THE SAVE TOOLKIT

For Faith Leader Workshops on HIV

INTRODUCTION to the SAVE Toolkit

THIRD EDITION

Contents

Abbreviations & Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immunodeficiency Syndrome
ADC	AIDS Dementia Complex
AMS	Altered Mental Status
ANERELA+	African Network of Religious Leaders Living with or personally Affected by HIV & AIDS
APCASO	Asia Pacific Council of AIDS Service Organisations
APN+	Asia Pacific Network of People Living with HIV and AIDS
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual Reproductive Health
AU	African Union
AZT	Azido Thymidine
BC	Behaviour Change
BCC	Behaviour Change Communication
CD4	Cluster of Differentiation 4
CDC	Centres for Disease Control
CLWHIV	Children Living with HIV
CMV	Cytomegalovirus
CNS	Central Nervous System
COVID-19	Corona Virus Disease
CRC	UN Convention on the Rights of the Child
CRP	Child Rights Programming
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DNA	Deoxyribonucleic Acid
EHAIA	Ecumenical HIV and AIDS Initiative in Africa
EVD	Ebola Virus Disease (Ebola)
FDA	Food and Drug Administration
FGM	Female Genital Mutilation
FSWs	Female Sex Workers
GAD	General Anxiety Disorder
GRID	Gay Related Immune Deficiency
GBV	Gender Based Violence
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HHH	Homosexuals, Haitians, Haemophiliacs
HIV	Human Immunodeficiency Virus
HAD	HIV-associated Dementia
HAND	HIV-Associated Neuro-cognitive Disorder
HPV	Human Papilloma Virus

HR	Human Rights
HRV	Human Rights Violations
HSV	Herpes Simplex Virus
HTS	HIV Testing Services
ICCPR	International Covenant on Civil and Political Rights
ICTs	Information and Communication Technologies
INERELA+	International Network of Religious Leaders Living with or personally affected by HIV & AIDS
IPV	Intimate Partner Violence
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual +
LGBPTTQQIIAA+	Lesbian, Gay, Bisexual, Pansexual, Transgender, Transsexual, Queer, Questioning, Intersex, Intergender, Asexual, Ally
LMICs	Low- and Middle-Income Countries
MCP	Multiple and Concurrent Partners
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organisation
NSU	Non-Specific Urethritis
NVP	Nevipine
OCD	Obsessive Compulsive Disorder
PEP	Post Exposure Prophylaxis
PD	Panic Disorder
PID	Pelvic Inflammatory Disease
PLHIV	Persons Living with HIV
PLWD	Persons Living with Disabilities
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RNA	Ribonucleic acid
SADC	Southern African Development Community
SAVE	Safer practices; Access to treatment; Voluntary counselling and regular counselling and testing; Empowerment
SGBV	Sexual Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSDDIM	Stigma, Shame, Denial, Discrimination, Inaction and Misaction
SSOGIE	Sexual Orientations, Gender Identities and Expressions
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TCA	Trichloroacetic Acid
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNESCO	United Nations Education, Scientific and Cultural Organisation

UNFPA	United Nations Population Fund
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization
WLHIV	Women Living with HIV
WSM	Women who have Sex with Women

Icon Key

Facilitator's notes

Activity/Group Activity

Discussion

Caution

Case Study

Introduction to the SAVE Toolkit

There are many resources today on HIV responses for trainers and individuals. What makes this Toolkit different? Why is it written for leaders within faith communities and broader society to engage in responses to HIV together? In answer to the first question, most materials on HIV prevention ignore or underplay the impact of stigma, shame, denial, discrimination, inaction and misaction (SSDDIM). People think that if others know enough about HIV, there will be less stigma. Experience on ground, sadly, shows that this is not true. The Toolkit highlights aspects of SSDDIM. Action founded in prayer and meditation, to challenge stigma and address the impact of stigma, is a core component of the training.

The role of religious leaders in education around HIV and AIDS is frequently under-estimated. People tend to view religious leaders as obstacles to change rather than as drivers of change. Yet, in Africa, faith-based institutions provide healthcare services. According to the UNFP (2008), faith-based organizations in Africa provide over 50% of all heath care services, comprehensive HIV services included. Moreover, all religious leaders, from the Abrahamic or monotheistic traditions to the followers of Hinduism, have the responsibility to interpret tradition for the modern world or, in the context of the developing world, to straddle the divide between culture, science and religion. As such, religious leaders can be powerful agents of change.

It is envisioned that through this Toolkit, the influence and compassion of religious leaders can be harnessed to create healthy communities for Persons Living with HIV (PLHIV) as well as for the wider community. This Toolkit aims to equip both religious leaders and other HIV practitioners with the tools and strategies necessary to drive this transformation. The manual also intends to stimulate the greater engagement of religious leaders of all faiths in responding positively to HIV in their own lives and in the communities they serve.

HIV has been transmitted through ignorance, fear, denial and vulnerability. This Toolkit is designed to shed light on HIV SSDDIM for promotion of HIV and AIDS prevention and treatment as illustrated in the picture below.

From darkness to light

AIDS-related illnesses caused over 36.3 million [27.2 million–47.8 million] deaths worldwide by 2020, mostly in Africa, increasing livelihood vulnerability (UNAIDS, 2021). However, it is expected that by 2030, the number of AIDS-related deaths will reduce with improved access to treatment and reduction of stigma and shame. The SAVE Toolkit aims to provide individuals and communities with a resource to help them face their fears and put an end to the stigma associated with this virus. It provides key information and calls communities to action to face their fears and to build hope for the future. As with other materials developed on HIV and AIDS, the final goal is to stop the further spread of HIV; stop all deaths related to HIV or AIDS, and eliminate all SSDDIM related to HIV or AIDS. In short, zero infections, zero stigma and zero AIDS-related deaths (UNAIDS, 2010). At its heart, SAVE is a prevention methodology that takes account of the drivers of the epidemic. It provides a space to explore the unmentionable subjects of sexual practice and embedded cultural practices that lead to vulnerability

to new infections and inaccessibility to treatment. It assists communities in challenging the systemic and structural factors that lead to spirals of poverty, vulnerability, and abuse. In short, it challenges human beings to be humane.

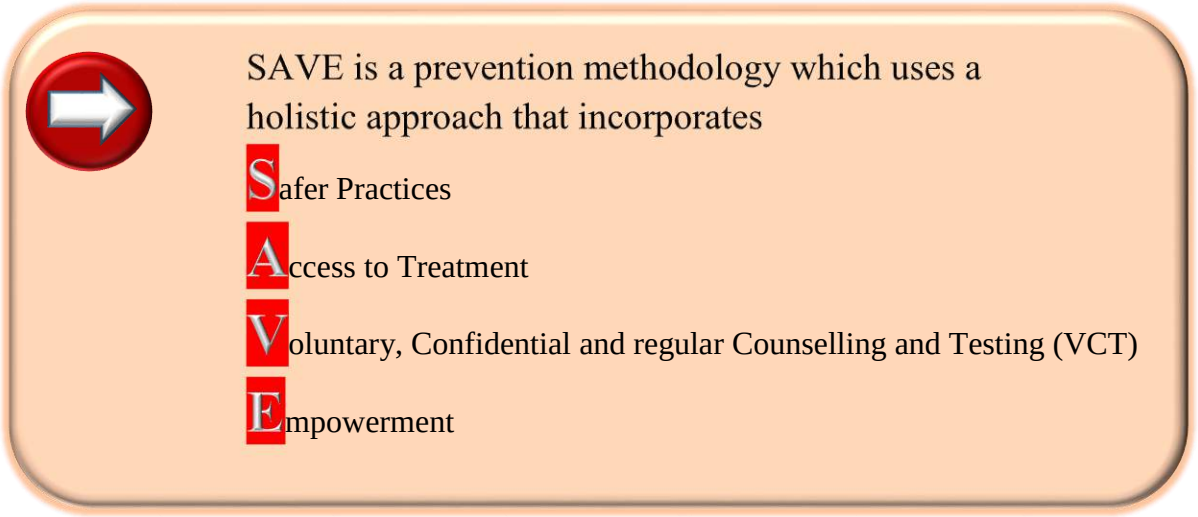
The role of religious leaders in education around HIV and AIDS is frequently underestimated.

The context

SAVE originated in an African pastoral context where leaders of faith communities recognised the need to respond to persons living with and affected by HIV in a way that reflected a loving God rather than a judgmental, dismissive God. Many of these leaders began their journey of learning about HIV through working with the African Network of Religious Leaders living with and personally affected by HIV and AIDS (ANERELA+). SAVE opened the way for religious leaders living with HIV to learn about the virus infecting their own bodies as well as affecting the lives of those around them. They realised that HIV represented a call for faith communities to lead by example and engage communities around HIV and AIDS. The focus of this engagement had to become more than merely addressing individual sexual practices but also structural factors that make a person vulnerable. Since HIV is not isolated to Africa, ANERELA+ grew and became global, transforming into the International Network of Religious Leaders living with or personally affected by HIV and AIDS (INERELA+).

Through the initial work of INERELA+ across Africa, the organisation came to realise that communities are in danger of the continued spread of HIV because of interrelated factors, including livelihood vulnerability that contributes to poverty, war, poor governance, gender imbalances and homophobia, all of which plague the African continent.

Halting the spread of HIV requires more than information about the virus: it requires that individuals and communities understand the drivers of the disease more fully and take collective action to stop its spread. In doing so, people can have a positive impact on their own lives and on the lives of those around them.



SAVE incorporates the understanding that stigma and discrimination need to be eradicated, misinformation needs to be corrected, and that Persons Living with and affected by HIV should no longer face shame, denial and community inaction.

Key to the understanding of empowerment is the question of vulnerability to HIV. Simply by being human, we are all vulnerable to HIV. Various factors can, however, increase our vulnerability. Exclusion, whether gender, sexual, social, cultural, economic, political or legal, increases vulnerability

to HIV because it prevents access to correct information and prevention methods for protection against HIV.

Below here is a set of questions for a quick assessment of individual vulnerability. The more "yes" answers participants give, the higher their risk of exposure to HIV. The facilitator should read these questions out at the start of the training. No pens or paper are required. Participants are asked to keep count of their answers in their heads. This is a private activity and no one is asked to reveal their answers.

Questions?

Questions	YES	NO
1.Have you ever had sex?		
2.Have you ever had an injection?		
3.Are you married?		
4.Have you ever had an operation?		
5.Have you ever had a blood transfusion?		
6.Have you ever injected drugs?		
7.Have you ever had a sexually transmitted infection?		
8.Have you had children?		
9.Have you ever travelled away from your sexual partner/spouse for more than two weeks?		
10.Are you human?		

How did you get it?

Reponses to HIV are generally judgmental and excluding. Faith communities tend to be moralistic, labelling people as immoral if they are living with HIV. Inappropriate questions such as: "How did you get it?" are asked. The sub-text here is: "Are you innocent or are you guilty?" If asked, "How did you get it?" the only appropriate reply is: "That's the wrong question. The right one is: How are you living with it?"

Judgements about HIV transmission are moralistic. If a person says they contracted the virus as a result of a blood transfusion, or an injection, or even while having an operation, the unspoken judgement will tend to be: "Who are you kidding? Do you think I'm stupid?" Asking somebody how he or she contracted the virus feeds stigma and shame, and makes it more difficult for people to be open about their HIV status.

When building your facilitation team

When choosing your facilitation team, it is important to make sure that people from different groups such as people of faiths, key groups are included, especially PLHIV. PLHIV will be able to offer insight and a wealth of personal experience, which will contribute to the breaking down of stigma. Including PLHIV as full facilitators in your facilitation team is not just about getting someone to give their testimony. The aim is to include, support, recognise and give a voice to people from within your community who are known and loved and can present information and guide activities from their unique perspective of being a PLHIV.

Levels of engagement or interaction

Working through the SAVE Toolkit the facilitator will experience three distinct levels of engagement with people participating in the learning/ experiential process. At each level, the facilitator, individuals and communities have different roles to play. As you grow in knowledge and understanding, and confidence about the subject matter you will engage with others more easily and more deeply.

(Although the levels are presented here as discrete steps, they are more often than not intertwined.)

Level 1: The beginning

Facilitator

- At this level, the facilitator is generally the one providing most information and stimulating interaction. Your role is to give general facts and figures about HIV and AIDS and to offer basic education on HIV and AIDS.
- If interaction is formal and distant initially, this is perfectly normal, even when people know one another. HIV remains a scary topic for many people so it is important to listen to questions thoughtfully and give accurate answers to fact-based questions. Providing factual information is the first step in building trust between the facilitator and participants. As people become more informed, they begin to feel comfortable enough to open up on deeper issues surrounding HIV and AIDS.
- If you do not know an answer, you may check with the participants to see if anyone knows the answer. You will need to refer to the section in the Toolkit that deals with the question to check that the answer is accurate, or make a commitment to find the answer. Under no circumstances should you provide half information or misinformation, as in doing so you will destroy trust, which is the basic building block of good facilitation and learning.
- It helps if you are already part of the community and are respected in the community.
- It is important, even at this early stage, that action becomes a key focus of discussions, for example:
    - Begin to challenge people to know their status.
    - Help people identify others that need basic information about HIV and AIDS.
    - Help the community to begin to identify simple resources that can be used to deal with HIV.
    - Encourage people to bring their friends and families to discussions where appropriate. The more accurate information about HIV we can spread, the better.
- Be aware that accurate information is the first step towards empowerment. Correct information becomes the most powerful tool in breaking myths and stigma around HIV and AIDS. Once individuals understand the facts, they can become good teachers in their communities. Even if the same question is asked over and over again, your answers should be consistent and based on facts.

Level 2: Personal stories

Facilitator:

- Your role is that of companion and guide on a journey, listening to people's stories.
- Ensure that there is an understanding of shared confidentiality. What is said in the room stays in the room.
- A box of tissues could be handy as these stories can be painful.
- As highlighted previously, you will need to listen carefully at this stage and make notes on key points that need to be addressed – let people talk, let your voice remain silent.
- You need to be careful that time is managed well. Too much time for an individual's story limits the time for others to speak, while too little time can be perceived as dismissive.
- Depending on your personal style you can give information or correct clearly identified inaccurate or wrong information as and when it arises in individual stories. It is recommended, however, that you allow individuals to complete their stories and then gently make corrections of information. Do not let any piece of inaccurate or wrong information, half-information or untruth go unchallenged.
- The number of discussion points that can emerge may seem overwhelming. You need to ensure good note-taking and agree with the individuals on how the issues will be covered in the future.
- You should focus much attention on reducing the stigma surrounding HIV and AIDS. For example,
  - Safer sexual practice will be a key topic for engagement. Do not judge another person's story or life. Focus on issues relating to the vulnerability to HIV rather than passing moral judgments.
  - Deal with the issues and not the person.
  - Do not judge people as they tell their stories.
  - Case studies can be used as conversation starters.

Level 3: Identifying vulnerabilities, both personal and community

Facilitator:

- The key to this area of engagement is the confrontation of denial.
- It is important for you to have created a safe space at this stage for individuals and their families to have the courage to know their status.
- You would either need to provide Voluntary Counselling and Testing (VCT) at the training site or help individuals access this service in the community. Other people who have been through a SAVE prevention methodology training could be part of the counselling portion of VCT.
- Sexual practices will be a key focus of discussion. Keep the lines of communication between yourself and participants open.

Level 4: **Active Responsibility**

Facilitator:

- This is the most exciting stage of the SAVE programme as individuals move from absorbing information for their own benefit to a broader community perspective. Active responsibility is the stage that you want to reach.
- Your role at this stage is to offer encouragement and to help people plan what they want to do in communities. You have identified lifestyle and livelihood vulnerabilities throughout the process and now it is time to help people DO something about them.
- Action, action, action – hold people accountable for their undertakings and help them to make links with government and community development partners, whilst engaging more people within the community to be part of the training sessions.
- Finally, keep insisting that individuals and communities are not powerless to motivate and support PLHIV and to prevent its transmission. We can all do something.

Structure of the learning modules

There are five main sections: SSDDIM, Safer Practices, Access to Treatment, VCT and Empowerment. The modules are divided into units that deal with separate issues with references to interrelated issues. Each unit looks at preventing transmission, supporting PLHIV, and empowering communities. Furthermore, issues of stigma, shame, denial, discrimination, inaction and misaction are highlighted.

A final note

The role of the facilitator has been highlighted here because of the toolkit's aim to help people work through the SAVE prevention methodology. It is, however, important to remember that communities contain knowledge and wisdom that make them experts in their own contexts. The aim is to help people to build on this embedded knowledge by drawing on facts, personal stories and action. Furthermore, your facilitation can help people gain the courage to confront deeply held beliefs about HIV and AIDS that are both harmful and dangerous. By challenging such beliefs, you can change community responses and harmful cultural practices. In becoming part of this process, you become part of the community. There is an implied commitment from your side that you will learn about the community **from** the community and **with** the community.

Undertaking to facilitate this programme is a commitment to "*Be the change you want to see in the world*". (Mahatma Gandhi)

Understanding and working with the SAVE model

Session Objective:	To provide participants with a model to communicate about the transmission and prevention of HIV in a non-stigmatising manner
Session Overview:	Facilitator-led session
Session Summary:	The booklet gives guidance to the facilitator on how to welcome the participants, establish rules of engagement and create rapport.
Biblical Scripture:	Scriptural reference to relevant topics from the bible
Scripture Emphasis:	Scripture explanation
Islam Scripture:	Scriptural reference to relevant topics from the Qur'an
Scripture Emphasis:	Scripture explanation
Materials Needed:	Indicates teaching and learning resources needed
Time:	Estimated time for holding activity

The SAVE prevention methodology:

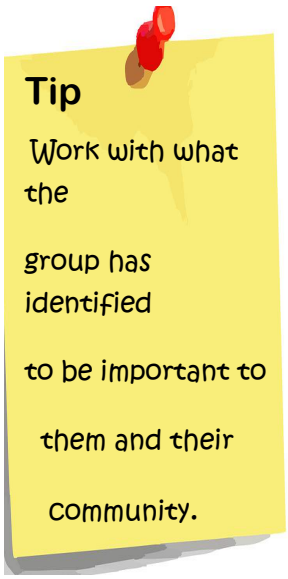
1. Facilitator indicates that this short session is aimed at providing participants with a framework to communicate about the transmission and prevention of HIV in a non- stigmatising manner.
2. The facilitator introduces the presentation on the SAVE model by noting the following:
   - The "ABC" approach has been used as the all-inclusive messaging tool for HIV prevention programmes around the world. ABC stands for Abstinence, Be faithful, Use Condoms.
   - Unfortunately, the way in which the message has been presented is more like: "Abstain! If you cannot abstain, be faithful! And if you cannot be faithful, use a condom!" implying that using a condom is a last resort. It also implies that people who are living with HIV have failed to abstain and to be faithful, which increases stigma around HIV.
   - ABC also fails to take into account the other ways in which HIV can be transmitted and other drivers of the epidemic, including gender inequalities and the role of power in sexual relations.
   - The ABC approach is seen to be:
     - *Narrow* – limiting itself to one mode of HIV transmission;

- *Inaccurate* – in assuming that people who are abstinent or faithful will completely avoid HIV, and by implying that those who are faithful do not need to use condoms as an added protective measure for sexual transmission;
- *Stigmatising of PLHIV* – by implying that persons who are living with HIV have failed in abstinence, faithfulness and condom use; and
- *Inadequate* – by leaving out messages for families, communities and nations, and placing the burden of prevention on the individual. The "ABC" message ignores the role of HIV counselling, testing and treatment in prevention, and fails to highlight other possible modes of HIV prevention such as safe blood transfusions, safe injections, safe circumcision, and prevention of mother-to-child transmission.

- INERELA+, in reaction to the conventional ABC model, has developed and promotes the SAVE prevention methodology for HIV prevention, awareness raising and education. The SAVE prevention methodology provides a more holistic way of preventing HIV transmission by incorporating the principles of ABC within the wider context within which sexuality is practiced. The methodology also provides additional information about: HIV transmission and prevention; providing support and care for those people already living with HIV; promoting access to treatment; and about actively challenging the denial, stigma and discrimination so commonly associated with HIV. The SAVE prevention methodology is described as follows:

S	**S** Refers to **safer** practices covering all the different modes of HIV transmission, for example, blood transfusions, the use of condoms, or use of sterile needles for injecting. Abstinence remains the most reliable method of avoiding exposure to STIs, but it must not be taught in isolation.
A	**A** Refers to **access** to preventive technologies such as condoms and treatment –not just Antiretroviral treatment (ART), but treatment for HIV-related infections as well as the provision of good nutrition to help adherence to ART, and clean water. It also refers to the need for all available pathological tests which can further inform treatment
V	**V** Refers to HIV-related **VCT**. It speaks of the need to test regularly, and for the testing to be respectful and confidential. If you know you have tested positive for HIV, you can protect yourself and others, and take steps to live a healthy, productive and positive life. If you know you are negative you can take the necessary steps to remain that way.
E	**E** Refers to **empowerment** through education and human rights advocacy. Stigma, shame, denial, discrimination, inaction and misaction associated with HIV remain massive challenges to the uptake of services associated with HIV, and get in the way of PLHIV living productive and healthy lives within their communities and countries. This is why empowerment remains a vital component of all HIV work. People need accurate information about HIV to make informed decisions and to protect themselves, their partners and their children from HIV. Empowered people are able to challenge the stigma and discrimination that can make the lives of people with HIV difficult.

WHAT IS SAVE, and what is SAVE to you?



Formulating your training programme, unlocking the formula

What does SAVE mean to you?

When organising training it is not possible to plan the agenda in advance. Although there can be a basic framework, the topics to be covered can only be put onto an agenda once the following activity has been carried out. SAVE is a holistic approach that can be used to fit into a variety of circumstances and communities, so until you have heard and captured the voice of the community you are teaching, you cannot formulate an agenda.

Method

Write SAVE across the top of the page. Begin by explaining that the letter 'S' stands for SAFER practices and ask: What does SAVE mean to you? As participants voice what SAFER practice means for them, capture their thoughts under the 'S' heading, making sure that what is listed applies to this particular group in their context. Follow this process for 'A', 'V' & 'E'. By the end of the exercise you should have a page or more of ideas under each letter.

The topics that have been raised and captured on the flipchart paper or board in this section will help you to formulate the programme and the way forward for teaching the SAVE Toolkit. You can now devise your programme tailored to suit a particular group.

Although you will make adjustments to the agenda to make it meaningful for the group you are working with, there are four components to the training that will remain constant for every group:

1. An introduction to the SAVE prevention methodology: This is the first session of the training and it should take around two to three hours.

2. Discussion on sex and sexuality: It is essential to make sure that a discussion on sex and sexuality is included in the training programme. This should not happen on the first day of the training as it can be a daunting experience and people need to understand SAVE and HIV before exploring these topics.

SAVE – the bigger picture: Now that your training programme has been developed around issues that are pressing for the group, you should return to the SAVE table and show how it can be expanded to make it meaningful for different communities. The SAVE grid enables you to identify what is missing.

The way forward: At the end of the training, participants should have a clear idea of next steps for themselves as individuals and for the group as a whole. Agreeing on a process for taking the training forward is very important because this will ensure that participants are committed to the rollout of this prevention methodology. Plotting the way forward should take one to two hours.

