewer lifetime sexual partners he or she has, the lower the risk of contracting or spreading HIV or another sexually transmitted infection.

Be faithful programs promote the following

- The elimination of casual sexual partnerships.
- The development of skills for sustaining marital fidelity.
- The importance of mutual faithfulness with an uninfected partner in reducing the transmission of HIV among individuals in long-term sexual partnerships.
- HIV counseling and testing with their partner for those couples that do not know their HIV status.
- The endorsement of social and community norms supportive of refraining from sex outside of marriage, partner reduction, and marital fidelity, by using strategies that respect and respond to local cultural customs and norms.
- The adoption of social and community norms that denounce cross-generational sex and transactional sex, and rape, incest, and other forced sexual activity.

**Correct and consistent condom use** programs support the provision of full and accurate information about correct and consistent condom use reducing, but not eliminating, the risk of HIV infection; and support access to condoms for those most at risk for transmitting or becoming infected with HIV.

Behaviors that increase risk for HIV transmission include: engaging in casual sexual encounters; engaging in sex in exchange for money or favors; having sex with an HIV-positive partner or one whose status is unknown; using drugs or abusing alcohol in the context of sexual interactions; and using intravenous

drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high-risk persons or groups include men who have sex with men and workers who are employed away from home.

To achieve the protective effect of condoms, people must use them *correctly and consistently, at every sexual encounter*. Failure to do so diminishes the protective effect and increases the risk of acquiring a sexually transmitted infection (STI) because transmission can occur with even a single sexual encounter.

Condom use programs promote the following

- The understanding that abstaining from sexual activity is the most effective and only certain way to avoid HIV infection.
- The understanding of how different behaviors increase risk of HIV infections.
- The importance of risk reduction and a consistent risk-reduction strategy when risk elimination is not practiced.
- The importance of correctly and consistently using condoms during every sexual encounter with partners known to be HIV-positive (discordant couples), or partners whose status is unknown.
- The critical role of HIV counseling and testing as a risk-reduction strategy.
- The development of skills for obtaining and correctly and consistently using condoms, including skills for vulnerable persons.
- The knowledge that condoms do not protect against all STIs.

### Implementing the ABC approach

Effective implementation of the ABC approach requires careful evaluation of risk behaviors that fuel local epidemics. Although prevention interventions are most successful when they are locally driven and responsive to local cultural values, epidemiological evidence can identify risky behaviors within populations and guide specific behavioral messages. For example, in some communities, as many as 20 percent of girls aged 15 to 19 are infected, compared to 5 percent of boys the same age. Coupled with high prevalence among older men, such data can point to transmission that is fueled by cross-generational sex. Prevention approaches must then address the risks of cross-generational and transactional sex through

abstinence programs for youth and be faithful programs for men that foster collective social norms that emphasize avoiding risky sexual behavior.

### Source

Guidance to United States Government In-Country Staff and Implementing Partners Applying the ABC Approach to Preventing Sexually Transmitted HIV Infections with the President's Emergency Plan for AIDS Relief. <http://www.pepfar.gov/guidance/c19545.htm> (accessed March 28, 2007).

PEPFAR: ABC Guidance #1 For United States Government In-Country Staff and Implementing Partners Applying the ABC Approach To Preventing Sexually-Transmitted HIV Infections Within The President's Emergency Plan for AIDS Relief. Available for download at: <http://www.state.gov/documents/organization/57241.pdf> (accessed March 28, 2007).





## Session Two: Creating Messages for Target Audiences

### Purpose

To provide the knowledge and skills needed for the development and dissemination of messages for target audiences that will be culturally appropriate and effective.

### Rationale

Participants have learned to identify target audiences and their need for information. In this session they learn how to determine goals and objectives for awareness-raising and extension activities and how to create and disseminate effective and appropriate messages.

### Target Audience

Peace Corps participants (trainees and/or Volunteers)

### Duration

3 hours

### Objectives

By the end of the session participants will be able to

1. Explain how to gather critical information on how to reach the target audience, in terms of when and where they can be approached and by what methods they are most receptive to information.
2. Determine goals and objectives for awareness-raising activities for a target audience.
3. Describe some of the issues around designing culturally appropriate messages for a target audience.

### Session Outline

- 
- I. **Introduction** (15 minutes)
  - II. **Learning More about the Target Audience** (45 minutes)
  - III. **Writing Goals and Objectives** (50 minutes)
  - IV. **Developing HIV/AIDS Messages** (60 minutes)
  - V. **Review and Evaluate** (10 minutes)
- 

### Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- HIV/AIDS prevention strategies
- Strategic communication approaches
- Targeted prevention and social marketing
- Behavior change theory and behavior change communication projects
- Learning theory and models

### Materials and Equipment

Flip charts, markers, tape or tacks

Pictures/slogans from local campaigns for things like safe sex, breast-feeding

Prepared flip charts

1. Session Two Outline
2. Objectives
3. Awareness-Raising Activity Worksheet (use Handout C)
4. Small Group Task #1
5. Small Group Task #2
6. Tentative Plans to Fill a Gap

Handouts

- A. *Behavior Change and Communication—Targeting Men with Multiple Partners*
- B. *Recommendations for Awareness-Raising Activities*
- C. *Preparation for Awareness-Raising Activity Worksheet*

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- If possible, work through the tasks yourself, using the case study from Session One.
- Prepare flip charts or other drawings.
- Make copies of group instructions and handouts.

## Methodology

### I. Introduction (15 minutes)

#### Introduce the session

**Step 1:** This session provides the knowledge and skills needed for the development and dissemination of messages that are culturally appropriate and effective.

**Step 2:** Provide an overview of the session, using flip chart 1.

Session Two Outline
<b>Creating Messages for Target Audiences</b>
<b>I. Introduction</b>
<b>II. Learning More about the Target Audience</b>
<b>III. Writing Goals and Objectives</b>
<b>IV. Developing HIV/AIDS Messages</b>
<b>V. Review and Evaluate</b>

FLIP CHART 1

#### What do campaigns say to us?

**Step 1:** Display pictures/slogans from local campaigns for things like safe sex, breast-feeding, etc.—making an effort to find samples that might not work well in a U.S. setting.

**Step 2:** Ask participants if these would be effective for them. Encourage discussion about both cultural and individual differences relating to effective messages. Do the slogans leave questions in your mind? Do they give you the information you need, or are ready for?

#### Matching the message to the need

**Step 1:** Review the target audiences and the information gaps that lead them to unproductive behavior, determined in the first session. Recall that different groups had different learning needs.

**Step 2:** Distribute *Handout A: Behavior Change and Communication—Targeting Men with Multiple Partners* and review together an example of what messages would be needed at different stages of behavior change. How and where might the different messages be delivered?

Participants will work toward identifying what and where to provide information to target audiences in this session.

### II. Learning More about the Target Audience

(45 minutes)

#### Determining information needed by target audiences

Lead a discussion about the following

*What information have they already received about HIV/AIDS? Explore the sources of HIV/AIDS messages*

**The medium** word of mouth, mass media posters/radio or TV announcements; newspapers, other

**The messages** Exactly what was said? What pictures used?

**The messenger** Who provided the information? Medical people? Leaders? TV or sports personalities? Nongovernmental organizations? Peers?

*What are the ways people learn?*

- Observe how people in the culture learn new things.
- What methods are used in school?
- What styles are used in religious ceremonies?
- How are meetings conducted? Do people get information in advance to think about?
- How do men and women get information informally?

*When do there appear to be learning opportunities?*

- What are the formal avenues: schools, special programs/celebrations/events, theaters, houses of worship?

- What groups are there within the community? When are there meetings?
- Where do people gather: clinics, cafes, bars, sports events?

### Methods to get information

**Step 1:** Discuss the possible methods of getting the information needed. At least the following four should come up: observation, participatory activities such as mapping and daily schedules, key informants, and focus groups.

**Step 2:** Have groups reassemble by their target audience around a flip chart and develop a plan for gathering the information they need to work with that audience on their HIV/AIDS need. The plan should include: How/Who/and What (how=method; who=people to talk with; what=information they want to get).

**Step 3:** Have groups report out and get suggestions from the other participants.

### Transition

Note that participants have done a lot of work learning about situations where new information is needed to address HIV/AIDS in the community. Now participants will focus on what awareness-raising/extension activities will try to accomplish.

## III. Writing Goals and Objectives (50 minutes)

### Goals

**Step 1:** Ask what a “goal” statement is. Note ideas on a flip chart. Get agreement on a definition such as “a general statement of intent.”

**Step 2:** Ask for some goal statements related to HIV/AIDS. Examples might include

- To make the three methods of HIV transmission known.
- To provide HIV/AIDS education to all youth sports leagues in the city.
- To prevent accidental infections in clinics through safe use of and disposal of needles.

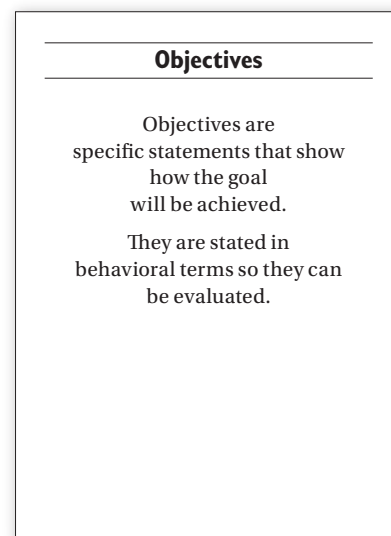
**Step 3:** Ask groups to meet again and develop a goal statement for work with their target audience.

**Step 4:** Have goal statements put on flip charts. Post them and ask everyone to move about and read them all.

**Step 5:** Ask if there is need for clarification of, or perhaps scaling down of, any of the goal statements to make them more realistic. If so, work as a team to help shape good goal statements.

### Objectives

**Step 1:** Reveal flip chart 2 with the following definition: “Objectives are specific statements that show how the goal will be achieved. They are stated in behavioral terms so they can be evaluated.”



FLIP CHART 2

**Step 2:** Discuss the following points

- Objectives can be related to knowledge, behaviors, or attitudes. What would be an example of each?

**Knowledge** Nurses will be able to describe how to protect themselves from infection of HIV in the clinic.

**Behavior** Families will show they understand how HIV is not transmitted by allowing infected family members to eat with the family and use the same utensils.

**Attitude** Women’s groups will allow HIV-infected members to continue to participate in their activities.

- To the extent possible, objectives should include who, what, how much, when. Review examples above for these components. Can they be made stronger by adding information?

- For small projects, it is better to have only one or two objectives.
- Be realistic: Can the action happen? In the time frame available? With the number of people?
- Plan how and when you'll measure whether the objectives have been met.

### Create your own objective(s)

**Step 1:** In your small groups, write one or two objectives to support your goal. When they are refined, put them on the flip chart under your goal.

**Step 2:** Review the objectives with the whole group.

An option to use for reviewing is to introduce RUMBA, and ask them to determine if each objective RUMBAs

R = realistic

U = understandable

M = measurable

B = behavioral

A = achievable

### Evaluate the direction the projects are taking

Go back to the recommendations from the studies about stigma *Handout B: Recommendations for Awareness-Raising Activities*, and see if the goals and objectives are in sync or not. If not, discuss how they might be refocused. (For example, are they proposing more mass messaging without a way to have discussion groups to clarify and ask questions?)

## IV. Developing HIV/AIDS Messages (60 minutes)

### Analyze the case a little more closely

**Step 1:** Reveal flip chart 3 with a sample worksheet and flip chart 4, "Small Group Task #1".

Awareness-Raising Worksheet
What they seemed to have been told (messages about HIV/AIDS)
Assumptions they have made
Behaviors that have resulted
Changes—additional clarifications—needed in messages

FLIP CHART 3

Small Group Task #1
1. Revisit the case study, this time trying to determine from the reactions of the participants, what kind of message you think they received.
2. What assumptions did they seem to make about HIV/AIDS?
3. What unexpected or counterproductive behaviors resulted?
4. What changes—additions or clarifications—are needed to original awareness-raising message?

FLIP CHART 4

**Step 2:** Distribute *Handout C: Awareness-Raising Activity Worksheet*, and allow 20 minutes to work.

**Step 3:** Ask for some examples of the messages they think were given. What assumptions did people make?

### Develop a new strategy

Have participants go back to their goals and objectives, and develop a way to counteract or correct the misunderstandings of past messages. Specifically, they should determine what/how/when/where. See flip chart 5, "Small Group Task #2".

**Small Group Task #2**

**What** might a new message or new information be?

**How** might it be presented? (Recall our discussion on how community members learn.)

**When** might our target audience be available?

**Where?**

**By whom** might the information be given to provide maximum impact?

FLIP CHART 5

**Share plans**

**Step 1:** Ask participants to put all of their materials together in order to share with others. Reveal flip chart 6, “Tentative Plans to Fill a Gap.”

**Tentative Plans to Fill a Gap**

**Target audience** (Who you chose.)

**Why?** (Why does this group need more/different information?)

**What happened before?** (What messages did they seem to get/what did they assume/what behaviors resulted?)

**Our tentative plan** (Goals and objectives; what/how/when/by whom.)

**What groups in the community** would we want/need to work with, collaborate with?

FLIP CHART 6

**Step 2:** Ask groups to put all of this information on a flip chart—in words and pictures (if they like) and post them.

**Step 3:** Have the group do a gallery walk, reading and discussing each others’ plans.

**V. Review and Evaluate** *(10 minutes)*

**Step 1:** Reflect on work done in small groups.

*What are some of your feelings after reading all of the potential awareness projects?*

*Did other groups think about things that hadn’t occurred to you? What are some examples?*

*What similarities did you see?*

*What do you think might result from working with other groups in the community?*

**Step 2:** Consider the big picture.

*How did your end products compare to some of the mass messaging you have seen? How are they the same and different?*

*What have you learned about awareness campaigns by working through these potential projects?*

*In what ways do you think you can make a contribution through HIV/AIDS awareness-raising/extension activities?*

**Step 3:** Transition

In session three, we will look at more ways to disseminate messages, pre-test, and some means of measuring the effects of awareness-building efforts.

**Evaluation**

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**References or Resources**

Mahler, Hally and Donna Flanagan, *How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions*, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA. [ICE No. HE369]

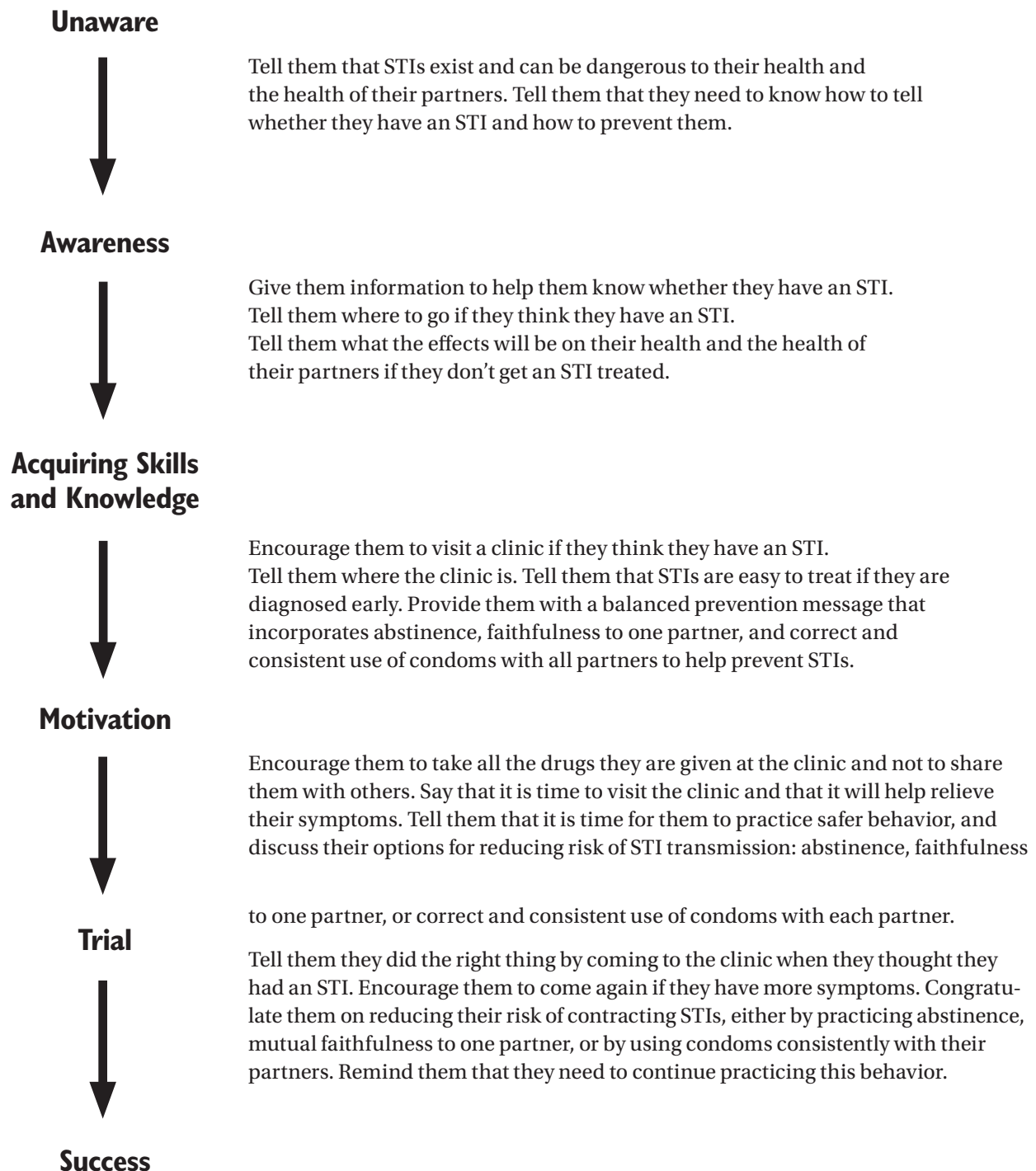
*Nonformal Education Manual*. Peace Corps: Washington, DC, 2004. [ICE No. M0042]

*Promoting Powerful People: A Process for Change*. Peace Corps: Washington, DC, 2000. [ICE No. T0104]

*The Roles of the Volunteer in Development*. Peace Corps: Washington, DC, 2002. [ICE No. T0005]

# Handout A: Behavior Change and Communication— Targeting Men with Multiple Partners

In a project targeting men with multiple partners you might want to help them recognize and treat sexually transmitted infections (STIs).



# Handout B: Recommendations for Awareness-Raising Activities

Research by the International Center for Research on Women (ICRW), which is where the case study was extracted, has indicated that a lack of specific, in-depth information about HIV transmission is a major cause of stigma, which in turn is a major barrier to behavior change. The study by ICRW in four countries produced several important recommendations relating to how awareness messages should be framed and delivered to be effective.

## Recommendations relating to content

- Provide information not only about how HIV is transmitted, but also about how it is not transmitted. Address concerns about casual contact situations with blood, sweat, saliva, and mosquitoes, or common situations such as sitting next to someone in a bus, eating/drinking from the same bowl/cup, sharing utensils.
- Provide clear and unambiguous information by explaining exactly how HIV is transmitted through each mode—enabling a person to distinguish relative risk. For example, the risk of transmission through IV drug use vs. sharing a nail clipper that has blood left on it.
- Provide information about living with HIV, including skills relating to living healthy and productive lives and practical tips for things like bringing up condom use.
- Create recognition and understanding of HIV stigma so that people can recognize their own behavior.

## Recommendations relating to style and delivery of messages

- Use an interactive format, facilitated by someone trusted and knowledgeable to encourage discussion, questions, and feedback about people's real concerns. Once people truly believe that HIV cannot be transmitted through casual contact they will be less likely to stigmatize people with HIV.
- Use positive images of people living with HIV/AIDS to combat the fear that drives stigma.
- Continually evaluate how people understand the messages they receive and address misconceptions quickly.

## Source

Ogden, Jessica and Laura Nyblade, *Common at Its Core: HIV-Related Stigma Across Contexts*, International Center for Research on Women: Washington, DC, 2005, pps. 38-40.



## Handout C: Awareness-Raising Activity Worksheet

What they seemed to have been told (messages about HIV/AIDS)	Assumptions they have made	Behaviors that have resulted	Changes—additions/clarifications—needed in messages



# Session Three: Pre-Testing, Disseminating, and Evaluating Awareness and Extension Activities

## Purpose

To provide strategies and practical experience to prepare trainees to pre-test, disseminate, and evaluate implemented awareness-raising and extension activities with their counterparts.

## Rationale

Participants have been introduced to strategic planning of awareness-raising and extension activities with their counterparts. This session focuses on how to verify that the message intended is the one received; approaches that engage participation from those with strong influence over the target audience and those directly affected by HIV/AIDS; and some measures of the effects of the campaign.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

2 hours, 30 minutes

3 hours with option A or B added

3 hours, 30 minutes with both options added

## Objectives

By the end of the session participants will be able to

1. Analyze the role of secondary target audiences.
2. Identify the role of people living with HIV/AIDS.
3. Describe why and how to pre-test awareness-raising activities.
4. List several ways the objectives can be measured.

## Session Outline

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- I. **Introduction** (5 minutes)

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  - II. **The Role of Secondary Target Audiences** (30 minutes)

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  - III. **Engaging People Living with HIV/AIDS** (30 minutes)

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  - IV. **Disseminating Your Message** (30 minutes)

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  - V. **Pre-Testing** (40 minutes)

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  - VI. **Wrap up** (15 minutes)

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## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- HIV/AIDS prevention strategies.
- Strategic communication approaches.
- Targeted prevention and social marketing.
- Behavior change theory and behavior change communication projects.
- Potential role of secondary target audiences.
- Role of people living with HIV/AIDS in programming.

## Materials and Equipment

Flip charts, markers, tape or tacks

Prepared flip charts

1. Session Three Outline
2. Why Pre-Test?

Activity Sheet

*Role Play: Diffusion of Innovation*

Handouts

- A. *Potential Pre-Test Questions for Awareness-Raising Materials*
- B. *Follow up to Pre-Test*
- C. *Measures of Success*
- D. *Should I Use a Peer Education Approach?*
- E. *Diffusion of Innovation*

Cards (3"x5" or 5"x7") one per person, plus 20

Charts of "Tentative Plans to Fill a Gap" from Awareness-Raising/Extension Activities, Session Two

## Preparation Checklist

- Read the entire session and plan the session according to the time you have available.
- Prepare flip charts.
- Make copies of handouts.
- Position "Tentative Plans to Fill a Gap" flip charts from Awareness-Raising/Extension Activities, Session Two, where they can be worked on by small groups and read by the entire group.

## Methodology

### I. Introduction (5 minutes)

**Step 1:** Introduce the session.

We have been working on building your knowledge and skills to be strategic in planning awareness-raising and extension activities with your counterparts. This session focuses on approaches that engage participation from those with strong influence over the target audience and those directly affected by HIV/AIDS; ways to pre-test your ideas; and some way to measure whether your objectives are met.

**Step 2:** Reveal flip chart 1 and describe session outline.

Session Three Outline
<b>Pre-Testing, Disseminating, and Evaluating Awareness and Extension Activities</b>
<b>I. Introduction</b>
<b>II. The Role of Secondary Target Audiences)</b>
<b>III. Engaging People Living with HIV/AIDS</b>
<b>IV. Disseminating Your Message</b>
<b>V. Pre-Testing</b>
<b>VI. Wrap up</b>

FLIP CHART 1

### II. The Role of Secondary Target Audiences

(30 minutes)

#### Introduction—secondary target audience

**Step 1:** Ask: Who do you think would be secondary target audiences to the groups on whom you have focused?

*The people who influence, or are influenced, by your primary audience.*

**Step 2:** Who might some secondary target audiences be? List on a flip chart.

*Peers, community leaders, family members, organizations.*

**Step 3:** What roles might they play?

*Influence, education, role modeling, support, resources.*

#### Small groups (for target groups, previous sessions) activity

**Step 1:** Form small groups. Distribute a card to each person.

**Step 2:** To focus on those who influence the target audience, each person in the group should write on a card one secondary target audience and a role that audience can play in promoting messages. After each person has done this individually, discuss the contents of the cards in the group. If necessary, add some other cards.

**Step 3:** Ask one group at a time to take its cards to the "Tentative Plans" charts from the last session and add them, reading them to the rest of the groups. Ask if there are other people who should be included as secondary audiences. If missing any, have them fill in audiences and roles. *Suggested secondary audiences: peers [education, role modeling, etc.], community leaders [influence, role modeling, etc.], partners [staffing, resources, etc.] such as nongovernmental organizations, faith-based organizations, community-based organizations.*

#### Diffusion of innovation activity (20 minutes)

*Optional: see end of session plan for notes and handout.*

#### Peer education (30 minutes)

*Optional: see end of session plan for notes and handout.*

**Transition: Every project should engage people living with HIV/AIDS**

**Step 1:** If any groups mentioned people living with HIV/AIDS, ask them to explain why. If no one has, ask if they considered them. Why or why not?