S	A	V	E
Safer Practices	**Access to Treatment**	**Voluntary Counselling and Testing**	**Empowerment & Human Rights Advocacy**
• Safe Blood • Sterile medical • Instruments • Oral substitution therapy • Abstinence • Delay of sexual debut • Mutual fidelity • Microbicides • Condoms • Partner reduction • Male Circumcision • Clean needles and blades, • Safer traditional practices and treatment as prevention	• Treatment for opportunistic infections • Nutritional support • ART • PMTCT • PEP • PrEP • All necessary pathological support/tests • STI treatment	• Respect • Confidential • Regular • Moving from 'AIDS friendly congregations' to 'congregations that know their HIV status' • Teaching needs for knowing HIV status at all levels • Integrating HIV testing and treatment with other health services	• Comprehensive Sex Education • Gender, Sex and sexuality • Gender Based Violence • Criminalization • Travel restrictions • Migrant labour and refugees • Racism • Economic imbalance • Literacy • Prisons • Overcoming SSDDIM

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Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

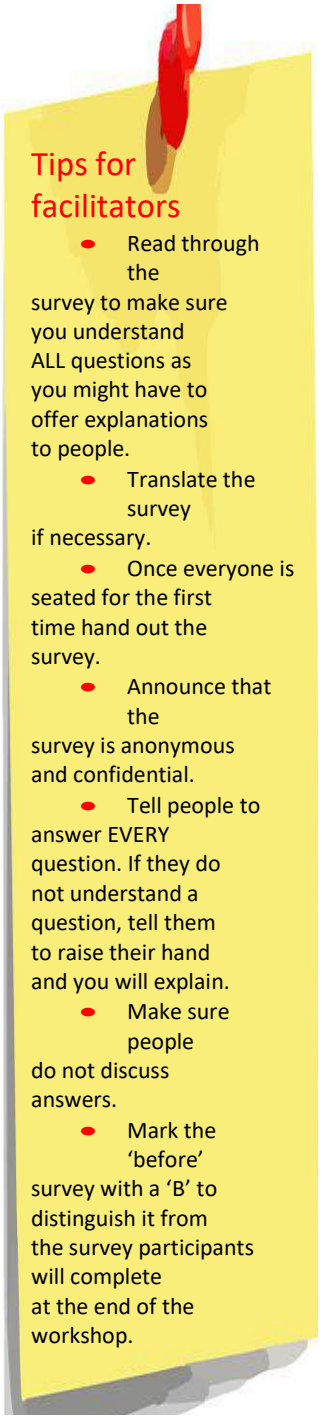
Church of Sweden

INERELA+

GUIDANCE
for Facilitator

THIRD EDITION

Welcome



Session Objective:	This session is designed to welcome participants to the training
Session Overview:	A facilitator-led session where participants are welcomed by the faith leader or trainer
Session Summary:	The booklet gives guidance to the facilitator on how to welcome the participants, establish rules of engagement and create rapport.
Biblical Scripture:	*Do two walk together unless they have agreed to do so?* (Amos 3:3 NIV)
Scripture Emphasis:	To have a successful engagement, there needs to be agreement on basic rules, and concurrence on the goals and expectations of a group undertaking.
Islamic Scripture:	*The prophet said "Pursue knowledge even to China, for its pursuance is a sacred duty (*Ibn Abdal-Barr)
Scripture Emphasis:	Islam encourages undertakings on the basis of knowledge
Expected Learning Outcomes:	By the end of this session, participants will be able to: • Explain how HIV is transmitted through contact with bodily fluid transmission • Identify ways of reducing the risks of HIV transmission
Time:	1 hour
Resources Needed	Felt Pen, Flip Chart, name tag, note books and pens for all participants.

Welcome by the facilitators:

- Begin by welcoming participants to the training workshop and thanking them for being part of this training.
- Every member of the facilitation team introduces themselves to the participants.
- Each participant may introduce the self in a fun way e.g., acting out an animal they like and other participants guess what the animal is before the participants tell their names.
- Briefly explain why this training is important, mentioning the following points:
    - Much has been done over the past 40+ years on HIV prevention but it has not produced the desired results, especially among young people.

- Issues of sex, sexuality, gender and reproductive health and rights have not been dealt with adequately from a faith perspective.
- The training offers an opportunity to begin to break down barriers to talking about sexuality so that a more informed and compassionate dialogue can take place with adults and children. The first step is an honest exploration of our own views on human sexuality; sexual and reproductive health and rights (SRHR); HIV and AIDS; gender; personal relationships, and other important, related issues.
- Workshop participants are encouraged to be open to new learnings and to actively participate in all sessions.

Knowledge, Attitudes and Values Survey

Participants should be asked to complete the survey after the welcome at the beginning of the workshop, and again once the training has been completed.

The knowledge survey is an important tool for understanding the knowledge, attitudes, and values that participants bring with them about the topics covered in the Toolkit. Once the training is completed the survey will reveal if there has been any growth in knowledge and understanding and give an indication of how effective the training has been in equipping participants with new knowledge of HIV.

Participants' introductions: Step-by-step

Participants introduce themselves to the group

Ask participants to sit around in an open circle facing one another. There should be no desks, tables or other furniture interfering with free movement within the circle. One by one, participants should be invited to stand up and tell the group:

- Who they are (their name, or the name they wish to be called by during the workshop)
- Where they come from
- Where they work
- Why they are participating in this training workshop

The signature game

(sheet is available at the end of this session)

Session Objective:	This session is designed to enable participants to interact with and get to know one another in a fun and creative way.
Session Overview:	This session involves an interactive game where a **'Signature Game'** sheet will be handed out to workshop participants who will go around the room attempting to get other workshop participants' signatures on their hand out.
Session Summary:	The booklet gives guidance to the facilitator on how to welcome the participants, establish rules of engagement and create rapport.
Expected Learning Outcomes:	By the end of this session, participants should be relaxed and familiar with each other
Time:	1 hour
Resources Needed	**'Signature Game'** hand-outs for all participants.

Tip

for facilitators

Tips for facilitators

This session should be kept as simple and short as possible. The focus is on welcoming participants and orienting them to the workshop.

In your preparation, make sure you have enough hand-outs for the number of participants in the group.

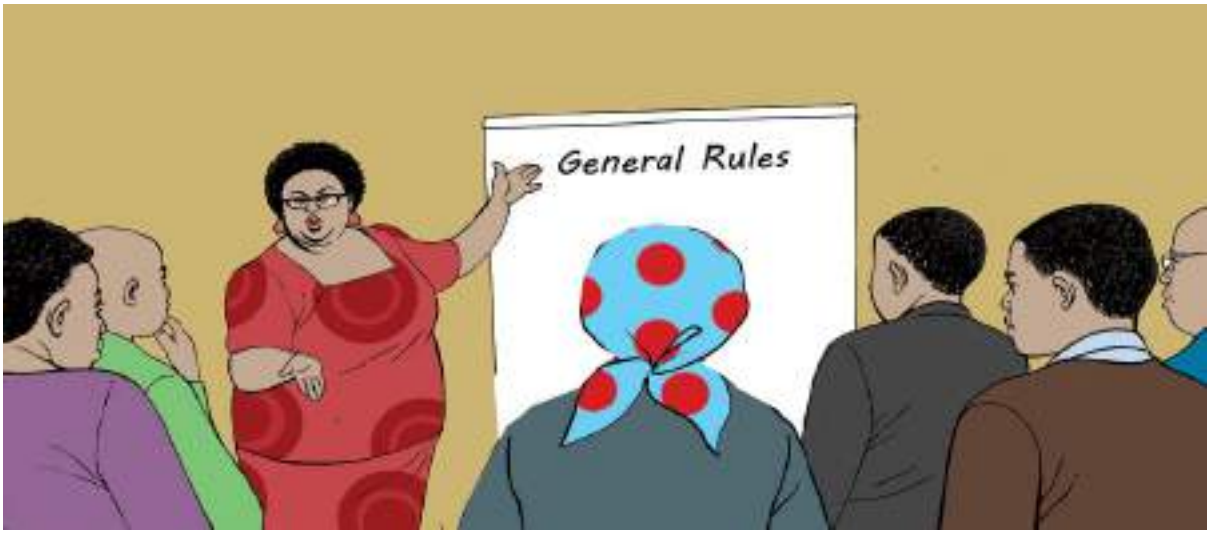
Signature Game:

- Explain to participants that they will engage in an exercise that will help them get to know one another better.
- Distribute the *Signature Game*, papers and pens to each participant.
- Explain that each participant must go around the room and get people to sign on their piece of paper according to the categories listed.
- Explain that the game's goal is not to get as many signatures as possible (as in a competition); rather, it is about getting to know people in a fun and creative way.
- Give participants approximately ten minutes to complete the game.
- Give participants a warning when there is one-minute left.
- Once everyone has done this, ask participants the following questions:
    - How did you find this exercise?
    - How did it feel to do this exercise with people you do not know?
    - Did you find any specific box that was difficult to get a signature in?
- Allow a few comments after each question.

- To round up this discussion: explain that it is important for everyone to get to know one another on a more personal level, as the work that follows requires that they work together and share experiences and challenges freely.
- Thank everyone for their participation.

Participants' expectations

- Explain to participants that the facilitators have shared the aims, objectives and expected outcomes for the workshop, and outlined the structure, design and approach of the training programme.
- Depending on the total number of participants at the workshop, ask the participants to:
  - gather in groups of three or four persons.
  - Decide on a person to capture their small group discussion on a notepad.
  - Share amongst themselves how they hope to benefit from the workshop.
- Facilitate a report back of the small group discussion, capturing the feedback on a flipchart.
- Place the flipcharts capturing participants' expectations on a wall somewhere in the meeting room that will be visible to participants for the duration of the workshop.



Establishing a group contract:

- Explain to the participants that it is important to set up general rules that will guide them to ensure that the workshop is a success.
- Ask participants to brainstorm ground-rules and write these up on a flipchart.
- Stick the flipchart with ground rules on it up on a wall for everyone to see.
- Through gentle questioning rather than prescribing, ensure that the following ground-rules are discussed:
  - **Confidentiality**: Whatever is said in the small group discussions may not be shared by others, unless explicit permission has been given by the participants.
  - **Respect and tolerance**: Different views and opinions on topics/issues should be received with an attitude of respect and non-judgment.
  - **Mobile phones:** Mobile phones should be switched off or put on silent mode to minimise disturbances.
  - **Full participation:** There should be a commitment from participants to engage with the content and share as much as they feel able to.

- **Time-keeping:** Both facilitators and participants need to agree to keep to the times allocated for each section of the agenda.
- **Sharing:** Participants should agree to speak one at a time and to listen respectfully, without interrupting, when somebody is speaking.
- **Environmental Care:** Both facilitators and participants need to keep the environment clean and safe all the time.
- **Penalties for not keeping to the rules:** You can ask participants to share their ideas on what should happen to someone who does not respect the group contract, and, provided it is not too punitive, agree to what participants come up with.
- **Monitors to guard the rules:** Invite two volunteers to be monitors for the day, explaining that their role is to ensure that the rules are observed. Different monitors can be appointed for each day of the training.

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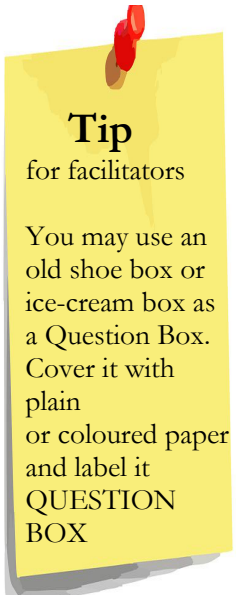


The Question Box:

- Emphasise that whilst the process-oriented approach of the workshop requires participants to open up and share their personal experiences and stories throughout the workshop, they are also advised to set their own limits for how much sharing they want to offer or the limits to the questions that they would like to pursue in public.

- Explain to participants that you will now take out a box which you will call a *Question Box*.
- The *Question Box* is as an anonymous way to raise issues or ask questions. Participants are encouraged not to put their names on the pieces of paper.
- Explain that there may be questions that come up in people's minds that they do not feel comfortable asking in front of the big group. Participants can write these questions on a piece of paper and put them in the *Question Box*.
- These may be questions or concerns about love, sexuality, sex, relationships, gender, HIV, AIDS, other STIs, contraceptives, sexual orientation or minority groups, and so on.
- Encourage participants to feel free to put their questions in the box and assure them that you will do your best to have them answered during the course of the workshop

Day-to-day tips for the facilitator

Pre-workshop preparation
For optimal use of this Toolkit, please read and understand the entire Toolkit. Familiarizing yourself with all the content is important because different sessions overlap.

Size of the group
A group of not more than twenty people works best. You may decide that a smaller group is preferable in the light of your level of experience and the diversity of the people in the group. Shy people participate more fully in a smaller group. In large group they might feel discouraged and unable to speak freely.

Gender, diversity, and inclusivity
When dealing with the group members take into account their gender, sex, level of education, abilities, marital status, social class and other variables in order to be sensitive and responsive to their different expectations and needs.

Time-keeping
Once you have gone through the agenda before each session, ask the group to choose one person to be the time keeper. This person should participate like everyone else while at the same time being mindful of the time allocations for each section of the workshop and reminding the facilitator, if necessary, when it is time for breaks, lunch, reflection time, group work, etc.

Permission from parents
When working with young people, you need to make sure you are working with them in an open workshop, i.e. the community knows about their participation in the workshop and nothing is being hidden. Parents or guardians need to give permission for young people to attend the workshop as some of the content and issues covered are controversial and graphic. It is not your role as the facilitator to rock the boat but to get everyone interested in learning and taking part in the discussions. For many people, HIV is confused with moral teaching but the purpose of this Toolkit is very clear: To provide comprehensive information in order to ensure they know everything they need to know in order to protect themselves from HIV infection. Under no circumstances is this Toolkit designed to encourage people to experiment or deviate from their moral position, but rather equip the individuals and communities to challenge HIV holistically.

Dealing with dominant people in the group
In a group setting, you will always get someone whose voice is heard more than others and whose opinions are stronger or more dominant than others. This is good as it shows their eagerness to take part, but it can also be intimidating to the other participants. Timid people might shy away from taking part because of the dominance of one or more participants. As the facilitator, you need to find a way to encourage others to speak while not discriminating against the dominant voices. Your particular style of leading will come in here. Remember, you are the leader and your role is to guide and encourage people in a space that allows participants to absorb new information and share their ideas and concerns confidently and without prejudice.

Parking lot

If a question is asked for which you do not know the answer, say: "I don't know but we can all find out later and report back tomorrow." Then write the question down on a piece of flipchart paper with the heading: "Parking Lot" on it. This should be stuck on the wall and added to whenever a question has not been dealt with fully. When you return for the next session, you can all report back on the answers to the questions that you have gathered. It is better to admit to not knowing the answer to a question than trying to bluff your way through, giving incorrect or misleading information.

Follow up

How are you as the facilitator and trainer going to follow up on the work you have done? How are you going to keep in touch with the people from the group? How will you give updated information to the group?

These are questions that you need to think about as a facilitator. You are not only training participants; you are also building relationships with communities. These relationships should not end once the trainings have ended. You should develop contact sheets and provide monthly/quarterly updates for all participants in the training workshop.

Personal commitment

This section is for the participants: After they have been trained, what are they going to do with what they have learned? How are they going to take this information forward? What commitment are they going to make?

A commitment could range from telling a friend or family member what they have learned, to arranging another training workshop for a different group of people, to community advocacy work. Each commitment, no matter how small, is important. A personal commitment to safer sex is also a very important outcome.

Flexibility

You should remain flexible on how to shape the various sessions. Some sessions may run longer than expected due to the relevance of some issues to a certain community, and topics to some groups might need more thorough explanation than others. You need to keep an eye on the time but allow people enough time and space to understand the session. You can always move a module to the next meeting of the group if necessary.

Energisers

These are tools which can be used at any time. The best time to use them is when you see the group fading, for instance, they may be tired from too much information. An energiser is a way to get the group to wake up and re-engage with the material by having fun and putting smiles on their faces. See Appendix.

Opening the day/session

Gather participants in a circle and before you begin the first module, ask them to express what they learned from the previous session or meeting. This is a great way for people to share and take part in acknowledgement of the learning. It also serves to reinforce lessons learned.

Closing the day/session

At the end of each day, have a round-up - gather in a circle and enter a moment of reflection as a group. Allow people to speak about anything that is on their minds, including frustrations, so that nothing negative is carried over to the next time you will meet.

Multi-faith environment/Neutral environment

When working with a multi-faith group, you want the training venue to be in a neutral setting so that everyone taking part feels comfortable and no one will feel intimidated by the surroundings. This neutrality will allow for greater participation and openness.

Devotions

Whether working with a single faith or multi-faith group, it is nice to start the meeting with devotion. You can pick a theme that will suit that day of training. A person from a different faith can lead the devotion each day.

Facilitating the process-oriented Approach

The process-orientated approach starts with personal reflection for the participants, and then moves on to general issues. To be able to facilitate this process, you need to be in touch with your own values and feelings about these issues. The success of a workshop is dependent on how well you, as a facilitator, are able to talk about difficult issues without your own values influencing the group's discussion.

As the workshop participants will go through a personal reflective process, it is important that they feel comfortable, free and confident to participate and to reflect on their experiences and feelings in an accepting and warm environment. Your own people-skills will determine how participants respond to your workshops. Here are some tips on how to create the right kind of conducive environment in your workshop:

- Get to know your own personal strengths and weaknesses.
- Understand the opportunities that the workshop holds.
- Investigate the potential barriers that you might face, such as cultural or religious attitudes.
- Read, listen and gather information which will be useful in your training.
- Gather as much knowledge and information as you can before the workshop so that you are prepared for questions on a wide range of topics.
- Keep up to date with information and research so that you are well-informed and can pass this information to your participants.
- Do not pass on information which has not been verified – there are many myths and dreams round HIV. It is wrong to lead people into false hope or fear.
- Be clear about your outcomes. Know what you are trying to achieve, why you are there, what you expect, and what type of knowledge you want people to have.

- Understand the reason behind what you are doing in the workshop.
- Have a plan, but be prepared to be flexible and creative.
- Ensure that you have done all the necessary preparation.
- Arrange your room so that it creates a conductive environment for participation.
- Avoid furniture that cuts people off from each other.
- Arrange seating so that everybody is on an equal level.
- Get close to the participants so that you break down barriers and make the
- space for open communication.
- Ensure that everybody in the group can see and hear one another.
- Try to minimise any outside interference or disturbance to your workshops.
- Get to know your workshop participants as early as possible.
- Establish ground-rules for your workshops right at the beginning.
- Use effective icebreakers to get the participants comfortable with one another
- Use a variety of different methods, and mix these around so that people are
- engaged in different ways at different times.
- Find smooth ways to transition from one exercise to the next.
- Make people feel safe by being accepting and acknowledging all contributions.
- Be aware of your own body-language, posture and mannerisms and how
- these affect participants.
- Use eye contact and participants' names to keep them engaged and part of
- the group.
- Use non-verbal signs such as smiling and nodding when listening.
- Make note of the dynamics and power-positions in the group and how these might affect your workshop outcomes.
- Avoid stereotyping, judging and criticising the actions, thoughts or beliefs of others, and challenge the participants if they are doing so.
- Affirm the participants through positive acknowledgement of their input.
- Use stories, anecdotes and experiences that will help people to understand what you are talking about.
- Keep your use of language simple, straightforward and appropriate for your audience.
- Paraphrase what people are saying to ensure that you understand them correctly (but ensure that this does not become mechanical).
- Use open-ended questions to encourage participation.
- Speak loudly and clearly enough so that everybody can hear you.
- Always ask for feedback at the end of the training.
- Allow yourself to make mistakes – but learn from those mistakes and find ways to improve your training.
- Confidence comes in part from knowledge, self-awareness, and self-motivation.
- Practice and practice some more to build your own confidence
- Have fun – and your participants will have fun too!

Working with values games

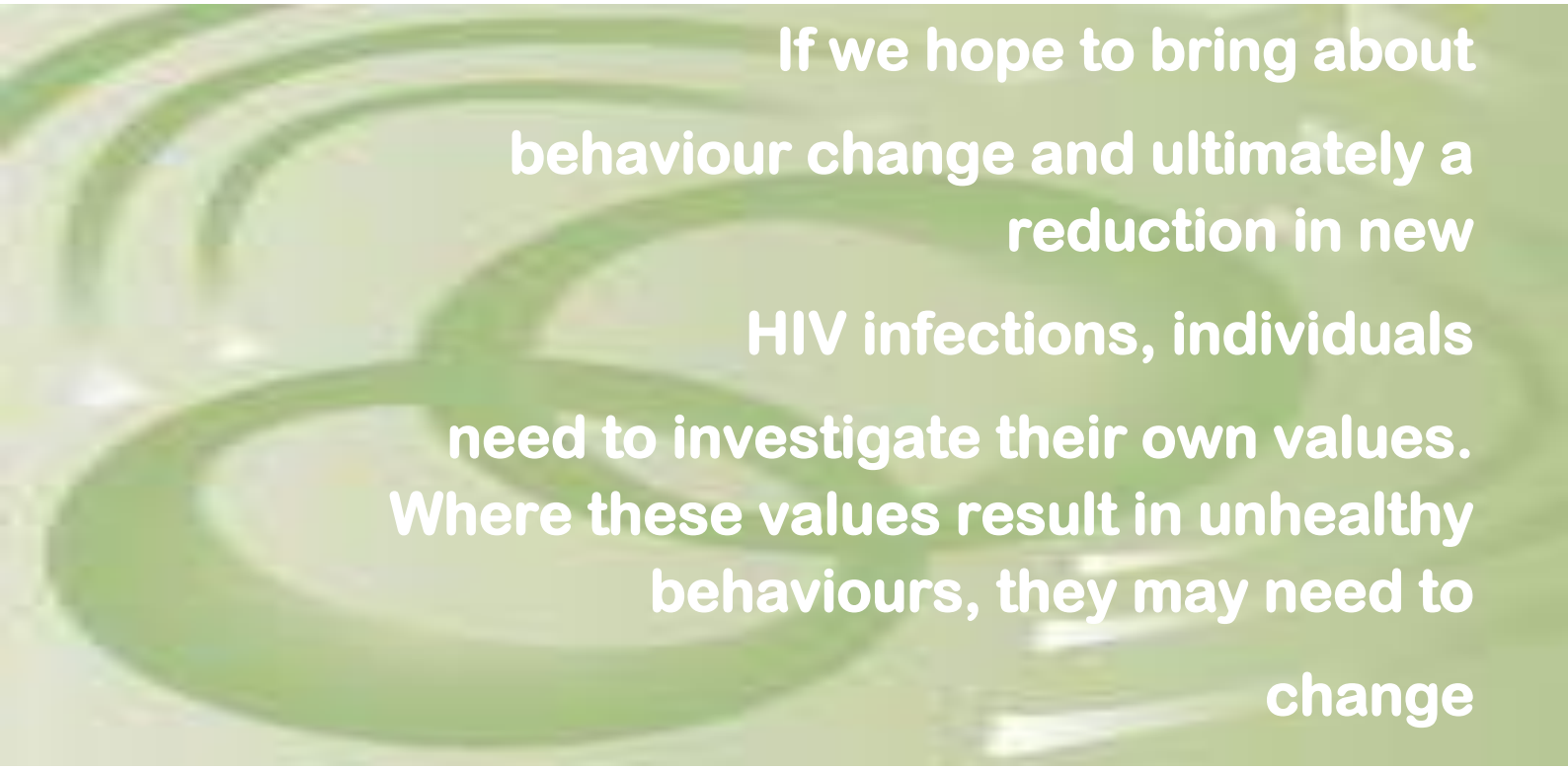
This Toolkit includes a number of games that explore people's values and attitudes. Values are the core beliefs, principles or general rules about how we choose to live our lives. Many of our values about human sexuality are influenced by what we perceive as the norm in our own communities regarding sexuality and gender roles. These values come from our families, mass media, and religious, cultural and societal messages about what is perceived as "right or wrong".

If we hope to bring about behaviour change and ultimately a reduction in new HIV infections, individuals need to investigate their own values. Where these values result in unhealthy behaviours, they may need to change.