**Step 2:** Note that in the next segment, we'll discuss why it is important to engage people living with HIV/AIDS in every activity, if possible.

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### III. Engaging People Living with HIV/AIDS

*(30 minutes)*

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#### Introduction

Ask why people living with HIV/AIDS are important to activities. Points that should be brought up are

- First-hand perspective
- Personalizes the issue
- Can dispel notion of how people living with HIV/AIDS look/feel
- Addresses stigma and discrimination

#### Reflection

**Step 1:** Ask participants to think about their first encounter with someone who was HIV-positive or who had AIDS. Ask them to recall their own thoughts, including any fears they may have had about the encounter.

**Step 2:** In pairs or triads ask participants to talk about the issues they might encounter, both personally and with others, and how they can confront these as they work to engage people living with HIV/AIDS in activities.

**Step 3:** Ask small groups to consider how people living with HIV/AIDS can be a part of their strategy, if they have not considered this before.

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### IV. Disseminating Your Message *(30 minutes)*

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#### Defining communication channels

**Step 1:** Explain: In planning your strategy, you will have to decide one or more ways to get your messages across to your target (and secondary) population.

**Step 2:** Write "Communication Channels" on flip chart—defining communication channels as the means by which messages will get to your target pop-

ulation. Ask participants to name examples they have observed locally.

The list will include

- One-to-one communication
- Workshops
- Outreach
- Posters
- Brochures
- Billboards
- Theater
- Music
- Radio
- Television
- Newspaper
- Others

**Step 3:** Explain that these sources of information generally can be divided into four different "channels" of communication or media that use various kinds of material

- Interpersonal methods (any face-to-face contact, including training and peer education)
- Print (posters, bulletins, flyers)
- Mass media (radio, television, loudspeakers, film/video, newspaper)
- Folk media (dance, drama, puppets)

**Step 4:** Ask participants to consider which of the channels are most appropriate to their target audience. If they have not done so, note the channels on their chart.

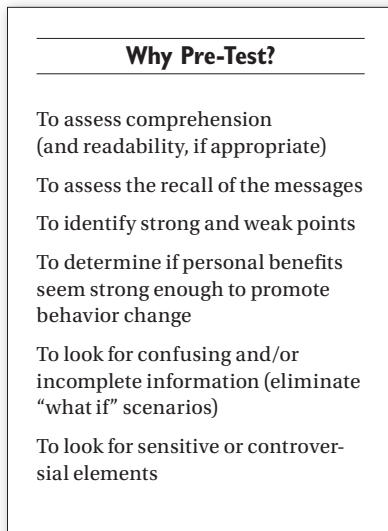
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### V. Pre-Testing *(40 minutes)*

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#### Why pre-test?

Reveal flip chart 2, and go over the reasons pre-testing is important.



FLIP CHART 2

*Do you think some of the results of stigma and discrimination found in the case studies might have been avoided by pre-testing? If so, how?*

### How to pre-test

Pre-testing is usually done through individual interviews or focus group interviews.

Individuals or focus groups need to have time to read and reflect on written messages, if that is what your activity is, or participate in and reflect on a more interactive presentation.

**Step 1:** Distribute *Handout A: Potential Pre-Test Questions for Awareness-Raising Materials*. Ask small groups to meet and discuss how they might pre-test their strategy. (For example, hold discussions with focus group audiences, if that is the strategy, and then individually interview the focus group.)

**Step 2:** Ask each group to briefly report out its discussion.

**Step 3:** Distribute *Handout B: Follow Up to Pre-Test* and describe it as a tool for compiling the results of pre-testing, and a way to determine what, if anything, needs to be changed. Note that if there are changes made, they should pre-test again.

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## VI. Wrap up (15 minutes)

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### Review of the process

Ask participants to think back on how they began this unit: reading the results of a study that showed how

stigma and discrimination can come from awareness messages that are not complete enough. What have they learned about

- How awareness-raising/extension activities should be determined?
- What sources of information they need to review?
- Who in their host communities they should work with on awareness-raising activities?
- How to carefully focus what they are trying to accomplish?
- Selecting the appropriate channel of communication?
- How to check out messages and activities before doing them for large numbers of people?

### How to measure success

**Step 1:** Ask participants to look at the objectives they wrote for their potential project. How do objectives help focus on the desired end result?

**Step 2:** Distribute *Handout C: Measures of Success*. Ask which kinds of measures they think will be most likely for their potential project.

**Step 3:** Ask participants why Volunteers who are really tuned into their communities might be well-suited to working on targeted awareness-raising activities.

**Step 4:** Ask how they are feeling about the challenge.

*Be careful to caution about large-scale goals; their person-to-person interactions—working with people living with HIV/AIDS, youth, mothers, and their immediate community—may make a difference for some people in terms of living productively with and around HIV/AIDS. They should end the session feeling they can make some difference, no matter how small.*

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### Option A: Diffusion of Innovation (20 minutes)

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**Step 1:** Ask two participants to perform a brief role play. Give them each the role play character descriptions from the *Activity Sheet: Role Play Description* at the end of this session. Allow a couple of minutes to prepare themselves.

**Step 2:** Two participants perform the role play and the rest of the group observes.

**Step 3:** Ask observers to list the factors they think were important in getting the chief to agree. List these on a flip chart. Be sure to bring out those factors that have been suggested as predictors of how a group will adopt an innovation

- Relative advantage of the innovation
- Compatibility of the innovation with existing values, past experience, and needs
- Simplicity of the innovation
- Trialability—degree to which it can be experimented
- Observability—degree to which the results of the innovation are visible to others

**Step 4:** Explain: As a community worker you will be actively involved in communicating and promoting new practices and ideas. We have just seen a demonstration of the basic theory of the “diffusion of innovation.” The factors we have listed are some of the things that influence how a group will take on a new idea or practice. What are some of the others you have noticed? *Example: influence of American or European products.*

Provide *Handout E: Diffusion of Innovation* for future reference.

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**Optional Activity B: Peer Education** (30 minutes)

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Peer education is an important method of training and education. Ask participants if they have talked about peer education methods as part of their training.

**Discussion**

**Step 1:** If there has been previous training on peer education, break into small groups and instruct each group to talk about what it would consider the benefits and challenges relating to peer education and HIV/AIDS. (10 minutes)

If there has been no previous training on peer education, do this as a large group to ensure that particular points are made. Discussion should include

**Strengths**

- Effective
- Culture/gender/age-appropriate messages
- Cost effective

**Requirements**

- Training
- Support
- Supervision
- Incentives
- Evaluation

**Challenges may include**

- Adequate staffing and skills to provide requirements
- Supply of potential peer educators who meet qualifications needed

**Step 2:** Ask the groups to evaluate the potential of their project for a peer education approach. Point out that this may be for youth, men, and/or women. Provide *Handout D: Should I Use a Peer Education Approach?* to be used as a guideline. (10 minutes)

**Step 3:** Ask groups to report to one another.

There are many additional resources on peer education. If you decide to create a peer education project you should utilize these valuable resources. (10 minutes)

**Evaluation**

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## References or Resources

*HIV/AIDS: Integrating Prevention and Care into Your Sector, IDEA Book.* Peace Corps: Washington, DC, 2000. [ICE No. M0081]

Mahler, Hally and Donna Flanagan, *How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions*, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA. [ICE No. HE369]

*STD/AIDS Peer Educator Training Manual: A complete guide for trainers of peer educations in the prevention of STDs including HIV/AIDS.* Peace Corps: Washington, DC, 2000. [ICE No. HE258]



## Activity Sheet: Role Play—Diffusion of Innovation

### **Peace Corps Volunteer**

As a nutrition worker, you are trying to create acceptance for a new high-protein vegetable food in this community to supplement the dwindling source of protein available to community members from animals. Disease has ravished the cattle herds of community members for the past three years and malnutrition has resulted. You are told that the community used to enjoy health and relative wealth in terms of their cattle. You are aware that for any idea to be adopted in this community you must get the chief to approve and wield his influence. In the role play, show how you convince the chief of the village to demonstrate acceptance for the food by eating it publicly and encouraging others to do so. Be sure to point out how the food is compatible with local habits—it can be grown by each family and harvested and it can be eaten with rice just like beef. Also, talk about how community members can grow it themselves and try it to see if they like it.

### **Chief**

You are the chief of a community where disease has ravished the cattle herds of community members for the past three years. You are very worried about the malnutrition that is now apparent in the community. A new Peace Corps Volunteer in the community wants to meet with you about a new food source he thinks can help. You are hesitant for several reasons but one of the major reasons is that you have tried to persuade people not to take on ideas of westerners. However, this idea may be a good one and it might help your people.

## Handout A: Potential Pre-Test Questions for Awareness-Raising Materials

<p><b>1.</b> <i>What information is this page/activity trying to convey?</i></p>	<p><b>2.</b> <i>In your own words, what does the text mean? What does the activity mean?</i></p>
<p><b>3.</b> <i>What does the picture/drawing show? Is it telling you to do something? If yes, what?</i></p>	<p><b>4.</b> <i>Do the words match the picture on the page? Why or why not?</i></p>
<p><b>5.</b> <i>What do you like/dislike about the page/activity?</i></p>	<p><b>6.</b> <i>Are there any words you do not understand? Which ones? (If so, explain the meaning and ask respondents to suggest other words that can be used to convey that meaning.)</i></p>
<p><b>7.</b> <i>Are there any words you think others would have trouble understanding? (If so, ask for alternatives.)</i></p>	<p><b>8.</b> <i>Are there sentences or ideas that are not clear? (Which ones? Explain intended message and ask for better ways to convey the message.)</i></p>
<p><b>9.</b> <i>Is there anything you like/dislike about these messages?</i></p>	<p><b>10.</b> <i>Is there anything you like/dislike about the pictures or drawings? (Use of colors, kind of people represented, etc.)</i></p>
<p><b>11.</b> <i>Is there anything controversial or sensitive about these messages or pictures?</i></p>	<p><b>12.</b> <i>We want these materials to be as good as possible and to be easily understood by others. How can we improve the pictures? The words? The ideas?</i></p>
<p><b>13.</b> <i>What other suggestions do you have for improvement?</i></p>	<p><b>14.</b> (After collecting the material or doing the activity say . . . ) <i>“Let’s review. Tell me what you think were the most important messages.”</i></p>

**Source** Mahler, Hally and Donna Flanagan, How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA, pps. 49-50. [ICE No. HE369]

## Handout B: Follow up to Pre-Test

Summarize pre-testing events for your group with the following questions

1. *Were the target audience members able to understand the messages and the language in which the messages were presented?*  
Yes/No Explain:
2. *Were the target audience members able to remember the messages they were presented?*  
Yes/No Explain:
3. *What did the target audience like best about the materials and messages?*  
Explain:
4. *What did the target audience like least about the materials and messages?*  
Explain:
5. *Was the target audience able to perceive the benefit(s) recommended in the messages?*  
Yes/No Explain:
6. *Were there any controversial or sensitive issues raised by the target audience?*  
Yes/No Explain:
7. *What changes, if any, were recommended by the target audience?*  
Explain:

If the answers to these questions tell you to change the messages and materials, re-test the new materials after revisions.

**Source** Mahler, Hally and Donna Flanagan, How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA, pps. 51-53. [ICE No. HE369]

## Handout C: Measures of Success

Well-written objectives should give you an idea how you can measure success. Depending upon your objectives, you may use indicators, such as

- Self-reported movement in behavior change from one stage to the next
- Recall of messages in random surveys
- Actual production and distribution of materials among the target group
- Number of people trained
- Number of discussion groups held
- Findings from surveys of reported behavior or attitude
- Questionnaires (with information knowledge questions)
- Observations of activities
- Sales reports (e.g., condom sales)
- Attendance records (e.g., number of clinic visits; tests given)
- Other?

**Source** Mahler, Hally and Donna Flanagan, How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA, page 59. [ICE No. HE369]

# Handout D: Should I Use a Peer Education Approach?

Peer education can be useful and powerful. However, it is not appropriate in all situations. You will need to do some formative research to decide whether peer education is the best approach to meet your objectives. Also, before making your final decision, use the following questions to help you think about the appropriateness of peer education for your target audience.

1. *What are the goals of this project?*
2. *Who is the target audience?*
3. *Will it be possible to attract and maintain interest and support for this project from opinion leaders and influential people in the target community? If the answer is “no,” a peer education strategy may not be appropriate.*
4. *Are there people within the target group who have the time, interest, and ability to work as peer educators? If the answer is “no,” you should develop another strategy that does not involve peer education.*
5. *What will these peer educators need to do?*
  - Teach their peers about STDs/HIV/AIDS.
  - Teach their peers how to avoid becoming infected through a balanced prevention message that incorporates abstinence, faithfulness, and when appropriate, correct and consistent use of condoms.
  - Create more supportive and understanding attitudes toward people who are infected with HIV.
  - Recognize risks and risky situations.
  - Teach peers how to care for people living with HIV/AIDS.
  - Make referrals to health-care workers.
  - Empower peers to make informed lifestyle decisions.
  - Emphasize decision-making, assertiveness, and relationship skills.
  - Support the maintenance of behavior change.
6. *What will the peer educators need in order to meet these objectives?*
  - Initial training
  - Refresher training
  - Educational materials
  - Condoms (when appropriate)
  - Penis model for condom demonstrations (when appropriate)
  - Supervision
  - Meeting space
  - Other
7. *Can the project provide these things? If the answer is “no,” examine the goal(s) of the project. You might need to change the goal, reduce the size of the target group, or use a different strategy (not peer education).*
8. *How large is the target group?*
9. *How many peer educators will be needed to reach the members of this target group?*
10. *Can the project train and support that many peer educators? If the answer is “no,” examine the goal(s) of the project. You might need to change the goal, reduce the size of the target group, or use a different strategy (not peer education).*
11. *Will the peer educators need incentives? If “yes,” what type of incentives will they need?*
  - Salaries
  - Paid expenses
  - Meal allowances
  - Bicycles
  - Special badges or awards
  - Other

*Can the project provide these incentives? If “no,” what are other options?*

12. *How long will the peer education continue?*
13. *Can the peer educators be supported with supervision, refresher training, and incentives over the long term? If the answer is “no,” examine the goal(s) of the project. You might need to change the goals, reduce the size of the target group, or use a different strategy (not peer education).*
14. *How many staff members will be needed to help train and supervise the required number of peer educators?*
15. *Does the budget include supervision expenses? If the answer is “no,” you must find a way to provide regular ongoing supervision.*
16. *Are other communication strategies used in this HIV/AIDS prevention project? If “yes,” how will peer education complement them? Your answers to these questions will help you decide whether a peer education approach is possible or appropriate for your situation. When thinking about the budget, include funds for recruitment and training of peer educators, refresher training, supervision, materials, and condom supplies.*

If you believe that peer education is an appropriate strategy for your HIV/AIDS prevention project, please review the information in the AIDSCAP booklet entitled, *How to Create an Effective Communication Project*. It will help you design your peer education project.

### Source

Mahler, Hally and Donna Flanagan, *How to Create an Effective Communication Project: Using the AIDSCAP Strategy to Develop Successful Behavior Change Interventions*, The AIDS Control and Prevention (AIDSCAP) Project, Family Health International: Arlington, VA, pps. 9-12. [ICE No. HE369]

## Handout E: Diffusion of Innovation

As a development worker, you will be actively involved in the “diffusion of innovation,” such as communicating and promoting new practices and ideas. An understanding of the process of diffusion will give you insight into how to go about promoting new ideas and how to gauge the effectiveness of your activities over time. Here is a discussion of the basic theory.

Diffusion is the process by which an innovation is communicated through certain channels over time among the members of a social system.

An innovation is an idea, practice, or object that is perceived as new by an individual or group. It doesn't matter if the idea is really new—it could have already been around for years. If the idea seems new to the individual or group, it is an innovation. Once approximately 10-25 percent of the population has adopted an innovation, the adoption rate accelerates. In other words, the innovation takes off. (The use of cell phones is one such example.)

People see innovations in a number of ways that influence how soon they adopt them.

**Relative advantage** is the degree to which an innovation is perceived as better than the idea or practice it supersedes. Relative advantage may be measured in terms of economics, social prestige, convenience, and/or satisfaction.

**Compatibility** is the degree to which an innovation is perceived as being consistent with the existing values, past experience, and needs of the potential adopters. An idea that is not compatible with the prevalent values and norms of a social system will not be adopted as rapidly as an innovation that is compatible. An example of an incompatible innovation is the encouragement of condom use for HIV prevention in a country where religion and cultural norms discourage condom use.

**Complexity** is the degree to which an innovation is perceived as difficult to understand and use. For example, in some water and sanitation projects, health workers tried to explain germ theory to villagers as a reason they should boil their drinking water. The villagers did not understand the theory as presented and did not adopt the practice.

**Trialability** is the degree to which an innovation can be experimented with on a limited basis. New ideas that can be tried on the installment plan will generally be adopted more quickly than innovations that are all or nothing. For example, farmers will often try out a new crop variety by planting a small plot to see if it will work in the local environment.

**Observability** is the degree to which the results of an innovation are visible to others. The easier it is for people to see the results of an innovation, the more likely they are to adopt it. Such visibility stimulates peer discussion of a new idea. For example, one or two local artisans might adopt the innovation of staying open later on certain evenings to attract tourist groups; other artisans notice the new business traffic and begin to experiment with extended hours and services, too.

### Communication channels

Communication channels are the means by which messages get from one individual to another. Mass media channels are often the most efficient means to inform an audience about the existence of an innovation—that is, to create awareness. Mass media channels (radio, television, Internet, newspapers, and so on) enable a source of one or a few individuals to reach an audience of many. On the other hand, interpersonal channels are more effective in persuading an individual to adopt a new idea, especially if the interpersonal channels link two or more individuals who are near peers. Interpersonal channels involve face-to-face exchange between two or more individuals.

Results from studies show that most individuals do not evaluate an innovation on the basis of scientific studies. Instead, most people depend mainly upon the opinions and experiences of other individuals like themselves who have previously adopted the innovation.

### The innovation decision process

There are five main steps in the adoption of an innovation

1. Knowledge (the innovation exists)
2. Persuasion (a favorable attitude)

3. Decision (to try it)
4. Implementation (trying it)
5. Confirmation (permanent or long-term adoption of the innovation)

A sixth step, discontinuance, may occur. This is a later decision to reject the innovation that had previously been adopted.

### **Role of opinion leaders in diffusion of innovation**

Every society has certain people who are influential in forming opinions. This is a type of informal leadership rather than a function of the individual's position or status in the system. Opinion leadership is earned and maintained by the individual's technical competence, social accessibility, and conformity to the system's norms. They can be quite crucial to a community's adopting or rejecting an innovation.

One of the most striking characteristics of opinion leaders is their unique and influential position in their system's communication structure: they are at the center of interpersonal communication networks. The opinion leader's interpersonal networks allow him or her to serve as a social model whose innovative behavior is imitated by many other members of the system. The influence and respect the opinion leader holds can be lost, however, as happens when the leader deviates too far from the norms of his or her system. There is research evidence that opinion leaders can be "worn out" by change agents who overuse them. Opinion leaders may be perceived by their peers as being too much like the change agents, and may therefore lose their credibility with their followers.

### **Reflection question**

Think about a time when you were persuaded or influenced to consider and adopt a new idea or practice. The innovation might have been to stop doing something (such as stop smoking), to start doing/using something (such as buy and start using a cell phone), or to make a significant change in a process (such as change your major in college, change your job or career). Once you have centered on a particular example of "change" in your life, analyze it for a few minutes

*Who was involved in promoting the innovation? Who persuaded or influenced you? What about this person/these people made you want to listen and take action?*

*What aspects about the proposed innovation made it appealing? Was it easy or difficult to adopt this change? Why?*

### **Source**

*Roles of the Volunteer in Development: Toolkits for Building Capacity*, Peace Corps: Washington, DC, 2002. Capacity Building Toolkit 2, "Volunteer as Change Agent" pgs. 28-30. [ICE No. T0005]









# Mitigation and Care

## HIV/AIDS TRAINING RESOURCE KIT

**Session 1: Defining the Issues for Volunteers**

**Session 2: Major Issues**

**Session 3: Putting It All Together**



# Session One: Defining the Issues for Volunteers

## Purpose

To provide an overview of the issues relating to mitigation and care for people living with HIV/AIDS, their families, and communities, and the role of the Peace Corps Volunteer.

## Rationale

While prevention of HIV/AIDS is the focus for most Peace Corps Volunteers, many prevention projects will take place within the context of mitigation and care for people living with HIV/AIDS, their families, and communities. In addition, some Volunteers will work on primary projects relating to mitigation and care issues for people living with HIV/AIDS. All Peace Corps Volunteers should contribute to creating positive living environments for people living with HIV/AIDS. This session will introduce trainees/Volunteers to the concept of “positive living” for people living with HIV/AIDS and provide an overview of what is needed to create an environment where positive living is possible.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

## Duration

3 hours

## Objectives

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

1. Articulate what it means to “live positively” with HIV/AIDS.
2. Describe the major issues relating to mitigation and care for people living with HIV/AIDS, their families, and communities.
3. Define a range of mitigation and care activities appropriate for Volunteers.

## Session Outline

- I. **Introduction and Opening Activity**  
(30 minutes)
- II. **Personal Stories—People Living with HIV/AIDS**  
(45-60 minutes)
- III. **Identifying the Issues** (30 minutes)
- IV. **Tying HIV/AIDS Mitigation and Care Activities to the Bridge Model** (30 minutes)
- V. **Wrap up: Fears and Feelings about People Living with HIV/AIDS** (30 minutes)

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- The concept of “positive living” with HIV/AIDS.
- The range of needs for people living with HIV/AIDS, their families, and communities to live positively with HIV/AIDS.
- Facilitating discussions that evoke powerful feelings and emotions with large groups.
- Stigma and discrimination.
- Appreciative approach.

## Materials and Equipment

Blank flip charts

Markers

Piece of paper and pen/pencil for each trainee

Cards in three different colors—there should be enough for 2-3 cards of each color per participant

Tape or pins for posting cards on wall

Prepared flip charts

1. Session One Outline
2. Individual flip charts with outline figures of a man, a woman, a pregnant woman, a boy, and a girl (see samples)

3. *The Bridge Model of Behavior Change* (reproduced here, or you can copy page 31 from the *Life Skills Manual* [Part III, pg. 9 in previous three-ring binder version])

#### Handouts

- A. *Profiles of People Living with HIV/AIDS*  
*Esther*  
*Lucy*  
*Pauline*  
*Naledi*  
*Peter*
- B. *Preparing for Guest Speakers Who Are Living with HIV/AIDS*
- C. *The Bridge Model of Behavior Change*

### Preparation Checklist

- Read the entire session and decide if any optional activities need to be added, depending on previous training experience of the group.
- Invite guest speakers or prepare reader's theater. **Guest speakers:** Identify up to four people living with HIV/AIDS to come as guest speakers. Find speakers through a local association of people living with HIV/AIDS, a local support group, or a local community where the Peace Corps is active. To the extent possible, get a variety of people (man, woman, youth, etc.) You may need a translator to work with you. When talking to prospective speakers, explain the purpose and objectives of the session, the format of the session, their role, and something about the group to whom they will be speaking. Ask what experience they have telling their stories, whether they have spoken to cross-cultural groups, and what their experiences speaking out have meant to them. Select those who will meet the needs of this session. Participants should gain personalized understanding of the range of issues confronting people living with HIV/AIDS, particularly in the context of the local culture, and what it means to live positively with HIV/AIDS. Let speakers know if you are able to pay their transportation, meals, and lodging. Ask if speakers would like their comments to be kept confidential and whether there is anything they would like you to do to prepare participants. See *Handout B: Preparing for Guest Speakers Who Are Living with HIV/AIDS*.
- If guest speakers living with HIV/AIDS are not an option for you, prepare to tell some people living

with HIV/AIDS stories through an activity called reader's theater. Use some of the stories provided on Handout A (rewrite to make appropriate to your setting), or write your own stories to represent the issues for people living with HIV/AIDS in communities where Volunteers will serve. Each story should be no longer than one page in length. Participants will read the stories as if they were the people.

- Prepare participants for guest speakers before the day of the session. Let them know this will be a powerful and possibly emotional session. Explain that there will be a panel presentation of personal stories. Spend a few minutes processing feelings if needed. Discuss the kinds of questions that are appropriate and those that are not, if you will do questions and answers. Advise participants of the confidential nature of the session, if appropriate.
- Prepare flip charts.

### Methodology

#### I. Introduction and Opening Activity (30 minutes)

##### Welcome and introduction

**Step 1:** Welcome participants and guest speakers, if any, to this session on mitigation and care. Ask each person to briefly introduce him or herself if there are guests.

**Step 2:** Provide an overview of the session by reviewing flip chart 1. Explain the purpose and objectives of Session One.

Session One Outline
<b>Defining the Issues for Volunteers</b>
<b>I. Introduction and Opening Activity</b>
<b>II. Personal Stories—People Living with HIV/AIDS</b>
<b>III. Identifying the Issues</b>
<b>IV. Tying HIV/AIDS Mitigation and Care Activities to the Bridge Model</b>
<b>V. Wrap up</b>

FLIP CHART 1

**Step 3:** Inform participants that the content of this session may be quite emotional.

### Opening activity: The loss exercise

**Step 1:** Explain: *We are going to begin with an experience that will provide a way to discuss empathy and compassion for people who are experiencing grief or loss, especially those infected or affected by HIV/AIDS.* (This is the “Loss Exercise” from the *Life Skills Manual*, Appendix 4, page 244 [Appendix 4, pg. 21 in previous three-ring binder version].)

**Step 2:** Ask everyone to get a piece of paper and a pen or pencil; distribute supplies to those who need them. Ask them to number their papers from 1 to 5.

**Step 3:** Explain that you are going to read five statements, and they will need to respond to the statements on paper. No one else will see their papers and they won't be collected after this exercise.

Do this exercise slowly and seriously. One by one, read each statement and tell participants to write down their responses.

1. Write down the name of the personal possession that you love most. Maybe it is your house, or a special item that your grandmother gave you, a book or something else. What one thing means the most to you? Write that as item #1.
2. Write down the part of your body of which you are most proud. Perhaps you like your eyes because they help you see, or you are very proud of your hair, or you love your ears because they help you listen to music, or you love your voice because it helps you to sing. Write down the one part of your body that you are most proud of as item #2.
3. Write down the name of the activity you enjoy most doing. Maybe it is going to church, playing football, dancing, or something else. What do you love doing more than anything else? Write that activity as item #3.
4. Write down one secret or very confidential thing about yourself that no one else in the world or only one other person knows about. Every one of us has some secret or very private things that he or she does not want anyone to know about. Write that secret as #4.

5. Lastly, write down the name of the person whose love and support means more to you than anything else in the world. Write that person's name as #5.

**Step 4:** After everyone has finished, explain that you will now go through the list again. As you go through each statement, they should imagine that they are living through what you are saying.

1. Imagine that something terrible has happened that causes you to lose the material thing that you love most. Either someone steals it from you or some other loss happens that takes that thing away from you completely. You will never again see the thing listed on line #1. Cross it off your list now. *(Pause while participants think about this and do it.)*
2. Imagine that an accident or other unfortunate occurrence causes you to lose the part of your body of which you are most proud. This part of your body is gone, and you will never have it again as long as you live. Cross out #2 now. *(Pause.)*
3. Imagine that this same accident or unfortunate occurrence makes it impossible for you to do your favorite activity ever again. You will never again, in your entire life, be able to do the activity you wrote in #3. Cross out #3 now. *(Pause.)*
4. Imagine that because of all of the above situations, your secret has been exposed. Everyone now knows what you wrote for #4. It has become public knowledge—everyone in school, town, church, and community is talking about what you wrote as item #4. Circle #4 with your pen now. *(Pause.)*
5. Lastly, because of all these changes (losing your possession, losing your body part, not being able to do your favorite activity, and everyone knowing your secret), the person that you love most in the world leaves you forever. You will never again see this person that you love and who is your most important source of support. Cross out #5 now. *(Allow a few moments of silence for people to feel what has been said. People may feel uncomfortable.)*

**Step 5:** Ask participants to say one word that describes how they feel. Write all ideas on a flip chart. *(Answers may include sad, suicidal, depressed, angry, etc.)*

**Step 6:** Ask the participants to look at the list, and imagine how these feelings might relate to testing positive for HIV/AIDS. Many people who are living with HIV say this is how they feel everyday.

Discuss

*How would you want other people to treat you if you were having these feelings?*

*How would you feel if someone you loved was going through this?*

*How can we show compassion for people living with HIV/AIDS, now that we have a better idea of how they feel?*

Explain that participants will be exploring this more in this session.

### Transition

Explain: *As we go through this module, we learn more about what having HIV/AIDS in this country means. Our goal is to contribute to the ability of those living with HIV/AIDS to live their lives to the fullest.*

*In the next segment we will be hearing actual voices of people living with HIV or AIDS.*

Trainer's note: Choose the explanation that fits what you will do—guest speakers or reader's theater.

*We have some guests who have agreed to share their personal stories with us. Each person will introduce him or herself. We will just listen—please don't interrupt or ask questions. If you developed some questions in advance, please give them to me.*

OR

*We have the stories of some people who are living with HIV or AIDS. I am going to ask some of you to take the place of those people here at the front table. I will ask each of you in turn to read aloud the story you have.*

## II. Personal Stories—People Living with HIV/AIDS

(45-60 minutes)

### Option A: People living with HIV/AIDS panel

(40 minutes)

For this to have the most impact you want speakers to just talk (7-8 minutes), without further introductions by you, and without interruptions from questions.

**Step 1:** Each person tells his or her story.

**Step 2:** Ask questions, if it seems appropriate.

**Step 3:** Thank the speakers for their courage in telling their stories for the group and express your appreciation for their commitment to improving the lives of all those affected by HIV/AIDS.

**Step 4:** If giving small gifts is appropriate, present each with the gift and guide guests from the room.

**Step 5:** Acknowledge that what the group just heard was very powerful and that it may have evoked strong emotions for some. Give the participants a few minutes to think quietly about what was said.

**Step 6:** Provide an opportunity for people to process their feelings. You can begin by simply asking: How did these stories make you feel? If participants are reluctant to speak, you can go around the room and allow everyone to just say a word or two. Allow the option to pass.

### Option B: Reader's theater (25 minutes)

**Step 1:** We are going to hear the stories of several people living with HIV or AIDS. I'm going to ask some of you to read their stories. First, listen to who they are: *(Pauline is an 87-year-old grandmother caring for her grandchildren; Esther is 36 years old and her husband left her when she told him she was HIV-positive; . . .)* Who would like to read each one?

**Step 2:** Come to the front and take a seat. I'd like you to read each story fairly slowly, like you were telling it. After one finishes, the next person can start. Continue until everyone has finished.

**Step 3:** Acknowledge that what the group just heard was very powerful and that it may have evoked strong emotions. Take a few minutes of quiet time to think about what was heard. *(Pause for a few minutes.)*

**Step 4:** Thank the readers and ask them to take their seats.

**Step 5:** Provide an opportunity for people to process their feelings. You can begin by simply asking: How did these stories make you feel? If participants are reluctant to speak you can go around the room and allow everyone to just say a word or two. Allow the option to pass.



**Card activity** (20 minutes)

**Step 1:** Explain: We have just heard some powerful stories. We are trying to learn how we can increase the longevity and improve the quality of life for people living with HIV and AIDS, their families, friends, and community. It will be easier for us to see the big picture if we begin thinking about people we know.

**Step 2:** Ask participants to take a few minutes to think of someone they know or knew who has/had HIV or AIDS. If they don't know anyone, they can think of someone, perhaps a relative, who had a terminal illness (cancer, multiple sclerosis, a failing heart) or a disability (blindness, wheel-chair bound) that limited his or her life in some way.

Visualize that person . . . how they looked . . . what they could or could not do . . . how they dealt with their condition . . . how others treated them . . .

**Step 3:** Put stacks of colored cards on the table. Ask participants to

- On a (blue) card, indicate who the person was by his or her initials or perhaps a picture or symbol that represents him or her.
- On some (yellow) cards, write some things they do (or did) to cope with their condition. Write one idea per card. Write as many as you wish.
- On some (pink) cards, write some things that they or others could have done to help them live longer, more comfortably, more productively, more happily. Write one idea per card. Use as many as you wish.

**Step 4:** When participants are done, ask them to post their cards on the wall. Cluster the (yellow) and (pink) ones around the person, or put them in whatever configuration desired.

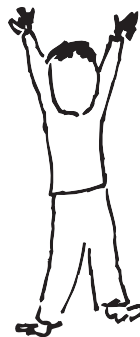
**Step 5:** Browse and read some of the cards posted by others silently. Give them a few minutes to browse.

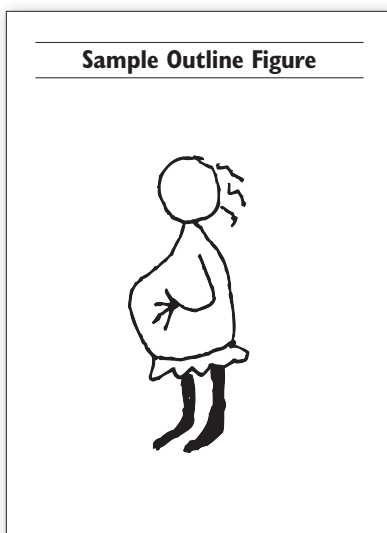
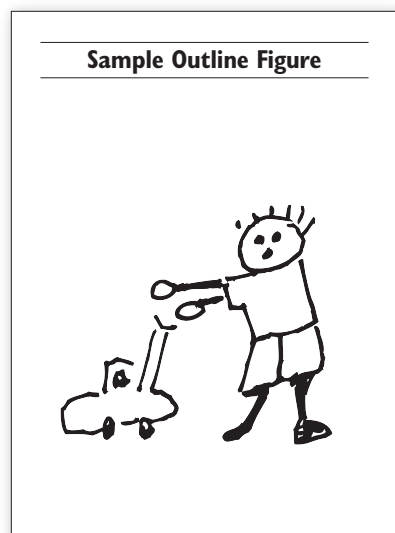
Again, participants may have had a powerful experience . . . the remembering part, the writing part, and the reading part. These are difficult issues. Move on to start thinking specifically about what the issues are and how participants can work with them.

**III. Identifying the Issues** (30 minutes)**Small groups** (20 minutes)

**Step 1:** Reveal the flip charts with outline figures. Introduce them as people who are living with HIV/AIDS. Although the participants don't know the person, they can imagine that she or he has life experiences, skills, knowledge, a spiritual life, and inner strength. The person also is living with AIDS and so will need support and care from others as well.

**Step 2:** Ask participants to think about what they learned from the loss exercise, the card activity, and from the stories of people living with HIV/AIDS. What kind of mitigation and care is needed by people living with HIV/AIDS and their families in order to "live positively" with HIV/AIDS?

**Sample Outline Figure****Sample Outline Figure****Sample Outline Figure**



- By “mitigation” we mean lessening the effects of illness.
- “Living positively” means addressing physical, mental, and social aspects of life to live longer and in a productive manner
- “Care” means all clinic and home or community-based activities aimed at optimizing quality of life of HIV-infected people and their families throughout the continuum of illness.

Ask participants to look at the outline of their person and imagine different areas of need—some are physical and relate to various parts of the body or the whole body (point); some are psychological (point to the head), some are emotional (draw a heart), some relate to work (point to the hands), and so on. Ask participants to imagine and draw these things symbolically, near the part of the body that might relate to what you are suggesting.

**Step 3:** Divide participants into six small groups and send a representative to come and select a flip chart. Give 10 minutes for this work.

#### **Debrief** (10 minutes)

**Step 1:** Reconvene the entire group and have each group post its flip chart where all can be seen.

**Step 2:** Ask someone to make a list on a clean flip chart of what it means to “live positively” with HIV or AIDS as the groups briefly share their ideas.

#### A sample list

- Spending time with family and friends
- Planning for the future of loved ones
- Keeping busy and remaining productive
- Having hope
- Maintaining spiritual health
- Going for individual and/or group counseling
- Eating a balanced diet
- Learning about the virus
- Protecting others from HIV infection

- Limiting the use of alcohol and tobacco
- Self care
- Getting enough physical exercise
- Getting enough sleep and rest
- Seeking medical help whenever an illness arises

#### **Step 3:** Discuss

*What are some of the key challenges to living positively?*

- Stigma and discrimination
- Lack of information
- Lack of medical care
- Lack of proper food/energy
- Lack of money

*What is the role of prevention in mitigation and care activities, including*

- Preventing transmission from the infected person to partners.
- Using opportunities provided by mitigation and care activities to spread prevention messages to others involved in care of the people living with HIV/AIDS.

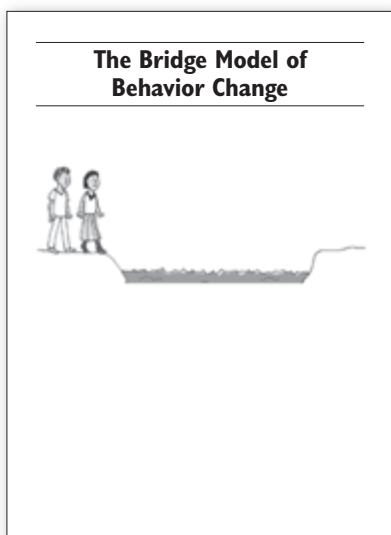
**Step 4:** State that the drawings and list will be kept in view for the remainder of the module.

#### IV. Tying HIV/AIDS Mitigation and Care Activities to the Bridge Model (30 minutes)

##### Recalling the Bridge Model (5 minutes)

Refer to Part 1, Session One on the Bridge Model in the *Life Skills Manual* for more talking points (Part III, pg. 15 in previous three-ring binder version).

**Step 1:** Reveal flip chart 3 with the young people having a body of water to cross with no bridge.



FLIP CHART 3

**Step 2:** Ask who can recall what “planks” build the bridge to help young people move from information to behavior change in order to live productive healthy lives? (communication skills, understanding consequences, good role models, resistance to peer pressure, goals for the future, decision-making skills, negotiation skills, strength, assertiveness, empowerment of girls, sense of responsibility, confidence, self-respect, opportunities for the future, new values for boys, self-esteem)

*What were some of the behaviors we learned about from people living with HIV or AIDS that lead them to their infection?*

*How could learning the skills needed for the planks have helped them?*

##### Applying the Bridge Model to mitigation and care (10 minutes)

Look back at the flip chart, and let’s change the scenario a bit. The side they are now standing on lacks

knowledge of STIs, HIV/AIDS, alcohol/drugs. And the people aren’t the same either, as they all now have HIV or AIDS. They need to build a bridge that will allow them to live positively with their disease.

*What should the planks be to get them to the other side where they can live positively and longer and not infect others?* (knowledge about their health status and how to deal with it medically, how to prevent transmission, social/emotional/psychological support, spiritual beliefs, means of economic security for themselves and their families, knowledge about nutrition)

As suggestions for planks are made in this round, draw planks and write one suggestion on each plank

*From all the work we did earlier, what are some specific examples of things related to these planks?*

##### Identifying the Volunteers’ role in mitigation and care (15 minutes)

**Step 1:** Ask participants to divide into as many groups as there are planks on the bridge for people living with HIV/AIDS. Ask each group to take one of the planks, discuss the activities that might be included, and create a list of the kinds of specific initiatives in which a Volunteer might engage. They can refer to the various charts, cards, and drawings still posted. (10 minutes)

**Step 2:** Have groups share lists with one another. Clarify any activities they should not be doing (direct medical care, counseling), and remind that they are building capacity in others with their work, not just “doing things” on their own. (5 minutes)

*Now that you have thought about some roles you might play in mitigation and care, how does that make you feel? Let’s explore that a little bit.*

#### V. Wrap up: Fears and Feelings about People Living with HIV/AIDS

(30 minutes)

##### Individual reflection (5 minutes)

Ask participants to think about their feelings and fears related to working with people living with AIDS. Recall all that was heard and shared in this session. Take a few minutes to think about reactions to working with people living with HIV/AIDS.



**Notes**

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**Changes to Session**

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## Handout A: Profiles of People Living with HIV/AIDS

### Esther

I am 36 years old and have lived with HIV for more than 13 years.

I was married a virgin to the one and only man I have ever known, who is now my ex-husband. I had my first child 16 years ago before I contracted the virus. My second child passed away. That's how I knew that I was HIV-positive, and then I started dying slowly. I didn't know what being HIV-positive meant, so I was just waiting to die.

I feared rejection by my family, so I did not tell anybody except my husband. That's when much of my suffering began. My husband denied it and abandoned me and went to stay in a different town.

My husband worked in a mine and lived away from me during our marriage, and I believe that his behavior while he was away led to his being infected with HIV.

Sadly, my 43-year-old husband has since re-married. Last year, he married a 17-year-old girl. The young girl did not know the condition of my ex-husband. Last year, my son told her that his father was HIV-positive, but she dismissed him saying he was doing it because I was jealous of her.

My son lives with me and he is very supportive, but he would prefer it if we were in a proper family set up where there is a father in the house. He goes now and again to see his father.

The depressing part is that my son blames me for the break-up with my husband. My ex-husband has been trying to get back with me. But he has a new wife and I am not prepared for that. He wants to have two wives.

I have established my own life and broken away from the confinement placed on women in my nation by culture. I take vitamin supplements. I can't afford anti-retrovirals.

Am I bitter with my husband? Yes, at first I was. But after counseling, I realize it is no use. I don't hate him now. But he cannot be my husband again. I actually feel sorry for him. I think he doesn't realize how terrible it is what he is doing.

**Source** United Nations Development Fund for Women. "Living Positively With HIV," [http://www.unifem.org/gender\\_issues/voices\\_from\\_the\\_field/story.php?StoryID=215](http://www.unifem.org/gender_issues/voices_from_the_field/story.php?StoryID=215), (accessed April 4, 2007).

### Lucy

When my family learned of my HIV status, they advised me to find a house close to the public cemetery. "We do not have money to put into your funeral arrangements, let alone your husband's," they told me.

I was 23 and pregnant with my second child, and I was caring for my ailing husband and our five-year-old son with proceeds from my vegetable kiosk. But when word got out that both my husband and I were living with HIV, my customers stopped coming. I was so upset. After my baby was born, I weighed only 45 kg (99 pounds).

Then in October, our two-month-old infant died from pneumonia. As I watched my world tumble down, I wanted to give up living so badly. What stopped me was the hope that I saw radiate every day from my five-year-old son.

When a church social worker introduced me to a support group for people living with HIV/AIDS at a church, I welcomed the chance to meet others who shared my circumstances. When I came here, I was very lonely and was looking for friends I could talk to.

In addition to finding a much-needed support network, I and the 39 other support group members were very lucky—we were selected to participate in a nutrition program designed to boost our immune systems. Since the program started, my health has greatly improved. I have gained 10 kilos and my CD4 count has risen from 280 to 540.

I used to throw up all the time and couldn't retain the food I ate. I was always sickly and spent most of my time in bed. Though I still fall sick once in a while, my life has taken a complete turn from last year. I feel strong most days and can take better care of my husband and child. I look forward to starting a second-hand clothing business in a few months.

When we started our nutrition program, we used to meet behind closed doors because many of the members were afraid that we would be ostracized when people learned our HIV status. Today, all of our meetings are held in the open, and most of us are ready to share our experiences with people living with HIV/AIDS and those free from the virus.

**Source** *Feeding the Body and Strengthening the Spirit: Nutrition Project Gives Hope to PLHA in Nairobi's Slums*, FHI: Arlington, VA, December, 2004.

# Handout A: Profiles of People Living with HIV/AIDS

## Pauline

I have been looking after three grandchildren since my daughter died of AIDS two years ago. She was the last of my four adult children to die. If the parents leave the children, you just carry on with it. You have no choice.

I am 87 years old. Being a parent again is not easy—especially without my husband. He died almost 40 years ago.

It's been an uphill struggle. We live on the outskirts of a big city, on my pension of about US\$75 a month. Almost two-thirds goes to rent. A foster-care grant of a similar amount secured by a local voluntary organization helps. The organization's volunteers have also brought us food parcels and helped find school uniforms. They even cared for the kids when I was sick.

School fees are equivalent to almost three weeks' pension money. I spend every cent I have. There is nothing to save.

## Naledi

The funeral took place a week after my husband's death, followed by a week of being insulted by my in-laws for bewitching their only son and brother. As I watched the coffin being lowered into the grave, I whispered to myself, "If you had only listened to me, you would still be alive. I would not have to take so many insults from your family."

As I tried to stand up to throw soil into the grave, I fainted. My husband's family said that it was my guilty conscience for killing my husband so that I could inherit the big house he had just finished building.

I knew my husband had died of AIDS, but I decided to keep it to myself. Even if I told them they would never believe me. If anything they would say I had infected him with it.

My problem started two years earlier when I decided to go for an HIV test. My husband refused to go with me. When my test results were positive, my husband would not accept it. He kept denying the fact that I had the virus and that he might also have it. He even insisted that we should not use condoms, until it reached a point where we fought over condom use.

He still refused to go for a test when he started to lose weight, claiming that he was on a diet. He finally agreed on his deathbed that he could be tested for AIDS. He died knowing that he had the virus. But he was my husband, and I will love him always. That is why I will keep his secret.

**Source** *Policy Report—Forgotten Families: Older people as carers of orphans and vulnerable children.* HelpAge International/International HIV/AIDS Alliance: Brighton, UK, 2003.

**Source** Kidd, Ross and Sue Clay, *Understanding and Challenging HIV Stigma: Toolkit for Action – Module E, Exercise 4*, pg. 86, The Change Project: Washington, DC, 2003.

Source of Case Study: Article "Me Go for a Test? No Way!" by Gregory Kelebonye in *Mmegi Monitor* (Botswana), 29 April to 5 May 2003.

## Handout A: Profiles of People Living with HIV/AIDS

### **Peter**

When my weight dropped below 48 kilos, I realized that I had to find out the truth about my health. My doctor advised me to test for HIV. But I was terrified of being diagnosed HIV-positive. I found it easier to hide from the truth than to confront a certain death sentence.

The test results were ready within one week. They were positive. At 22 years of age, I learned I had HIV. I was devastated.

I had been hiding from the truth for a long time. I had been involved with intravenous drugs for a period of time a few years ago. They were ruining my life. My parents convinced me to get treatment and I did. I carried the fear of AIDS because I had shared needles. I kept denying early symptoms.

But over a few months, my body started to shut down. In addition to losing weight, I was in incredible pain. I had no energy. I found it increasingly difficult to continue my job as a teller at the local bank.

As I got sicker, I was afraid of what people would say. The stigma surrounding HIV in this country is still so massive. Too many people still link HIV to witchcraft. Too many people think that the virus is incurable. They don't understand that HIV can be beaten with proper testing and the right kind of treatment.

I was really lucky. After giving me the test results, my doctor prescribed AIDS treatment immediately, and I was able to pay for the drugs. The treatment gave me renewed energy. The pain eased and I regained my strength. The AIDS medicines lifted my death sentence. They obliterated the fear and helplessness. I realized that access to treatment gives people a reason to test for HIV. I now want to spread that message.

I am also motivated to live a healthier life. No more drinking, no more smoking. I eat healthily. Every day I spend with my family is a gift.

Yes, I am HIV-positive. But now that I can take my medicine, I feel alive again. Taking care of my daughter is my number one priority. She is my reason for living.



# Handout B: Preparing for Guest Speakers Who Are People Living with AIDS

## Why invite people living with AIDS?

One strategy to encourage behavior change, create awareness, and fight the spread of HIV/AIDS is to invite people living with AIDS to share their personal experiences. In Tanzania, due to the fear and blame unjustly surrounding people living with HIV/AIDS, it is crucial to prepare and train both the people living with HIV/AIDS as well as the audience before the session takes place.

In order to prepare, it is important for the Volunteer first to clearly identify her or his session objectives. Some possible objectives may include

- To help participants face their own prejudices about people living with HIV/AIDS
- To erase the stigma surrounding people living with HIV/AIDS
- To emphasize the fact that people living with HIV/AIDS cannot always be identified on sight
- To personalize HIV/AIDS
- To provide concrete examples of the impact of HIV/AIDS
- To personify the courage and fortitude of people living with HIV/AIDS
- To show support and discuss ways to support and care for people living with HIV/AIDS
- To test the participants' ability to put HIV/AIDS education into practice
- To reinforce lessons of behavior change

## People living with HIV/AIDS preparation

Training for people living with HIV/AIDS should include a clear description of the information they are expected to present. Some discussion topics may include

- Birth location
- Testing method used
- Family history
- Reaction of family and friends
- Educational background
- Current situation
- Employment history
- Strategies for a healthy lifestyle
- Family life (marriage, children)
- Suggestions for how to support people living with HIV/AIDS
- Description of HIV contraction

The topics should be agreed upon, making sure that people living with HIV/AIDS are comfortable with the Volunteer's expectations.

In addition to the discussion topics, the Volunteer and people living with HIV/AIDS guests should agree on how the session will be facilitated. It may be helpful to invite several people living with HIV/AIDS, as well as an HIV/AIDS counselor to help facilitate the session. Experience has shown that the best method for a question and answer session is to have the participants write anonymous questions on blank slips of paper, to be collected and given to the guests (or panel moderator). Open question and answer sessions may be difficult, and even painful, as the questions cannot be screened in advance.

One possible session to hold with people living with HIV/AIDS prior to the workshop is "Answering Difficult Questions" (see notes below). This session will help prepare the guests to face/address the possible prejudices of the participants.