Using games to explore and challenge these values is an important part of the process-oriented approach. We suggest games in this manual that explore particular values that are linked to different topics. These games are a good way to find out how we really feel about certain issues. The discussion after these games allows us to see the consequences of holding particular views.

When using these games, make sure that the issues you are addressing are genuine values and are not facts or opinions. Use realistic situations and statements that the group is able to relate to in your games and examples.

Ensure that your approach is non-judgmental and encourages the group to participate and to share their own values. You need to make sure that the environment that you create in the workshop is one where people feel safe to share these personal values, and you should thank them for doing so.



Workshop Evaluation

Session Objective:	The session is designed to provide workshop participants with an opportunity to objectively evaluate the success of the training in terms of the adequacy of the content and the facilitation process in attaining expected outcomes.
Session Overview:	Participants reflect individually and provide written answers outlined in the evaluation form.
Session Outcome:	By the end of this session, facilitators will be able to tell what worked well and what did not work well in terms of the content and the facilitation process in attaining expected outcomes.
Time	30 minutes
Resources	Prepared evaluation sheets

Individual written evaluation:

Tip for facilitators

Remember to emphasize that evaluation forms must be filled in anonymously.

The first part of the form will be completed immediately before the start of the workshop and again at the end of the workshop together with the second part. Please see the pre-workshop and post-workshop evaluation forms in the section titled 'Extras'.

The feedback from these forms will not be used to evaluate the participants, but rather to improve the training and facilitation of the programme.

- Explain to participants that the written evaluation sheets that are being handed out should be completed by each individual.
- The aim of the personal evaluation is to ascertain whether the expected outcomes of the training event were achieved; and to evaluate the workshop with a view to improving facilitation processes at future training events.
- After they have completed answering the questions as honestly as possible, collect all evaluation forms and thank participants for their input.
- Please note that this same evaluation will be repeated at the end of the workshop.
- An evaluation sheet should be provided for each participant individually before the workshop and after the workshop

- The difference in individual score before and after the workshop indicate impact of the workshop

INERELA + Positive Faith in Action
Workshop Evaluation Questions

Note: This knowledge, attitudes and values evaluation is confidential and ANONYMOUS. Do not write your name anywhere on this form. We would like you to complete it honestly. We need your honest views to assess the impact of the workshop in order to improve the Toolkit and deliver better services. Please do not leave any questions blank.

Part 1

Age	Sex	Type of community
		(Insert a number (1-4) as indicated below)

1. Urban – I live in a large city
2. Peri-urban – I live outside the city on a plot of land
3. Small town – I live in a small town
4. Village – I live in the rural areas

Questions:

Please circle YES or NO

1.	There is no need for me to know about HIV because I am not at risk.	**Yes**	No
2.	I think women with many sexual partners are loose women.	**Yes**	No
3.	I think men with many sexual partners are loose men.	**Yes**	No
4.	I believe that Persons Living with HIV bring contamination into my community.	**Yes**	No
5.	I believe that Persons who are Living with HIV should not have sex.	**Yes**	No
6.	I think AIDS is God's way of punishing homosexuals.	**Yes**	No
7.	I think AIDS is God's way of punishing sexually immoral people.	**Yes**	No
8.	I believe good sex education for children and teens is essential in reducing HIV transmission.	**Yes**	No
9.	I think that masturbation is a SAFER sex practice.	**Yes**	No
10	I know that women can transmit HIV to men.	**Yes**	No
11	I know that men can transmit HIV to women.	**Yes**	No
12	I think that a woman who asks for a condom to be used during sex must have many partners.	**Yes**	No
13	I think that a man who uses a condom during sex with his partner is not man enough.	**Yes**	No

14	If my partner is living with HIV, I would drive them out or leave myself.	**Yes**	No
15	I think that circumcision ensures that a man is not at risk of HIV transmission.	**Yes**	No
16	I believe that governments need to develop laws that punish people who transmit HIV	**Yes**	No
17	I think that lesbians (women who have sexual relationships with women) should be made to have sex with men.	**Yes**	No
18	I know that anti-retroviral therapy (ART) cures HIV.	**Yes**	No
19	I would not allow my children to play with children who are living with HIV.	**Yes**	No
20	If I test positive for HIV, I will not be able to care for my children.	**Yes**	No
21	I think that a Person Living with HIV should not be allowed to have children.	**Yes**	No
22	I know that using a condom during sex is 100% safe in preventing HIV transmission.	**Yes**	No
23	I think that sex workers who are living with HIV should not have access to HIV treatment such as ART.	**Yes**	No
24	I think that Persons Living with HIV should not be allowed to have formal employment.	**Yes**	No
25	I know that good nutrition supports the immune system of Persons Living with HIV.	**Yes**	No
26	I know that having multiple sexual partners does not lead to HIV transmission.	**Yes**	No

Part 2: How Do You Feel About the Training?

Please comment on the training that you have attended. This is anonymous feedback to help facilitators refine and improve their own training.

1. Were your expectations of the training met?

2. Were the outcomes stated by the facilitator?

3. Were you encouraged to actively participate during the workshop?

4. Were you given opportunities to express yourself?

5. Were you given opportunities to ask questions?

6. Were all your questions answered to your satisfaction?

7. Were there areas you felt you needed more information?

8. Which sessions were most interesting for you?

9. Were there any sessions you felt were unnecessary?

10. Was there a good balance of different activities in the training?

11. Were the training materials and hand-outs useful to you?

12. How do you feel about how the facilitator managed the training?

13. Do you feel that the facilitator had adequate information and experience?

14.Would you recommend this training to others?

15.Who do you think could benefit from it?

16.How can you take the information from this training forward in your own work/life?

17.Are there any other comments you would like to add?

The Signature Game

Find three people with a hairstyle you like. Sign here: 1. 2. 3.	**Find someone with a birthday in the next three months.** Sign here:	**Find someone of the same religion.** Get him/her to Sign here:	**Ask someone why she/he is attending the workshop.** Sign here:
Link arms with two people. Sign here: 1. 2.	**Tickle someone.** Get him/her to sign here:	**Find someone with an earring.** Sign here:	**Shake hands with three people.** Sign here: 1. 2. 3.
Swap sitting positions with someone. Get him/her to sign here:	**Find someone with brown eyes.** Get him/her to sign here:	**Give three people a hug.** Sign here: 1. 2. 3.	**Find someone taller than you.** Get him/her to sign here:
Find someone who is prepared to take risks. Get him/her to sign here:	**Find someone wearing black socks:** Get him/her to sign here:	**Find someone younger than you.** Get him/her to sign here:	**Find someone who likes chocolates.** Get him/her to sign here:

Reflection and Notes

SAVE

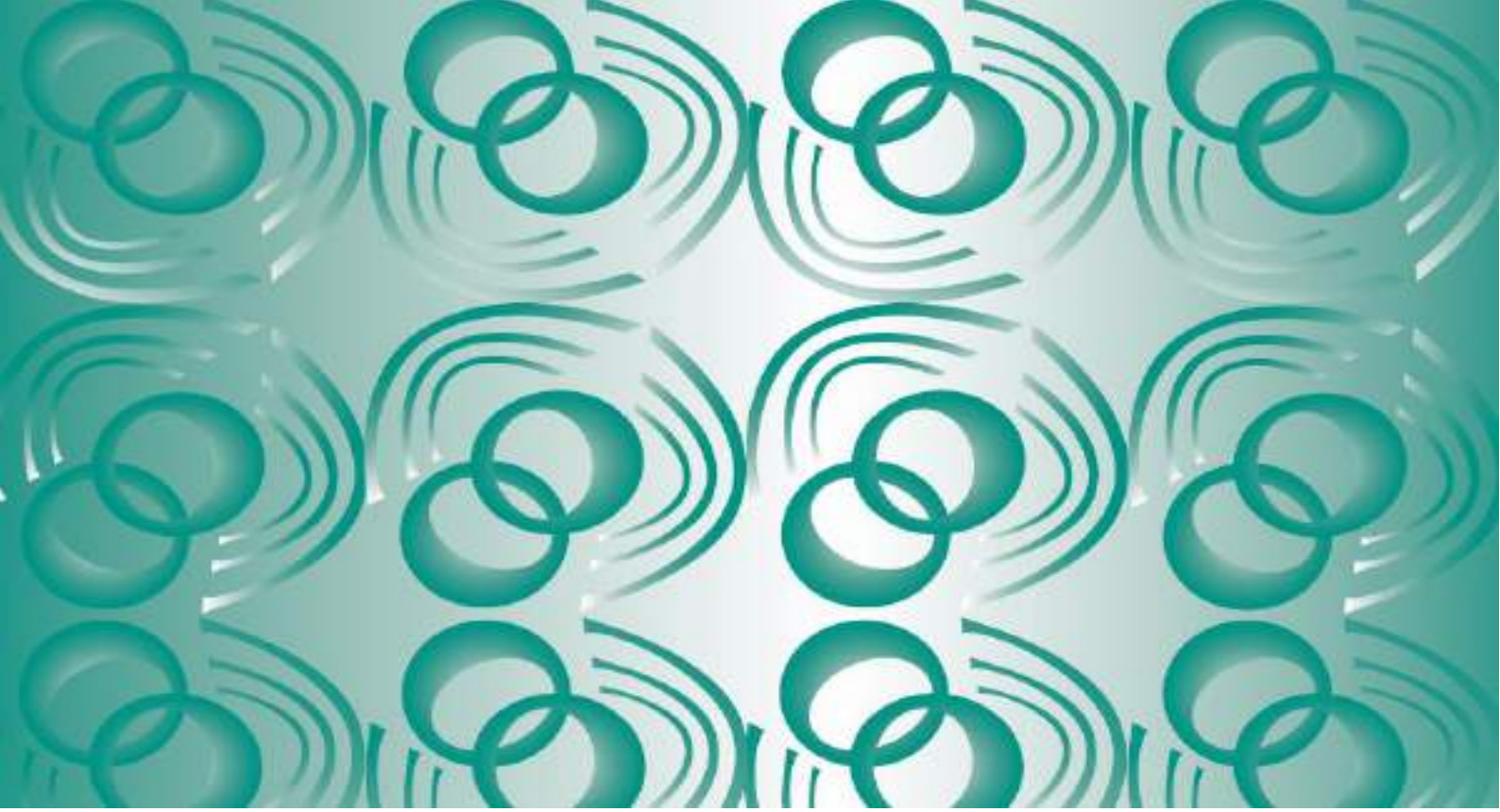
TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

SSDDIM: STIGMA, SHAME, DENIAL, DISCRIMINATION, INACTION, MISACTION



Introduction to SSDDM

THIRD EDITION

Stigma, Shame, Denial, Discrimination, Inaction and Misaction

Note to facilitator:

This section can become quite theoretical. Based on the dynamics of your group, you will need to determine how much of this material should be covered in detail. There will be a natural break in the module when you have completed the SSDDIM wheel. For many groups it is suggested that you move from there on to tackling SSDDIM. A smaller number of groups may need to work through some of the theory that is provided. However, as a facilitator you should have worked through the theory section.

This module is only an introduction to the concepts of SSDDIM and is followed by more in-depth modules on the various aspects of SSDDIM.

Session Objective:	To illustrate that Stigma, Shame, Denial, Discrimination, Inaction and Misaction or SSDDIM arise out of fear and anger and lead to HIV infections and AIDS-related deaths.
Session Overview:	Stigma, Shame, Denial, Discrimination, Inaction and Misaction or SSDDIM arise out of anger and fear. The core aim of addressing SSDDIM is a conscious effort to recognise the fears, and through good information, reduce fear, thereby reducing the drivers of SSDDIM.
Key Message:	Fear and anger results into SSDDIM which leads to HIV infections and AIDS-related deaths.
Biblical Scripture:	*For God gave us a spirit not of fear but of power and love and self-control* (2 Timothy 1:7, ESV).
Scripture Emphasis:	We should not live in fear, rather our actions towards others should be exercised in love and self-control.
Islamic Scripture:	*And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient, who, when disaster strikes them, say, 'Indeed we belong to Allah, and indeed to Him we will return.' Those are the ones upon whom are blessings from their Lord and mercy. And it is those who are the [rightly] guided.* [Qur'an 2:155-57]
Scripture Emphasis:	The world is full of different types of calamities and disasters at individual and community levels. God advises that in such cases we need to put our trust in Him and he will definitely give us relief. We should not succumb to fear.
Session Outcomes:	By the end of this session, participants should be able: • To explain why Stigma, Shame, Denial, Discrimination, Inaction and Misaction (SSDDIM) leads to HIV transmission and AIDS-related deaths. • To Illustrate how SSDDIM arise out of anger and fear
Toolkit References:	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed	A ball of string

Introduction:

***Activity**:*
Note that this activity also appears in the Introduction to HIV and AIDS. If you do the activity here, you do not need to repeat the same activity in the later section.

***Purpose**:*
The purpose of the activity is to check that the group understands that they are all connected; although they are individuals, they are also part of a community; and therefore, demonstrate the need for each person to play their role in their communities and play it well.

You will need a ball of string

Ask all the participants to sit in a circle. Explain to the participants that this training is designed to give each and every one of them good information about HIV and AIDS. However, along with the information will come emotions that may be difficult to cope with. Some of them may be angry, some sad as we all have stories about HIV that have touched and affected our lives. Thus, we need to create a safe confidential space so that we can all share our experiences.

Hold the ball of string in your lap and explain that you will be throwing it to a participant. Before you throw it, the participant will answer the question: "Why am I attending the training and what do I hope to gain from it?" Holding on to the end of the string, throw the ball of string to the next participant, who will catch it and you will be linked by the piece of string between you. The participant should answer the same question.

Then, holding onto their end of the string, they throw the ball to the next participant, who answers the same question and throws it to the next. This process continues until everyone has had a chance to catch the ball of string, answer the question and throw it on.

When it is completed, ask the participants to look at what they have created. Someone should say that this looks like a web. Explain that each person in the group is connected by the web. If we each keep hold of our end of the web, we will remain connected. Furthermore, we are all supported by the web. If someone does not hold on to their section of the web it will break, which will break the connections within the group.

Why a focus on SSDDIM?

Certain psychologists tell us that all human beings feel four key emotions: anger, sadness, joy and fear. All other emotions flow from these four. Stigma, Shame, Denial, Discrimination, Inaction and Misaction or SSDDIM arise out of anger and fear. The core aims of addressing SSDDIM in separate sections and throughout the rest of the Toolkit is to recognise fears, and through information, reduce fear, thereby reducing the drivers of SSDDIM.

Note for Facilitators:

When it is completed, ask the participants to look at what they have created. Someone should say that this looks like a web. Explain that each person in the group is connected by the web. If we each keep hold of our end of the web, we will remain connected. Furthermore, we are all supported by the web. If someone does not hold on to their section of the web it will break, which will break the connections within the group. One participant may let go of the string to demonstrate what happens when only one person in a community does not play their role.

What do we fear about HIV? What do we fear about AIDS?

Questions:

Ask the group these questions: What do you fear about HIV? What do you fear about AIDS? Write the responses on a flipchart and keep them visible throughout the sessions.

You may get some of the following answers:

- Fear of the unknown
- Fear of being contaminated
- Fear of not having access to resources if they are needed (this is true in communities where basic resources are lacking)
- Fear of being excluded by people whom we love
- Fear of leaving our children orphans
- Fear that we cannot do anything about AIDS (especially true in places where there is lack of access to ARV treatment)
- Fear of death
- Assure people that these fears are normal human response to HIV and AIDS. It is how we deal with our fear that remains key to reducing SSDDIM.

The tentacles of fear

- Knowledge
  - For many people, their knowledge of HIV and AIDS is gained at community level. Even if they have access to positive media messages and good training on HIV and AIDS, they have seen SSDDIM in their communities, and perhaps have experienced it through close family ties. Naturally, no one wants to be excluded from their community.
  - In many communities, particularly those that do not have access to good HIV and AIDS medical treatment, people have seen others die. Where there is no intervention, either to challenge stigma or make treatment available, death from AIDS is slow and painful.
  - Misinformation from unregulated mass media sources which are mostly driven by consumerism.

- Practices
  - Unprotected sex with a person who is living with HIV is the main mode of transmission for HIV. In many communities there are taboos around sex and sexual practice. As human beings we are created to have and enjoy sex; however, this is not the message that we receive. Thus, sex is forced underground.
  - In adopting SAFER sexual practice, we may be going against the customs and traditions of our society. Once again, we can fear ridicule and shame from adopting a sexual practice that is different. While the sexual practices may be safe for ourselves and our partners, we may not feel safe in our communities.
  - Sex education around SAFER sexual practice may cause the fear that we will be promoting promiscuity. Sex education may also be difficult for mothers, fathers and other care-givers because of cultural taboos. A good sex education is possibly the strongest SAFER sexual practice a community can adopt but we can, once again, fear the misery of rejection.

- Attitudes
  If fear becomes our attitude towards HIV and AIDS, this will spill over to persons living with HIV and AIDS.

  We will:
  - Regard persons living with HIV and AIDS with suspicion and a threat to our wellbeing. Our behaviour will then result in denying persons living with HIV and AIDS the resources to lead positive lives.
  - Be anxious about our own health and that of our loved-ones

- Be frozen as to how to interact with Persons Living with HIV and AIDS and thus deny ourselves and them the gift of friendship. We could feel overwhelmed by the scope and extent of HIV and AIDS
- We can feel vulnerable and afraid

Living in fear is a debilitating way to live. In terms of HIV and AIDS it leads to SSDDIM

The SSDDIM wheel

In response to the fear that occurs around HIV and AIDS and the stigma, shame, denial, discrimination, inaction and misaction that result, INERELA+ designed this section of the Toolkit to address these issues separately to reduce people's fear.

Note to the facilitator:

Please draw this wheel as you explain concepts

- *The rim of the wheel is fear.*
- *Inside the wheel we have the six spokes that develop out of that fear.*
- *In the middle of the wheel is the result of SSDDIM – Continued HIV transmission and continued death from AIDS.*

Thus, if we weaken any one of the spokes that hold up our fear, the wheel begins to buckle. As this process takes root, we lessen fear and the wheel becomes useless. As a result, the transmission of the virus is halted and death from AIDS-related illnesses becomes a tragic memory in human consciousness.

In contrast, if SSDDIM is strengthened, the wheel simply gains pace which increases the risks and vulnerabilities that can lead to HIV transmission. It can also further inhibit people from accessing treatment and services and thus increase the number of people dying from AIDS-related illnesses.

NOTE: At this point most groups can move onto the exercises directly related to SSDDIM.

Developing SSDDIM in individuals and in communities

SSDDIM develops in stages in many ways, both in individuals and communities. (Note: The text loosely adapts the Kohlberg stages of moral development). Social scientists theorise that we have to move through these stages, but some move faster than others and we can get stuck in one stage or another. In this brief scheme we will be looking at responses to HIV.

Stage 1

- **In the first stage we focus on the direct consequences of our actions.**

Thus "if I do something wrong, I will be punished." The punishment comes from an authority figure. There is also the understanding that "if I do not get caught, I will not get punished."

- The worse the punishment, the worse the crime.

Question:

How does this impact our understanding of HIV in terms of SSDDIM?

Note to facilitator:

***You are looking for the following responses*:**

- *The punishment for sex outside of marriage is that you get AIDS and you die.*
- *The punishment for being homosexual is that you get AIDS and you die.*
- *A person has sinned and is being punished. We must accept the punishment.*
- *Sex is driven underground – if I am not caught, I will not get AIDS and die.*
- *Note that while many of the responses you receive at this stage may be referring to AIDS - HIV and AIDS are not the same thing. AIDS cannot be transmitted. Only HIV can be transmitted. People don't die of HIV: they die of AIDS-related illnesses, or even the shame and stigma associated with HIV.*
- *While this may not be the right place to introduce people to the differences between HIV and AIDS, you as facilitator need to keep this in mind. By the end of this session start introducing the differences, and the way in which the use of wrong terminology can feed our misunderstandings, actually increasing the SSDDIM rather than decreasing it.*
- *At this level AIDS is often the focus because people regard this death as a punishment. This results in the belief that the punishment (which is severe) must fit the crime, and therefore the crime must have been awful.*
- *The punishment usually comes from an authority figure. For AIDS, individuals and communities have generally (although not always) ascribed this authority to God. Therefore, the community needs to support this punishment.*
- *In setting up this idea of crime and punishment, people and communities can justifiably set up the concept of "us" and "them"*

Questions:

In terms of persons living with HIV, what negative words do you use or have you used to describe them? What words do you use for a person whose HIV status is unknown but it is suspected that they may test positive for HIV? How and why do we use such words?

Note to facilitator:

You are looking for some of the following:

- *Unclean*
- *Contaminated*
- *Infectious*
- *Sinful*
- *Evil etc.*

All of the above words ensure that there is a group that is considered "pure" and one that is considered "impure"; lawful and unlawful; moral and immoral etc.

- The social structures of communities will begin to harden their taboos around sex. There will be absolute positions about what are acceptable behaviours and unacceptable behaviours.
- The goal here is to ensure that one group remains "pure" by excluding the group that is being "punished".

Global Question:
What behaviours by individuals and communities reinforce SSDDIM?
Identify the "sinful" act and the punishment. Keep the focus on HIV.

Note to facilitator:

Deal with each area of stigma, shame, denial, discrimination, inaction and misaction. It would be useful to have flipchart paper where you write each behaviour down in terms of where it falls. You might have an action where it falls into two different categories. Stress the crime and punishment idea.

Here is an example:

A young man that you know is thought to be homosexual. He has had a couple of girlfriends but does not date extensively. He has a small group of friends with whom he spends time – all male. These friends keep to themselves.

To teach him a lesson, a group of students from his school decide to give him a severe beating just in case he is homosexual. Some of his friends also participate in this beating. A warning to him is that this is unacceptable and not normal. He is left to make his way home by himself even though he needs medical help. Where would you stand?

SINFUL ACT (as seen by the young man's peers):

STIGMA:

- Peers: Homosexuality is not normal and needs to be corrected.

SHAME

- Peers: Having a homosexual person as part of our group brings shame to all of us. The person needs to be removed or corrected.
- It is not normal to be homosexual. Even though his peers do not know whether or not he is homosexual.
- His friends may not want to be associated with a person who is suspected of being homosexual, thus they participate in the beating to show others that they are "normal".

DISCRIMINATION:

- Peers: He is singled out for a beating

DENIAL:

- Peers: Believe that homosexuality is a choice and not a biological
- Self: If the young man is homosexual, he needs to hide his sexuality by going out with girls. This enables him to appear as if he is conforming to the norms of the wider group.

INACTION:

- Peers: No one is prepared to step in and prevent the beating. They may fear that by showing compassion they will also be considered homosexual and become a future target.
- No one is prepared to help him get to a doctor. Once again, fear of rejection and retaliation from one's peers comes into play.

MISACTION:

- Peers: Violence of any sort is an inappropriate response to people who have a different sexual orientation.

Stage 2

- **In the second stage the focus of action becomes laws, and obeying laws.** Thus, the focus moves to upholding "the law" and increased conformity to what is seen or understood to be correct.
- This differs from the crime and punishment model as people begin to interact with their society. Thus, obeying "the law" or "the tradition" or "the culture" preserves society, and so everyone is expected to obey. If an individual step outside "the law" or "tradition" or "culture" they will cause chaos for everyone. No one will know their role in society.
- If you disobey "the law" or "tradition" or "culture" you will be punished and you will bring chaos to society. Punishment for disobeying "the law" generally comes from a whole group of authority figures within the community.

Question:
Why is disobeying the law or tradition or culture in the context of HIV infection lead to SSDDIM?

Note to facilitator:
You are looking for responses such as:

Persons Living with HIV bring contamination into the community.
Getting HIV means that you have been immoral - you have broken the 'law'
Although you can treat HIV you have brought death to this community.