## Audience preparation

It is important to prepare the audience for the people living with HIV/AIDS session to make the guest speakers as comfortable as possible. In general, it is beneficial to teach the participants the basic facts about HIV/AIDS, especially points concerning transmission. One suggested session from the *Life Skills Manual* is "How HIV is Transmitted", pg. 63 (Part II, pg. 51 in previous 3 ring binder version)

In addition, some sessions about living with HIV/AIDS should be included in preparation for guests. Some possible activities from the *Life Skills Manual* may include

- The Loss Game
- Case Studies
- The Wheel of Care

- True/False Game
- “I Have AIDS” role play
- Statement of Faith
- “HIV/AIDS and You” small group discussions

In general, inviting people living with HIV/AIDS guest speakers can be the highlight of any workshop or seminar, if handled correctly. It is one significant way to allow participants to experience the reality of HIV/AIDS, and often serves as a catalyst for our main goal: behavior change.

### Answering difficult questions

It may be helpful to people living with HIV/AIDS to discuss how they can handle questions they may receive during a panel, individual talk, or just in conversation. It will be less stressful, perhaps, to do this in a small group, where no one is singled out and they can help each other strategize.

Start by asking what kinds of questions they would find difficult. Make a list.

Then try to group and label the questions, using categories such as

#### Hostile questions

Examples: *Isn't it your fault you have AIDS?*  
*Why do you always have to talk about sex?*

#### Questions that have no answer

Example: *Where did AIDS come from?*

#### When you don't know the answer.

Example: *How many people in this town have AIDS?*

#### Personal questions

Example: *Do you use condoms?*

#### Controversial questions

Example: *My pastor says condoms have holes in them. Are you saying he's lying?*

Talk about strategies for handling difficult questions. Some ideas include

- Repeat the question to make sure you understood it and to give yourself some time to think.
- Open up the question to the whole group (panel and/or audience).
- Admit it if you don't know the answer. If you have suggestions how people can find out the answers, provide them.
- Don't feel you have to speak for everyone. Use a phrase such as, “In my experience . . .” or “From what I have heard from others . . .”
- Appeal to universals, such as “We all make mistakes, and mine was . . .” or “Doing risky things is not uncommon, but unfortunately . . .”
- Diffuse hostile or controversial questions by turning away from the questioner and addressing the whole group.
- Preface opinion as such, “In my opinion . . .”
- Know that you don't have to answer questions that are offensive or too personal. “I just don't feel I can talk about that.”

### Source

Based on work by school health education Volunteers, Tanzania, July 2000

### Resource

*Using Participatory Analysis for Community Action: PACA Idea Book Manual* [ICE No. M0086]. See Chapter 4: “Preparing for PACA” which includes a section on facilitation and dealing with difficult group members.

## Handout C: The Bridge Model of Behavior Change



Information provides a solid foundation.  
Begin by providing accurate information.

Our goal is to see members of our communities  
living healthy, happy, fulfilling lives.

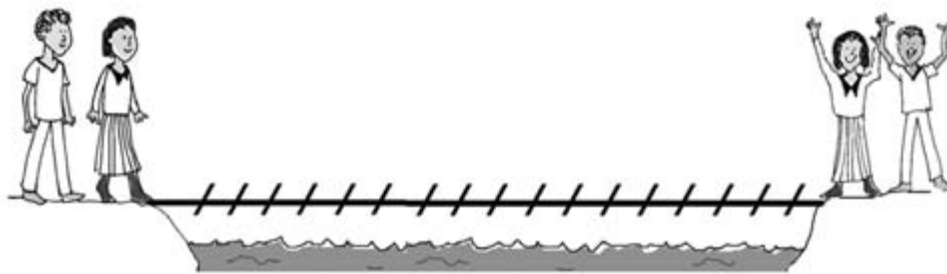


But in order to realize a positive, healthy life, we need to avoid the consequences of negative behavior.

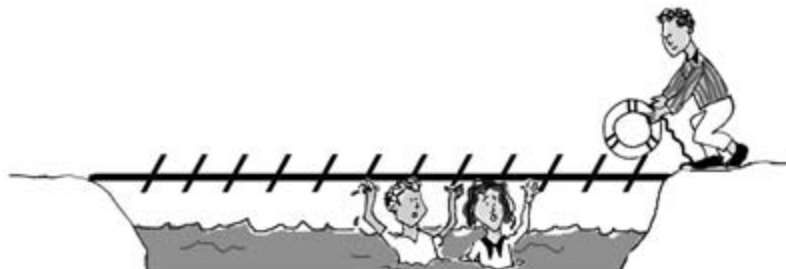


How do we build a bridge from information to behavior change?

A Life Skills Program focuses on building the “planks” in the bridge—working on the individual skills that help people to make healthier decisions about their lives.



Relapse is expected in any behavior change, so we must build in “life-preservers” or ways to bring people back onto the “bridge” should they suffer the consequences of a negative behavior.





## Session Two: Major Issues

### Purpose

To provide knowledge relating to specific aspects of mitigation and care for people living with HIV/AIDS, their families, and communities.

### Rationale

Peace Corps Volunteers will have opportunities to build capacity of individuals, families, and organizations to address issues relating to the mitigation and care of people impacted by HIV/AIDS. To be effective and strategic, Volunteers need a basic understanding of promising practices relating to some of the major issues for people living with HIV/AIDS, their families, caretakers, and communities. This session will provide introductory knowledge about health and medical issues, social/emotional/psychological support, special needs of orphans and vulnerable children, spiritual issues, economic security, and nutrition and food.

Trainer's note: Home-based care is addressed as one of the methods of providing services that relate to each area of need. Palliative care and death and dying are addressed as part of issues listed above. Each of these topics, however, could be addressed on its own if time permits.

### Target Audience

Peace Corps participants (trainees and/or Volunteers)

### Duration

2 hours to 2 hours and 30 minutes

### Objectives

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

1. Identify promising practices in the host country relating to: health and medical issues; social/emotional/psychological support; special needs of orphans and vulnerable children; spiritual issues; economic security; and nutrition and food security.
2. Identify capacity-building roles of participants in the major areas of support to people living with HIV/AIDS.
3. Utilize an exercise designed to reduce stress and replace negative thoughts with positive thoughts resulting from the stresses of working with HIV/AIDS.

### Session Outline

#### I. Introduction (20 minutes)

#### II. Promising Practices of Major Issues (90-120 minutes)

#### III. Wrap up (30 minutes)

### Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- The concept of “positive living” with HIV/AIDS.
- The range of needs for people living with HIV/AIDS, their families, and communities to live positively with HIV/AIDS.
- Facilitating discussions that evoke powerful feelings and emotions with large groups.
- Stigma and discrimination.
- Appreciative approach.

### Materials and Equipment

Blank flip charts

Markers

Part III Activity—“True or False Activity Statements” (for trainers only)

Part III Activity—Signs to post on walls: “True” “False” “Not Sure”

Prepared flip charts

1. Session Two Outline

Handouts/Fact Sheets

- A. *Guiding Questions for Discussions with Experts*

- B. *Fact Sheet: Care for Orphans and Vulnerable Children*
- C. *Fact Sheet: Antiretroviral Drugs for HIV/AIDS*
- D. *Fact Sheet: Nutrition and HIV/AIDS*
- E. *Fact Sheet: HIV Counseling and Testing*
- F. *Fact Sheet: HIV/AIDS and Economic Security*
- G. *Fact Sheet: Supporting People with HIV/AIDS: Community Home-Based Care*
- H. *Fact Sheet: Spirituality and Treatment of People Living With HIV*

### Preparation Checklist

- Read the entire session and decide if any optional activities need to be added, depending on previous training experience of the group.
- Read the Tip Sheet “Preparing for Guest Speakers Who Are Experts” at the end of the session plan. Determine how many experts might be available to assist with this session. Provide them some guidelines (see sample “Guidelines for Expert Speakers” at the end of the session plan). Their role will be to cover some of the topics (listed under “Guiding Questions for Discussion with Experts”) to help participants understand promising practices in the host country and to identify their possible roles in building individual, family, organizational, and community capacity to meet needs in each area. Provide each invited expert with the relevant “Guiding Questions for Discussions with Experts” and relevant fact sheets/handouts that participants will be asked to read prior to the session. Look at the options for using the experts in Part II; select one or develop your own plan based on your circumstances. (Another source of ideas is the Peace Corps’ publication *Nonformal Education Manual* [ICE No. M0042], pages 96-98.)
- Prepare handouts and provide to participants prior to the session to read.
- Read the “True and False Activity Statements” and revise if needed.
- Prepare signs for Part III activity.
- Meet with expert speakers prior to the session to go over format and timing.

## Methodology

### I. Introduction (20 minutes)

#### Welcome and introduction (10 minutes)

**Step 1:** Welcome participants and new guest speakers, if any. Ask each person to briefly introduce him or herself if there are guests.

**Step 2:** Provide an overview of the session by reviewing flip chart 1, “Session Two Outline.”

Session Two Outline
<b>Major Issues</b>
<b>I. Introduction</b>
<b>II. Promising Practices of Major Issues</b>
<b>III. Wrap up</b>

FLIP CHART 1

#### Opening activity—Breathe in life, breathe out trouble (10 minutes)

It may help to write out notes or phrases on reminder cards so that the guided imagery exercise runs smoothly. Repeat this exercise whenever the training session gets very emotional or when participants are feeling overwhelmed. Using it during the training will help participants get used to using it as a stress-reduction tool. Chairs should be in a circle or other casual arrangement.

*Say: As we begin the second session of the mitigation and care module, and continue to deal with difficult issues, one of the things we want to remember is that each of us individually, as well as the community as a whole, has the power to make a positive contribution to this important community issue.*

**Step 1:** Ask the participants to think about the many problems that HIV/AIDS has created—in our families,

our communities, and our nations. Suggest that they reflect again on the people in all of our lives who have died from AIDS (point to the wall where cards are posted from Session One), who live with AIDS, and people who are working with others in the struggle. Allow a few silent moments for participants to reflect.

Suggest that working with the issue of HIV/AIDS can often be difficult, and it is important that those doing such work continually recharge their batteries, so that they can be strong for both their own sakes and for the people with whom they are working. This brief visualization exercise can be a powerful way to recharge those batteries—to help us to continually keep a positive image of our goal in mind, and to allow us to expel all of the negative thoughts and feelings that may be weighing us down.

**Step 2:** Ask participants to close their eyes. Ask them to imagine their community as they would wish to see it. This may be a fantasy image of the community—with no HIV/AIDS, no orphans, people living healthily and in harmony, and so on. They should not feel constrained by reality, but should allow themselves to imagine everything that they would wish for their community. Allow a few moments for participants to silently visualize this happy, healthy community.

Next, suggest that participants take a deep breath. They should imagine that they are breathing in this beautiful life, this hope, this image of their communities. They should allow that breath to absolutely fill them, as if it is entering every particle of their being—their bodies, their minds, their souls. Allow everyone a chance to take in this deep breath. Ask them to hold it, and to retain that beautiful image of the community.

Then ask participants to breathe out, and to imagine that they are expelling from their bodies, their minds, their souls all of the negative issues associated with HIV/AIDS. They should imagine that all of the pain, the bad memories, the community problems, all of these things are leaving them completely—carried away on that exhaled breath.

**Step 3:** Ask participants to do the exercise again a few more times with you. They breathe in a positive vision of the way they would like life to be, and they breathe out all of the pain and suffering that currently has a hold on the community. Breathe in life; breathe out trouble. Breathe in life; breathe out trouble . . .

**Step 4:** Give participants a few minutes to relax. Then ask, “What did this exercise do for you?”

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## II. Promising Practices of Major Issues

*(90-120 minutes)*

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### Review major issues *(5 minutes)*

Direct participants’ attention to the drawings, lists, and the chart made in Mitigation and Care Module, Session One.

If there has been some time between the sessions, briefly recall some of what was said during Session One.

### Learning from the experts *(60-90 minutes, depending upon how many experts and the number of topics being covered.)*

Experts can be used in various ways, and the number of experts you have available may dictate the format you want to follow. Below are a couple of options, and you may have others. Select one that will be effective in your environment, taking into consideration the expectations of expert speakers as well as the need to make the training as interactive as possible for the participants.

#### Option 1: Expert panel as press conference

Tell participants who will be speaking at the press conference about their area of expertise. Divide participants into groups, each to review the fact sheet(s) on a particular topic and prepare questions for the panel. The moderator should run the panel as a press conference.

#### Option 2: Essence

Each guest speaker provides information for 10-15 minutes. After each speaker, the participants work in small groups to summarize the presentation. Use a different method after each speaker. Some possible methods

#### Summaries

1. Write a 20-word summary of the material presented. Share summaries with the full group.
2. Write a 12-word summary of the materials presented. Share summaries with the full group.
3. Write an 8-word summary. Share summaries with the full group.
4. Summaries may be posted for later reference, voted on to select the “best” of each number of words, or selected as the speaker’s preference for a prize.

### Questions and Confusion

One group writes five closed-ended questions to ask the other groups.

One group writes two open-ended questions to ask the other groups.

One or more groups write a point of confusion about the presentation that the other groups can try to answer or the expert can answer.

In all cases the expert should verify the answers and correct any misconceptions about the information.

### Nonverbal Summary

Small groups create a visual representation of the key points on a flip chart, without using words.

### Option 3: Application

Each speaker provides information for 15-20 minutes. Allow questions and answers after each. Then assign one topic to each small group of 5-6 participants. They are to create a short skit on the topic that reflects a role a Volunteer might be engaged in related to the topic.

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## III. Wrap up (30 minutes)

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### True or false activity (20 minutes)

This activity also works well as “Agree”, “Disagree”, “Not Sure” activity with brief vignettes that present issues, or actions with which participants can agree or disagree.

#### Step 1: Introduction

Explain that you will read a statement and after each statement, participants should move to stand next to the “True”, “False” or “Not Sure” signs you are posting on different walls of the room. *(Put signs far enough apart so that groups can congregate by them.)*

#### Step 2: Activity

Read statements listed on the “True or False Activity Statements” sheet. Ask participants to move to the sign that represents their response. After each statement facilitate a brief discussion among participants about why they took the position they did.

### Transition (5 minutes)

Ask participants to reconvene in chairs in a circle or other casual arrangement, as in the opening exercise. Ask

*How has this session helped to identify major areas of concern when talking about helping people live positively with HIV/AIDS? Has it added information to what was explored in the first session? (Refer to flip charts with outlines of people and the cards they put on the wall.)*

*How has this session helped clarify appropriate roles for participants as capacity builders?*

### Build a machine (5 minutes)

**Step 1:** Change the pace by announcing, “Let’s build a machine!”

**Step 2:** Ask someone to go into the center of the room and start making some kind of motion that a piece of a machine might make. *(It could be moving an arm around in a circular motion, dipping at the knees, etc.)* Suggest adding a sound if they like.

**Step 3:** Then invite others to join the machine, one by one, at whatever point they wish, adding a motion and a sound. Encourage everyone to take part. Let the machine run with every piece in motion for a moment.

**Step 4:** Then ask them to stop. Ask: how does this machine represent what we can do to help people live positively with HIV/AIDS? *(Ideas might include that any little action will contribute to the whole picture, each piece in the machine might represent one aspect of helping people live positively, each act of capacity building by Volunteers will help the machine function, etc.)*

**Step 5:** Thank participants for their participation and good work during the session.

## Evaluation

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**Notes**

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# Tip Sheet: Preparing for Guest Speakers

## Who Are Experts

### Why invite guest speakers who are experts?

One approach to present high quality information and foster host country technical resources is to invite guest speakers who are *experts* in their chosen field. These experts have firsthand knowledge about their specialty area and are often quite willing to share their knowledge and even serve as future resources for Peace Corps Volunteers and their counterparts. However, because their time is often in demand by many individuals and organizations, it is crucial to prepare the experts as well as the audience before the session takes place.

#### Strategies for expert guest speaker selection

- Recruit expert guest speakers who are well versed in the required session content areas and will add value.
- Provide expert guest speakers with a copy of the training session plan so that he/she knows what is required of the audience members.
- Invite expert guest speakers who are engaging and enthusiastic as well as knowledgeable.
- Prior to their presentations, brief expert guest speakers about the content that is relevant to their audience.

### Expert guest speaker preparation

In order to prepare, it is important for the trainer to clearly identify the session objectives and the role of the guest speaker(s). Some example roles include: panelist(s) for a group discussion; co-facilitator(s); or lead facilitator.

Preparation for an expert should include a clear description of the information the expert is expected to present, to whom he or she is presenting the information, and a briefing regarding the Peace Corps and the role of Peace Corps Volunteers if he or she is unfamiliar. Discussion or presentation topics may vary depending upon the guest speaker's area of expertise; but some examples include: food security, religion/spirituality, medicine, psychosocial services, and economics.

In addition to the presentation topic(s), the trainer and expert guest speaker(s) should agree on how the ses-

sion will be facilitated. It may be helpful to invite more than one expert guest speaker, though it is important to inform them of the total number of expert guest speakers so that adequate time may be allotted to each one.

Experience has shown that the best method for a question-and-answer session is to have prepared questions for the participants highlighting the various background areas of the different guest speakers. Sometimes it is even helpful to provide a list of these questions to your guest speaker in advance. Additional questions may be posed, but these prepared questions ensure that the required information is shared in the timeframe provided. Open question-and-answer sessions may be difficult, especially related to the language level of the participants.

### Audience preparation

It is important to prepare the audience for this session to make the guest speakers as comfortable as possible. In general, it is beneficial to brief the participants about the individuals that will be facilitating or assisting with the facilitation of this session. Highlight various aspects of their resumes, experience, or current positions that will be applicable to the session. A review of the prepared questions might be helpful, especially if the session will be conducted in a language other than English.

In general, inviting experts as guest speakers can be the highlight of any workshop or seminar, if handled correctly. It is one significant way to allow participants to experience the reality of the technical resources in country, and often serves as a future resource builder for Volunteers and their counterparts.

### Answering difficult questions

It may be helpful to discuss how to manage difficult questions that may be posed during a panel, individual talk, or just in conversation—either with experts or other individuals.

Start by asking what kinds of questions they would find difficult. Make a list.

Then try to group and label the questions, using categories such as

**Hostile questions**

**Questions that have no answer**

**When you don't know the answer**

**Personal questions**

**Controversial questions**

Talk about strategies for handling difficult questions. Some ideas include

- Repeat the question to make sure you understood it and to give yourself some time to think.
- Open up the question to the whole group (panel and/or audience).
- Admit it if you don't know the answer. If you have suggestions how people can find out, provide them.
- Don't feel you have to speak for everyone. Use a phrase such as, "In my experience . . ." or "From what I have heard from others . . ."
- Diffuse hostile or controversial questions by turning away from the questioner and addressing the whole group.
- Preface opinion as such, "In my opinion . . ."
- Know that you don't have to answer questions that are offensive or too personal. "I just don't feel I can talk about that."

**Resource**

*PACA Idea Book—Participatory Analysis for Community Action*, Peace Corps: Washington, DC, 2005. [ICE No. M0086] See the section on Facilitation which includes "Dealing with Difficult Group Members" pages 70-74.

## Guidelines for Expert Speakers

Note: Modify to make appropriate to your setting.

Thank you for agreeing to assist the Peace Corps in preparing Volunteers to work in areas and with people infected with and affected by HIV/AIDS.

The goal of this session is to provide participants with knowledge relating to specific aspects of mitigation and care for people living with HIV/AIDS, their families and communities. In a prior session they heard stories of people living with HIV/AIDS, shared their own experiences with family or friends who had critical or terminal illnesses, and discussed some of the many needs that people of different ages, sexes, and situations have to live positively with HIV/AIDS.

You will be part of a two-hour session, addressing the questions on the attached sheet and/or other related questions you think are important. Some or all of the following issues will be addressed by you, other guests, or through research.

- Voluntary counseling and testing
- Antiretroviral drugs for HIV/AIDS
- Care for orphans and vulnerable children
- Nutrition and HIV/AIDS
- Home-based care
- Economic security
- Spiritual issues

Please keep in mind that Peace Corps Volunteers are in communities to help build local capacity; they do not provide direct service, such as counseling patients, distributing drugs, or providing medical treatment. They may work with individuals or groups to enhance their knowledge, build skills, and develop positive attitudes toward the many tasks that help people live positively with HIV/AIDS.

We will meet for 30 minutes prior to the beginning of the session to discuss the specific format of your information sharing. We look forward to the expertise you will bring to this training session!

## Part III Activity: True or False Activity Statements

Instructions: Place signs “True” and “False” at either end of the room with the “Not Sure” in between so that people can go there as they consider their responses. Read a statement and ask participants to go stand near the “True,” “False,” or “Not Sure” sign. Then ask people why they believe the statement is true or false. Facilitate a brief discussion.

While some statements should elicit a clear “true” or “false,” others may not, particularly given what participants have learned about the local context and how HIV/AIDS is currently being addressed. Discussion is useful for helping participants think about putting into practice what they have learned. The following statements can be used or others developed.

Statement	True/False/Not Sure
<i>Home-based care is a critical aspect of services related to mitigating the impact of HIV/AIDS and/or caring for people living with AIDS.</i>	<b>TRUE</b> Other services include the cultivation of low-labor input crops, improving basic water and sanitation facilities and services, and peer psychosocial support through the establishment of support groups of people living with HIV/AIDS.
<i>If funding is limited, it would be better to develop orphanages to care for large numbers of orphans rather than focusing on increasing the capacity of extended families and communities to care for orphans.</i>	<b>FALSE</b> According to USAID, care in institutional settings often fails to meet the developmental needs of children. <sup>1</sup> To the extent possible, the care for orphans and vulnerable children should be kept in the village in a family setting. Assistance may need to be provided for overburdened caregivers who may be elderly and/or for some other reason unable to fully provide care for many children in their home.
<i>A critical component of strengthening a family's ability to care for orphans and vulnerable children is providing income-generating skills and resources.</i>	<b>TRUE</b> One effect of HIV/AIDS on a household is the lack of income from the sick or dying family member. In this situation, other family members, usually children, must somehow find a way to support the remaining family members. They usually leave school and search for whatever work is available. Income-generating skills and life skills are critical for the millions of youth facing this situation today.
<i>It is always a good idea to talk to a person living with HIV/AIDS about spiritual issues.</i>	<b>FALSE</b> This really depends on the world view of the person, and if it is important to them to do so, in the context of their culture, age, and spiritual life up to this point. The person may bring this up on his or her own. Keep in mind that there may be cultural taboos against this, and one must be sensitive to the needs and interests of the person infected.
<i>A good Peace Corps activity related to mitigation might be to create a demonstration community garden where new high-yield, low-labor crops can be introduced.</i>	<b>TRUE</b> Improving nutrition and decreasing the dependency on physically exerting work (such as walking many miles to farm) can help people living with HIV/AIDS live more healthy and positively.
<i>Nutrition is not important in mitigating the immune weakening effects of HIV.</i>	<b>FALSE</b> A healthy balanced diet is essential in helping the body keep up its defenses and therefore keep the viral load from going up. A weaker immune system could make HIV progress more rapidly to full blown AIDS.

Statement	True/False/Not Sure
<i>An appropriate role for a Volunteer in a high prevalence community would be to spend most of his/her time feeding and sitting with people in the last stages of life.</i>	<b>FALSE</b> This would be seen as direct care. The role of the Volunteer should be to provide assistance indirectly—through training and capacity building of those who do provide the direct services, such as health committee workers or home-based care providers.
<i>Once a person is diagnosed as HIV-positive the most important issues are treatment related.</i>	<b>TRUE AND FALSE</b> Treatment-related issues, such as accessing antiretroviral medicines and/or holistic methods are important, but also very important are prevention, nutrition, social/emotional/psychological issues, etc. If the focus is made entirely on ARV therapy then people will think that there is nothing in their control they can do to alleviate symptoms.
<i>Traditional healers are not good sources of care for AIDS-related issues.</i>	<b>TRUE AND FALSE</b> In general, traditional healers can be excellent sources of treatment for a range of symptoms and illnesses associated with AIDS and for psychological and spiritual care. However, in some places healers continue to utilize practices that could contribute to the transmission of HIV, e.g., cutting the skin to rub in medicines and using the same blade from person to person, or providing incorrect information about HIV/AIDS. If they are sensitized and mobilized, they can be great advocates for voluntary counseling and testing and home-based care.
<i>Voluntary counseling and testing can be an excellent point of entry for other HIV/AIDS services.</i>	<b>TRUE</b> Although not always the case, voluntary counseling and testing centers can sometimes have other related services available such as testing for STIs, reproductive health services, and assistance in getting ARV therapy. Also voluntary counseling and testing centers can refer people to care-related services such as people living with HIV/AIDS support groups and home-based care programs that link with social service agencies.
<i>If there are no HIV/AIDS programs or services in a community a good idea would be to work towards establishing a center for voluntary counseling and testing as a starting place.</i>	<b>TRUE AND FALSE</b> Not necessarily. There are many activities that can take place without the existence of a voluntary counseling and testing center, such as awareness-raising and prevention education campaigns and activities such as youth clubs and stigma-reduction activities. At some point however, once the demand has grown for these services, it would be beneficial to have one in town or nearby so that people can have easy access to those services.

**Resource:** Fact Sheet, *Children Affected by HIV/AIDS*, USAID: Washington, DC.

# Handout A: Guiding Questions for Discussions with Experts

## Health and medical issues

What health and medical services are needed, who are the providers (family, community-based providers, medical personnel, traditional healers, other) and where should services be provided (e.g., home or clinic/hospital)?

What symptoms and illnesses are significant for people living with HIV/AIDS?

For family and home-based care providers

- What knowledge and skills are needed?
- How can a Volunteer assess gaps in knowledge and skills?
- What are training priorities?
- What treatments should caregivers be able to administer?

What model(s) of home-based care is (are) most effective and why?

What is the role of voluntary counseling and testing in the overall service delivery system addressing HIV/AIDS?

What are appropriate models of voluntary counseling and testing centers?

What is the role of antiretroviral therapy? How can a person with HIV/AIDS live positively in the absence of antiretroviral therapy (if relevant)?

What is highly active antiretroviral therapy (HAART)?

What are the challenges relating to antiretroviral therapy—for people living with HIV/AIDS and for the health-care system?

What is the role of palliative care and how is it delivered within the local context?

What are some of the physical manifestations of the dying process and how can people living with HIV/AIDS, family members, and caretakers be prepared to address these?

What kinds of health and medical systems are currently in place to address the needs of people living with HIV/AIDS?

## Social/Emotional/Psychological issues

What kinds of social, emotional, and psychological supports are needed for people living with HIV/AIDS? Who are the appropriate providers of each type of support—family, other caregivers, medical and mental health professionals, organizations/institutions, traditional healers, others?

What is the role of voluntary counseling and testing in terms of the emotional and psychological well-being of people living with HIV/AIDS?

What are the issues relating to disclosure of HIV status—to family members, friends, and community?

What are some of the meaningful work (paid or voluntary) opportunities for people living with HIV/AIDS and how can these opportunities be expanded in a community?

How can support groups and other kinds of social networks for people living with HIV/AIDS be organized and facilitated?

How can stigma be addressed to alleviate fears and experiences of discrimination by those unsure of their HIV status, people living with HIV/AIDS, their families, and others?

How can people living with HIV/AIDS, family members, and caretakers be prepared to address the emotional and psychological aspects of the dying process?

What is currently in place to address social, economic, and psychological needs of people living with HIV/AIDS and their families?

## Orphans and vulnerable children

How are orphans and vulnerable children defined in the local context?

What are the unique aspects of HIV/AIDS stigma and discrimination for orphans and vulnerable children?

What are the other problems faced by orphans and vulnerable children?

What does “vulnerable household” mean? Why do so many households in high-prevalence countries face poverty and hunger?

How can the capacity of children themselves, extended families, and communities be strengthened to address the needs of orphans and vulnerable children?

What kinds of government policy and legal frameworks are needed to provide protection and care for orphans and vulnerable children?

What kinds of community-based responses can address issues faced by orphans and vulnerable children and their families?

What community assets and resources can be used to respond to orphans and vulnerable children needs?

What is currently in place to address needs of orphans and vulnerable children?

### **Spiritual issues**

What are the cultural norms related to discussing death and dying, religious, and spiritual beliefs?

What/who are resources for spiritual care and support?

Are spirituality and religion always connected in the local culture?

How should a Volunteer discuss spirituality and/or religious beliefs?

What skills/knowledge are needed to provide appropriate spiritual support?

What is currently in place to address spiritual needs of those impacted by HIV/AIDS?

### **Economic security issues**

In what ways does HIV/AIDS create reductions in the labor force?

How does HIV/AIDS create impoverished families and communities?

What kinds of labor-saving strategies can a family/community use to enhance economic (and food) security?

What are some cash- and asset-management strategies that can be used to help households improve their economic security?

What are the roles of micro-enterprise and small loan programs in helping people living with HIV/AIDS and their families achieve economic security?

What kinds of skills are needed to expand income-generating options and how can people access these?

How can traditional practices/customs and laws be modified to mitigate the impact of HIV/AIDS? For example: costly funeral practices, land tenure/ownership that may negatively impact widows, orphans and their caretakers, etc.

What is currently in place to address economic needs of those impacted by HIV/AIDS?

### **Nutrition and food security issues**

What is the inter-relationship between nutrition and HIV progression?

What are the nutritional needs of people living with HIV/AIDS and why is malnutrition such a significant issue?

What is the role of vitamins and minerals and what are local sources of these nutrients?

How does HIV/AIDS contribute to a reduction in labor productivity and how does this affect nutrition?

How can new or improved agricultural practices save labor and improve the quantity and nutrient-quality of crops?

Are there indigenous wild foods that have been forgotten or neglected that can be utilized?

What other strategies can be used to mitigate the labor shortages that impact food production—both for cash crops and crops for food consumption?

What is currently in place to address the nutritional needs of those affected by HIV/AIDS?



## Handout B: Care for Orphans and Vulnerable Children

### FACT SHEET This information is provided courtesy of Family Health International (FHI).

The impact of HIV/AIDS on children and their families is not a simple problem with an easy solution. The current situation is complex, interrelated on all levels of life, and cuts across all sectors of development. State-of-the-art components for the care and support of orphans and other vulnerable children have evolved from lessons learned in various countries and experiences from development, child survival, children of war, and other HIV/AIDS-related programs. These lessons include

**Policy and law** Appropriate government policies are essential to protect orphans and other vulnerable children and their families. These policies must contain clauses to prohibit discrimination in access to medical services, education, employment, and housing, and protect the inheritance rights of widows and orphans.

**Medical care** For the maximum well-being of orphans and other vulnerable children, they and their guardians need to have access to complete, relevant information and appropriate health care including clinical and preventive health-care services, nutritional support, palliative and home-based care.

**Socioeconomic support** Orphans and other vulnerable children and their families are confronted with severe threats to their well-being including isolation, loss of income, educational access, shelter, nutrition, and other essentials. When families and children are forced to focus on basic daily needs to decrease their suffering, attention is diverted from factors that contribute to long-term health and well-being.

**Psychological support** The psychological needs of children continue to be one of the most neglected areas of support. But the AIDS pandemic has increased the urgency to address the psychological problems of children on a par with other interventions.

**Education** Education plays a vital role in the well-being of children. It offers them a chance for their future as well as developmental stimuli. The impact of HIV/AIDS on the educational system has resulted

in a decreasing number of teachers due to mortality, a growing number of children who are not able to attend or stay in school, and rising numbers of pupils whose ability to take advantage of schooling is undermined by other factors including poor nutrition and psychological stress.

**Human rights** Human rights-based approaches have been increasingly recognized as essential to the success of HIV prevention and care programs, including those working with children and adolescents. Especially important are those tenets outlined in the convention of the rights of the child.

**Community-based programs** There is agreement on the components of community-based programs for orphans and other vulnerable children. Prioritizing program activities will depend upon community needs, abilities, and preferences, as well as on the nature of sponsoring or partner organizations. The community is best able to identify target groups for interventions, although the government may wish to select target regions or communities for program implementation.

**Emphasizing community care rather than institutional care** Long-term institutionalization of children in orphanages and other facilities is not a desirable solution to the impacts of HIV/AIDS. Resources expended to fund institutional care for a single child can assist scores of children if used effectively to support a community-based initiative. The institutionalization of children separates them from families and communities and often delays healthy childhood development.

**Strengthening the care and coping capacities of families and communities** The first line of response to the needs of children affected by HIV/AIDS comes from extended families. Strengthening the capacity of communities to fill the widening gaps in the safety net traditionally provided by the extended family may be the most efficient, cost-effective, and sustainable way of assisting orphans and other vulnerable children. Families and communities also play a crucial role in identifying children who are most in need, both those affected by HIV/AIDS and other vulnerable children.

**Involving children and youth as part of the solution, not part of the problem** Children are not simply a passive, powerless target group to be aided, but capable actors and important resources to engage in a community response to HIV/AIDS. Actively involving children in care initiatives can build their sense of self-esteem and efficacy and cultivate skills they can use in the future.

**Building broad collaboration among key stakeholders in all sectors** To meet the needs of children affected by HIV/AIDS, there have to be broad networks and targeted advocacy to involve government, civil society, and nongovernmental organizations in shared initiatives of community action for orphans and other vulnerable children.

**Application of long-term perspective** Children will continue to be affected by AIDS for decades to come. Due to the scope and scale of the pandemic, program design requires sustainable and replicable approaches. Although material assistance is important, it is also important to ensure that community projects are not driven by material support alone but by ownership and responsibility.

**Integration with other services** Since the problems experienced by orphans and other vulnerable children begin well before the death of their parents, care for children affected by HIV/AIDS should start at the earliest possible point. Services for orphans and other vulnerable children should be integrated with the elements of comprehensive care such as a voluntary counseling and testing for HIV, prevention of mother-to-child-transmission of HIV, and others.

**Linking care and prevention** Orphans and other vulnerable children are themselves at high risk of HIV infection due to economic hardship and loss of parental care and protection. For this reason alone, care programs should include a strong prevention component targeting children and youth.

#### Source

Family Health International. "Care for Orphans, Children affected by HI/AIDS, and Other Vulnerable Children," <http://www.FHI.org/en/HIVAIDS/pub/fact/carorphans.htm>, (accessed April 4, 2007).

#### Resource

PEPFAR. "Orphans and Other Vulnerable Children Programming Guidance," July, 2006, <http://www.state.gov/documents/organization/75356.pdf>, (accessed April 4, 2007).

# Handout C: Antiretroviral Drugs for HIV/AIDS

## FACT SHEET

International (FHI).

*This fact sheet is based on information summarized from Family Health*

### Safe and effective introduction of antiretroviral (ARV) drugs for HIV/AIDS

The introduction of antiretroviral drugs as part of HIV clinical care has made AIDS more of a manageable chronic illness with restored economic productivity and social functioning. But these effects have been seen only in settings where resources were available to make the drugs affordable and there are health service capacities to optimize their sustained, safe and effective use. There are multiple requirements for such an effect that can be grouped into three areas: (1) the drugs, (2) the client, and (3) the health system.

### Antiretroviral drugs

A dramatic reduction in viral load (the level of virus in the blood) with resulting arrest in immune damage is achieved by combining at least three drugs from the various classes of antiretroviral drugs into a “cocktail.” This three-drug cocktail is called “Highly Active Antiretroviral Therapy” (HAART). Each class of anti-HIV drugs attacks the virus at a different stage of replication while it is growing in the human cell. Drug-related issues that influence their use include the following

- All ARVs are still costly, even with recent dramatic price reductions, when compared to sexually transmitted disease (STD) or tuberculosis (TB) drugs, for example. However, many resource-poor countries are benefiting from worldwide efforts, such as the President’s Emergency Plan for AIDS Relief (PEPFAR), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund), to expand drug availability.
- Side effects of the drugs are common and need to be clinically monitored. Side effects may lead to stopping or changing the drug, or making lifestyle or diet changes.
- HIV can easily become resistant to ARVs, hence the need to combine different kinds of ARVs to treat patients.
- Some ARVs interact with other drugs commonly used in the treatment of opportunistic diseases such as tuberculosis and fungal infections. This requires adjusting the dosage of the drugs and careful monitoring of the patient.
- Many ARVs have strict medication schedules or storage requirements (although medical advances are developing new drugs and drug combinations to make them easier to take with fewer side effects).
- ARVs must be taken for a lifetime if AIDS is to be a manageable chronic illness. It requires a lifelong relationship between client and the health team.

### The client on ARV

Adherence (also called compliance or concurrence) to ARV therapy is crucial for effective results, and lessens the chance that HIV will become resistant to ARVs. The following are issues from the client’s perspective that should be considered and incorporated in planning

- Starting ARVs is a commitment to lifelong medication and entails enduring an initial period of unpleasant side effects. It also requires identifying financial resources necessary for regular medical visits, costs of laboratory tests and treatment costs. The self-discipline and financial burden associated with ARVs should be discussed at the start of treatment.
- Continuous drug information and counseling by the health-care provider is important for adherence.
- There should be links between drug treatment, home-based care, and palliative care.
- ARVs may create a false hope of safety among users and may result in increased high-risk behavior. Services should include ongoing counseling about the need to continue protective action for clients and their sexual partners.
- ARVs are neither a cure nor a preventive tool. Information and education for communities and society on the realities of ARV use should also be in place.

## The health systems

To optimize the benefits of ARVs for greatly reduced morbidity, mortality, and improved quality of life, the following need to be addressed simultaneously

- Training health teams (doctor, nurse, counselor, pharmacist, laboratory staff) in both the public and private sectors, with regular updates on treatment and care options.
- Reorganizing services to integrate HIV care in outpatient departments and at health centers to allow for space, privacy, and time and links with tuberculosis Directly Observed Therapy (TB-DOT) and sexually transmitted infection (STI) programs.
- Strengthening rapid registration of new drugs and drug procurement and management systems to ensure continuous availability of the drugs and avoidance of pilferage and misuse.
- Expanding and integrating quality voluntary counseling and testing into health systems as an entry point to prevention and care.
- Strengthening and upgrading laboratory facilities. Although viral load measurements may not be essential for safe and effective use, CD4 counts or cheaper alternatives are needed to help providers and clients decide together when to start and when to switch or stop treatment. There needs to be laboratory monitoring for potential side effects.
- Communicating to the public at large on the benefits and risks of ARV treatment.
- Strengthening and scaling up comprehensive care programs (management of opportunistic infections, preventive therapies, TB-DOT, home care, palliative care, social support) to accommodate ARV use and continue to care for a majority of patients not on ARVs.
- Strengthening prevention programs to link closely with care and ARV treatment programs and reinforce the need for prevention as a primary goal within and beyond the health sector.

In summary, the good news is that ARVs are becoming a welcome addition to greatly improve the quality of life of many more people living with HIV/AIDS. All

efforts need to be made to ensure that patients can adhere and health systems can accommodate these new interventions.

## What can Peace Corps Volunteers do?

Volunteers can play an important role in ARV programs by helping to educate people living with HIV/AIDS, family, friends and other care givers about ARV compliance, benefits and risks of ARV treatment, and strengthening prevention programs that are closely linked to care and treatment activities that include ARVs. Volunteers can also advocate and facilitate the points outlined above to strengthen in-country systems for the management and distribution of ARVs.

### Source

Family Health International. "Safe and Effective Introduction of Antiretroviral (ARV) Drugs for HIV/AIDS." <http://www.fhi.org/en/HIVAIDS/pub/fact/introarv.htm> (accessed March 12, 2007).

### Resources

Panel on clinical practices for treatment of HIV infection. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. U.S. Department of Health and Human Services and the Henry J. Kaiser Foundation, January 2000.

World Health Organization. International AIDS Society and UNAIDS, Safe and Effective Use of Antiretroviral Treatments in Adults with Particular Reference to Resource Limited Settings. Geneva: WHO, 2000.

National Minority AIDS Council. <http://www.nmac.org>

The Body: The Complete HIV/AIDS Resource. <http://www.thebody.org>

AIDSinfo: HIV/AIDS Information from the U.S. Department of Health and Human Services. <http://www.hivatis.org>

Johns Hopkins AIDS Service. <http://www.hopkins-aids.edu>

# Handout D: Nutrition and HIV/AIDS

**FACT SHEET** *This Fact Sheet is based on information summarized from PEPFAR, UNAIDS, USAID and WHO.*

Proper nutrition is an important part of the overall care of people living with HIV/AIDS since it plays a vital role in improving and prolonging the quality of life of those infected and affected. A healthy diet can help to strengthen the immune system which boosts resistance to disease and infection, increases energy, allows an individual to remain productive and effectively able to contribute to family and community for as long as possible.

### What is the link between nutrition and HIV/AIDS?

There is a strong relationship between HIV and nutrition. Malnutrition leads to a weakened immune system, which allows HIV to more quickly progress to AIDS. Both HIV and malnutrition can independently cause progressive damage to the immune system and increased susceptibility to infection, morbidity, and mortality through opportunistic infections, fever, diarrhea, loss of appetite, nutrient malabsorption and weight loss. HIV **specifically** affects nutritional status by increasing energy requirements, reducing food intake, and adversely affecting nutrient absorption and metabolism.

### What is good nutrition for people living with HIV/AIDS?

Overall, good or adequate nutrition for people living with HIV/AIDS is considered the consumption of a balanced healthy diet, consisting of locally available foods

(animal foods, beans, fruits, nuts, starchy staples and vegetables), and clean water. However, depending upon the age and phase of the virus, individuals infected with HIV can require an additional energy intake of 10 percent (asymptomatic adults) to 100 percent (symptomatic children with weight loss); therefore, their nutrient requirements would be greater than those of healthy individuals.

### What are the components of a nutritional care and support program for people living with HIV/AIDS?

It is important for Volunteers to work with their counterpart(s) when implementing a nutritional care and support program. Additionally, efforts should be made to minimize any aspect that might stigmatize an individual and/or family.

#### Nutrition assessment

- Gather information about the current nutritional status and diet.
- Identify potential risk factors, as well as positive eating habits. Make sure to include: food prices, food seasonality, perceived importance of the food item, local preferences, food assistance program participation, access to clean water sources, and other relevant data. If possible, ascertain the nutritional value of foods most easily accessible and/or grown, and explore ways with community members to diversify the diet.
- When applicable, refer the individual for a physical assessment: measurements of weight, mid-arm circumference, height, and a calculation of body mass index.

### Energy Requirement Increases for People Living with HIV/AIDS

Population Group	Asymptomatic Phase	Symptomatic Phase
Adults	10% increase	20-30% increase
Pregnant/lactating women	10% increase (in addition to requirements of pregnancy/lactation)	20-30% increase (in addition to requirements of pregnancy/lactation)
Children	10% increase	With no weight loss: 20-30% increase. With weight loss: 50-100% increase.

### Nutrition education and counseling

Include information about

- Adequate nutrient intake
- Food safety and hygiene
- Physical activity
- Healthy lifestyle

### Symptom management

Provide people living with HIV/AIDS strategies to manage nutrition-related HIV symptoms and/or side effects: nausea, vomiting, diarrhea, anorexia, difficulty chewing/swallowing, mouth sores, and/or changes in taste.

### Nutrition management of antiretroviral therapy

- Address any drug interactions with foods, beverages, and herbs.
- Discuss the management of nutrition related to drug/medication side effects.

### Psychosocial support

Listen and allow the person living with HIV/AIDS to voice any concerns and/or emotions about his/her disease and nutritional status.

### Targeted nutritional supplements

Know what type of (if any) nutritional supplementation is provided—food rations to micronutrient supplementation.

### Other support mechanisms

Inquire about additional resources available in the community that seek to enhance nutrition and food security of individuals and families affected by HIV/AIDS.

### What can Volunteers do to help improve the nutritional status of people living with HIV/AIDS?

- Nutrition education
- Promotion of indigenous plants that boost immune system
- Incorporation of the permaculture philosophy into farming
- Support for community gardens
- Enhanced small-scale livestock production
- Hygiene and sanitation education
- Promote access to clean water sources

### Resources

Executive summary of a scientific review, WHO, April 2005. UNAIDS.

Food and Nutritional Technical Assistance Project, 2004. *HIV/AIDS: A Guide for Nutritional Care and Support*. [www.fantaproject.org](http://www.fantaproject.org).

*Living Well with HIV/AIDS: A Manual for Nutritional Care and Support for People Living with HIV/AIDS*, Rome, Italy: FAO/WHO, 2002. Available at: [www.fao.org](http://www.fao.org).

Lwanga, Dorcas (2004) "Nutritional needs of People Living with HIV/AIDS: Technical Issues for Nutrition Care and Support." *Nutrition and HIV/AIDS: Opportunities and Challenges*. Support for Analysis and Research in Africa (SARA) Project, USAID.

Nutrient Requirements for People Living with HIV/AIDS Report of a Technical Consultation, World Health Organization, Geneva, 13-15 May 2003. Website: [http://www.who.int/nutrition/publications/Content\\_nutrient\\_requirements.pdf](http://www.who.int/nutrition/publications/Content_nutrient_requirements.pdf)

Piwoz, Ellen et al (2004) "Nutrition and HIV/AIDS: Evidence, Gaps, and Priority Actions." *Support Analysis and Research in Africa (SARA) Project*, USAID.

*Policy Guidance on the Use of Emergency Plan Funds to Address Food and Nutrition Needs: President's Emergency Plan for AIDS Relief*, September, 2006. Website: <http://www.pepfar.gov/guidance/>

*Report on Food and Nutrition for People Living with HIV/AIDS*, Washington, DC: The President's Emergency Plan for AIDS Relief, May 2006. Website: <http://www.state.gov/documents/organization/66769.pdf>

## Handout E: HIV Counseling and Testing

**FACT SHEET** *This Fact Sheet is based on information summarized from Family Health International (FHI).*

Counseling and testing for HIV is now acknowledged within the international arena as an efficacious and pivotal strategy for both HIV/AIDS prevention and care. Research conducted in Kenya, Tanzania, and Trinidad by Family Health International in collaboration with UNAIDS, WHO, and the Center for AIDS Prevention Studies at the University of California at San Francisco has provided strong evidence to support the tenet that counseling and testing is both effective and cost-effective as a strategy for facilitating behavior change. Counseling and testing is also an important entry point for care and support. These findings have boosted interest and support for counseling and testing as a valuable component of a comprehensive HIV/AIDS program among international organizations including the National AIDS Programs of many countries and donors.

The **rationale** for counseling and testing can be summarized by the following four points

1. Counseling and testing is more than drawing and testing blood and offering a few counseling sessions. It is a vital point of entry to other HIV/AIDS services including prevention of mother-to-child transmission; prevention and clinical management of HIV-related illnesses, tuberculosis control, and psychosocial and legal support.
2. There is demand (i.e. people want to know their HIV serostatus), or demand can be created when comprehensive services are made available.
3. Counseling and testing provides benefits for those who test positive as well as those who test negative. Counseling and testing alleviates anxiety, increases client's perception of their vulnerability to HIV, promotes behavioral change, facilitates early referral for care and support including access to antiretroviral therapy and assists reduction of stigma in the community.

4. Counseling and testing offers a holistic approach that can address HIV in the broader context of peoples' lives, including the context of poverty and its relationship to risk practice.

Several lessons have been learned from experience in counseling and testing programming to date and include

- Counseling and testing is a service that can be offered by government, nongovernment, community, and private sectors.
- The gold standard for counseling and testing follows a regimen of pre-test counseling, testing (as desired by the client and after informed consent is provided), and post-test counseling (which may involve one or more sessions depending on the client's needs). Individual risk assessment and risk reduction planning are integral components of pre- and post-test counseling.
- A range of innovative service delivery models can be applied depending on the context. Models include variations on integration within the existing health facilities, freestanding, and mobile services.
- The model of choice must ensure adequate cost consideration to guarantee sustainability of services. Service sustainability still remains a challenge in many settings, especially within non-integrated sites in which initial start-up costs are often provided by external international donors.
- Counseling and testing is a public health intervention, so governments and donors will need to subsume some of the associated costs to ensure the widest possible access.
- National HIV/AIDS policies and strategies should ensure adequate coverage of counseling and testing services and set national service provision standards.
- Counseling and testing must be accessible and affordable for those at highest risk of HIV infection or those suspected to have HIV-related illness. These services should be available to the range of clients who may benefit from knowing their HIV serostatus including couples, individuals, and young people.

- Sites must be adequately staffed by individuals with high-quality training in counseling and testing practices.
- Management of sites must support staff to sustain high quality service provision, retain skilled staff, and prevent burnout of the counselors.
- Counseling and testing for couples must be widely encouraged and promoted. Couple pre- and post-test counseling has significant benefits for addressing risk assessment and risk reduction planning—in particular for women in countries where there is substantial gender inequity. In addition, it is well acknowledged that targeting couples is cost-efficient.
- Counseling and testing design must address service promotion within the planning and establishment of high-quality services. This includes identifying or strengthening other care and support services, community, and hospital referral networks.
- The design and establishment of counseling and testing services must be tailored to the unique epidemiological, behavioral, and socioeconomic context of each country and setting. Such designs must also take into account stigma reduction and demand creation interventions.
- In developing new sites or scaling up existing sites, a coordinated response by all stakeholders—including partnerships between donors, government and nongovernmental organizations—is crucial to ensure a standardization of services in terms of quality of care and support offered to clients and avoid duplication of services within regions.
- Monitoring and evaluation systems should be established from the onset for both counseling and testing components. Counseling and testing protocols may vary from one program to another based on the goals and objectives of the program. But whatever the approach taken, the intervention must be regularly evaluated to determine whether it is provided in accordance with the pre-determined protocol and satisfies client needs.
- Innovative approaches to counseling and testing that respond to country-specific needs should be developed. These include services for adolescents, and the integration of VCT practices within antenatal sites that might employ group pre-test information sessions in settings with high client load as part of a comprehensive strategy for prevention of mother-to-child transmission.