Note: These ways of thinking are generally more focussed on living with HIV rather than death from AIDS-related illnesses. The punishment is in the hands of the authority figures or institutions with the community. Thus, the community has the right and the responsibility of punishment

- The community and institutions of authority use their authority to force people into conformity with the community-accepted traditions. Not only are Persons Living with HIV excluded from communities, but their care-givers, family members and friends are as well. Essentially the circle of SSDDIM widens.
- Attitudes about "acceptable" sex and "unacceptable" sex are hardened.

Question:
What is 'acceptable' sex and what is unacceptable sex in your tradition?

Note to facilitator:
Simply note these down as attitudes towards sex. They are dealt with at a later stage in the Toolkit.

Question:
What actions does your tradition take to ensure conformity to 'acceptable' sexual practice?

- People will often use the phrase – "that is not in my tradition". The reference point for moral action becomes law or tradition.

Stage 3

- **During the third stage the focus for action becomes more personal.** People begin to think about their actions in terms of creating an environment which benefits the community at large rather than any individual.
- Individuals begin to take on responsibility for their beliefs and feelings. They may refer to "tradition" but they rely on an inner personal morality to drive their actions.

Question:
How does this impact our understanding of HIV in terms of SSDDIM?

Note to facilitator:
You are looking for responses such as:

- Persons Living with HIV should live outside the community because their sexual immorality will encourage young people to be promiscuous. Women living with HIV should be sterilized so that they cannot pass HIV to their babies.
- Moral positions on HIV harden during the stage of development.

The BIG Question:
If compassion for others was our central moral value, how would that change attitudes and behaviours through the levels of moral development?

Note to facilitator:
For example:

- ***Stage 1:*** *The crime is lack of compassion, and this lack of compassion leads to long lingering death. This is especially true as HIV becomes an increasingly manageable condition.*
- ***Stage 2:*** *The law of compassion would compel individuals and groups to embrace and care for each other.*
- ***Stage 3:*** *Each individual act from a centre of compassion.*

Note to facilitator:
We all move through these various stages of development. They key is to make compassion the central way of relating to the world.

The role of institutional religion in SSDDIM

Institutional religion is a very important part of a society's culture in many parts of the world. Perhaps in Western Europe the influence of religious institutions may be declining, but in other parts of the world their voice is being heard increasingly clearly. Institutional religion has the following functions:

- It is a moral voice and is therefore recognised by large, concentrated sections of people
- It gives people certainty in times of chaos and fear
- It can choose to be the voice of the voiceless OR the voice of the powerful
- In many contexts it provides important social welfare services
- It provides access to often scarce resources

Questions:

- If your religious institution represented the voice of power, what would it be saying about HIV?
- If your religious institution was a voice for the voiceless, what would it be saying to Persons Living with HIV?
- Should religious institutions be right or should they be compassionate?
- When does the silence of religious institutions speak louder than their words?

Notes to facilitator:

These questions may either be tackled in a group or through individual reflection. You will need to decide based on the interactions of the group.

Questions:

- What is my gift to the world and how do I use it?
- How would you feel if you were not allowed to use this gift? How would you act?
- We all know People who are Living with HIV, or we may ourselves be living with HIV. What are the gifts that they have given to us and to the world? How would our lives be less rich without their influence?

Sex, Sexuality and Gender

In terms of sex, sexuality and gender we often have a very divisive theology. Throughout the Toolkit you will be encouraged to engage in discussions around these issues. However, at this stage it is important to recognise that the lack of discussion about sex, sexuality and gender is a huge driver of SSDDIM. We will come back to this later on in this Toolkit.

Reference

You Tube Video: Kohlberg's Stages of Moral Development
https://www.youtube.com/watch?v=f0axVjiTe9Q

Reflection and Notes

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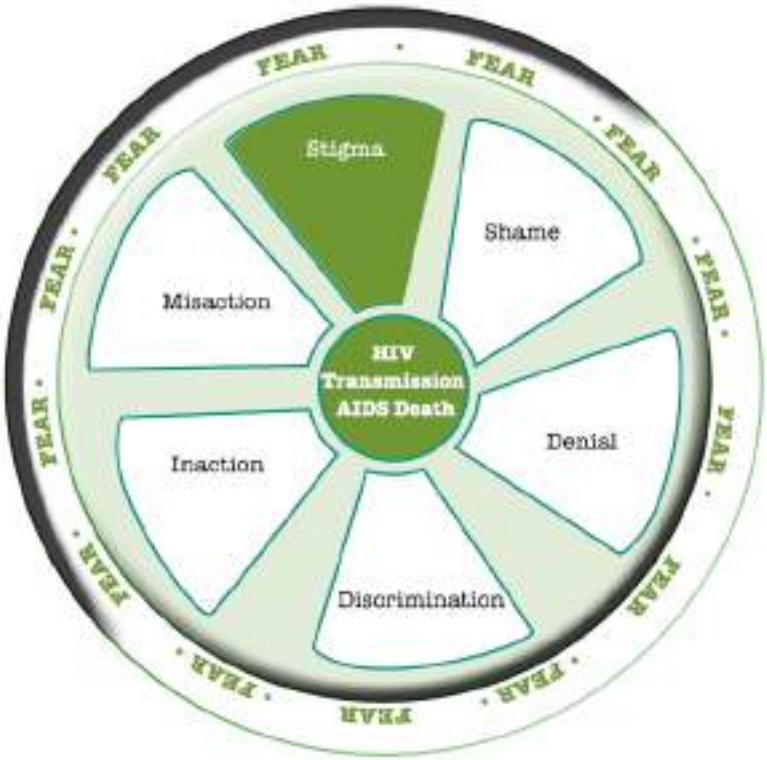
Stigma

THIRD EDITION

Stigma

Session Objectives:	This session will enable participants to understand how stigma contributes to the transmission of HIV and to AIDS-related deaths.
Session Overview:	What is HIV stigma? Cause of Stigma; Stigma emanates from fear. Usually, fear is caused by lack of knowledge about something. Stigma is the death sentence – not HIV. Stigma spreads HIV and leads to AIDS-related deaths.
Key Message:	Stigma resulting from fear leads to HIV infections and AIDS-related deaths.
Biblical Scripture:	*There is no fear in love; but perfect love casts out fear, because fear involves torment. But he who fears has not been made perfect in love (1 John 4:18, NIV)*
Scripture Emphasis:	Love for other people can overcome our fear of them. Fear can lead to unpleasant results.
Islamic Scripture:	*The moment a trial strikes you, remember to be patient. The Prophet said, the real patience is at the first stroke of a calamity*. [Sahih Al Bukhari] *Care for those who are on earth for the Lord in heaven to care for you (Sahih Al Bukhari*
Scripture Emphasis:	One of the most effective ways to prevent fear which contributes to stigmatization of self and of others is to do everything possible to acquire knowledge about that which we fear and then put our trust in God who is in control at all times.
Expected Learning Outcome:	By the end of this sessions, participants should be able to: • Explain the relationship between fear and HIV stigma • Illustrate how negative attitudes and reactions towards HIV and AIDS could lead to HIV transmission and to death. • Illustrate how stigma affects both individuals and communities. • How to deal with HIV and AIDS stigma.
Toolkit References:	• Introduction to SSDDIM • Modules on Shame, Denial, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1hr
Resources Needed:	• Flipchart, papers, pens; • Scissors, glue, paints, magazines (these are for an optional exercise)



Definition: **Stigma is a social mark that singles out individuals or groups for disgrace, humiliation, and rejection.**

Story for Reflection and Discussion

The external manifestations of stigma are horrific. At Christmas time 1998, a 36-year-old South African woman, Gugu Dlamini, was stoned and stabbed to death… What is clear is that shortly before her death, Gugu told Zulu-language radio listeners that she was living with HIV. Three weeks later, members of her own neighbourhood rounded on her. Her attackers accused her of shaming her community by announcing her HIV status. She died in hospital – her body broken not by the HIV that she faced with such conspicuous courage, but by the injuries her neighbours inflicted on her. She left a thirteen-year-old daughter.

Ask the question - “If you were part of Gugu Dlamini’s community, what would you have done?” They do not need to give you an answer - simply ask them to think about it, and then break down the story of Gugu Dlamini as follows:

Group work: How to deal with HIV Stigma

The facilitator may divide the participants into groups to respond to the following questions. Each group would report in plenary:

- What impact has this story had on you?
- Is stigma felt the same across gender?
- What forms of discrimination and stigma have you seen in your community and what have been the related issues?

Stigma – a little deeper

Questions:

- How have we experienced stigma in our lives? Have we been stigmatised due to our race, gender, religion, caste, or sexual orientation? Remember that stigma often uses visual symbols to differentiate between what group is acceptable and what group is not. These symbols are on the surface only and we deny ourselves the joy of really getting to know people because we have created barriers.
- How do we feel when we have been stigmatised?

Fear underlies stigma:

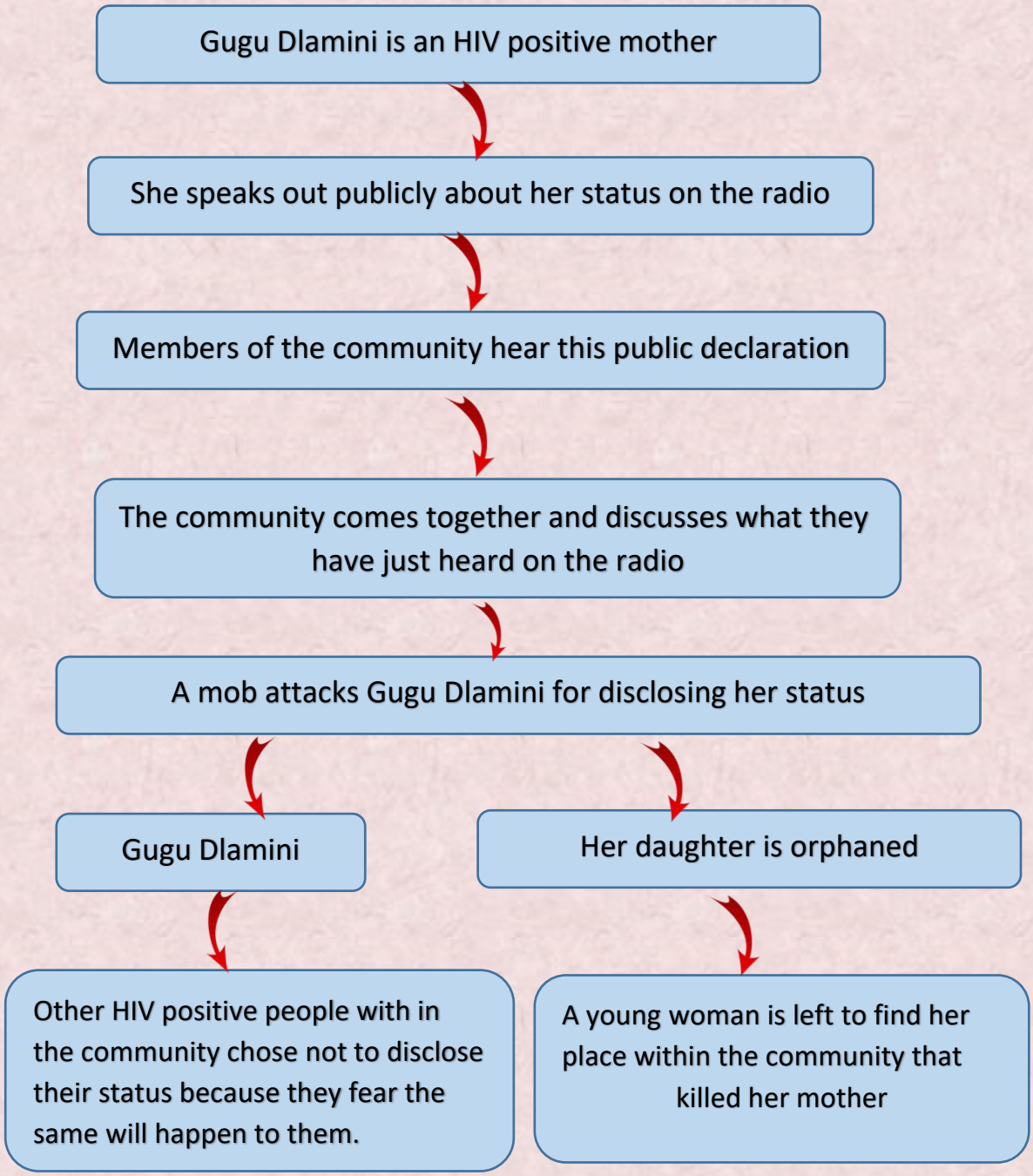
- Of what are we afraid when we stigmatise Persons Living with HIV?

If you have access to creative materials scissors, paper, glue, paint, magazines, try the following exercise:

- Ask questions 1 and 2 above,
- Then ask participants to use the creative materials to make a collage, a piece of art work that expresses their fears about HIV. They can either present this to the group or simply hang it on the wall without comment.
- The purpose of the exercise is to name their fear, if fear is not named, it will not be recognised and we cannot work with it.

Use flipchart paper to record people’s fears. Throughout the Toolkit there are exercises to deal with these fears, so simply recording them at this stage is good.

An illustration of how stigma leads to HIV infections and AIDS-related deaths



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Shame

THIRD EDITION

Shame

Session Objectives:	To enable learning about how shame contributes to the transmission of HIV and AIDS-related deaths.
Session Overview:	What is HIV shame, how shame affects individuals and communities, how shame leads to HIV transmission and how to deal with shame.
Key Message:	Shame leads to HIV infections and AIDS-related deaths.
Biblical Scripture:	*Anyone who believes in him will never be put to shame, (Romans 10:1, NIV)*
Scripture Emphasis:	We have reason to live joyfully. God demonstrates His love to us by covering our guilt and shame and helping us deal with fear.
Islamic Scripture:	*Allah's apostle said, "Every son of Adam sins. The best of the sinners are those who repent." Sunan al-Tirmidhi, no. 2499*
Scripture Emphasis:	God promises us to give relief so that we can cope with life challenges. We need to put our trust in Him.
Expected Learning Outcome:	By the end of this session, participants should be able to: • Explain what causes HIV shame • Illustrate how negative attitudes and reactions towards HIV and AIDS could lead to HIV transmission and to death. • Explain how shame affects both individuals and communities. • Illustrate how to reduce HIV shame • Support others to be confident enough to avoid feeling HIV shame.
Toolkit References:	• Introduction to SSDDIM • Stigma, Denial, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	45 Minutes
Resources Needed	**C**ase of Rhayal; Flipchart; paper; pens

Definition: Shame is a painful feeling arising from the realisation that one has done something dishonourable, improper or ridiculous. Shame results from a violation of cultural or social values and thus brings disgrace onto the individual, the family and the community. Interestingly, it is believed that the word *shame* comes from an older word meaning *to cover*. Thus the feeling of shame often leads individuals to cover-up the actions believed to be dishonourable.

Examining the definition:

Ask the question:

- What does this definition tell you about shame?

Note to the facilitator:

You will need the following to be stressed by the group:

- *Shame is felt both by the individual and by the community.*
- *Dishonourable actions are defined by individuals and communities. (For example: it is wrong to have sex before marriage).*
- *Shame is a feeling resulting from an action.*

Question:

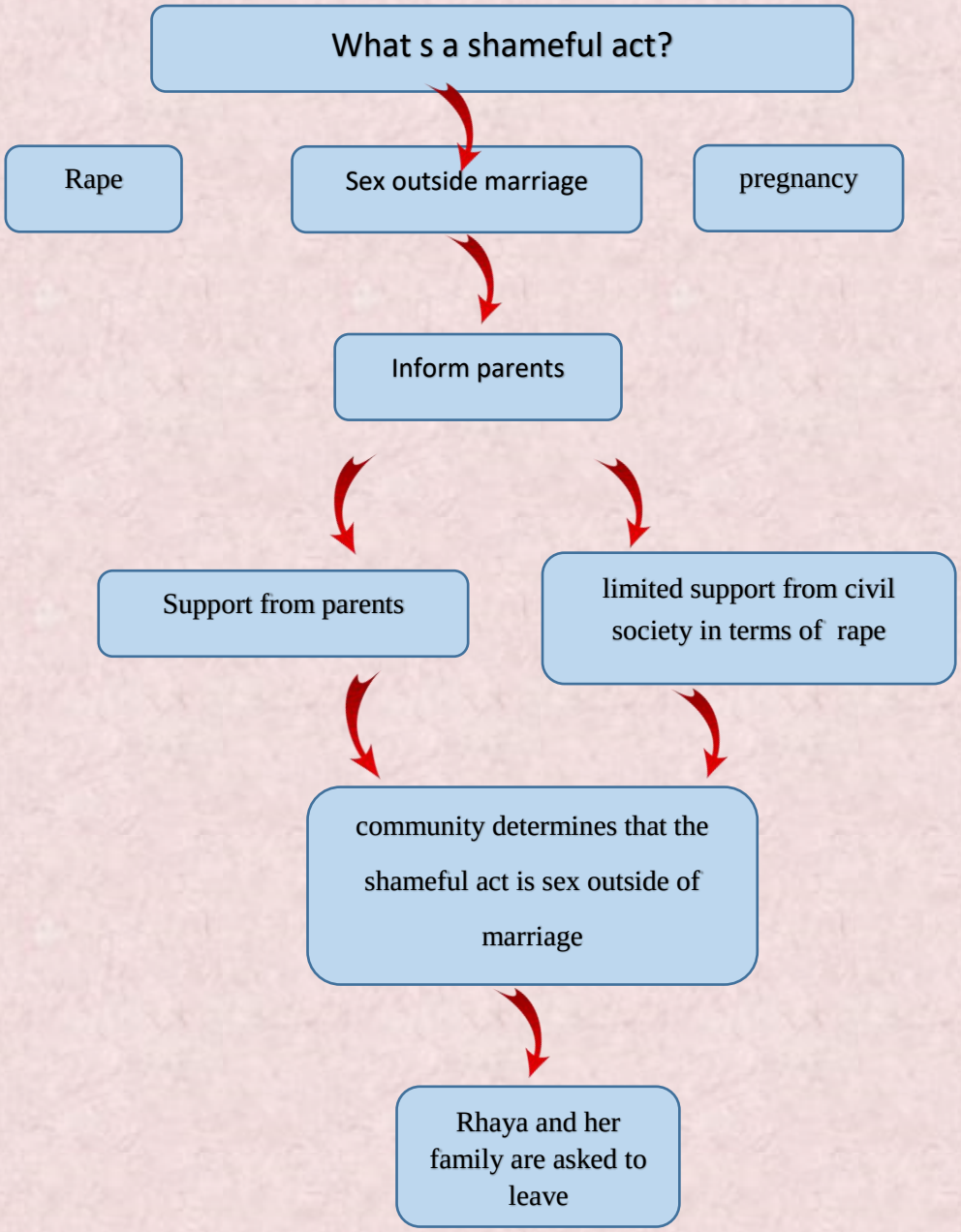
- *What actions in your community are considered shameful? Write these down on flipchart paper.*

Story for reflection and discussion

Rhaya was going home from school when a man dragged her into a bush and raped her. Sadly, Rhaya learnt later that the men had infected her with HIV. She started taking antiretroviral drugs to control her viral load. Her parents took her to hospital and when people in Rhaya's village learned that she had tested HIV positive they started isolating and stigmatizing her. Her girlfriends deserted her. Some parents warned their children against associating with Rhaya and her family. They said that Rhaya had brought *aib* (shame) to her family and by extension to the whole village.

Rhaya hated the way everyone was treating her and her family. To save her family from *aib*, Rhaya decided to run away to a far-off place. She settled well in her new location. Sooner than later, she ran out of her ARVs. Rhaya was afraid that if she went to hospital for more, people would know that she is HIV positive and treat her like they had treated her back home. She decided to stop taking the medication. Then she started engaging in commercial sex to survive. She infected many men in the process. She also got re-infected. Less than two years after her relocation, Rhaya contracted tuberculosis and died shortly after diagnosis.

An illustration of how shame leads to HIV infections and related deaths



Group work: How to deal with Shame

The facilitator may divide the participants into groups to respond to the following questions. Each group would report in plenary:

- What impact does this story have on you?
- What forms of shame do you see playing out in this story?
- How would you deal with HIV and AIDS shame at a personal and community level?

Shame – a little deeper

Game:

Write the following character on separate cards, and give one card to five of the participants:

- Lesbian woman
- Male sex worker
- A single mother living positively with HIV
- A child living with HIV
- Intravenous drug abuser

Do the same with the following characters and give to three participants:

- Religious leader
- Teacher
- Nurse

Members of the group not assigned roles will act as members of the community.

Each of the members of the top group needs to tell a member of the community who they are according to what is written on their card (e.g. “A single mother living with HIV” or “male sex worker” etc.). When each one has finished ask the participants how they felt “disclosing” that they were different and analyse together the reaction of the community. Identify the following: What shame arose within the individual?

- What shame arose from the group? Focus on and write down the language that the group used in describing the various different people.
- At the end of the game discuss the pressure that society puts on individuals to feel ashamed of their HIV status.

Conclusion:

Shame is culturally determined act. It may be felt by an individual person or by a group. We can change the meaning of acts and thus we can reduce the shame of HIV transmission and HIV positive status. The question is: are we willing to risk change?