### **“Opt-out” or routine counseling and testing**

In a traditional, or “opt-in” approach to HIV counseling and testing, a patient is given pre- HIV test counseling, and must agree to getting an HIV test, usually in writing. Over the past years, several countries have integrated HIV counseling and testing into the routine package of health service- an “opt-out” approach. Patients are told that an HIV test will be included in the standard group of tests, and they are given the option to decline the test. Unless they decline, they will receive an HIV test. The “opt-out” approach has led to an increased number of people getting tested for HIV, and is particularly effective in settings such as pre-natal clinics and TB clinics, where a critical opportunity exists to reduce HIV transmission from mothers to babies, and treat people who may be showing the first signs of HIV progression.

#### **Source**

Family Health International. “Counseling and Testing for HIV.” <http://www.FHI.org/en/HIVAIDS/pub/fact/vctforhiv.htm> (accessed May 8, 2007).

#### **Resources**

Current Issues in HIV Counseling and Testing in South and South-east Asia. Horizons Project/IMPACT Project. 2000.

VCT Counseling Training Manual. FHI.

Evaluating HIV Counseling and Testing in Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A Handbook for Program Managers and Decision-Makers. Family Health International. (Available in September 2001).

Efficacy of voluntary HIV-1 counseling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomized trial. The Voluntary HIV-Counseling and Testing Efficacy group. *The Lancet*, July 8, 2000.

Cost-effectiveness of voluntary HIV-1 counseling and testing in reducing sexual transmission of HIV-1 Kenya and Tanzania. Sweat et al. *The Lancet*, July 8, 2000.

UNAIDS. Caring for carers: Managing stress in those who care for people with HIV and AIDS. UNAIDS Case Study. 2000.

UNAIDS. The impact of Voluntary Counseling and Testing—A global review of the benefits and challenges. UNAIDS Best Practice Collection. June 2001.

UNAIDS. Tools for Evaluating Voluntary Counseling and Testing. UNAIDS Best Practice Collection. May 2000.

WHO: Voluntary Counseling and testing for HIV infection in antenatal Care. Practical considerations for implementation. WHO/HIS/00.05, Geneva. September, 1999.



## Handout F: HIV/AIDS and Economic Security

**FACT SHEET** *This Fact Sheet is based on information summarized from UN, UNICEF, and WHO.*

HIV/AIDS has taken a huge toll on the economic security of individuals, families, and communities, with a disproportionate impact on those who are already living in poverty, and on women and girls.

### What is the relationship between poverty and HIV/AIDS?

HIV/AIDS contributes to poverty and poverty contributes to HIV. This two-way relationship is complex and not well understood. What is known includes the following

- HIV/AIDS decreases a family's and community's available labor pool and HIV/AIDS often strikes those with the most income-generating potential. Food security is particularly threatened.
- Providing for the needs of those infected with and affected by HIV/AIDS (ranging from medications to funerals) costs time, money, and human and material resources further impoverishing families and communities.
- Families already living in difficult circumstances may be forced into caring for orphans and children of sick or dying relatives.
- Families may be forced to deplete savings, sell assets, reduce consumption, remove children from school, send children to work, to be able to make ends meet—all strategies that put family members at increased risk from both HIV/AIDS and poverty.
- Stigma and discrimination affect the income-generating potential of people living with HIV/AIDS.
- Malnutrition leads to a weakened immune system, which allows HIV to more quickly progress to AIDS. According to one researcher: "HIV prevalence is highly correlated with falling calorie consumption, falling protein consumption, unequal distribution of income and other variables conventionally associated with susceptibility to infectious disease, however transmitted" (Stillwagon, 2001).

- Poverty in developing countries has exacerbated global economic inequalities and increased the vulnerability of these countries to HIV/AIDS, both in terms of infection and impact.
- Diminished resources for social spending, such as health care and education, increase the vulnerability and risk of a population—with women impacted more than men.

### How are women and girls disproportionately affected?

Women and children, particularly girls, are disproportionately affected by HIV/AIDS for many reasons, including their biological vulnerability to becoming infected, their limited power, status and control over their own bodies, and because they often lack economic independence. Factors relating to economic security include

- Women and girls may have less education and less access to jobs.
- Women may not have access to family assets.
- Women and girls may be subject to unequal inheritance and property rights.
- Women and girls are relied on as caretakers of those who are sick or dying, often preventing them from engaging in the work/school activities that would increase their ability to generate income.
- Economic dependence may prevent a woman from leaving a relationship that puts her at risk for HIV.
- Women and girls may engage in sex to provide for their families, putting them at even higher risk for HIV.

### What strategies can be used to increase economic security?

Strategies to improve economic security include the following

- Mainstreaming HIV/AIDS into national poverty-reduction strategies to ensure a multi-sectoral scaled-up response that addresses the specific needs associated with HIV/AIDS.

- Addressing gender inequalities by improving access by girls and women to education, health care, job training, and employment opportunities.
- Policy development to ensure the rights of children, particularly girls, and women to inherit property, as well as to eradicate other forms of legal gender discrimination.
- Improving the nutritional status of communities through improved food quality and quantity, development of low input agricultural techniques, and improved access to high-quality food sources for those at risk.
- Improving a community's capacity to address the needs of people living with HIV/AIDS, orphans and vulnerable children, and others affected by HIV/AIDS so that it can serve as a "safety net" for families unable to cope financially. This may include providing services to help families care for those who are sick (through cooperative home-based or center-based care and respite), establishing funds for orphans, and ways to pay for funeral costs (i.e. co-operative burial societies).
- Improve the capacity of households to address their financial needs now and in the future through strategies including improving/promoting

#### **Income-generating skills**

#### **Opportunities for employment**

#### **Access to microfinance**

#### **Savings plans**

#### **Help for caregivers so they can go to school/work**

### **What can Peace Corps Volunteers do?**

Peace Corps Volunteers can address the need for economic security in an endless number of ways. Projects that focus on increasing the capacity of households and communities to increase the yield of high-quality food, to generate income, to provide care for people living with HIV/AIDS, to address the costs for families who care for people living with HIV/AIDS, orphans and vulnerable children, to provide respite for caretakers, and to address the needs of the dead all address economic security. Volunteers can work with community members to plan, identify and develop the linkages among community organizations, provide training, and assist setting up monitoring and evaluation systems. Projects should target the entire community and Volunteers should be cognizant of not singling out people living with HIV/AIDS who may be targets of stigma and discrimination.

### **Resources**

Barnett, Tony and Alan Whiteside. "Poverty and HIV/AIDS: Impact, Coping and Mitigation Policy", Chapter 11 in *AIDS, Public Policy and Child Well-Being*, Florence, Italy: UNICEF Innocenti Research Centre, 2002.

Björkman, Håkan, *HIV/AIDS and Poverty Reduction Strategies, Policy Note*, Bureau for Development Policy, United Nations Development Programme, 2002.

Stillwagon, E. "HIV Transmission in Latin America: Comparison with Africa and Policy Implications", in *South African Journal of Economics*, vol. 68(5), 2000, pp. 985-1011.

Sy, Elhadj. "Gender, HIV/AIDS, and Human Security." <http://www.un.org/womenwatch/daw/csw/Sy2001.htm> (accessed May 8, 2007).

*Women, Girls, HIV/AIDS – Advocacy Note, World AIDS Day Campaign 2004*, Philippines: Western Pacific Regional Office, World Health Organization.

# Handout G: Supporting People with HIV/AIDS/ Community Home-Based Care

## FACT SHEET

*This Fact Sheet is based on information summarized from Centre for Development and Population Activities, Family Health International, Pathfinder International and PEPFAR.*

There is an increasing awareness across the globe that community home-based care is a critical component of the full array of services needed to address the needs of people living with HIV/AIDS. Home-based care may be low-tech and is cost-efficient, allowing for the scaling up of services, and an effective means of promoting positive living for people living with HIV/AIDS. Home-based care may be more culturally accepted and accessible than other forms of care.

### What is community home-based care?

Community home-based care (CHBC) addresses the range of needs of people living with HIV/AIDS and their families, including services relating to medical and health needs, social/emotional and psychological support, economic security, orphans and vulnerable children, nutrition and food security, as well as addressing prevention and stigma and discrimination.

There are many different models of home-based care, including the following

- Facility-based or outreach: A hospital or other facility may send health-care workers to visit patients and their families in their homes, with a focus on health and medical needs, although it may include broader types of support also.
- Community-based model: Typically this is staffed by community-based volunteers who provide basic nursing care to people living with HIV/AIDS, and who address other needs, including social and psychological, economic and spiritual needs. This model is cost-efficient but it may be challenging to keep volunteers engaged and skill levels may vary considerably.
- Integrated model: A local hospital or other health facility may provide the training, support, and supplies for community-based providers of home care.

- Community day-care model: This can operate as a center where people living with HIV/AIDS come each day for a few hours to receive a variety of services, while at the same time providing respite to caregivers.

### What are the key characteristics of home-based care programs?

Successful home-based care programs exhibit the following key characteristics.

- Uphold the rights and dignity of people infected and affected by HIV/AIDS.
- Ensure involvement and active participation of family and community members, particularly people living with HIV/AIDS and affected children.
- Provide for equal partnership and mutual respect between the community and the facilitating NGO/CBO or government department.
- Improve quality of life of infected and affected family and community members, for example affected children, elderly parents, and the immediate bereaved family.
- Build capacity and ensure continued momentum.
- Build on the realities of living with HIV/AIDS while maintaining hope based on community collective action.
- Maximize community use of community resources and mechanisms while identifying and using additional external ones as needed.

### What do community home-based care programs do?

As stated above, home-based care programs provide a comprehensive range of care and support services and referrals for people living with HIV/AIDS and their families. These can include

- Prevention for the patient and caregivers, including supplies such as condoms and sanitizing solutions or bleach.
- Basic care and treatment of symptoms, including diarrhea, vomiting, pain, fever, mouth and throat, genital problems, etc.

- Basic nursing care, including bathing, skin care, wound cleansing, positioning, oral hygiene, nutritional guidance, etc.
- Managing antiretroviral treatment regimens.
- Identification and treatment of opportunistic infections.
- Provision of referrals for the range of care and support needed, along with the establishment of mechanisms for follow up.
- Palliative care.
- Psychosocial support and counseling for people living with HIV/AIDS, family, and other caregivers.
- Establishment of income-generating activities.
- Addressing concerns about children.
- Care, support, and planning for orphans and vulnerable children.
- Care for affected and infected children.
- Referrals for legal assistance.
- Spiritual support.

CHBC programs assess patients in their homes and help them and their families establish and maintain effective care and support plans. CHBC programs help the family set realistic goals, establish linkages to other programs for services needed, and help build the capacity of family and other caretakers.

CHBC programs rely on family and community members. By engaging people at this level CHBC programs promote information and education about HIV/AIDS, thereby promoting prevention, addressing stigma relating to HIV/AIDS and discrimination against people living with HIV/AIDS and encouraging voluntary counseling and testing for HIV.

### What can Peace Corps Volunteers do?

Peace Corps Volunteers can play significant roles by helping communities who do not have a community home-based care program learn about and develop a strategic plan to create one. In communities with an existing program Volunteers can work with counterparts to develop training programs, curricula, and other materials for training of CHBC volunteers, family members, and/or staff; by helping community organizations and medical providers develop effective referral and service networks; by providing training relating to the role of information technology in record keeping, fiscal management, program planning and implementation and evaluation; and by providing assistance developing monitoring and evaluation for programs.

### Resources

- Callahan, Kathy, MA and Laurette Cucuzza, MPH, *Home Care for People Living with HIV/AIDS: The Power of Our Community*. Washington, DC: Centre for Development and Population Activities, 2003.
- Community Home-Based Care, HIV/AIDS Fact Sheet*, Pathfinder International, 2004.
- HIV/AIDS Care and Treatment: A Clinical Course for People Caring for Persons Living with HIV/AIDS*, Arlington, VA: Family Health International and IMPACT, 2004.
- PEPFAR “HIV/AIDS Palliative Care Guidance #1, For the United States Government In-Country Staff And Implementing Partners,” February 2006. <http://www.state.gov/documents/organization/64416.pdf> (accessed May 8, 2007).

# Handout H: Spirituality and Treatment of People Living with HIV

**FACT SHEET** *This Fact Sheet is based on information excerpted from HRSA Care ACTION: Providing HIV/AIDS Care in a Changing Environment, February 2002.*

As if the physical challenges of HIV/AIDS were not hard enough, infection with the virus also raises the difficult spiritual questions that confront most people with life-threatening illnesses: What is life about? Why is there pain and suffering? What happens when life ends? Because HIV/AIDS has been so highly stigmatized as a result of its associations with sexuality, drug use, and death, many people living with HIV/AIDS also grapple with other painful questions: Did I bring this on myself? Do I “deserve” to be cut off by my religious community because of it? Does God love me?

The way people living with HIV answer spiritual questions has profound implications for both their physical health and their health-care providers. A growing body of research shows strong connections between the way people define the “meaning” of their illness and the strength of their immune systems and their ability to cope with illness and loss—and even the likelihood that they will adhere to medical treatment as prescribed. Evidence increasingly suggests that the attitude of medical caregivers toward their patients’ spirituality has serious ramifications for the level of trust and cooperation between patient and provider—and even for the efficacy of medical care itself.

“Whether you know it or not, patients have belief systems, and they may not be stated,” says Pat Fosarelli, M.D., D.Min. Dr. Fosarelli is a pediatrician at Johns Hopkins University Medical School and professor of spirituality and practical theology at the Ecumenical Institute of St. Mary’s Seminary and University in Baltimore. She adds, “these belief systems have implications for the care you’re giving, so it’s good to find out about them.” For some people—particularly those with HIV/AIDS—Fosarelli says that “the belief systems may have something to do with God and punishment and why they are in the position they are in.”

The stigma associated with HIV/AIDS has led many people living with the disease to believe that it is a kind of divine punishment for their behavior by “a

very angry God who is just waiting until you mess up and will punish you,” as Fosarelli puts it. She points out that even young children with an HIV diagnosis may think they are being punished for something they have done. Such beliefs can have devastating consequences. “I’ve had people not want to take their medicines because [they think that] if HIV is God’s punishment for the life they live, who are they to frustrate God’s plan,” says Fosarelli.

## Care is more than just physical

Historically, Western medicine has tended to use a biomedical model of care that defines disease as a biological phenomenon. But patients increasingly want care to focus on more than their bodies—and certainly on more than a disease or constellation of symptoms. The medical system was not prepared to meet the needs of people living with HIV/AIDS, a disease that carries considerable emotional and moral “baggage.” Change has been brought about by people

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**A growing body of research shows strong connections between the way people define the “meaning” of their illness and the strength of their immune systems and their ability to cope with illness and loss.**

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living with HIV/AIDS, working in concert with care providers, to build a system of care that encompasses physical, emotional, economic, relational and, indeed, spiritual elements.

Christina Puchalski, M.D., director of the George Washington University Institute for Spirituality and Health in Washington, DC, observes that patients have become increasingly disillusioned with traditional clinical care over the past 20 years. “The biomedical model addresses biological aspects of disease, but it doesn’t focus on the whole person,” she explains. “Patients got discouraged with that because they wanted their doctor to be compassionate and understanding about their suffering.” An internist and geriatrician, Puchalski is a leading advocate of a “biopsychosocial” approach to medical care, in which

the spiritual orientation of both patient and provider matters. She defines spirituality simply as “that which gives meaning to a person’s life.” It can be a belief in God, relationships, nature, or anything else that helps people understand their lives.

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**Spiritual care addresses the major life events that cause people to question themselves, their purpose, and their meaning in life.**

**The interventions should be sensitive to the culture, religion(s), and rituals of the individual and community, and can include (but are not limited to): life review and assessment; counseling related to hopes and fears, meaning and purpose, guilt and forgiveness, and life-completion tasks.**

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Puchalski says that to provide true whole-person care—or integrative medicine, as it is increasingly called—physicians must include a “spiritual history” as part of their intake and evaluation of their patients. Puchalski has outlined four areas of questioning that can provide an effective spiritual inventory. The categories are easily remembered by the acronym FICA (see box).

“The FICA assessment is a good start,” says Puchalski. “Think of it as just getting to know your patient.” In her experience, she says: “when asking about hobbies, jobs, and significant relationships, I just ask if spirituality is important to them, what helps them cope with stress. I ask whether there are any particular rituals or beliefs that I need to know about in their health care—restrictions in diet, for example.” In her effort to gauge the patient’s strengths and supports, Puchalski says that she also finds it natural to address issues related to advance directives, such as living wills and powers of attorney.

### **Whole-Person care is good for patients and providers**

Harold G. Koenig, associate professor of psychiatry and medicine at Duke University Medical Center and founder of the Duke Center for the Study of Religion,

#### **The FICA Inventory**

The FICA Inventory uses four areas of questioning to take an effective spiritual inventory

The **faith and belief** category includes questions such as, “Do you consider yourself spiritual or religious?” If the answer is no, the physician might ask, “What gives your life meaning?”

**Importance** probes the value patients place on their faith or beliefs. Typical questions might include, “What importance does your faith or beliefs have in your life? Have your beliefs influenced how you take care of yourself in this illness?”

**Community** asks about the patient’s connections with churches, temples, mosques, or simply like-minded friends who can serve as a support system. One might ask, “Are you part of a spiritual or religious community? Is this of support to you, and how? Is there a group of people you really love or who are important to you?”

**Address in care** simply asks how patients want the first three areas addressed in their health care: “How would you like me, your health-care provider, to address these issues in your care?”

Adapted from Puchalski CM, Romer AL. “Taking a spiritual history allows clinicians to understand patients more fully.” *Journal of Palliative Medicine*, 2000; 3:129-37.

Spirituality and Health cites a large study from the University of Miami that looked at the role of spirituality and prayer in the lives and health of people who have been infected with HIV for a long time. “It really does make a difference,” says Koenig. “It is clearly connected with CD4 counts.”

The implications are potentially tremendous for people living with HIV disease. “It makes common sense,” Koenig says. “We’re not talking about something weird here. If people feel at peace spiritually, feel a connection with God, if they’re not going to be struggling as much psychologically, they will be more optimistic, and have a sense of connection.”

For Fosarelli, who has doctorates in both medicine and ministry, making connections between the spiritual and medical was a natural evolution in her career. “Children were always asking me hard questions,” she says. “Does God want me to be sick? I pray to God, why doesn’t God let me be well? Why did God let my daddy die?” Despite a Catholic education through the high school level, Fosarelli said she did not know how to handle such spiritual issues in her medical work. She thought to herself, “Maybe I could be a better doctor if I could address what was bothering people.” She pursued the second doctorate and, as she puts it, “looked at the spiritual development of people [throughout the course of] disease.”

## Resources

**The George Washington Institute for Spirituality and Health at The George Washington University Medical Center, Washington, DC**, is dedicated to fostering the benefits of spirituality and health through educational and clinical programs. <http://www.gwish.org>

**Balm in Gilead** offers resources on HIV/AIDS and spirituality focused on the needs of African Americans. <http://www.balmingilead.org/resources/spirituality.shtml>

**TheBody.com** offers articles and links related to HIV/AIDS and spirituality from a variety of religious viewpoints. <http://www.thebody.com/religion.html>

**The Mind/Body Medical Institute** is a nonprofit scientific and educational organization dedicated to the study of mind-body interactions, including the relaxation response pioneered by Herbert Benson, M.D., and his colleagues at Harvard Medical School. <http://www.mbmi.org>

**National Catholic AIDS Network** is the only national organization devoted exclusively to helping the Catholic Church and its members respond in an informed, compassionate manner to the challenges presented by HIV/AIDS. Its membership reflects the church’s diversity and includes members of the clergy, the hierarchy, religious men and women, and lay people who direct and staff Catholic educational and pastoral services. <http://www.ncan.org>

PEPFAR “HIV/AIDS Palliative Care Guidance #1, For the United States Government In-Country Staff And Implementing Partners,” February 2006. <http://www.state.gov/documents/organization/64416.pdf> (accessed May 8, 2007).





## Session Three: Putting It All Together

### Purpose

This session will provide an opportunity for participants to bring together information learned in all previous modules and apply that knowledge and those skills by identifying areas of need in HIV/AIDS mitigation and care. Participants will practice developing action plans appropriate to their roles in helping address specific gaps in services for people living with HIV/AIDS, their families, and communities.

### Rationale

The sessions in this module have raised the emotional issues around working with people living with HIV/AIDS as well as providing information on the multiple approaches to helping people living with HIV/AIDS live positively. This session provides participants with a new method of thinking through the circumstances of people living with HIV/AIDS so that they can begin to see the many places awareness raising and services might make a difference in the lives of people living with HIV/AIDS. By practicing with a case study, participants identify possible gaps in services and how they might use appropriate capacity-building roles to work with others to address those gaps.

### Target Audience

Peace Corps participants (trainees and/or Volunteers)

### Duration

1 hour and 35 minutes

### Objectives

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

1. Apply knowledge about best practices and strategies for positive living to a case study situation.
2. Create an action plan from the perspective of a Peace Corps Volunteer in a community where a specific service has been identified as needed to mitigate the effects of HIV and/or provide care to people living with HIV/AIDS.

### Session Outline

- 
- I. **Introduction** (5 minutes)
  - II. **Case Study and What If?** (45 minutes)
  - III. **Addressing the Gaps** (35 minutes)
  - IV. **Wrap up** (10 minutes)
- 

### Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- The range of needs for people living with HIV/AIDS, their families, and communities to live positively with HIV/AIDS.
- A range of best practices for prevention, behavior change, capacity building, and mitigation and care activities relating to HIV/AIDS.
- The Peace Corps' approach to development as one that builds capacity of individuals, families, and communities; uses appreciative and participatory approaches; and is gender sensitive.

### Materials and Equipment

Blank flip charts

Markers

Paper for Part II, Step 2: Two rows of flip chart paper taped end to end to create a wide and long piece of paper.

10 pebbles per participant

Prepared flip charts

1. Session Objectives
2. Small Group Task
3. Target

Activity Sheet

*Action Plan*

Handouts

*A-1. Case Studies*

What Would Have Helped Mrs. Nzalo and Her Children?

What Would Have Helped Ana?

*A-2: Case Studies*

What Would Have Helped Sara?

What Would Have Helped John and Mary?

*A-3: Case Study*

What Would Have Helped Sergei?

#### Optional Resources

Fact Sheet: Sources for HIV/AIDS Assessment Information (from Assessment Analysis and Prioritizing Activities Module, Session One)

Host Country's Strategic Plan for HIV/AIDS (if there is one)

Listing of national, regional, local organizations working on HIV/AIDS in the host country (compiled by trainer—refer to Capacity Building Module, Session Two)

List of sample capacity-building activities of Volunteers in country (compile)

### Preparation Checklist

- Read the entire session and decide if any optional activities need to be added, depending on previous training experience of the group.
- Read all of the case studies and determine (1) if “What Would Have Helped Mrs. Nzalo and Her Children?” is appropriate to use in teaching the “what if” sequence; and (2) which case study(ies) to use for the small group work, if not the same one as used in (1). If necessary, write new case studies or adapt some that are provided.
- Collect or prepare any of the optional resources.
- Prepare flip chart paper on wall for Part II, Step 2.
- Prepare flip charts.
- Copy handouts.

### Methodology

#### I. Introduction (5 minutes)

##### Welcome and introduction

**Step 1:** Welcome participants.

**Step 2:** Provide an overview of the session by reviewing flip chart 1, “Session Objectives.”

#### Session Objectives

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

1. Apply knowledge about best practices and strategies for positive living to a case study situation.
2. Create an action plan from the perspective of a Peace Corps Volunteer in a community where a specific service has been identified as needed to mitigate the effects of HIV and/or provide care to people living with HIV/AIDS.

FLIP CHART 1

**Step 3:** Ask participants to recall the content of the first two sessions in the module. (Session One focused on the stories of people living with HIV/AIDS or people living with other critical illnesses and what helps them live positively. It also dealt with participants’ [trainee/Volunteer] fears about working with people living with HIV/AIDS. Session Two provided information on the many ways people living with HIV/AIDS can be helped to live positively.

Explain that this session should help them put all this information to work.

#### II. Case Study and What If? (45 minutes)

##### Case study (10 minutes)

**Step 1:** Distribute the case study to participants, and have different individuals read the paragraphs.

If you chose one of the alternative case studies (Ana, Sara, John and Mary, or Sergei) please refer to the steps following each individual case study.

**Step 2:** Ask for a volunteer artist or two. Ask the group to imagine Mrs. Nzalo standing on her “road of life” before she contracted HIV. (Point to the long flip chart.) Imagine her at age 25 with a one-year-old and an infant at one end of the flip chart. Before her is a road with all kinds of potential. Ask artists to draw her with her children at the start of a road going along the center of flip chart to the other end.

**Step 3:** Ask the group to determine each event that happen to Mrs. Nzalo and have the artists picture them along the road.

**What if?** (30 minutes)

**Step 1:** Say, pointing at the first scene of Mrs. Nzalo, her baby, and infant

*Here is Mrs. Nzalo and her first two children before she contracted HIV.*

*Then she is raped. This is a “crossroad” in her life. What if something had been in place to help her that was not present in her community, or in her life? Let’s create a “what if” story to see how the outcome could have been different for Mrs. Nzalo and her children.*

Trainer’s note: If anyone tries to suggest the rape was caused by something she did: point out that the rape, even if we know little about it, was not her fault. A point could be made that work focused on changing male behaviors relating to violence against women might have prevented the rape.

**Step 2:** At the rape scene, have volunteer artists draw an “offshoot” road and continue following it with subsequent events and “what ifs.” Participants could take this in many different directions—there is no “right” or “wrong” way to do the exercise.

Examples

- Mrs. Nzalo is raped. After the rape, instead of telling no one, **what if** she knows about the risk of contracting HIV as a result of a rape, so she goes to a voluntary counseling and testing center, where she is given rape counseling, along with pre-testing counseling? **What if** the voluntary counseling and testing center is able to help her learn strategies that convince her husband to come for counseling and he accepts the fact of the rape? **What if** he is with her in a supportive role when she tests positive? **What if** follow-up counseling for both her and her husband gives them the opportunity to learn about how HIV can and cannot be transmitted, how to prevent his becoming infected, and how she can stay healthy and live positively with HIV/AIDS? **What if** they practice safe sex and she does not become pregnant again. **What if** because she is healthier, she lives longer and by then antiretroviral treatment has become more available in her community?  
[Put an X to entrance to this side road as none of this happened.]

- Mrs. Nzalo has another baby who becomes ill when he is five. He is tested and found to be HIV-positive. (New crossroad.) **What if** Mrs. Nzalo is tested immediately when the baby is born and learns how not to infect her child? **What if** she learns how to live positively with HIV, eating correctly, etc? **What if** there is counseling to help her husband to deal with the situation and not leave the family and get tested himself?  
[Put an X at this crossroad as none of these things happened.]

**Step 3:** Continue with other major event points, thinking about the what ifs . . .

**Summary of issues** (5 minutes)

**Step 1:** On a flip chart, ask participants to create a list of the things that were in not place to help Mrs. Nzalo, her husband, and her children.

**Step 2:** Explain that these are the kinds of “gaps” in mitigation and care that the participants may face as Volunteers. Identifying apparent gaps provides a place to begin exploring what roles they might play.

### Additional case study and what if . . . (Ana)

**Case study** (10 minutes)

**Step 1:** Distribute the case study to participants, and have different individuals read the paragraphs.

**Step 2:** Ask for a volunteer artist or two. Ask the group to imagine Ana standing on her “road of life” before she contracted HIV. (Point to the long flip chart.) Imagine her before she became frequently ill and fearful of her HIV status. Before her is a road with all kinds of potential. Ask artists to draw her at the start of a road going along the center of flip chart to the other end.

**Step 3:** Ask the group to determine each event that happen to Ana and have the artists picture them along the road.

**What if?** (30 minutes)

**Step 1:** Say, pointing at the first scene of Ana.

*Here is Ana before she contracted HIV.*

*Then she gets married, frequently fell ill, and became pregnant. This is a “crossroad” in her life. What if something had been in place to help her that was not present*

*in her community, or in her life? Let's create a "what if" story to see how the outcome could have been different for Ana and eventually her child.*

**Step 2:** At the first scene or first time that Ana falls ill, have volunteer artists draw an "offshoot" road and continue following it with subsequent events and "what ifs." Participants could take this in many different directions—there is no "right" or "wrong" way to do the exercise.

#### Example

- Ana is ill or sick. While ill or sick, instead of telling no one, **what if** she went to the local health center and discussed her illness with a health-care provider? **What if** the health-care provider takes a complete medical history, including the information about her husband's illnesses and his work in another town and is able to help Ana learn her HIV status? **What if** she is able to learn her status and speak with her husband about it? **What if** her husband gets tested too? **What if** the health-care provider is able to support the couple positively during their attempts to have a family? **What if** Ana is able to begin antiretroviral treatment during her pregnancy and delivers a baby who is HIV-negative? **What if** Ana is able to receive infant formula supplements so that she does not have to breastfeed her child?

[Put an X to entrance to this side road as none of this happened.]

**Step 3:** Continue with other major event points, thinking about the what ifs . . .

#### Summary of issues (5 minutes)

**Step 1:** On a flip chart, ask participants to create a list of the things that were in not place to help Ana, her husband, and her children.

**Step 2:** Explain that these are the kinds of "gaps" in mitigation and care that the participants may face as Volunteers. Identifying apparent gaps provides a place to begin exploring what roles they might play.

#### Additional case study and what if . . . (Sara)

##### Case study (10 minutes)

**Step 1:** Distribute the case study to participants, and have different individuals read the paragraphs.

**Step 2:** Ask for a volunteer artist or two. Ask the group to imagine Sara standing on her "road of life" before she contracted HIV. (Point to the long flip chart.)

Imagine her before she was coerced into sex with her professor. Before her is a road with all kinds of potential. Ask artists to draw her at the start of a road going along the center of flip chart to the other end.

**Step 3:** Ask the group to determine each event that happen to Sara and have the artists picture them along the road.

#### What if? (30 minutes)

**Step 1:** Say, pointing at the first scene of Sara.

*Here is Sara before she contracted HIV.*

*Then she is forced to have sex with her professor. This is a "crossroad" in her life. What if something had been in place to help her that was not present in her community, or in her life? Let's create a "what if" story to see how the outcome could have been different for Sara.*

**Step 2:** After the first time that Sara is coerced to have sex with her professor, have volunteer artists draw an "offshoot" road and continue following it with subsequent events and "what ifs." Participants could take this in many different directions—there is no "right" or "wrong" way to do the exercise.

#### Example

- Sara is forced to have sex with her professor. Instead of telling no one, **what if** she told her parents what happened and they believed her and helped her receive medical care? **What if** her parents (especially her father) confronted Professor Doe? **What if** Sara got tested for HIV as soon as she learned about HIV/AIDS in biology class? **What if** Sara told another female student what had happened to her, and learned that the other young woman had also been forced to have sex with a teacher—**what if** they felt empowered enough to talk/complain to school officials and spoke out against the offending teachers?

[Put an X to entrance to this side road as none of this happened.]

- Sara graduates, decides to get an HIV test, learns that she is HIV-positive. (New crossroad.) **What if** Sara learns how to live positively with HIV, including using consistent and correct protection during sexual intercourse? **What if** Sara is able to discuss her HIV status with the nice, young man

she has been dating before they become sexually active? **What if** there is counseling to assist Sara and her “nice young man” as they work through their relationship and any potential issues related to HIV?

[Put an X at this crossroad as none of these things happened.]

**Step 3:** Continue with other major event points, thinking about the what ifs . . .

#### Summary of issues (5 minutes)

**Step 1:** On a flip chart, ask participants to create a list of the things that were in not place to help Sara.

**Step 2:** Explain that these are the kinds of “gaps” in mitigation and care that the participants may face as Volunteers. Identifying apparent gaps provides a place to begin exploring what roles they might play.

#### Additional case study and what if . . . (John and Mary)

##### Case study (10 minutes)

**Step 1:** Distribute the case study to participants, and have different individuals read the paragraphs.

**Step 2:** Ask for a volunteer artist or two. Ask the group to imagine John and Mary standing on their “roads of life” before they contracted HIV. (Point to the long flip chart.) Imagine them before the death of Mary’s first husband, Moses. Before them is a road with all kinds of potential. Ask artists to draw them at the start of a road going along the center of flip chart to the other end.

**Step 3:** Ask the group to determine each event that happened to Mary and John and have the artists picture them along the road.

##### What if? (30 minutes)

**Step 1:** Say, pointing at the first scene of Mary and John.

*Here are Mary and John before they contracted HIV.*

*Then Mary’s husband, Moses, dies and John inherits Mary. This is a “crossroad” in their lives. What if something had been in place to help them that was not present in their community, or in their lives? Let’s create a “what if” story to see how the outcome could have been different for Mary and John*

**Step 2:** After John inherits Mary and marries her, have volunteer artists draw an “offshoot” road and continue following it with subsequent events and “what ifs.” Participants could take this in many different directions—there is no “right” or “wrong” way to do the exercise.

##### Example

- Moses, Mary’s first husband, is sick for a long time before he dies. **What if** he is tested for HIV before he dies? **What if** he learns he is positive, receives counseling and insists that Mary and their children also receive testing and counseling? **What if** John still marries Mary after Moses’ death; but because there are testing and counseling services available in their community, he is also able to get tested, learn his status and live with Mary in a positive way?

[Put an X to entrance to this side road as none of this happened.]

- Mary marries John, receives testing and counseling from the mobile clinic and decides to tell John that she is HIV-positive. (New crossroad.) **What if** when she tells John he understands and is supportive of her and her children, and even offers to get tested himself? **What if** John gets tested and is HIV-negative? **What is** John is HIV-positive? **What if** Mary and John learn how to live positively with HIV together? [

Put an X at this crossroad as none of these things happened.]

**Step 3:** Continue with other major event points, thinking about the what ifs . . .

#### Summary of issues (5 minutes)

**Step 1:** On a flip chart, ask participants to create a list of the things that were in not place to help Mary and John.

**Step 2:** Explain that these are the kinds of “gaps” in mitigation and care that the participants may face as Volunteers. Identifying apparent gaps provides a place to begin exploring what roles they might play.

#### Additional case study and what if . . . (Sergei)

##### Case study (10 minutes)

**Step 1:** Distribute the case study to participants, and have different individuals read the paragraphs.

**Step 2:** Ask for a volunteer artist or two. Ask the group to imagine Sergei standing on their “roads of life” before they contracted HIV. (Point to the long flip chart.) Imagine him before he experimented with heroin and became an addict. Before them is a road with all kinds of potential. Ask artists to draw them at the start of a road going along the center of flip chart to the other end.

**Step 3:** Ask the group to determine each event that happened to Sergei and have the artists picture them along the road.

**What if?** (30 minutes)

**Step 1:** Say, pointing at the first scene of Sergei.

*Here is Sergei before he contracted HIV.*

*Then Sergei, experiments with heroin, a highly addictive narcotic. This is a “crossroad” in his life. What if something had been in place to help him that was not present in their community, or in his life? Let’s create a “what if” story to see how the outcome could have been different for Sergei.*

**Step 2:** After Sergei begins using heroin, have the volunteer artists draw an “offshoot” road and continue following it with subsequent events and “what ifs.” Participants could take this in many different directions—there is no “right” or “wrong” way to do the exercise.

Example

- Sergei learns of a needle-exchange program at a local health center. **What if** he is able to access this program and is able to use sterile needles? **What if** he then enters a counseling program at the health center and decides to get tested for HIV? **What if** he learns that he is HIV-positive and begins living positively? **What if** he also assists his friends and they are able to enter the counseling program? **What if** the health center hires Sergei as a peer educator in their program?
- Sergei accepts his sister, Katiya’s, offer and gets a full medical exam. (New crossroad.) **What if** during his exam Sergei receives testing and counseling from the doctor and learns that he

is HIV-negative? **What if** he is positive? **What if** Sergei decides to live with Katiya, enters a drug treatment/detoxification program, begins to live positively with his HIV status and eventually is able to begin antiretroviral treatment? **What if** during this time he meets a young woman and wants to marry her?

[Put an X at this crossroad as none of these things happened.]

**Step 3:** Continue with other major event points, thinking about the what ifs . . .

**Summary of issues** (5 minutes)

**Step 1:** On a flip chart, ask participants to create a list of the things that were in not place to help Sergei.

**Step 2:** Explain that these are the kinds of “gaps” in mitigation and care that the participants may face as Volunteers. Identifying apparent gaps provides a place to begin exploring what roles they might play.

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### III. Addressing the Gaps (35 minutes)

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**Filling a gap** (5 minutes)

**Step 1:** Ask participants to identify one of the gaps from the chart they made that seems like something they might be able to help with. Write it on the top of a flip chart.

**Step 2:** Distribute the *Activity Sheet: Action Plan*. Use the questions to discuss the gap listed on the flip chart.

**Step 3:** Ask what more they would need to know about the “gap” before they could do anything about it. (*Don’t list their ideas; just have them mention them.*) (Possible answers: Learning if the service is provided anywhere in the country, how, by whom. Have there been any awareness campaigns about it? Why whom? Results? What other services are available in the community that might relate to this gap? Who is offering them? Why is this service not being addressed: lack of knowledge, no facility, lack of funds? Etc.).

*Who might they work with on such a project? (Ideas of individuals, organizations.)*

*What might be some capacity-building roles they could play in regard to this gap? (Co-trainer, co-teacher, etc.)*

### Small group assignments (15 minutes)

**Step 1:** Reveal flip chart 2, “Small Group Task.”

**Small Group Task**

1. Select one of the “gaps” in service from the case study.
2. Discuss and list how you would learn more about the gap.
3. Consider with whom you might be able to work.
4. Suggest how you might work in a capacity-building role to address the gap.

FLIP CHART 2

**Step 2:** Have participants break into small groups to work for 10 minutes.

**Step 3:** Warn groups when five minutes remain. Provide each group with a blank flip chart and markers. Ask groups to summarize their discussion.

### Report in plenary session (15 minutes)

**Step 1:** Ask each group to bring the flip chart up and briefly review its discussion. If more than one group picked the same gap, have them come to the front at the same time and add to one another’s presentation.

**Step 2:** Share with groups any additional resources you have. (Optional handouts.)

## IV. Wrap up (10 minutes)

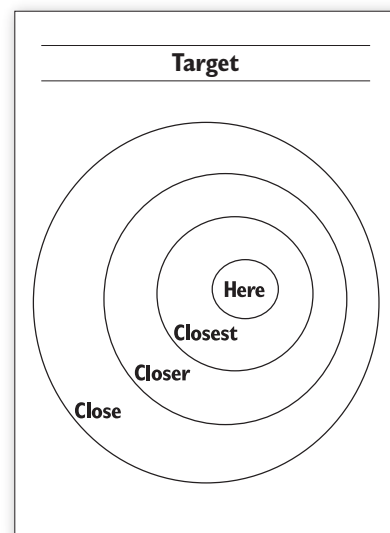
### Tossing pebbles activity

**Step 1:** Distribute about 10 pebbles to each participant.

**Step 2:** Ask them to walk around the room, tossing five of their pebbles as they walk.

**Step 3:** Ask them to “freeze” where they are after a moment. What do they see on the floor?

**Step 4:** Place the target (flip chart 3) in the center of the room. Then ask the participants to gently toss their remaining pebbles from wherever they are toward the target.



FLIP CHART 3

**Step 5:** Ask them to come closer to the target. Ask *What do you see on the floor now?*

*How is it different from before?*

*How might this relate to your activities related to HIV/AIDS?*





# Activity Sheet: Action Plan

Discuss and note answers to these questions, as you should in preparation for any work on HIV/AIDS-related activities.

- 1. What is the apparent gap in services that is needed?**
- 2. What do you need to do to find out about this gap? (Who? What? Where?)**
- 3. Who might you contact to work with on some aspect of narrowing this gap?**
- 4. What might be a role/some roles you can play in capacity-building to fill this gap?**

## Handout A-I: Case Studies

### What would have helped Mrs. Nzalo and her children?

Mrs. Nzalo died of AIDS at age 35. At the time of her death she was the mother of two living children, ages 11 and 10. Her third child, the youngest son died two years earlier. She and her children lived with her mother, who was also living with AIDS. In the last few months of Mrs. Nzalo's life, her mother was too sick to provide any real assistance to her or the children. The children did all the cooking and household chores, and did as well as they could in terms of caring for their mother and grandmother. Most of their friends and relatives avoided the house because they were afraid of "catching" the disease. Both children eventually dropped out of school.

Mrs. Nzalo was raped 10 years before she died, several weeks after the birth of her second child. She did not tell anyone because she was afraid her husband would not believe her. Two years later she gave birth to her third son. When this son was five years old the doctor at the clinic suspected he might be HIV-positive and he convinced Mrs. Nzalo to have her son and herself tested. He explained that even though it is unlikely that Mrs. Nzalo or her son will qualify for the limited antiretroviral drugs available, knowing their status would help her prevent the further spread of HIV. She consented. When she tested positive she decided to tell her husband, even though she was afraid of what he would do her. He did not beat her as she had suspected, but he did leave her and the three children, yelling at her within earshot of neighbors that the story about being raped was a lie to cover up the truth about her sleeping with other men.

Treatment options were very limited in the community where Mrs. Nzalo lived so neither she nor her son were able to get antiretroviral treatment or any other kind of care. Her son died three years after diagnosis.

When Mrs. Nzalo died she did not know what would happen to her two oldest sons. No relatives were willing to take them because they were afraid they would also get AIDS. She knew that her mother would die shortly after her.

### What would have helped Ana?

When Ana was pregnant, people in the town were suspicious that Ana was infected with HIV because she was often sick and her husband worked in another town a long distance away. Ana was also very afraid that she was HIV-positive and because of this, did not seek out prenatal care.

When her baby was born, Ana followed the local custom of breastfeeding the baby while supplementing the diet with gruel and water. She was afraid that her baby would get sick, too, and tried her best to boil the water before giving it to her baby because she heard that it keeps infants from getting sick. Yet, she was often too busy or sick to boil the water first.

She also heard that mothers with HIV can give it to their children through breastfeeding, but her mother warned her that if she stopped breastfeeding, everyone will think she has AIDS.

Her sister also had a young child whom she left with Ana when she went to farm. It is customary for women to nurse other women's children when left in their care. Ana didn't think that she could infect a child that wasn't hers, so she nursed her sister's child as well.

Ana's baby started getting sick when she was two years old. Ana was still afraid to get an HIV test or seek treatment for her baby. The stigma was too strong in her community, and she knew that the nurses at the local clinic would tell others in the community. She continued nursing her child because she was very small, and the child often suffered from diarrhea and other intestinal infections.

Ana's baby died at the age of three. When she died, Ana was pregnant with her second child, still too afraid to get an HIV test.

## Handout A-2: Case Studies

### What would have helped Sara?

Sara is a secondary student at a boarding school located four hours away from her home town. Although the school is about 50 percent boys, most of the household chores are assigned to the girl students. Each teacher is assigned a student to help with the teacher's personal housekeeping, such as sweeping the floor, laundry, and ironing. Sara is assigned to a male teacher, Professor Doe. Professor Doe also teaches Sara mathematics, which is a subject that she excels in.

Often when Sara goes to Professor Doe's house in the evening to complete the chores, he coerces her into sex. He threatens her and says that if she doesn't behave, she will earn bad marks in his class. He also tells her that no one will believe her stories if she tries to tell others what is going on. Sara knows that other girls are in similar situations, and thinks that her parents would be angry at her if they found out. She is also very afraid that her marks in mathematics will suffer if she refuses Professor Doe's advances.

In biology, Sara learns about HIV and AIDS, and is terrified that she may be at risk. Professor Does has never used condoms, and she knows that he has many girlfriends in town. She feels alone and without any choices, so she remains silent.

After Sara graduates from secondary school she decides to get an HIV test during a health drive in the next town. She is devastated to find out that she is HIV-positive. She has been dating a very nice man for a few months now, but is too ashamed to tell him what happened to her in secondary school. They have been sexually active, but she thinks that if she asks him to start using condoms, he will know that something is wrong. So she remains silent.

### What would have helped John and Mary?

John and Mary have been married for three years. Before they were married, Mary was married to John's brother Moses, who died after a long illness. As is the custom, John married Mary to keep Mary and her children in the family.

An HIV-awareness campaign comes to town with a mobile clinic and motivates Mary to get tested. She learns that she is positive, and wonders if she became infected from Moses or from John.

She is worried about her children and her future, but she joins a positive living support group, which has been a life saver for her psychologically and spiritually. She knows she must tell John the news, and finally summons up the courage. He is furious and beats her, and proceeds to do what is culturally acceptable when a wife has been unfaithful—he kicks her out of the house with her children. Mary and her children are viewed as outcasts and return to Mary's home town to find a place to live and seek acceptance into a community.

John lives alone for many months. He is sad, not feeling well, has lost weight, and finds it difficult to do his work and regular chores. He is also bitter about how his wife infected him. How could she have done this to him? Then he wonders if perhaps he might have also been exposed from another woman he knew before Mary.

Worried, he borrows money to make the long trip to the clinic and gets an HIV test. Finally when he finds a way to get to the clinic and is tested positive, he is told that there no antiretroviral treatment available. Distraught and discouraged, he returns home, and wonders whether his life is worth living.

## Handout A-3: Case Study

### **What would have helped Sergei?**

Sergei is a 20-year-old high school drop out living in a medium-sized city in an economically depressed area of the country. He spends most of his time looking for work and hanging out with his friends—they usually listen to music and drink vodka. Lately he has experimenting with heroin by injecting it. He says that the escape he feels while high on heroin helps him better forget the misery of his everyday life. Because Sergei and the majority of his friends are unemployed and have limited financial resources, they often share needles and syringes in order to save money to purchase more drugs. Although Sergei has heard about a needle-exchange program and the importance of using sterile needles to prevent disease transmission, he does not patronize it as he does not want anyone outside his circle of friends to know he uses drugs. He believes that should this information be known, it would hurt his chances of ever finding employment.

After months of injecting, Sergei notices that he has lost weight, is often tired and fatigued, and has open sores in his mouth. He travels to consult his sister, Katiya, a nursing student. She is shocked when she sees his wasted state. She is deeply concerned about his health and inquires about his lifestyle. After much prodding, Sergei admits to using drugs intravenously. Katiya becomes more concerned, given the health risks associated with injection drug use, and believes that he might have contracted HIV. She encourages him to see a doctor, have a complete medical exam, and get tested for HIV. She offers to go with him and pay for the exam and test. Sergei accepts her offer to pay for the exam and test, but declines to have Katiya accompany him. He promises her that he will go in the morning.

The next morning when Sergei awakes he remembers their discussion, becomes fearful about testing positive for HIV and instead of going to the clinic, returns to his drug dealer and buys more heroin.



# Building Partnerships

**HIV/AIDS TRAINING RESOURCE KIT**

**Session: Partnership as a Strategic Response to HIV/AIDS**



# Session: Partnership as a Strategic Response to HIV/AIDS

## Purpose

To provide knowledge and skills to prepare participants to help organizations and communities identify and form strategic and effective partnerships in order to provide comprehensive HIV/AIDS services.

## Rationale

Collaboration and partnering are integral aspects of the Peace Corps approach to development. This session provides knowledge and skills to help participants understand how organizations function and how to identify gaps in HIV/AIDS service provision that can be addressed by forming effective partnerships.

## Target Audience

Peace Corps participants (trainees and/or Volunteers)

Trainer's note: Unless participants are assigned to organizations, this module is probably best suited for in-service training.

## Duration

**PART ONE:** 2 hours, 30 minutes to 3 hours

**PART TWO:** Community-Based Learning: 4 hours to 8 hours

**PART THREE:** 2 hours

## Objectives

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

1. Describe the role of collaboration and partnerships in meeting goals to address HIV/AIDS.
2. Explain how different organizations function.
3. Describe how to learn about local organizations and their partnerships.
4. Identify ways that organizations can plan to build effective and strategic partnerships.
5. Identify the various roles Volunteers can take in their work with organizations related to creating partnerships.

## Session Outline

### PART ONE

- I. **Introduction** (15 minutes)
- II. **Understanding Partnering and Collaboration** (20 minutes)
- III. **Characteristics of Different Organizations** (55 minutes)
- IV. **Skill Building for Community-Based Learning (Interview Skills)** (50 minutes)
- V. **Preparing for Community-Based Learning** (20 minutes)

### PART TWO

#### Community-Based Learning (4-8 hours)

### PART THREE

- I. **Community Mapping** (30 to 45 minutes)
- II. **The Volunteer's Role in Developing Partnerships** (25 minutes)
- III. **Optional Practicum: Helping an Organization Plan to Partner** (40 minutes)
- IV. **Closing Activity: Essence** (20 minutes)

## Facilitators/Technical Expertise

Facilitator must be knowledgeable about

- How organizations function.
- The role of partnering and collaboration in creating strategic alliances and effective responses to HIV/AIDS.
- The benefits and challenges of organizational partnering and collaboration.
- Cross-cultural communication.
- The local community and its organizations.