Reflection and Notes

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Denial

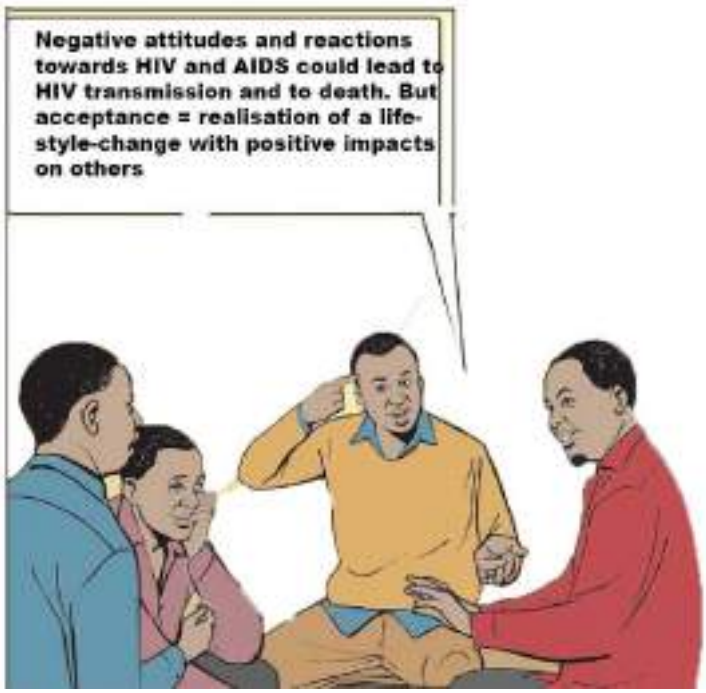
THIRD EDITION

Denial

Session Objectives:	To enable learning about how denial contributes to the transmission of HIV and to AIDS-related deaths.
Session Overview:	Definition of denial, causes of HIV denial, how denial leads to HIV transmission and death and how to deal with HIV denial.
Key Message:	Denial spreads HIV infections and AIDS-related deaths.
Biblical Scripture:	*And you will know the truth, and the truth will set you free.* (John 8:32, NIV)
Scripture Emphasis:	Truth is liberating and empowering. We need to live truthfully in order to receive help and the necessary support to move us into action.
Islamic Scripture:	*Say "Never will we be struck except by what Allah has declared for us: He is our protector" And upon Allah, let believers rely.* Qur'an 9.51 *"'This is the Day when the truthful will benefit from their truthfulness.' For them are gardens [in Paradise] beneath which rivers flow, wherein they will abide forever, Allah being pleased with them, and they with Him. That is the great attainment,"* (Qur'an 5: 119).
Scripture Emphasis:	A common saying is that the rope of lying is short and one denial of truth leads to many lies and much discomfort as a consequence.
Expected Learning Outcome:	By the end of this session, participants should be able to: • Explain how our attitudes and reactions towards HIV and AIDS can lead to death. • Explain what causes HIV denial • Explain how denial affects both individuals and communities. • How to reduce HIV and AIDS denial • How to deal with HIV and AIDS denial
Toolkit References:	• Introduction to SSDDIM • Stigma, Shame, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1hour
Resources Needed	Flipchart paper and pens

Definition: Denial is a psychological defence mechanism in which a person or a community is faced with a fact that is too uncomfortable to accept and thus rejects it. This rejection is often in the face of overwhelming evidence that the fact is true. There are three forms of denial:

- Simple denial – deny the reality of the unpleasant fact altogether
- Minimisation – admit the fact but deny that it is serious
- Projection – admit both the fact and the seriousness but deny responsibility



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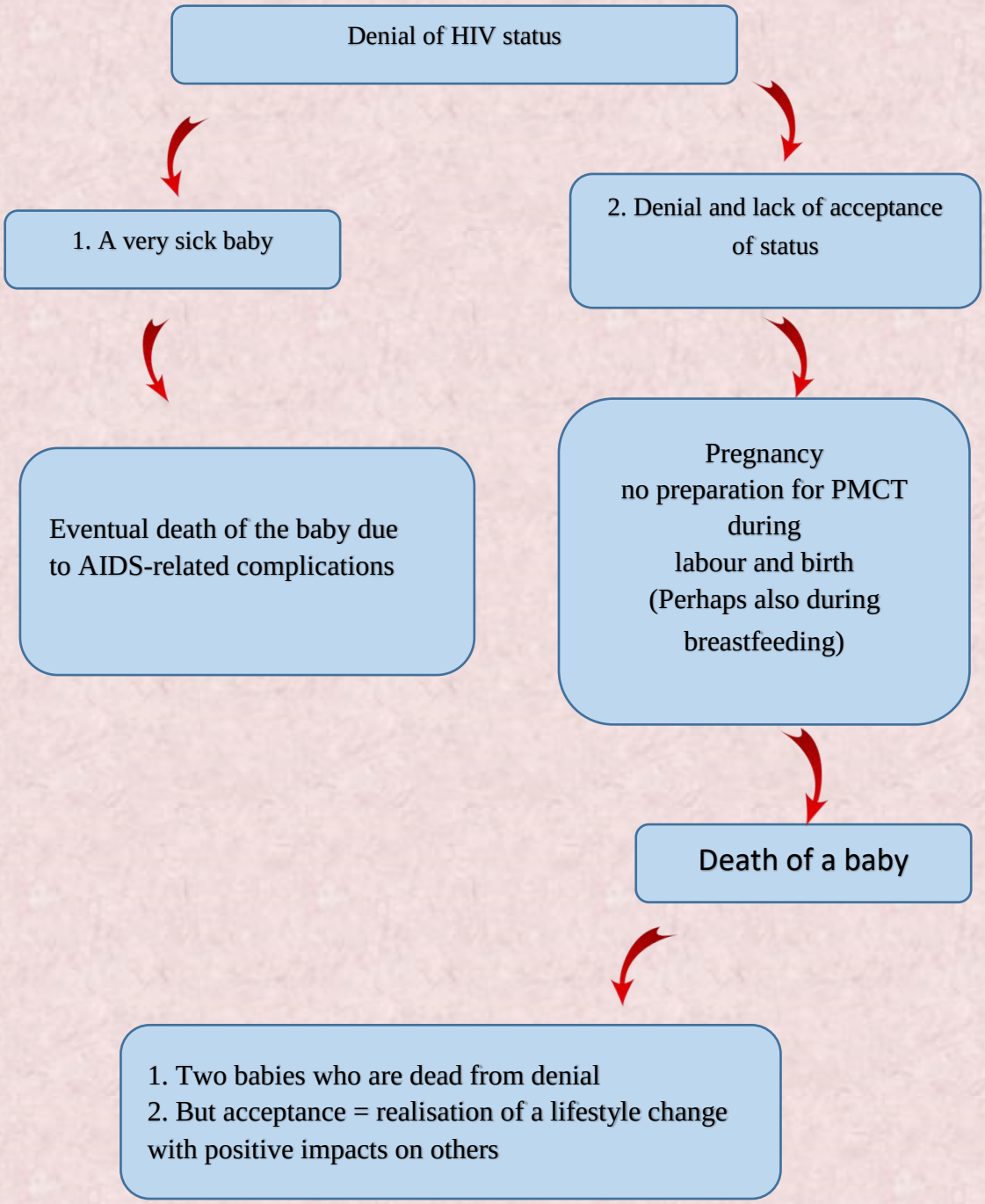
Story for reflection and discussion:

I was diagnosed with HIV in 1989, after giving birth to my son. Mikey had always seemed to be sick but it wasn't until he was about four months old that we found out why. He was admitted to Akron Children's Hospital for a hernia. It was then that the doctor asked if he could do an AIDS test. Well, I was seventeen at the time and never gave any thought to it actually coming back positive. Then two weeks later I was being told my son had full-blown AIDS and that meant I was positive also. My mother tried to strangle me that day and just kept asking how could I do this to her. I still don't believe she did not realise that it is not what I did to her, but to my children and to myself.

See, I did not deal with this diagnosis very well and went into complete denial. Mikey passed away in August of 1990, but I was convinced that he did not die of AIDS. I assumed that the doctor was wrong and that Mikey had died of something else. My denial went on for the next two years resulting in giving birth to another AIDS-infected child, who was born three months early. Kayla became a lot sicker a lot quicker than Mikey but it wasn't until she was close to death that I began realizing that this disease was real. Now I had to deal with giving my two precious children AIDS. To this day, this is still very hard for me to deal with. At one point, the City & County health departments were threatening to have me committed because I was not dealing with the disease and was a risk to myself and to others.

Now I have finally began speaking publicly about my story and this disease but I still find it very hard to understand how or why so many people still put themselves at risk. For what, a half hour of fun or pleasure? So many still believe that it will not happen to them.

An illustration of how denial leads to HIV infections and AIDS-related deaths



Activity

Divide the group into smaller groups of three or four. Give each of the smaller groups a photocopy of the story, some flipchart paper and pens. Ask the groups to reread the story and answer the following questions.

Topics for discussion in the groups:

- *What impact does this story have on you?*
- *Please identify wrong language usage around HIV and AIDS?*
- *What impact does use incorrect language in a situation like this promote?*
- *What does this teach us about the power of language to convey inaccurate messages?*
- *How has the denial in this story affected the lives of those involved?*
- *Please share similar stories.*

Denial – a little deeper

Questions:

- When did you deny something despite the overwhelming evidence that what you where denying was true?
  - Example: When I was at University, I knew that I would be failing one of my courses. I hated the course, I disliked the lectures, and avoided working for the course at all costs. However, I told my parents that I was doing well and was in control. It was only when they were sent the results – I had failed badly, and I knew that I would fail – that I was able to share my total dislike of what I was studying.
- How does it feel to deny something?
- If you have acknowledged your denial – how did this feel?
  - What helped you to confront your denial?
  - What made confronting denial difficult?

Note to facilitators:

You want to stress that denial is used by individuals and communities to protect themselves from:

- *reality and the impact of that reality on their lives*
- *taking responsibility for change.*

Keep stressing that it is only truth that can set us free. Although the consequences of denial can be very painful, People who are Living with HIV lose families and homes. They are beaten and killed.

Confronting denial can also lead to freedom. For many this entails the freedom to access the right treatment and care. It can also allow people to live healthy and productive lives free from the many fears that surround HIV.

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Discrimination

THIRD EDITION

Discrimination

Session Objectives:	To enable learning about how discrimination contributes to the transmission of HIV and AIDS-related deaths.
Session Overview:	What causes discrimination, how it leads to HIV transmission and death, how it affects individuals and community, and how to deal with it.
Key Message:	Discrimination leads to HIV infections and AIDS-related deaths.
Biblical Scripture:	*Therefore, remember that formerly you who are Gentiles by birth and called "uncircumcised" by those who call themselves "the circumcision" (which is done in the body by human hands) — remember that at that time you were separate from Christ, excluded from citizenship in Israel and foreigners to the covenants of the promise, without hope and without God in the world. But now in Christ Jesus you who once were far away have been brought near by the blood of Christ. For he himself is our peace, who has made us both one and has broken down in his flesh the dividing wall of hostility. (Ephesians 2: 11- 14, ESV)*
Scripture Emphasis:	Through Christ, we can overcome the forces that divide us and cause us to be hostile towards others.
Islamic Scripture:	*O mankind, indeed We have created you from male and female and made you peoples and tribes that you may know one another. Indeed, the most noble of you in the sight of Allah is the most righteous of you. Indeed, Allah is Knowing and Acquainted. (Qur'an 49:13)*
Scripture Emphasis:	God is always in control and He has all the powers to elevate an individual or put another in some calamity. We need not discriminate against anyone because we have no right to judge others.
Expected Learning Outcome:	By the end of this sessions, participants should be able to: • Define HIV and AIDS discrimination • Explain what causes HIV and AIDS discrimination • Illustrate how discrimination towards Persons Living with HIV could lead to HIV transmission and to AIDS-related deaths. • Explain how discrimination affects both individuals and communities. • Describe how to deal with HIV and AIDS discrimination
Toolkit References:	• Introduction to SSDDIM • Stigma, Shame, Denial, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed	• Flipchart paper and pens

	Preparation for discrimination game

Definition: Discrimination is the prejudicial treatment of an individual or group based on a specific identifiable or perceived difference. Discrimination can be behavioural or institutional (i.e. a law) aimed towards an individual or members of a group. It involves excluding or restricting people from situations and opportunities that are available to others.

Activity:
Discrimination game:

Aim: This game is designed to let participants have a first-hand experience of discrimination, and get them thinking about attitudes relating to discrimination. It may therefore make people feel angry, uncomfortable and question the purpose of the game. It is important that you don't react - just keep a straight face and an open mind. All will be revealed.

The day before you schedule the game, give each participant a piece of paper as they are leaving the last session of the day. The pieces of paper will be different colours – the majority of them red and the rest any other colour. Give just over half the group red paper. (Note: If coloured paper is not available, draw a square on more than half of the paper slips and a triangle or circle on the rest. The size of the paper is not important).

As you hand these out to the group tell them that they MUST all bring them along in the morning, as they will be needed.

Variations:

If breakfast is provided for the group, they must present their pieces of paper upon arrival in the morning. This will determine what they get for breakfast. Those with the red paper (or with a square drawn on their paper) can have the full range of breakfast – no problems. For the rest of the group, only a basic amount is allowed. Explain that this is because of the colour of the piece of paper they were given. That is the rule, and rules must be followed. (People get very angry around the area of food – be aware of this.)

If breakfast is not available, then change it to suit a tea break. Let the majority red-paper people get tea and biscuits, while the rest get only a glass of water.

Or allow only the majority red-paper people to be seated for the first part of the session, while the rest have to stand, even though there are empty chairs available.

To those doing the discriminating – how did you feel?

After 10 minutes, allow the group to come back together on equal ground.

Outcomes:

Lead the group in a discussion by first asking the minority group:

- *What was it like to be left out, to not receive as much as the other group?*
- *How did that make you feel?*
- *What did you think about the people in the other group?*

Then address the majority group and ask them:

- *Why did you not offer to share what you had with the others, or offer to swap places with them?*
- *Why did you go along with the rest of the group?*

Note: *The majority group had the power to make a difference.*
How is this reflected in their community?

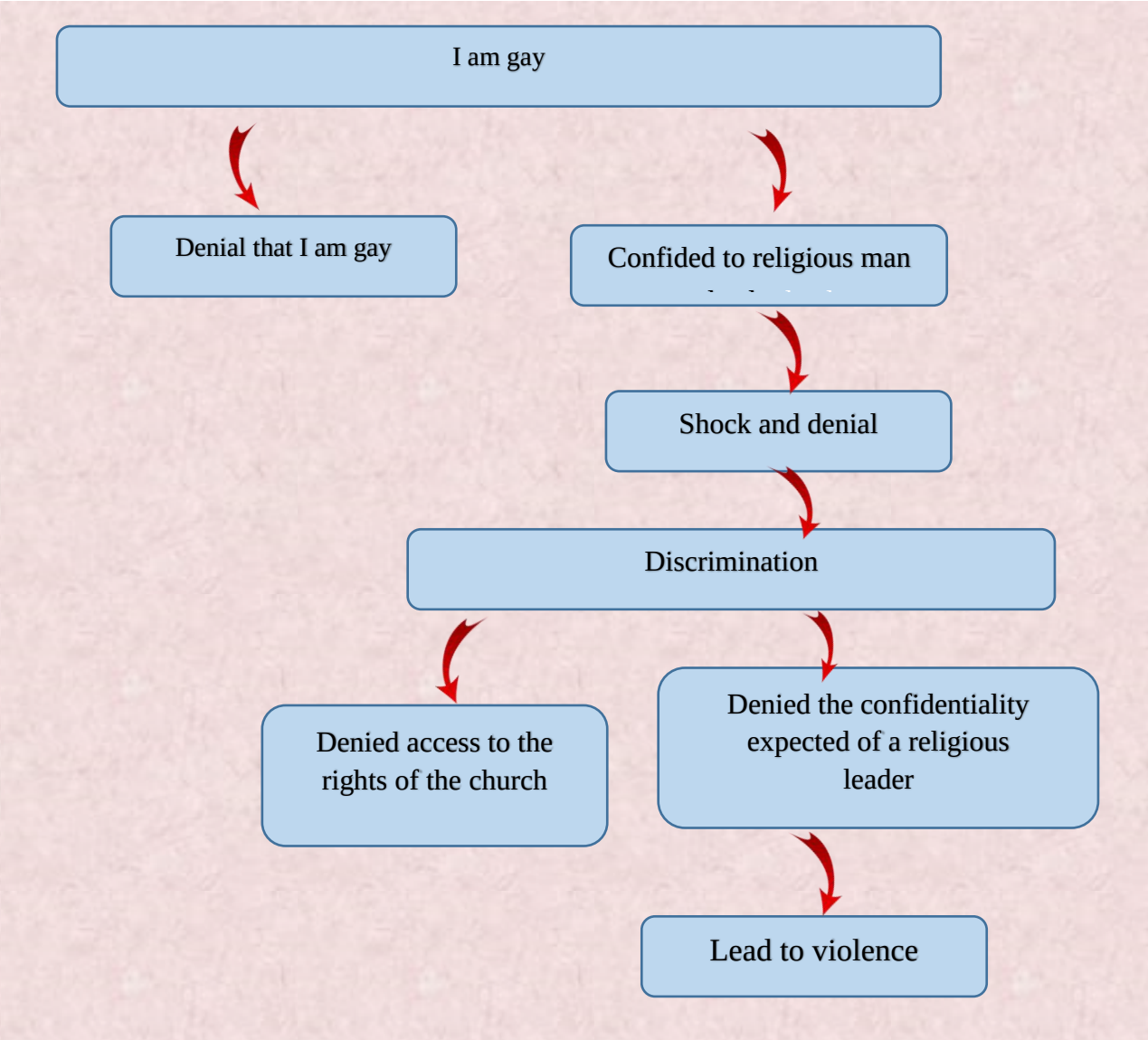
Discussion Questions:

To those discriminated against – how did you feel?
To those doing the discriminating – how did you feel?

Story for reflection and discussion:

"I was very religious, and active in the youth club, taught Sunday School, and attended youth camps. I prayed regularly that God would take this affliction away from me, but he never did. I began to think that my faith was not strong enough and so I sought advice from our minister. He was shocked and refused to believe me. When I was 17 he refused to confirm me, and two weeks after the confirmation service I was attacked by a group of 'gay-bashers'. It took a couple of months to recover from my injuries. The minister's son was one of the attackers, and he swore at me, calling me a 'bad dog and a moffie'*. His father must have told him about me. After that I refused to go back to church".

*moffie - a derogatory term for a homosexual male


I am gay
Denial that I am gay
Confided to religious man
Shock and denial
Discrimination
Denied access to the rights of the church
Denied the confidentiality expected of a religious leader
Lead to violence

Discussion:

In a large group ask the following questions. Allow people to take their time to speak without being prompted. These are hard questions to address and can bring out many issues and emotions.

Ask the following questions:

- When have you been discriminated against?
- When have you discriminated against someone else?
- Were you discriminated because of your gender?
- How would we deal with discrimination at personal and community levels?

Discrimination – a little deeper

Questions for group discussion:

- Do you feel discriminated against because you belong to a certain race, religion or gender? If you are able to tell the group, tell them about these experiences and how they make you feel.
- Do you lump groups of people together, making generalisations about the whole group based on your negative experiences of an individual?
- Do you question a person's ability because they are different from you?
- What words do you use to discriminate between different groups of people? Write these words on a flipchart and talk about their meanings.
- **Example:** the word "moffie" is a derogatory and stigmatising word for a homosexual man.
- **Example:** the word "slut" is a derogatory, stigmatizing and judgmental word for a woman.

Reflection and Notes

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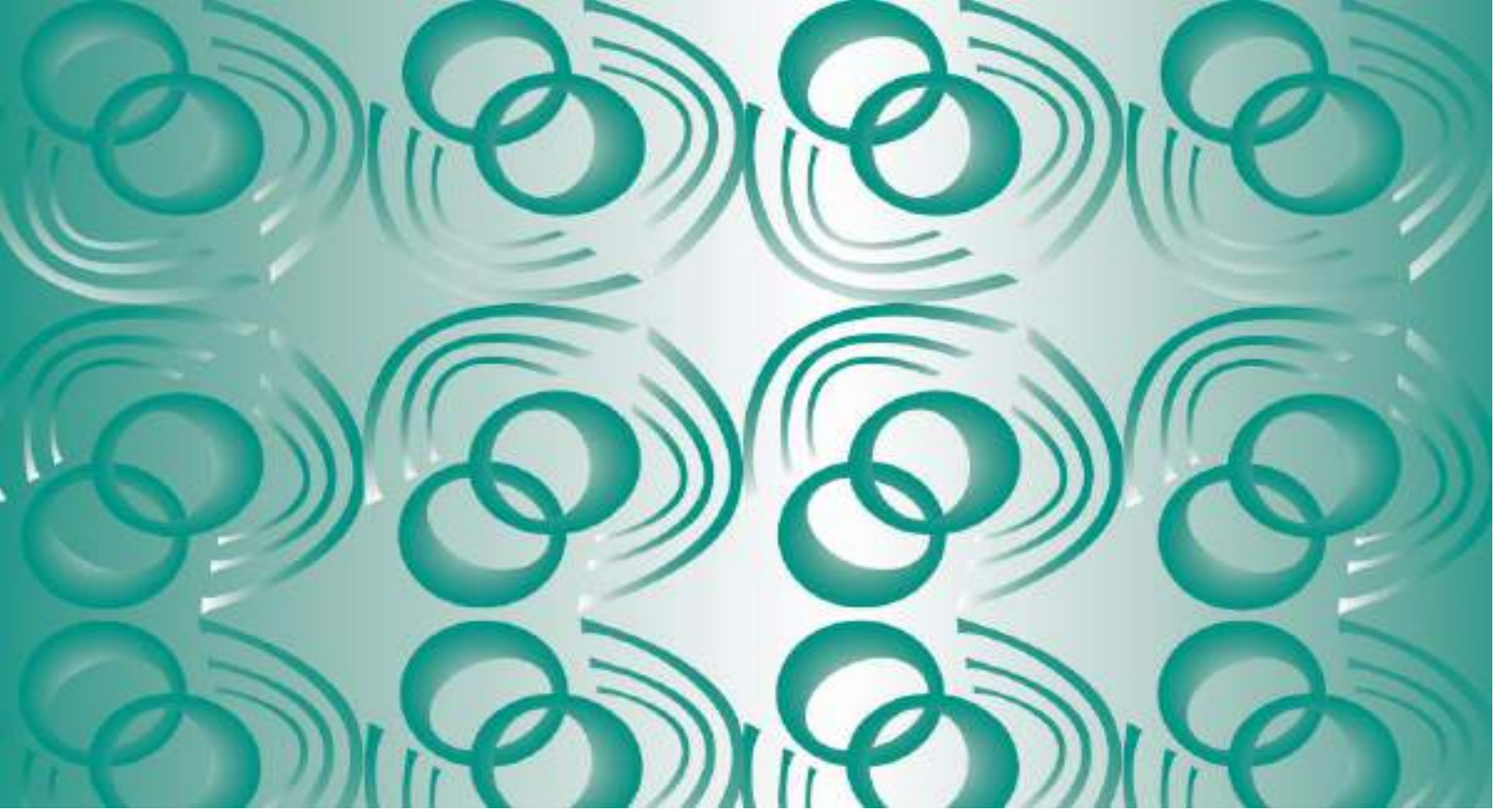
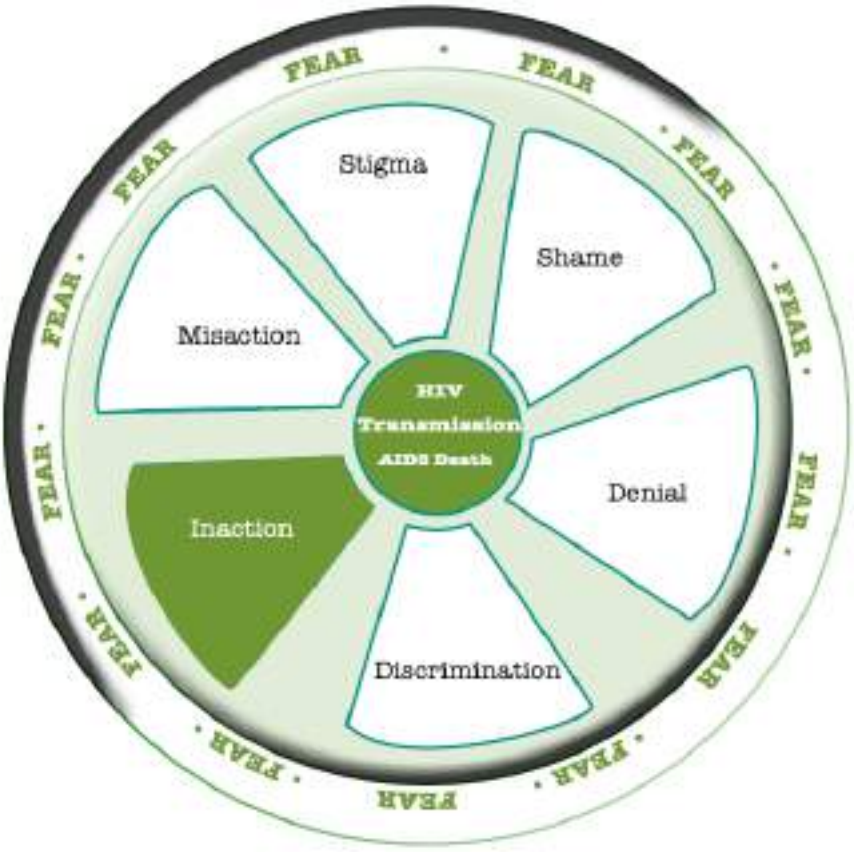


Inaction

THIRD EDITION

Inaction

Session Objectives:	To enable learning about how Inaction contributes to the transmission of HIV and AIDS-related death
Session Overview:	Understand how fear cause inaction, how inaction affects individuals and communities, how inaction leads to HIV transmission and death and how to deal with inaction.
Key Message:	Inaction is the death sentence – not HIV. Fear spreads HIV and leads to AIDS related illnesses.
Biblical Scripture:	*If a brother or sister is poorly clothed and lacking in daily food, and one of you says to them, "Go in peace, be warmed and filled," without giving them the things needed for the body, what good is that? (James 2:15-16, NIV)* *"If anyone, then, knows the good they ought to do and doesn't do it, it is sin for them." (James 4:17)*
Scripture Emphasis:	We have a Christian duty to take action to address needs in our society. Lack of practical action is an indication of lack of faith and is rebellion.
Islamic Scripture:	*And spend in the way of God and not throw yourselves with your own hands to destruction. and do good. Indeed, Allah loves the door of good. (2:195)*
Scripture Emphasis:	We should not put ourselves and others to any risk or destruction by the wrong action we take. We are answerable for our health and for other human beings.
Expected Learning Outcome:	• Define Inaction • Explain how fear causes Inaction • Describe how Inaction could lead to HIV transmission and death. • Explain how Inaction affects both individuals and communities. • Illustrate how to reduce Inaction • Support others to face their fears to avoid feeling Inaction
Toolkit References:	• Introduction to SSDDIM • Stigma, Shame, Denial, Discrimination, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed	• Flipchart paper and pens • Story for Reflection and discussion



“Inaction breeds doubt and fear. Action breeds confidence and courage. If you want to conquer fear, do not sit home and think about it. Go out and get busy”.

Dale Carnegie

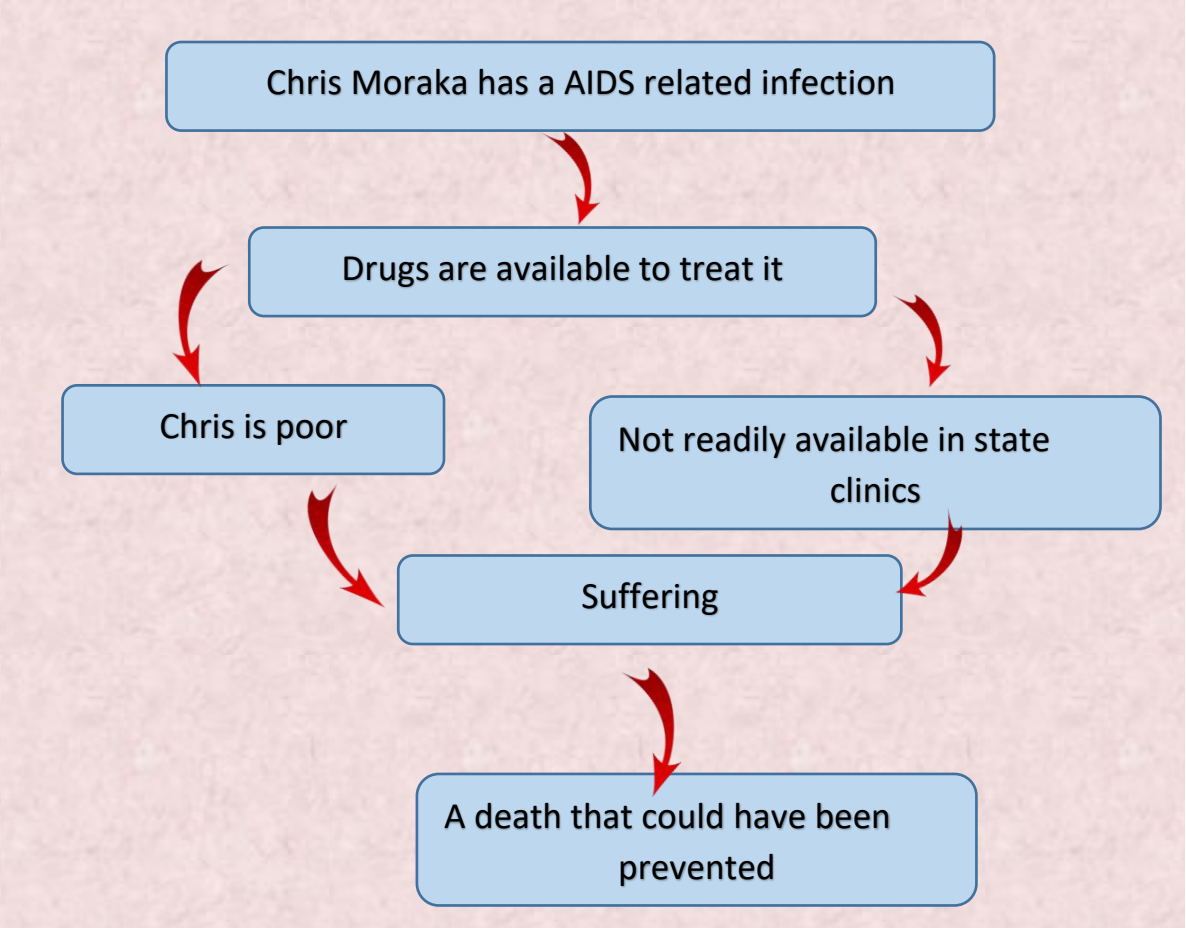
Definition: Inaction is the failure to act although the circumstances require action. There are several reasons for inaction: Inaction because we are frozen in the face of the challenge to action.
Inaction because we are in denial.
Inaction because we are overwhelmed.
Inaction because it is more convenient for us not to act

Remember: Inaction is a choice.

Story for reflection and discussion:

In early 2002 Christopher Moraka had oesophageal thrush. This is a painful fungal infection of the throat. The white fungal spores cover the tongue, palate and throat, the gullet and eventually the stomach and the whole intestinal system. Eating and drinking eventually become too painful and patients begin to die of dehydration or starvation. It is a fungal infection associated with AIDS. A simple prescription for fluconazole – an antifungal preparation – would have cleared the thrush within two weeks. However, because he came from a poor area in Cape Town, he could not afford the drug through a private doctor and very few public health services had the drug available. Even in the public health system the drug was prohibitively expensive. He testified before the South African parliamentary health committee that unless he had access to the drug his suffering would increase and he would die. The crux of the matter was that the drug manufacturing company had a registered patent in South Africa so the drug could not be made locally, or imported from other countries, at a lower cost. Christopher was dying from a preventable illness as were many poor people across the country because the drug they needed was too expensive.

Three months later Christopher was dead. With access to fluconazole he may have been given a few more months or even years of life. However, the oesophageal thrush had ravaged his digestive system to such a degree that he could not eat. While politicians and companies fought over patents and access to medication, people died



Group work: How to deal with inaction

The facilitator may divide the participants into groups and request them to answer the questions below. The groups would report in plenary.

- What are examples of inaction you know in your life and community?
- What are examples of inaction in your faith community?
- What contributes to inaction in your life and in your community?
- How would you deal with inaction in your life and in community?

Inaction – a little deeper

Questions:

- Think back to a time in your life when a person or a group could have helped you and chose not to
- How did this make you feel?
- What actions, either small or large, could help people with HIV to live more positively?
- Whether you are living with HIV or not, how can you live more positively in taking action?

Reflection and Notes

Reflection and Notes

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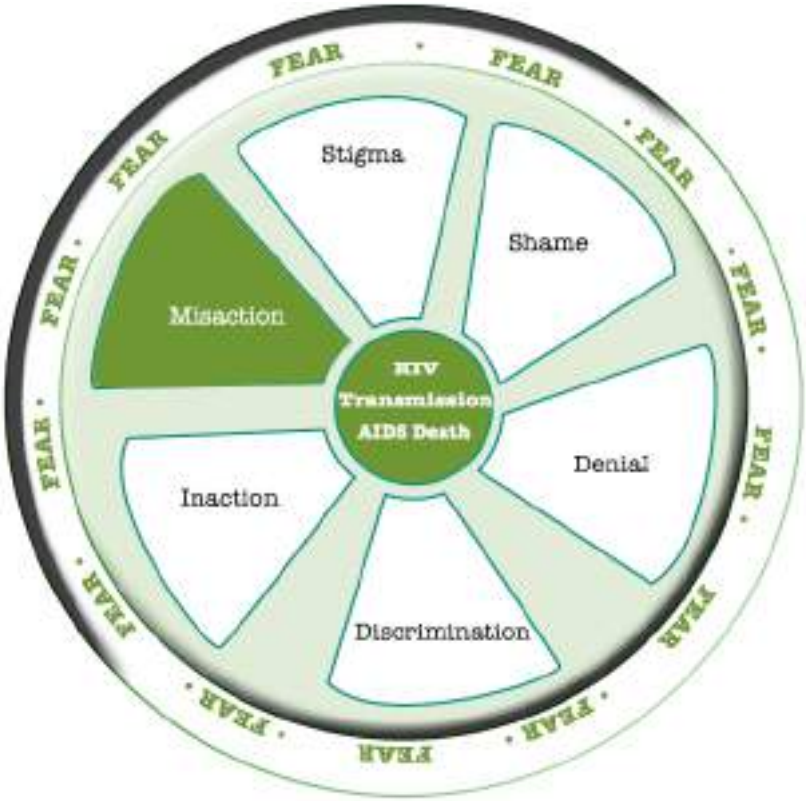
Misaction

THIRD EDITION

Misaction

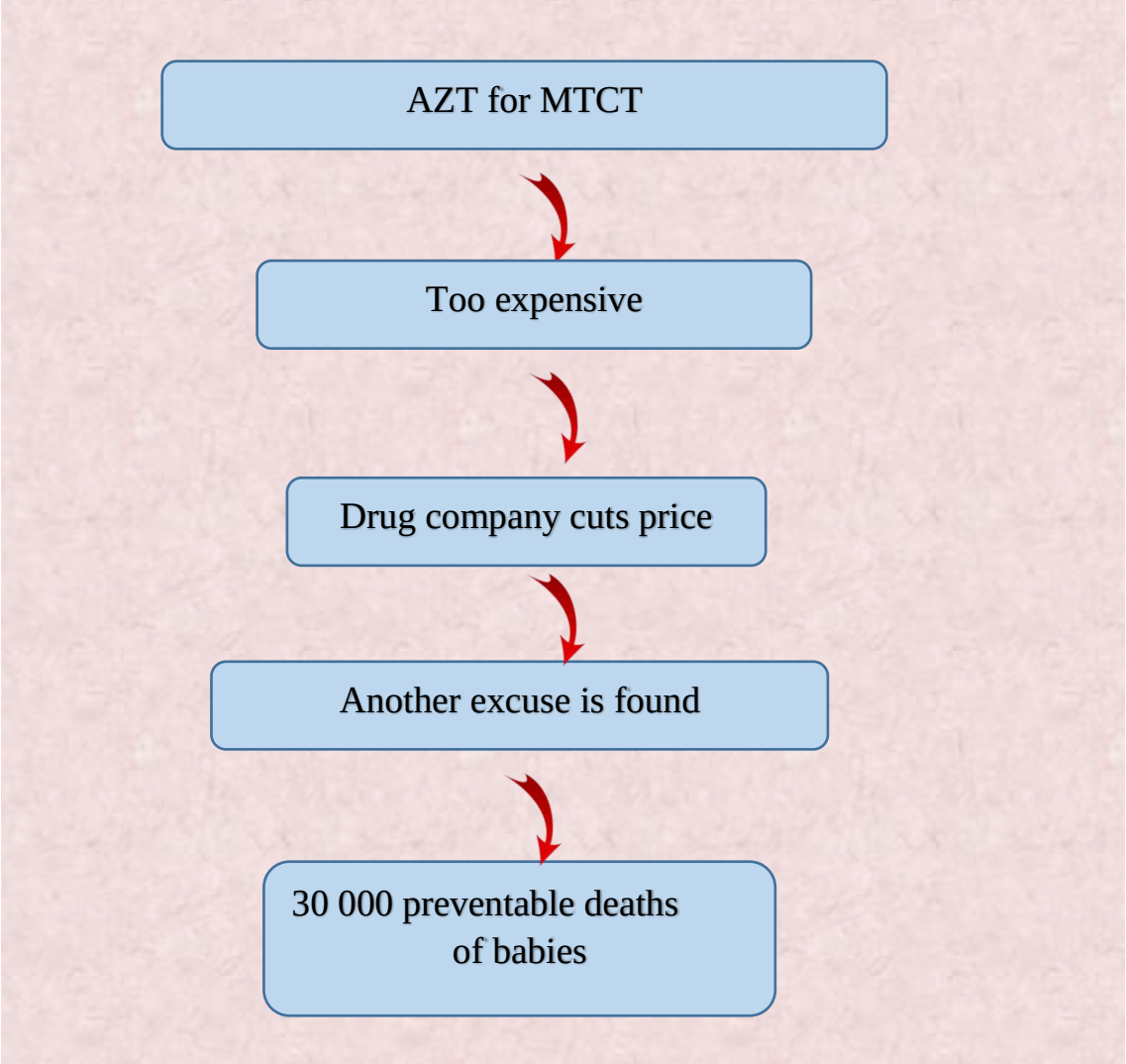
Session Objectives:	To enable learning about how Misaction contributes to the transmission of HIV and AIDS-related deaths.
Session Overview:	• Definition of Misaction • Sources of Misaction • Misaction and HIV transmission and death • Effects of misaction on individual and community • Stories of Misaction • Dealing with Misaction
Key Message:	Misaction is the death sentence – not HIV. Misaction spreads HIV and leads to AIDS-related illnesses.
Biblical Scripture:	*And Jesus said, "Father, forgive them, for they know not what they do… (Luke 23:34, ESV)* *"For I can testify about them that they are zealous for God, but their zeal is not based on knowledge." (Romans 10:2)*
Scripture Emphasis:	When an action is not based on knowledge, it has the potential to bring harm to others. Our actions should be based on knowledge to avoid potential to harm us or harm others.
Islamic Scripture:	*Ask those who know (reminders) if you do not know (Qur'an 21: 6-7)*
Scripture Emphasis:	It is prudent that people should be encouraged seek knowledge from those who know so that they do the right thing. Any wrong we do the consequences will be too big to comprehend including risking other people's lives.
Expected Learning Outcome:	By the end of this session, participants should be able to: • Define Misaction • Explain how fear causes Misaction • Illustrate how Misaction could lead to HIV transmission and to death. • Explain how Misaction affects both individuals and communities. • Describe how to reduce Misaction • Support others to face their fears of HIV and AIDS in order to avoid Misaction
Toolkit References:	• Introduction to SSDDIM • Stigma, Shame, Denial, Discrimination, Inaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed	• Flipchart paper and pens • Story for reflection and discussion



Definition: Misaction is an action taken to achieve an objective; however, there is a strong and negative consequence that was not anticipated or welcomed.

Story for reflection and discussion:

"The arrival of the drug AZT [in South Africa], a drug which cuts mother-to-child HIV transmission by 50 per cent (sic), brought new hope....Yet in 1998 Dr Dlamini-Zuma [the South African Minister of Health at the time] announced that she and the Provincial Health Ministers had decided against making AZT available, because they wished to focus on prevention instead. When it was pointed out that AZT was a preventative drug, she said it was too expensive. When AZT's makers, GlaxoWellcome, cut the drug's price by 70 per cent (sic) she said it (and its successor, nevirapine) was toxic and those advocating its use were just trying to poison blacks. ... With 5,000 babies testing HIV-positive at birth every month, the decision against AZT meant condemning 30,000 (sic), children to death every year"



Group work: How to deal with Misaction

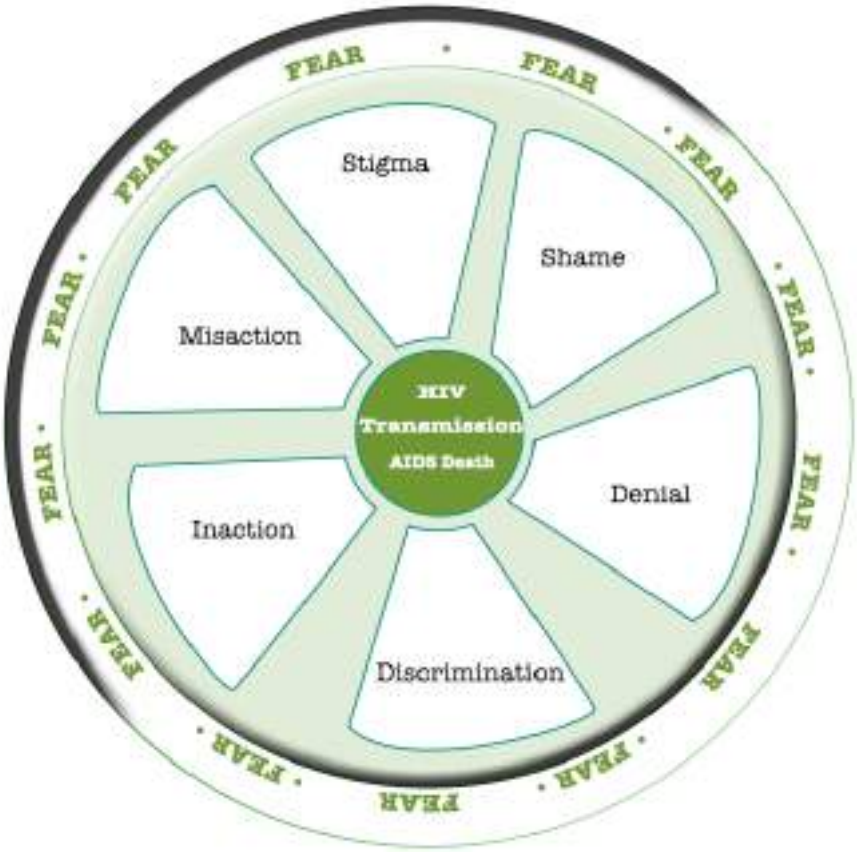
The facilitator may divide the participants into groups and request them to answer the questions below. The groups would report in plenary.

- What is the misaction in this story?
- Can you think of other misactions in relation to HIV?
- How would you deal with misactions in your life and in community?

Misaction – a little deeper

- Can you give examples of misaction that you have experienced?
- What have been the consequences?

Conclusion:



HIV is not a death sentence but SSDDIM can make it so.

At the end of the session on Misaction the group should understand that responses should always be carefully considered, and if unwanted consequences emerge, the actions need to be considered again.

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Reflection and Notes

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HIV

THE HUMAN IMMUNODEFICIENCY VIRUS

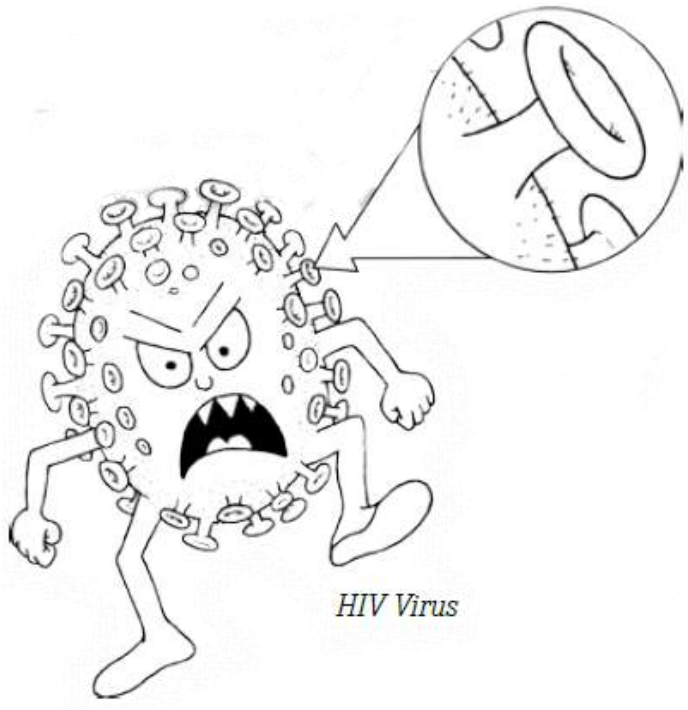
What is HIV?

THIRD EDITION

What is HIV?

How does it compromise the immune system?

Session Objective:	To enable learning on and empowerment around the Human Immunodeficiency Virus (HIV)
Session Overview:	What is HIV? What is AIDS? Keeping the natural immune system strong through diet, exercise, sleep, and a positive attitude; Managing HIV and AIDS using ARVs;
Key Message:	HIV is a virus not a death sentence. It can be managed successfully.
Biblical Scripture:	*My people are destroyed for lack of knowledge… (Hosea 4:6 NIV)*
Scripture Emphasis:	Knowledge can save lives. Ignorance is a danger to people.
Islamic Scripture:	*Ask the people of knowledge if you do not know. (Qur'an 16:43)*
Scripture emphasis:	Those who do not have knowledge are not equal to those who have knowledge. Facilitator to recognize the different levels of understanding of the participants
Expected Empowerment Outcomes:	By the end of this session, participants should be empowered to know what is HIV and AIDS, how to live positively with HIV and how to manage HIV and AIDS using ARVs.
Toolkit References:	• HIV transmission • Antiretroviral therapy • PrEP • PEP
Time:	1 hour
Resources Needed:	• Flipchart • Markers



Terminology for HIV

In 1981 Dr. Michael Gottlieb from USA was treating a patient who had two distinct and unusual diseases. One of these was a rare type of skin cancer, the other a rare lung infection. In an article published on 5th June 1981 he described this unusual combination. Within a very short period of time other doctors contacted him and indicated that they had had similar cases. Initially it seemed that these cases were limited to gay men, and so this syndrome or collection of diseases or infections was called GRID – Gay Related Immune Deficiency. Very soon it was obvious that this syndrome was not only related to gay men, but in fact it was noticed that there seemed to be three distinct groups of people who were affected: the three H's, namely Homosexuals, Haitians (people from Haiti) and Haemophiliacs (people who are also sometimes called bleeders because their blood does not clot). The syndrome was however never only limited to the three Hs. It was constantly challenging the stereotypes.

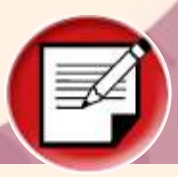
A new name was needed and coined for this syndrome in 1982 by CDC (Centre of Disease Control, USA) – AIDS or Acquired Immune Deficiency Syndrome. In 1982, 1600 people were diagnosed with AIDS in USA and 700 died. The race was on to find the cause of AIDS. By 1984 a virus which caused AIDS was identified and named HIV or Human Immunodeficiency Virus, and by 1985 the first antibody test to test for immune response to HIV had been developed.

1981 – GRID
1981 – HHH
1982 – AIDS
1984 – HIV

The progression of names has followed the attempt to classify the medical condition. This has inevitably led to the stereotyping of persons living with HIV, which has always carried its own associated stigma. AIDS, as a syndrome, having been coined before the discovery of HIV, has been a term which has stuck and which continually draws us back to the association of HIV and death. This level of stigma still needs to be challenged, even in a time where ARVs have made it possible both to manage HIV and to live a full and complete life even if you are living with HIV.

Over the last four or so decades, new social, scientific and technological developments have improved outcomes in HIV transmission and AIDS-related deaths through:

- Improved testing using more effective kits including introduction of self-testing kits which reduce stigma
- Better treatment in form of improved ARVs including PrEP, PEP, and HPV
- Improved use of male and female condoms
- Introduction of Voluntary Medical Male Circumcision (VMMC)
- Introduction of sensitive language – UNAIDS came up with a document on preferred Terminology which was last updated in 2015
- Mainstreaming of gender and inclusion in HIV services
- Recognition of HIV as a development issue
- Recognition of HIV as Human right issue



***Activity**:*

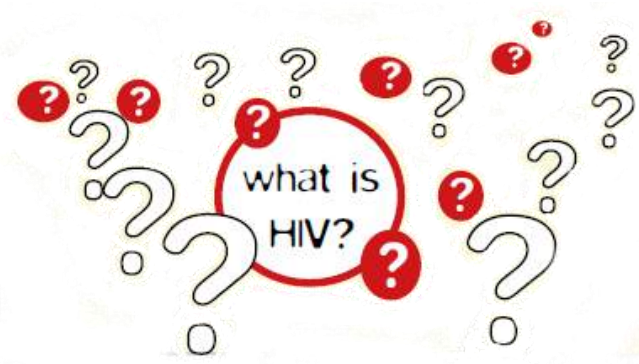
To prepare for this module, ideally you will need to give each participant:

- *A piece of flipchart paper.*
- *A large marker pen (make sure that they all get the same colour)*

Ask participants to write down what they know about HIV.