## Materials and Equipment

Blank flip charts

Markers

Paper taped together to create a large piece for the community map Part Three

Flip charts

1. Session Outline; Part One
2. Session Outline: Part Two and Three
3. Types of Organizations (for Part One, III. Common Characteristics of Organization)
4. Information to Explore about Organizations (for Part One, III. Transition; use Handout C)
5. Essential Characteristics of Interviewing (for Part One, IV)
6. Identifying Opportunities and Challenges (for Part Three, III)

Handouts

- A. *Questions about Organizations*
- B. *Characteristics of Different Types of Organizations*
- C. *Information to Explore about Organizations*
- D. *[Optional] Role Play for Exploring Partnerships of an Organization*
- E. *Local Organizations/Agencies—contact information for trainees (to be prepared by trainers)*

## Preparation Checklist

- Read the entire session and make any needed changes based on previous training experience of the group and their needs, and time available.
- Consider whether the term “collaboration” is acceptable in the host country. If not, choose appropriate terminology.
- Prepare paper for the community mapping activity.
- Prepare flip charts.
- Prepare handouts.
- Identify organizations with whom participants can hold informational meetings and prepare contact information for participants and/or set up meetings for participants.

## Methodology

PART ONE

### I. Introduction (15 minutes)

**Welcome and introduction** (5 minutes)

**Step 1:** Welcome participants.

**Step 2:** Provide an overview of the session by reviewing flip chart 1 and 2.

Session Outline
<b>Part One</b>
<b>I. Introduction</b>
<b>II. Understanding Partnering and Collaboration</b>
<b>III. Characteristics of Organizations</b>
<b>IV. Skill Building for Community-Based Learning (Interview Skills)</b>
<b>V. Preparing for Community-Based Learning</b>

FLIP CHART 1

Session Outline
<b>Part Two</b>
<b>Community-Based Learning</b>
<b>Part Three</b>
<b>I. Community Mapping</b>
<b>II. The Volunteer’s Role in Developing Partnerships</b>
<b>III. Practicum: Helping an Organization Plan to Partner (optional)</b>
<b>IV. Closing Activity: Essence</b>

FLIP CHART 2



**Step 3:** Explain the session’s purpose: To provide knowledge and skills to prepare Volunteers to help organizations and communities identify and form strategic alliances and effective partnerships.

#### Opening activity (10 minutes)

**Step 1:** Write the terms “partnering” and “collaboration” on a flip chart. Ask participants to think for a minute about these concepts. What are examples they can think of where organizations partnered or collaborated to get something done? (*Examples might include organizations collecting food or clothing for churches or nonprofits to distribute; “Toys for Tots” campaigns the Marines conduct; adopt-a-pet days where pet stores help animal rescue leagues place pets; two or more organizations joining to put on a fundraiser; businesses providing tutors to schools, etc.*)

**Step 2:** Ask participants to represent their definitions of partnering and collaboration with pictures or statements on sheets of paper.

**Step 3:** Ask participants to post their papers on a bulletin board or wall—inviting sharing during this process. Comment that the topic is a broad one with many different forms and functions—as diverse as what they have represented. We will be investigating these concepts in this session.

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## II. Understanding Partnering and Collaboration

(20 minutes)

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### Role of partnering and collaboration (5 minutes)

**Step 1:** Explain: As we have discussed throughout training, collaboration and partnering are integral aspects of the Peace Corps’ approach to development and important tools in creating strategic responses to the HIV/AIDS pandemic.

**Step 2:** Ask: What is the role of collaboration and partnering in addressing HIV/AIDS? Think about all we have talked about, what you know about nonprofit or community-based organizations from the U.S., and what you know about HIV/AIDS.

**Step 3:** With the responses, create a list on a flip chart. Elicit responses with prompts if needed to include the following

- To share limited resources—including human, financial, and material resources.

- To share information and strategies.
- To “scale up” or expand the response to more people.
- To broaden a response—to make it more comprehensive.
- To be able to reach a goal none could do alone.
- To create “synergy” among partners.
- To elicit more creative responses.
- To increase capacity of each organization through benefits of cross training.
- To increase credibility.
- To provide a united front, addressing stigma and discrimination.
- To develop proposals for funding projects.

### Types of collaboration/partnership (15 minutes)

**Step 1:** Explain: Organizations can partner in different kinds of ways—often depending on their goals. Think back to some of your original examples and others you can now remember: What are some of the ways they can work together?

**Step 2:** List ideas on a flip chart and provide prompts to elicit the following and/or others

**Partnerships** two or more organizations

**Coalitions** a group composed of individuals or organizations who have a common goal, often used to effectively work to create some kind of community change

**Associations** where groups of organizations or individuals come together based on a common interest, e.g., professional associations, neighborhood associations, etc.

**Resource centers** provide information and referral to organizations/services in the community

**Donor/grantee partnerships** work together to accomplish a task

**Service provider/community member** client relationship

**Media/NGO collaboration** expertise and network to spread messages

All of these relationships reflect collaboration.

### III. Characteristics of Different Organizations

(55 minutes)

#### Introduction (5 minutes)

Explain: There are several important things to know if you are trying to help an organization develop partnerships to reach its goals relating to HIV/AIDS. These include: how the organization functions, the kinds of partnerships that already exist, and how partnering can enhance its response.

#### Thinking about organizations we know (10 minutes)

All participants bring knowledge about how organizations function from experiences with them in the U.S. Many have volunteered or worked with an organization, or perhaps donated blood to a local blood bank or the Red Cross.

**Step 1:** Think about an organization you are familiar with and answer the questions on *Handout A: Questions about Organizations*.

*What programs and services did the organization offer?*

*Who were their stakeholders? Individuals who cared about or benefited from the organization? Why was the organization founded? Who founded the organization?*

*Who managed the organization: a board of directors, paid staff, volunteers?*

*How was the organization financed: donations, special fundraising, events, fees from beneficiaries, grants, or a combination of these?*

*How did you become involved with the organization: contributor, volunteer, board member, beneficiary, or staff member?*

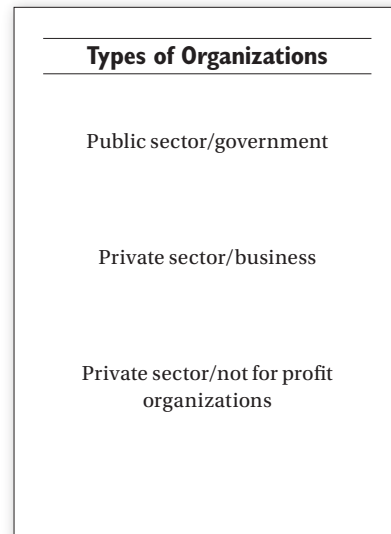
*What difference would it make in the community if the organization did not exist?*

**Step 2:** Ask if participants had any difficulty answering some of the questions. Which ones? Explain that they are going to learn more about these points in the rest of the session.

#### Common characteristics of organizations (30 minutes)

**Step 1:** Reveal flip chart 3 and say

*Organizations usually belong to one of three sectors of society: the public sector/government, private sector/businesses, and the private sector/not for profit organizations.*



FLIP CHART 3

*What are some examples of each of these types of organizations? (Fill them in on the chart.)*

The term nongovernmental organization (NGO) can refer to a variety of different types of organizations that are independent from the government. NGOs can be indigenous or foreign, religious or secular, advocacy or service delivery focused, and can operate at the community, national, or international level.

**Community-based NGOs** organizations established and managed by members of the community, also referred to as community-based organizations or CBOs. Types of CBOs include women's groups, credit circles, youth clubs, cooperatives, farmer associations.

**National-based NGOs** organizations that operate on a regional or national level, established and centrally managed by people in the host country.

**International NGOs** headquartered outside of the countries in which they operate, they usually carry out operations in more than one country.

**Step 2:** Ask participants to think of examples of different types of NGOs working in the country, also citing a brief explanation of what the organization does.

**Step 3:** Distribute *Handout B: Characteristics of Different Types of Organizations* and go over the common characteristics of government and private sector organizations.

**Step 4:** Brainstorm with the group the strengths of the different organizations that make them key partners for HIV/AIDS interventions (these strengths do

not necessarily have to be shared by all organizations within the groups).

**Transition** (10 minutes)

We looked at some of the elements of organizations with *Handout A: Questions About Organizations*.

**Step 1:** Reveal flip chart 4, “Information to Explore about Organizations” and distribute *Handout C: Information to Explore About Organizations*.

Information to Explore about Organizations			
Name of Organization			
Mission/Purpose			
Strengths/Services Provided			
Existing Partnerships? Why?			
Needs of the Organization			
Potential Roles of Volunteers with the Organization			

FLIP CHART 4

**Step 2:** Ask participants to refer to the organization they described on Handout A. Take one or two examples and work through the first four rows of the chart above.

The fifth row refers to needs of the organization. What might their needs be? (*Funding sources, better accounting systems, a delivery mechanism for services they can provide, access to media, etc.*) Partnering with other organizations is useful when one can provide for the needs of another.

**Step 3:** Note that they will have opportunities to explore some organizations in the community. As they are exploring them, you want them to consider potential roles Volunteers might play with the organizations. Remind them of appropriate and inappropriate roles: which ones are building capacity rather than just doing a job? Do a quick yes/no quiz: one hand up if the role you call out is inappropriate; two hands up if appropriate.

- Writing grants for an organization (*No, this does not build capacity.*)

- Training someone how to keep minutes to meetings (*Yes, this activity transfers skills.*)
- Distributing money (*No, Volunteers should not distribute money.*)
- Fundraising (*Depends on the situation. Yes, if a Volunteer is teaching staff members effective fundraising strategies. No, if the Volunteer is conducting the actual fundraising; it is not sustainable.*)
- Helping the board list and analyze fundraising possibilities (*Yes, if the board is given meaningful leadership roles in the process.*)
- Getting scholarships (*No, Volunteers should not get scholarships.*)
- Helping an organization find partner organizations to fund scholarships (*Yes, this is building linkages between organizations that can be sustained after the Volunteer has finished service.*)
- Planning an event for an organization (*Depends. Yes, if stakeholders and members of the targeted population are involved in the planning process, and are given leadership roles. No, if Volunteer is doing all the planning on their own.*)
- Teaching organizational staff how to match their needs with organizations who can provide them (*Yes, this is organizational capacity building.*)

**Step 4:** Can the group think of other appropriate or inappropriate roles the Volunteer might play in working with organizations?

**IV. Skill Building for Community-Based Learning**  
(50 minutes)

This is a segment that is both technical, cross-cultural, and addresses technical language. It is important at least to review the material with host country nationals (HCNs) and language instructors, and even better to have them involved in the session. Most of the essential characteristics of good interviews are culturally based, such as how one shows respect or asks questions.

**Introduction** (5 minutes)

**Step 1:** Explain: As a part of this session you will be doing some fieldwork to learn about local organizations and their partnerships. You will be meeting with organizations to talk with them about their work and how they collaborate. To prepare we are going to practice interview skills.

**Step 2:** Reveal and discuss flip chart 5 with the list of essential characteristics of interviewing.

**Essential Characteristics of Interviewing**

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Good interviews result from good preparation

Research the organization first, learning as much as you can. Base the interview on confirming information and learning more.

Essential characteristics of the interview

1. Show respect
2. Develop rapport
3. Use familiar, non-threatening topics
4. Use appropriate, non-threatening question forms
5. Read nonverbal cues
6. Listen more than talk
7. Accommodate culturally specific communication styles

FLIP CHART 5

Use one of the following

**Option 1: Interview practice** (25 minutes)

**Step 1:** Divide participants into small groups and have a cross-cultural trainer/language instructor/HCN go with each group.

**Step 2:** Ask each group to do the following

Instruct each group to have two people role play the interviews they will be doing with organizations. One person should be the Volunteer and the other the organization's representative. Others in the group should observe and provide feedback.

For the first role play ask that the cross-cultural trainer play the role of the Volunteer. Thereafter the trainer can provide helpful feedback and guidance.

**Option 2: Role play** (10 minutes)

**Step 1:** Ask for two participants to demonstrate a role play. Give each his/her role from Handout D and allow them to spend a minute or two preparing.

**Step 2:** Have the participants perform the role play.

**Step 3:** Debrief: Ask participants what they think happened? Lead a discussion with the following points

- One participant did not develop rapport before starting to ask questions.
- The questions may have been about topics that were new.

- This participant was not picking up nonverbal cues letting him/her know the interviewee was uncomfortable.
- Additionally, this participant did not follow cultural cues to stop asking questions.

**Debrief** (10 minutes)

How can you learn what you need to know? Facilitate a discussion about relevant essential characteristics of interviewing in the host country (using the flip chart 5 as a prompter). *Cross-cultural trainers/language instructors/other HCNs should be involved in this discussion.* Significant points

- Allocate enough time so that rapport can be established before questions are asked.
- Use indirect forms of questions (e.g., instead of asking "what kinds of partnerships do you have," you might say: "I know that in some communities different groups have combined efforts to do xyz. I wonder if that also happens here?").
- Identify nonverbal cues that may signal discomfort, embarrassment, etc., and appropriate responses.
- It is not always necessary to keep talking just because there is silence.
- Be sure to make the point that collaboration is often a requirement of funding so there may be a tendency to say there is partnering when in fact there is not.

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**V. Preparing for Community-Based Learning**

(20 minutes)

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**Introduction** (2 minutes)

You will have an opportunity to meet with one or two organizations to learn more about how they function, and particularly to learn about the role of collaboration or partnering in their work.

Learn whatever you can about with the organization's partners, and the benefits and the challenges of partnering.

**Preparation instructions** (18 minutes)

**Step 1:** Have participants form pairs or groups of three for the community learning activity. (*If necessary, they can go in larger groups.*)

**Step 2:** Provide organizational contact information for participants to set up appointments during a set time period (probably several days). Make sure that all organizations are covered by a group.

**Step 3:** Have them research the organizations and plan their interview questions, who will ask them, etc.

## PART TWO

### Community-Based Learning (4 to 8 hours)

Provide the appropriate level of assistance to ensure that participants can successfully meet with one or two agencies/organizations. Be sure that as a group participants meet with a range of public entities (national, regional, province or state, district or county, ward or village-level) and private (community-based organizations, NGOs, faith-based organizations, private for-profit companies, community groups, groups of people living with HIV/AIDS), as well as a range of those representing the different Peace Corps sectors (agriculture, business, education, health, etc.).

## PART THREE

### I. Community Mapping (30 to 45 minutes)

**Step 1:** Introduction.

Welcome everyone back.

Explain: We are going to create an “institutional map” of the community based on what you all have learned about the different kinds of institutions and organizations that exist. Once you’ve created the map, you’ll have a chance to share what you learned about the organization.

**Step 2:** Demonstrate some alternative ways of doing maps.

One way is to mark major landmarks in the community (roads, major buildings, etc.) and then draw in the actual location of the organizations visited.

Another option is to represent the organizations as circles, varying in sizes according to the size of the organization, and place them in physical relationship to each other according to how they partner or interact. To do this, they will need to identify all of

the organizations first, determine relative sizes, and cut circles according to a scale they determine, or just draw them, preferably in pencil first.

**Step 3:** Trainees develop maps.

**Step 4:** Discussion.

Ask participants to identify the organizations they met with, and briefly describe the mission, strengths, and who they’re partnered with and why.

After all of the organizations visited have been described, ask

*Are all of the groups who collaborate been connected in some way on the map? If not, let’s draw in the connections.*

*Are there other entities with whom they collaborate that are not on the map? Let’s add them and show the connections.*

*What strengths do we find on the map?*

*Are there any weaknesses you found that could be addressed by collaborations or partnerships that have not been made? Or any you think might be explored?*

*Are there any weaknesses that don’t seem to have solutions at the local level? What might be other options?* (Answers may include looking at regional or national levels, grants, new programs, or new organizations.)

Transition: Talk about how what they learned is only the “tip of the iceberg” in terms of what really exists in the community. What are some ways they could learn more?

### II. The Volunteer’s Role in Developing Partnerships (25 minutes)

#### Learning about local communities (10 minutes)

**Step 1:** State: To play a role in developing partnerships you need to know what kinds of resources exist in your community. We have covered a lot of approaches to assessment in other modules.

**Step 2:** Remind participants that there are many potential partnerships within local communities—including with groups that may not be specifically identified as addressing HIV/AIDS. These include local associations, neighborhood groups, labor groups, women’s groups, places of worship, traditional healers, etc.

**Step 3:** Ask about strategies to discover new partnership opportunities. Be sure that the following are mentioned

- Participatory assessment strategies
- Counterparts, host organizations
- Involvement of the targeted population
- Other key individuals
- Newspapers and magazines
- Directories (e.g., phone book, self-help directories, association lists)
- Local institutions (e.g., libraries, churches/mosques/synagogues, chambers of commerce)

#### **Working within organizations** (15 minutes)

**Step 1:** State: As a Volunteer, you may work with a particular organization to address HIV/AIDS. How can you help that organization develop and/or expand its collaboration with other organizations and entities? Let's consider the different roles you might take.

**Step 2:** Remind participants of the roles of the Volunteer in development discussed in the Capacity Building training module and use these to create examples. There are many examples of what can be done for each role, the following is just a sample

**Learner** you can learn and pass on your knowledge about the role of collaboration and partnering in addressing HIV/AIDS, as well learning about the potential collaborations in the community for the organization.

**Change Agent** you can co-lead a strategic planning process with partnership development as a prominent aspect.

**Co-Trainer** you can provide training with your counterpart relating to the role of partnerships and how to create strategic partnering.

**Co-Facilitator** you can co-facilitate a "potential partner day" hosted by your organization.

**Project Co-Planner** you can co-plan a host of projects in partnership with another agency or entity in the community.

**Mentor**—you can mentor the head of the organization in creating effective partnerships.

### **III. Optional Practicum: Helping an Organization Plan to Partner** (40 minutes)

#### **Introduction** (5 minutes)

A possible role participants might play is in steering an organization towards a planning process, with the goal of building effective and strategic partnerships.

To assist organizations in planning strategic partnering, look at the steps in a planning process

- Making a planning framework
- Revisiting the organization's mission and community priorities
- Identifying opportunities and challenges
- Prioritizing goals for building partnerships
- Selecting partners
- Deciding how to approach partners
- Selecting an outreach team
- Monitoring and sharing lessons about partnerships

**Transition:** We are going to do an activity around the third step in the planning process: identifying opportunities and challenges.

#### **Activity—Identifying opportunities and challenges** (20 minutes)

**Step 1:** Divide participants into small groups, and give each a blank flip chart. Ask each group to take on the identity of one of the organizations portrayed on the community map.

**Step 2:** Show flip chart 6 with the type of diagram they are to use.

**Step 3:** Ask participants to draw a similar diagram. In the center circle, ask them to write or draw the name of their organization.

Encourage participants to draw their partnerships map imaginatively. For example, they might draw a picture of a mosque, temple, or church to represent a religious organization. This makes it more fun and interesting.

**Step 4:** In the second circle, ask them to write or draw the communities their organization serves or collaborates with in its HIV/AIDS work.



FLIP CHART 6

Emphasize the difference between the communities an organization works with in its programs (in the second circle) and the groups it works with in its partnerships (in the third circle). It is vital that participants are clear about this difference.

**Step 5:** In the outside circle, ask them to write or draw the opportunities and challenges which influence their organization’s HIV/AIDS work.

**Step 6:** In the empty third circle, ask them to write or draw the partners (or people and organizations) that could help the organization address the opportunities and challenges.

Encourage participants to be imaginative about partners—not just mapping conventional ones (such as donors and government), but others as well (such as lawyers and nightclub owners).

**Debrief** (15 minutes)

Questions for discussion

*What does the map show about the number of people and other organizations that influence the organization’s work?*

*What does this say about the significance of all kinds of relationships for organizational partnering?*

*What opportunities can best be addressed through partnerships? Are there challenges that can be mitigated through partnerships?*

*What partners have been identified that the organization may not have considered working with in the past?*

**IV. Closing Activity: Essence** (20 minutes)

**Step 1:** Ask participants to form groups of five or six at a table.

**Step 2:** Remind them of the many topics covered in this session/module.

**Step 3:** Ask them to write a 32-word summary of what they have learned. Allow five minutes to do it.

**Step 4:** Ask each group to read its summary.

**Step 5:** Now ask groups to write a 16-word summary. Allow five minutes.

**Step 6:** Ask each group to read its summary.

**Step 7:** Now ask groups to use just eight words to capture the essence of this module. Allow five minutes.

**Step 8:** Have them write their eight word summaries on flip charts. Ask everyone to read all of them. If desired, vote on the best summary.

**Step 9:** Ask how this activity helped them recall the contents.

**Evaluation**

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# Handout A: Questions about Organizations

**Think about an organization you are familiar with and answer the following questions.**

1. *What programs and services did the organization offer?*
2. *Who were their stakeholders? Individuals who cared about or benefited from the organization? Why was the organization founded? Who founded the organization?*
3. *Who managed the organization: a board of directors, paid staff, volunteers?*
4. *How was the organization financed: donations, special fundraising, events, fees from beneficiaries, grants, or a combination of these?*
5. *How did you become involved with the organization: contributor, volunteer, board member, beneficiary, or staff member?*
6. *What difference would it make in the community if the organization did not exist?*

## Handout B: Characteristics of Different Types of Organizations

### Common Characteristics of Public Sector/Government Organizations

- Bureaucratic—many layers of decision making
- Must follow national government policies. Provide services to the public, so resources are often stretched. Funded by the government—often through multi-lateral agreements
- Role of ministry workers may be rigid, with varying degrees of competence
- Generally have regional and district level offices
- Relationships tend to be formal and diplomatic, with need for documentation and written agreements for collaborative work
- Other?

### Common Characteristics of Private Sector/Businesses

- Ultimate goal relates to profit margin/bottom line—usually distributed among the shareholders
- Typically have greater access to external resources—financial and human; sometimes greater flexibility within programming related to additional resources
- Management structure is varied—could be board of trustees, an individual, or company employees
- Financial resources/funding comes from competitive commercial ventures
- Are often image focused
- Other?

### Common Characteristics of Private Sector/Not for Profit Organizations

- Created to meet a need in a society that is not being met through government or private business
- Work with people to help them improve their social and economic situation and prospects
- Generally are independent, controlled by those who have formed it or by management boards representing the organization's stakeholders; sometimes controlled by a parent body
- Goal is not for profit; although may engage in revenue-generating activities in order to use the proceeds to pursue the organization's aims
- Other?

## Handout C: Information to Explore about Organizations

<b>Name of Organization</b>			
<b>Mission/Purpose</b>			
<b>Strengths/Services Provided</b>			
<b>Existing Partnerships</b> <b>Why?</b>			
<b>Needs of the Organization</b>			
<b>Potential Roles of Volunteers in/for the Organization</b>			

# Handout D: Role Play for Exploring Partnerships of an Organization

The role play should be adapted to the local culture.

## **Peace Corps Volunteer**

You are meeting with the director of the local counseling and testing center to learn about the kinds of collaborations/partnerships the center has and to learn more about local attitudes about collaboration.

After greeting the director, get right to the point and ask the following questions

*What kinds of partnerships do you currently have? With what organizations?*

*What kinds of projects have benefited the most through partnerships with other organizations?*

*What do you think the role of collaboration is in meeting your goals to have more people tested?*

If you don't get an adequate response to a question, rephrase the question and stay at it until you get some answers.

## **Director of Counseling and Testing Center**

You have been contacted by a Peace Corps trainee to talk about your center. You know that the person is interested in learning about the kinds of collaborations your center has. Your major partner is USAID, which provides funding for the center. As a part of the funding agreement with USAID you have committed to developing local partnerships, including those with private and public sector entities. Yet, developing partnerships is very time consuming and you are very busy just trying to keep the center operational. Privately you are also a bit concerned that partners may try to compete for funding you now have.

You will speak to the participant in very positive terms about partnerships and assure him or her that you have "plenty of partnerships" and that they are very productive. You won't give any specific information. If the interviewer persists, you will try to let him or her know through nonverbal cues that are known in your culture that you really don't want to talk about this. You are sure she or he will understand about "saving face" and will know how to end the interview in a way that everyone feels good.

# Handout E: Local Organizations/Agencies

## Contact Information for Trainees

(to be prepared by trainers)



## Information Collection and Exchange

The Peace Corps Information Collection and Exchange (ICE), a unit of the Center for Field Assistance and Applied Research (the Center), makes available the strategies and technologies developed by Peace Corps Volunteers, their co-workers, and their counterparts to development organizations and workers who might find them useful. ICE works with Peace Corps technical and training specialists to identify and develop information of all kind to support Volunteers and overseas staff. ICE also collects and disseminates training guides, curricula, lesson plans, project reports, manuals, and other Peace Corps-generated materials developed in the field. Some materials are reprinted "as-is"; others provide a source of field-based information for the production of manuals or for research in particular program areas. Materials that you submit to ICE become part of the Peace Corps' larger contribution to development.

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## The Center for Field Assistance and Applied Research

Information Collection and Exchange  
1111 20th Street, NW Room 1200  
Washington, DC 20526  
Tel: 202.692.2640  
Fax: 202.692.2641

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