If you do not have access to flipchart paper, simply do a discussion exercise about what people know about HIV. Note any myths that come up. You may

Note: You are looking for what people think they know. Thus, in this section focus on statements that are true or false and need factual clarification



Activity 1:

This activity is a traditional children's game that adults can also enjoy. Place chairs in a circle and have every person sit on one chair. Play music or get someone to sing and ask everyone to get up and move around the circle. While they are doing that, remove one of the chairs. Stop the music and everyone has to find a chair. The person without a chair needs to leave the game. Carry on doing this - playing the music, stopping the music, and removing a chair - until there is only one person left with a chair.

Explain that this activity is similar to the way HIV works: it removes immune cells from a person's system, to the point where the immune system becomes so depleted that there are only a few cells left to fight off infections.

You are now going to explain how this happens and its effects on the body.

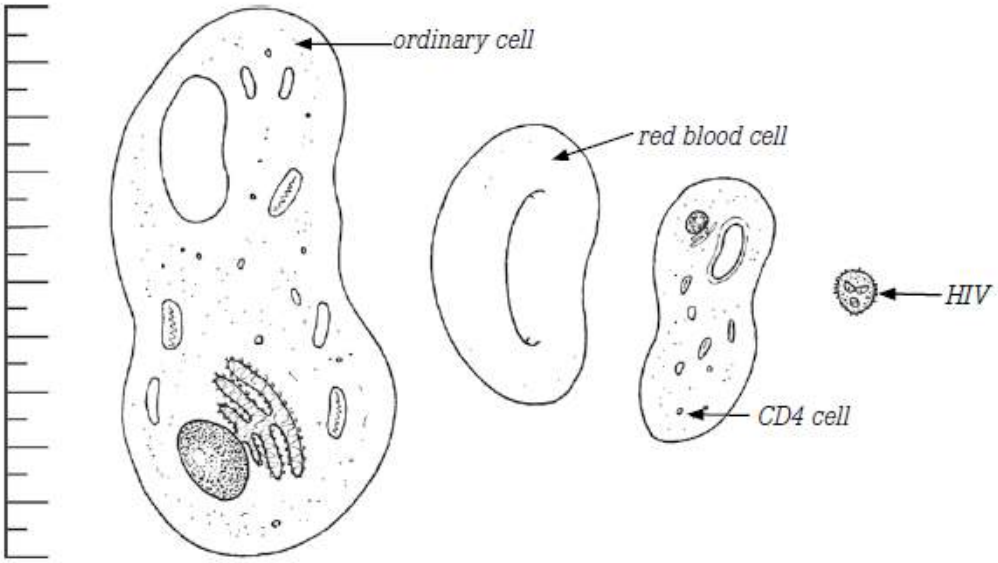
Facilitator's notes:

Although the explanation that is given here is basic, the information is enough for people to understand how the virus works in the body.

The nature of HIV

Understanding 1: HIV is a virus – What is a virus?

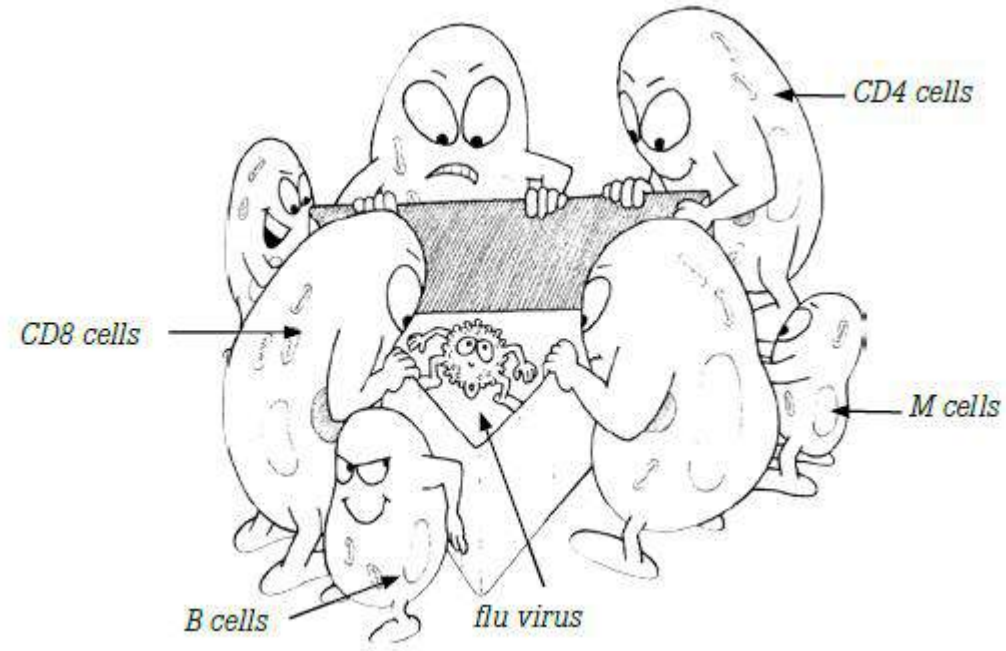
As you are speaking draw the following diagrams:



- A very small organism – smaller than we can see.
- It uses the living cells of other things to survive and multiply. HIV is specifically designed to target the human body. If HIV does not live inside the human body it dies.
- All viruses are species specific (e.g. bird flu is for birds; HIV is for humans) and target one particular cell or organ type in the body. HIV targets specific cells in the human immune system.
- All viruses have different shapes that help our bodies recognise the different viruses. This enables the immune system to mount a virus-specific attack. With most viruses, a healthy immune system is able to destroy the virus. This is true of HIV as well; however, in the case of HIV it uses the body's own immune system to replicate itself.

Historically, viruses could not be treated with antibiotics. They have mostly been treated with vaccines. Currently antibiotics for some viruses are being used and developed.

Understanding 2 – How the immune system reacts to a virus (under normal circumstances)



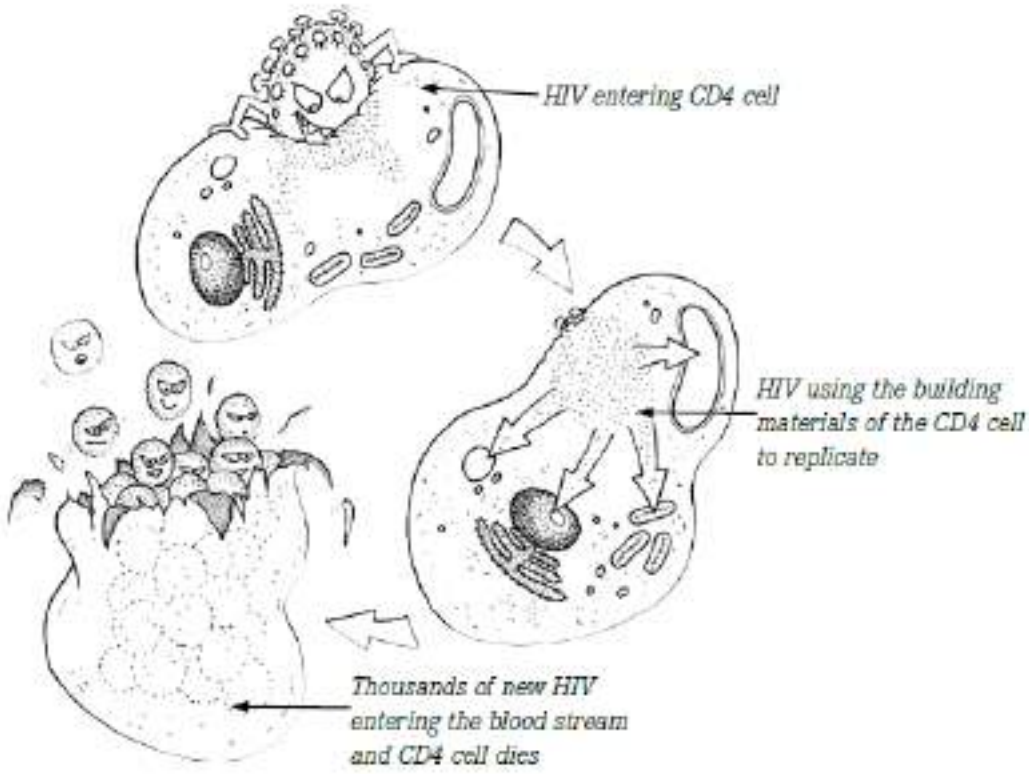
- There are four different types of cells within our blood that protect the body from infections like virus. The first line of defence is the guard cells, or M cells. They "march" through the body looking for foreign bodies. When a guard cell finds something, such as a virus, it sends a message of help to the command and control cells or CD4 T-cells.
- The command and control centre, or the CD4 T-cells, then send off two messages. One to the troops, or CD8 cells. These are the regular soldiers of the immune system and they go immediately to fight the invader.

- The second message that the command and control centre sends is to the sergeant majors, or B-cells, who are asked to send specialist troops, or antibodies, to surround and trap the invader.
- This response happens with every foreign body that enters our bodies. The immune system attacks millions of foreign bodies every day. Sometimes the immune system can become overwhelmed and we get sick. For most illnesses, medicine to reduce the symptoms caused by the invaders, including rest, will help the immune system to win the fight. Although our immune systems generally can cope well on their own, when an illness becomes serious we need to seek professional help from doctors.

Facilitator's notes:

Ensure that participants understand the different roles that each part of the immune system plays in attacking a virus. The war analogy is a good one as people can more readily identify with troops and guards than with CD8 cells and M-cells. The technical terminology can come later.

Why is HIV different?

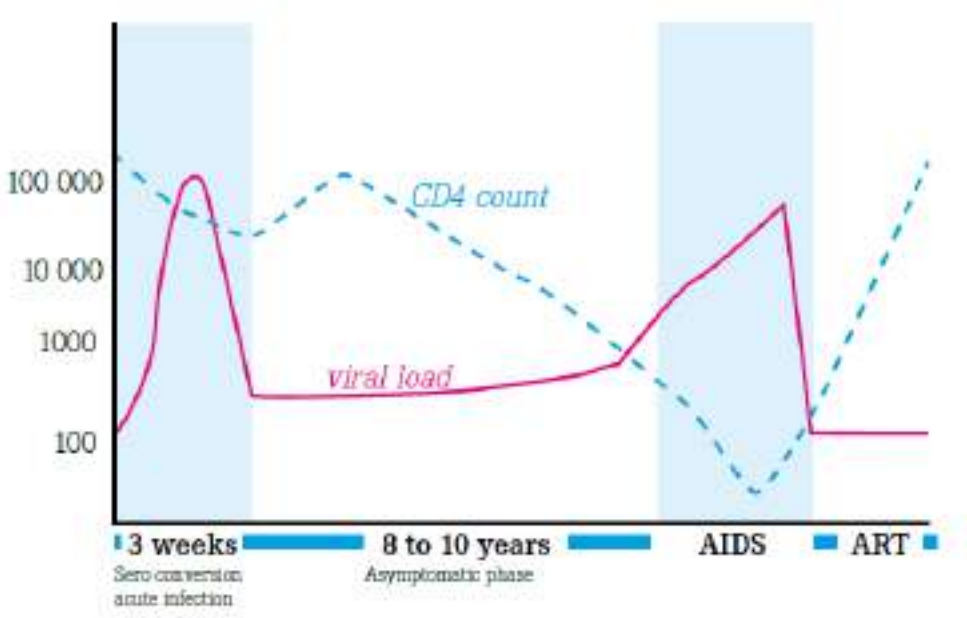


- HIV is like a stealthy guerrilla fighter. It knows its territory and its enemy. It launches its first attack on the guard cells (M-cells).
- It enters the guard cells (M-cells) and uses its material to make more HIV. Eventually, the M-cell becomes so full that it bursts, releasing more HIV into the body.

- While the M-cell is under attack, it still sends messages to command and control centres (CD4 T-cells) to send more troops and special forces.
- The guerrilla HIV, however, sneaks up on the command that controls CD 4-cells and invades this cell in the same way. It uses the cell's materials to manufacture more of itself. Like the guard cell, the CD4 cell will eventually explode, causing more HIV to enter the body.
- The soldiers, or CD8 cells, do a valiant job in vigorously fighting off the attack. They will kill some of the HIV, but their own army is working against them because the guards and command and control centres are being used to make hundreds of thousands of HIV cells. These will eventually overwhelm the soldiers, forcing them to surrender. The special forces (antibodies) are released into the body, but it takes a long time to bring the virus under control. This phase is known as the window period and usually lasts three months. At this point, any tests done for HIV antibodies will be negative because there are not enough HIV-specific antibodies in the blood for the tests to register.
- Once the antibodies are released into the blood stream, HIV changes its shape so that the antibodies do not recognise them.
- This slow war is waged between the guerrilla HIV and the body's army until the body has no more troops, and its army is completely depleted. This process can take up to ten years.
- HIV has depleted the army to a point where any other foreign body can invade the body with impunity. Many illnesses can rampage through the body and they will not meet any resistance. Illnesses like pneumonia, thrush, TB, malaria and cancer can take advantage of the body's weakened immune system.

Facilitator's notes

The graph shows the relationship between the disease and the immune system. It is recommended that you draw this graph in three stages so that people can see how HIV interacts with the immune system. It is these combined symptoms of various infections that will lead to a diagnosis of AIDS. The graph shows the relationship between a person's CD4 cell count, viral load and phases of HIV infection.



Risk of HIV transmission – relative to viral load GRAPH: CHANNELS OF HOPE

Draw the graph that depicts a person's viral load. Viral load is the amount of virus a person has in their body.

- 4-16 weeks – a person is first exposed to HIV.
- The army in the body goes mad; the guard cells are sending messages, and the command and control centres are relaying instructions to the body. But HIV is able to kill many of these cells and release hundreds of thousands of HIV into the body.
- You can see that within the first couple of weeks after infection, HIV is very busy and there is a lot of the virus in the body (as shown in the graph, about 300,000ml3* of virus enters the body at this stage). Because of the large viral load within the body, the infected person is highly infectious (i.e. highly likely to pass the virus from one person to another).
- As the immune system develops antibodies and therefore gains some control of the situation, the viral load decreases dramatically.
- It is only after a long war with the immune system that the body finally loses the fight and the viral load starts increasing dramatically. (Again, emphasise that this process can take up to ten years or even longer).

*Number of viruses per cubic millilitre of blood

CAUTION

- At the initial stage of the HIV infection, a person is highly infectious. If you suspect that you are newly infected, it is extra important for you to practice safer practices.
- If you are living with HIV and become pregnant advice your caregivers accordingly so that they can take the proper precautions during labour, pregnancy and birth.
- There are no available tests designed to detect the antibodies other than during the first four to sixteen weeks. Remember that the B-cells take a while to manufacture the antibodies and get them on the ground. If you believe that you have been infected and are within the early stages of the infection when you test for HIV, you may get an incorrect result. Always test THREE months after your first test to confirm your result.
- Within the first three months of infection, HIV attacks both the guard cells (M cells) and the command and control cells (CD4 cells).
- As you can see, initially the number of CD4 cells drops dramatically in the first weeks of infection.
- As the body is able to mount a defence, it produces more CD4 cells. Over the years, as HIV uses more CD4 cells to replicate itself, the number of CD4 cells drops. Without these cells the body cannot defend itself against infections.

Viral load and CD4 count are important in determining how a person progresses towards severe immune system compromise

If a CD4 count is high, then a person has enough command and control centres to enable the body to mount a proper defence. The immune system works well and HIV can be kept under control. As the viral load increases the CD4 count will steadily decrease. HIV is slowly depleting the body of its immune cells.

IMPORTANT, IMPORTANT, IMPORTANT

- It is vital for Persons Living with HIV to properly support their immune system. This includes good nutrition, enough sleep, exercise and support.
- By keeping the CD4 count high, the immune system can fight HIV more effectively. However, the cruel irony is that the more CD4 cells that are produced, the more cells are available for HIV to use to replicate. Thus:
    - **We need to keep the viral load low. This is where Antiretroviral Therapy is important; ART keeps the viral load at undetectable levels by inhibiting the virus's ability to replicate itself.**
- High CD4 count and low viral load ensure that persons living with HIV live long, productive lives. In such cases, many persons living with HIV will die of natural causes rather than complications relating to HIV.

HIV progress to AIDS – Tuberculosis

TB is the most common opportunistic infection to be found in patients progressing from HIV to AIDS. It is a bacterium that mainly attacks the tissue of the lungs. As the lung tissue is destroyed, the patient becomes less and less able to breath and eventually suffocates to death.

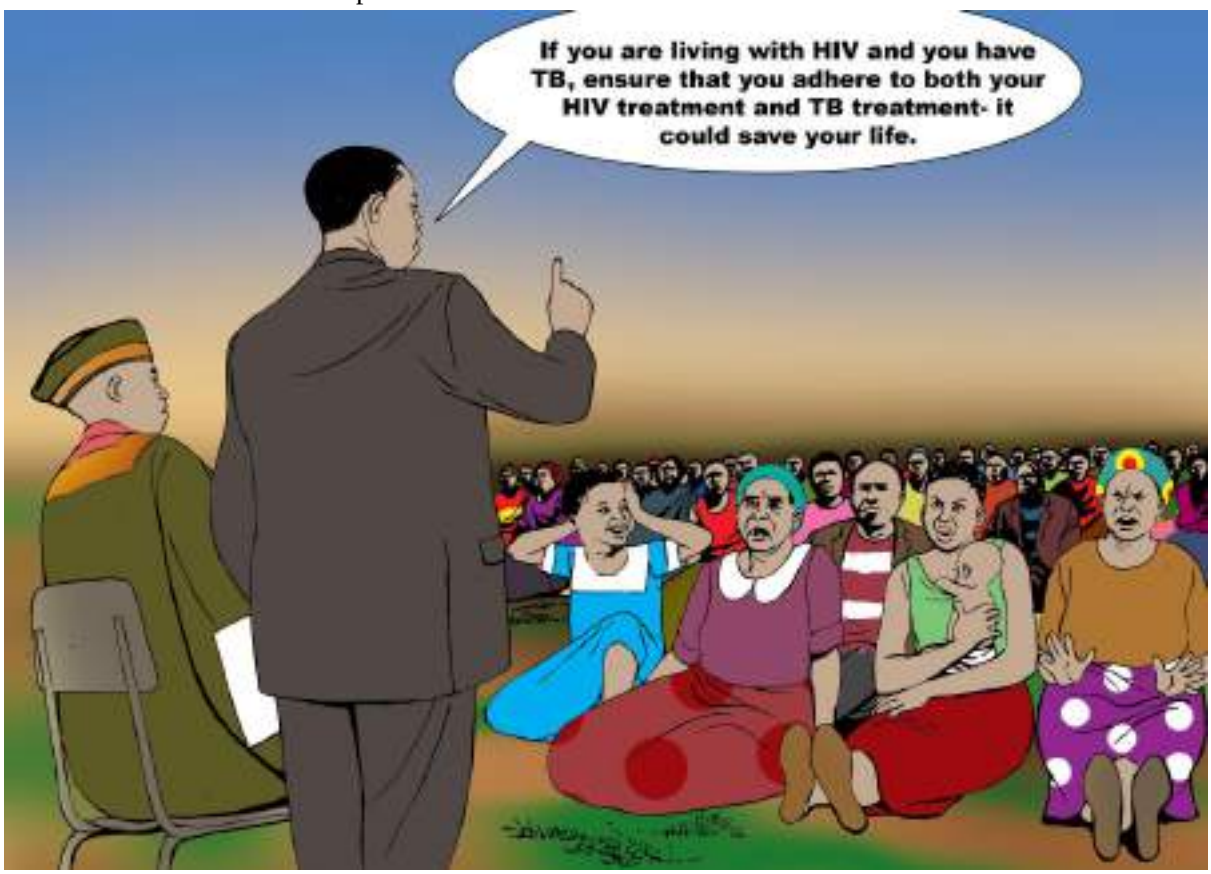
TB is an interesting bacterium for the following reasons:
1.It is a common infection BUT a healthy functioning immune system can keep it under control very successfully.
2. If the immune system fails, the bacteria are able to attack the lung tissue – such as is seen in many people whose HIV has progressed to AIDS.
3.It is transmitted very easily – coughing, sneezing, spitting, all transmit the TB bacteria.
4.It thrives in poor communities and in communities that live close together in crowded spaces. Furthermore, in an age of air travel, one infected person in a plane could infect many others, thereby transmitting the infection across the world.

TB treatment is difficult:
1.It takes at least six months of daily antibiotic treatment to eradicate the TB bacteria from the body. This is often very hard to do.

2.Since the TB bacteria can mutate easily, people who do not adhere to their treatment develop bacteria that resist the initial treatment, and the infection starts again. This second infection is extremely difficult to control. Furthermore, this type of bacteria spreads to other people who will now also not respond to the first treatment. (We call this multiple-drug-resistant-TB).
3.TB can mutate again and again until it becomes resistant to all drugs, and since it can no longer be treated, death is inevitable.

TB and HIV

- HIV depletes the immune system. A healthy immune system is more likely to be able to keep TB bacteria from infecting a person.
- A TB infection also challenges the immune system, further driving an individual's progress from HIV to AIDS.
- Persons who are living with HIV are four times more likely to die from TB than those who are not.
- Persons who are living with HIV have a higher likelihood of developing TB that attacks the rest of the body besides the lungs. This makes TB very hard to treat.
- TB can re-occur in patients who are living with HIV even after successful treatment.
- The TB drugs can interact negatively with ARV treatment.
- A person with HIV becomes more susceptible to TB infection if their CD4 count drops below 350.



CAUTION

If you are living with HIV and you have TB, ensure that you adhere to both your HIV treatment and TB treatment- it could save your life.

Misaction

Questions

It is important that both pillars of good HIV care are supported:

1. How can we support the immune systems of persons living with HIV? What do we do that does not support the immune system? For example, in certain parts of the Democratic Republic of the Congo, pregnant women are not allowed to eat eggs. This practice is a deeply ingrained cultural practice. Eggs are an excellent and often cheap source of protein. Thus, by limiting access to protein, a pregnant woman's health can be compromised if there is no other source available. Protein is vital in the functioning of the body and the immune system. Thus, if a pregnant woman is living with HIV and she is not allowed to eat eggs, her immune system may suffer causing her CD4 count to drop dramatically.

2. How do we reduce viral load?

Facilitator's notes

The only medical way to reduce the viral load is through the ART. This process will be covered in more detail later in the Toolkit (see: Access to Treatment). You may want to capture these answers and discuss them later.

Please stress the fact that both pillars of HIV care are important. For example, continue to take ARVs even if you are feeling well because it keeps your viral load in check. Keep exercising when you are on ARVs because exercise supports the healthy functioning of the immune system. The misaction is that we often focus on one pillar of HIV management and neglect or even revile the other. It is important to focus on both.

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Van Dyk, Atla. (2005) *HIVAIDS Care & Counselling – A Multidisciplinary Approach*, Pearsons Education South Africa (pg 48)

Reflection and Notes

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

HIV transmission
BLOOD

THIRD EDITION

HIV transmission: BLOOD

Session Objective:	To provide an overview of the ways HIV enters the blood stream through direct blood contact.
Session Overview:	There are several exercises and discussions by the participants with lessons on how HIV enters into the blood stream through the following: • Direct blood contact between people through blood transfusion • Direct blood contact through the use of unsafe surgical and other medical equipment • Direct blood contact through labour and birth
Key Message:	Transmission through direct blood contact can be managed – there are choices
Biblical Scripture:	*The life of every creature is its blood (Leviticus 17:14, NIV)*
Scripture Emphasis:	Blood is integral to life. Consequently, it needs to be handled with utmost care.
Islamic Scripture:	*O mankind! If you are in doubt about the resurrection, then verily We have created you (i.e. Adam) from dust, then from a Nutfah (mixed drops of male and female sexual discharge i.e. the offspring of Adam), then from a clot (a piece of thick coagulated blood) then from a little lump of flesh. (Qur'an 22:5)*
Scripture emphasis:	Blood is considered essential for life but Islam does appreciate it as a possible medium for transmission of diseases. Therefore, blood and blood products should be handled with care.
Expected Empowerment Outcomes:	By the end of this session, participants should be able to understand ways which HIV enters into the blood stream through direct blood contact.
Toolkit References:	• ARVs • Condom use • Mutual Fidelity • VCT • Sterile surgical equipment • Male Circumcision and cultural scarification • Sexually transmitted diseases
Time:	45 minutes
Resources Needed:	Flipchart paper and pen

How is HIV transmitted:

Note to facilitator:

This is a quick information session.

High risk body fluids:

- *Blood*
- *Breast milk*
- *Semen*
- *Vaginal & penile fluids*

Note that part of the human tragedy of HIV is that the virus is transmitted through our most intimate relationships; our first relationship is with our mothers and through our adult sexual relationships.

Effective transmission

- *HIV must find a way to enter the blood stream*
- *HIV needs to be present in sufficient quantities*
- *Duration of exposure needs to be long enough*

The transmission of HIV through blood exposure

Means of exposure:

- Contaminated blood products through a blood transfusion

Empowerment activity: Ask participants to:

- Find out about the blood supply in your country.
- Ask how blood is tested for HIV and other sexually transmitted infections. Also ask if the blood in your country is tested for malaria.
- Ask whether the blood services used in hospitals are from paid or unpaid donors.
- What would be the risks around using paid donors? You should provide information on negative outcomes.
- What are the risks of contracting HIV through contaminated blood or blood products?
- Who should and should not donate blood or organs?
- These questions can be asked through the local blood bank (if there is one) or through the administrator of the local hospital. If you have received blood products, ensure that you have an HIV test two months after receiving such products, even if you know all precautions have been taken. It not only sets a good example but will also increase the confidence of others in the safety of blood products where appropriate.
- Means of exposure: needles, razor blades, scalpels and other sharp objects that pierce the skin

Note to facilitator:

This is covered in more detail in the section on male circumcision and sterile surgical instruments in the Toolkit.

Means of exposure

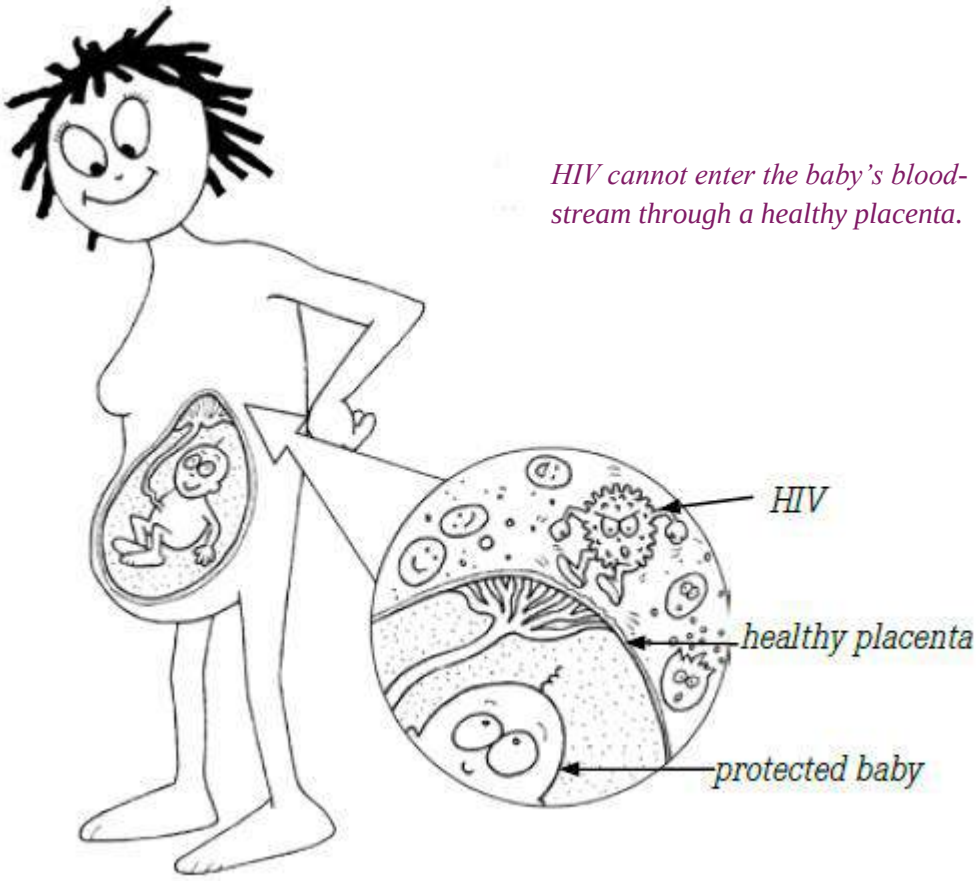
- People who use drugs through injections

Empowerment Activity:

Try this as a skit, or have three people who can read dramatically the following information.

Means of exposure

Mother to child transmission – blood exposure



HIV cannot enter the baby's blood-stream through a healthy placenta.

A mother is connected to her growing baby by the placenta and the umbilical cord. The placenta is the organ through which the baby is nourished, given oxygen, and waste products are eliminated. The baby is attached to the placenta by the umbilical cord. The blood supply of the mother and the developing baby almost never mix, so if a mother is living with HIV, the placenta actually protects the baby from infection. However, the placenta can only do this if the mother is healthy. The following situations increase the risk of HIV transmission from mother to child as they have a direct impact on the quality of the placenta:

1. If the mother is not well: smoking, substance abuse, vitamin A deficiency, malnutrition and other infections (such as sexually transmitted infections) are all associated with higher rates of mother-to-child transmission of HIV.
2. If the viral load of the mother is high: it is likely to be high if she has recently been exposed to the virus or her HIV is turning into AIDS.

Note to the facilitator:

You should reassure women that the baby has its own blood supply and that in a safe, healthy pregnancy, the blood of the mother and of the growing baby do not intermix. It is only when the health of the placenta is compromised in some way that the risk of HIV transmission between mother and child increases.

Reducing transmission during pregnancy:

Ensure that the mother is not exposed to a new HIV infection. She should use condoms during sex with her partner, and make sure that a new partner is tested before embarking on a sexual relationship. Getting the pregnant mother onto ARVs is a highly effective way of reducing the risk of transmission during pregnancy. In all cases, reducing the viral load through ART will be an effective means of reducing the risk of transmission.

Safe birthing for mothers living with HIV:

Note to facilitators:

There are many myths about birthing that may need to be addressed during this session.

You may want to invite a trained midwife to come and lead this section. Furthermore, it may turn into an ante-natal class. This may be necessary and useful for the participants but does not fall within the scope of the SAVE Toolkit. If this does happen, you will need to redirect the session and give people information to access proper ante-natal classes.

Preventing Transmission of HIV from mother-to-child during birth.

- Over 60% of mother-to-child transmissions of HIV occur during childbirth. This is because the baby leaves the protective environment of the womb and comes into contact with the mother's blood and mucous as it travels through the birth canal.

- **IMPORTANT:** The pregnant mother must keep her viral load as low as possible during the entire pregnancy. If she is on antiretroviral therapy, medication must be taken daily. If not on medication, she must ensure that she is living a healthy life style by supporting her immune system through a nutritious diet, exercise and rest.

- **EVEN MORE IMPORTANT:** Continue to use a condom during sex to avoid being re-infected with HIV. Re-infection increases the viral load and risks for contracting a new strain of the virus that might be resistant to your medication.

- **KNOW YOUR HIV STATUS AND MONITOR YOUR VIRAL LOAD**: We cannot stress this enough. A mother's health can be improved and her baby can be born without HIV if she knows her status and has access to the correct care. Antiretroviral therapy, along with quality ante-natal and post-natal care, will not only enhance a woman's health but also the health of her child. Furthermore, mothers are important people in the lives of their babies and children. Women who are living with HIV can live happy, healthy and productive lives if they have the proper treatment and support.

- **ANTIRETROVIRALS:** We cannot stress enough – know your status and monitor your viral load as this determines the type of antiretroviral therapy you will receive during pregnancy and birth. There are different drug regimens across countries. The regime that is provided below is the minimum required in South African State Facilities: Reducing stress during child birth by having a caesarean section is an effective way of reducing the risk of HIV transmission during birth.

Activity:

It is important to know two things in terms of access to treatment for pregnant mothers and their babies:

- *What is available locally?*
- *How is access controlled?*

Gather a group of respected local religious leaders and visit the local birthing unit to see what antiretroviral care is available. Make this information available through places of worship.

Although care might be available, access to this care can be problematic due to either unconcerned staff or supply line problems. A group of religious leaders can impact change by demanding better care for members of their communities. Become actively involved in the local clinics to ensure that community members are not denied access to treatment.

DURING BIRTH: A labouring woman is often not the best advocate for herself and her baby during labour. If possible, she should discuss the following with the caregiver or try and ensure that a friend is with her during labour. These guidelines are important for Traditional Birth Attendants to ensure that they practice as safely as possible.

- Do not artificially rupture membranes unless there is a specific reason for this. Prolonged rupture of membranes significantly increases the transmission of HIV because the baby no longer has the protection of the amniotic sac.
- Do not cut the vulva unless absolutely necessary. This cutting is called an episiotomy.
- Try to avoid a forceps delivery or vacuum extraction, as such methods cause cuts to the baby's head. If these cuts come into contact with the mother's blood (which is inevitable during birth) HIV transmission can occur.
- The friction caused by the baby passing through the birth canal can cause minute abrasions to the skin. This provides opportunity for HIV to pass from mother to child as their blood comes into direct contact. There is nothing we can do to prevent this as it is a normal process and the abrasions cause no harm or damage to the baby. However, much can be done to reduce the risk of HIV transmission at this stage:
- Giving the mother ARVs before giving birth
- Giving the baby ARV syrup just after birth
- Delivering the baby through caesarean section

SSDDIM:

Limiting ARVs simply to ante-natal and post-natal care will help prevent the transmission of HIV to the new-born baby, but will not significantly help the health of the mother. The best way to deal with orphans is to keep the parents alive! Wherever possible, a mother who has begun treatment in relation to pregnancy should be kept on treatment after the birth.

Note to facilitators:

The following activity can be carried out as part of a comprehensive antenatal care programme. You should stress the overall health and well-being of every pregnant, labouring and birthing woman. All pregnant women have a great need for good nutrition, proper medical care and community support. The special focus for women living with HIV is access to ARVs. However, in many contexts this access is either difficult or non-existent. It is thus critical to stress the important role of religious communities in pressuring the government and healthcare providers to enable pregnant women living with HIV to access ante-natal and post-natal ARV treatment.

Furthermore, quality pregnancy care and birthing practice can empower women to demand better care for themselves and for their infants.

Activity:

If the group is large, divide participants into smaller groups of five or six and give each group several sheets of presentation paper. Label each sheet of paper with the following: stigma, shame, denial, discrimination, inaction, misaction. The scenario is that there is a pregnant woman in your community who is living with HIV. The groups need to discuss under different headings what the consequences would be for the pregnant woman and her unborn baby if we do not address SSDDIM.

A group discussion would follow and the consequences highlighted for all.

Ask the group to develop action points that they can do to reduce SSDDIM against pregnant women living with HIV.

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Sharp P and Hahn B (2011): Origins of HIV and the AIDS pandemic. *Cold Spring Harb Perspect Med.* 2011 Sep;1(1): a006841. doi: 10.1101/cshperspect.a006841

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Reflection and Notes

Reflection and Notes

Reflection and Notes

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A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

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HIV transmission
BREAST MILK

THIRD EDITION

HIV TRANSMISSION: BREAST MILK

The decision to breastfeed or bottle-feed a new born baby is a very controversial issue. This module presents information for mothers to make informed choices on how to best feed their babies. For mothers who are living with HIV, the section provides options to either breastfeed or bottle-feed as safely as possible. The final choice about feeding is for the mother to make. All mothers and situations are different and mothers should make the decision without pressure.

Session Objectives:	• To provide information on how and why HIV is transmitted from mothers to babies through breastfeeding • To provide information to women and men on how it is best to feed babies when a mother is living with HIV.
Session Overview:	How and why HIV is transmitted from mothers to their babies through breastfeeding. How women and men can best feed a baby when the mother is living with HIV.
Key Message:	Mothers have choices when they feed their babies. These choices need to be available to all mothers.
Biblical Scripture:	*Elkanah her husband said to her, "Do what seems best to you; wait until you have weaned him; only, may the LORD establish his word." So the woman remained and nursed her son until she weaned him. (1 Samuel 1:23, ESV)*
Scripture Emphasis:	The mother has a great part to play in the choice of how to nurse the newborn baby. The choice will affect the health outcomes of the baby and so needs to be done from an informed position, and information is therefore critical to mothers living positively with HIV.
Islamic Scripture:	*"Mothers shall breastfeed their children for two whole years, for those who wish to complete the term" (Qur'an 2:233).* *His mother carried him with hardship, and gave birth to him with hardship. And the carrying of the child to his weaning is a period of thirty months" (Qur'an 46:15).*
Scripture emphasis:	Mothers are encouraged to breastfeed their children with an understanding of the benefits that breast milk brings to the child.
Expected Empowerment Outcomes:	By the end of this session, participants will be able to: • Explain how and why HIV is transmitted through breast milk • Identify ways of reducing the risks of transmission through breast milk • Make informed choices about how to feed their babies • Advocate for access to ARVs for themselves and their children during lactation and beyond • Advocate for access to baby formula, clean water and bottles so that women can also choose to bottle-feed with ease
Toolkit References:	• ARVs • Condom use
Time:	1 hour 30 minutes
Resources Needed:	• Flipchart paper and pens

How is HIV transmitted:

Note to facilitator:

This is a quick information session.

High risk body fluids:

- *Blood*
- *Breast milk*
- *Semen*
- *Vaginal & penile fluids*

Note that part of the human tragedy of HIV is that the virus is transmitted through our most intimate relationships; our first relationship with our mothers and through our adult sexual relationships.

Effective transmission

- *HIV must find a way to enter the blood stream*
- *HIV needs to be present in sufficient quantities*
- *Duration of exposure needs to be long enough*

HIV in breast milk

Note to facilitator:

Breastfeeding when a mother is living with HIV is a complex issue. It is recommended to invite a clinic sister to help you with this session if possible. Some of the activities can only be done if you have been trained. Please do not include those activities if you have not received training.
HIV is present in large quantities in breast milk. It is estimated that between 40% - 30% of babies will contract HIV from breastfeeding. In this session, we explore why this is the case and what we can do to prevent mother to child transmission through breastfeeding. The module will end by explaining how to breastfeed as safely as possible when ARVs and formula are not available.

Why is HIV transmission from mother to child so prevalent through breastfeeding?

Discussion:

Ask participants why we breastfeed. Write the answers on flipchart.

You may receive some of the following answers:

- Breastfeeding is best for babies
- It is the most nutritious form of food for babies
- It is cheap
- Cultural beliefs around breastfeeding
- It can create a very loving bond between mother and child
- It helps mothers recover from labour and delivery
- It is safe for babies as all the essential nutrients, enzymes and hormones are available.
- Giving babies breast milk gives them their mother's antibodies to help them through their first 18 months of life.

The general feeling is that breastfeeding is good for both mother and child and needs to be encouraged. Furthermore, it is often the only option for feeding in poor, rural and highly traditional communities.

BUT: What if I am living positively with HIV?

Note to facilitator:

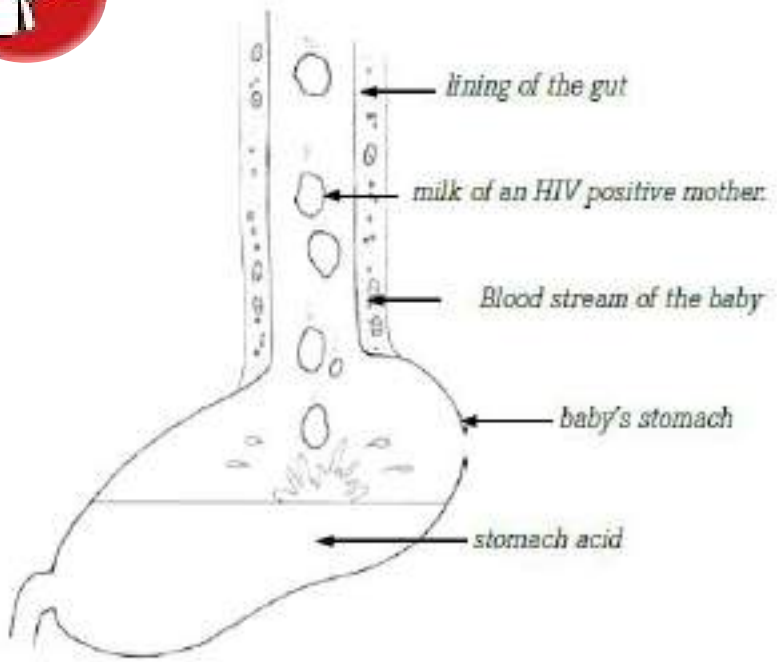
The information that follows should be given to all women as part of quality pre-natal care. Stress the importance of good breastfeeding habits, good bottle-feeding habits, and that every mother can choose what is best for her baby.

Exclusive breastfeeding for mothers living with HIV is the ideal option in many parts of the world that do not have access to ARVs, formula and clean water. However, while exclusive breastfeeding can significantly reduce the risk of transmission, it does not eliminate it. You will need to ensure that participants understand this fact. Also make sure, mothers understand that the greatest risk factor in transmission of HIV through breast milk is by "mix feeding" (breast feeding and bottle feeding at the same time).

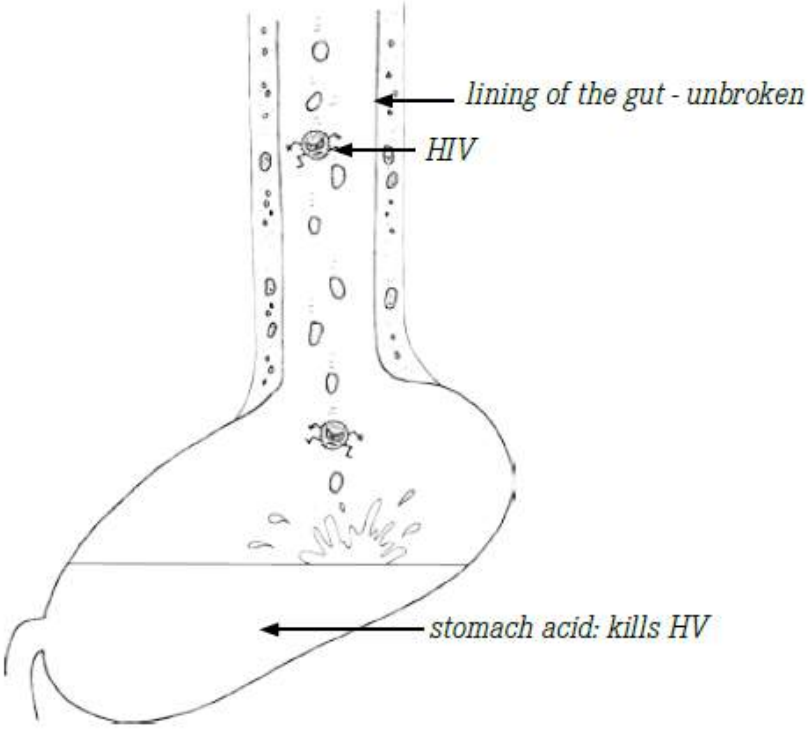
Breast milk and the gut (digestive system) of the developing baby:

Note to facilitator:

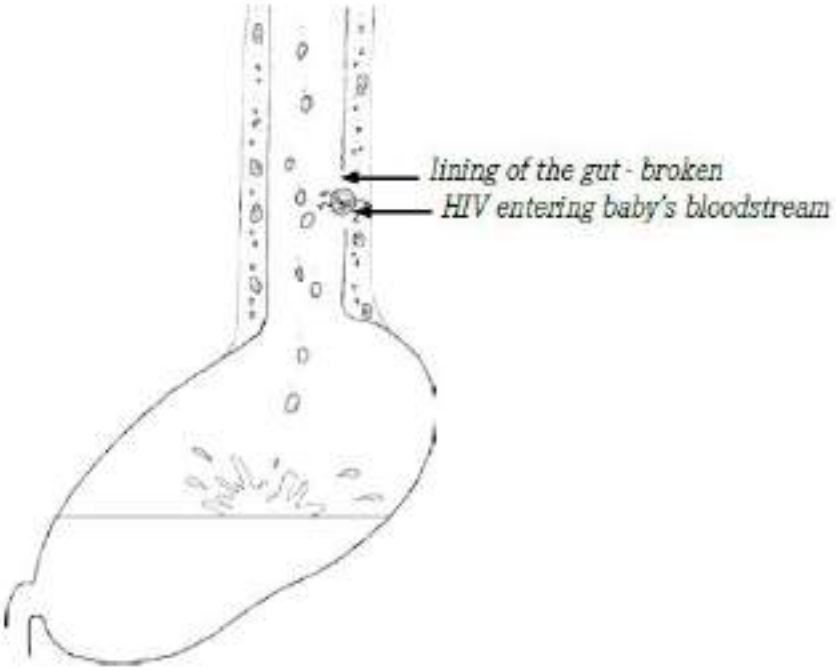
Here is the drawing you will need to do:



Upper part of baby's digestive system



Breast milk of a mother living with HIV



HIV entering the bloodstream through tears in the gut lining

Breast milk is very gentle on the gut of a baby. All the nutrients, enzymes and hormones are easily absorbed through the linings of the gut and enter the blood stream WITHOUT causing tears in the lining of the gut. During exclusive breastfeeding the risk of HIV gaining access to the baby's blood supply is reduced.

The nutrient molecules in either formula or food are much larger than those in breast milk and cause small tears in the membrane and lining of the gut. These tears provide HIV direct access to the baby's blood supply.

CHOICE 1: Breastfeed exclusively. As soon as you introduce either formula or any other type of food STOP BREASTFEEDING.

Note: The WHO recommends that mothers who are living positively with HIV can exclusively breastfeed until their babies are six months old. This recommendation is based on the needs of women in poor, rural and traditional communities, and on the science around the development of the immune system.

Note: Babies continue to need milk through the first year of their lives. If you choose to stop breastfeeding after a certain period, ensure that you have some milk either in the form of formula or cow's milk to feed your child. Note that goat's milk is the closes type of milk to human breast milk, which makes it a good feeding option for babies.

What if my baby is having difficulty feeding?

For most babies (although not all), their guts can digest breast milk successfully and HIV will be excreted. However, there may be problems with the gut, for example – reflux, gastric flu, diarrhoea constipation, vomiting which increases the rate of HIV transmission.

Mothers living with HIV

STOP Breastfeeding immediately if you can under these circumstances:

- Gut illnesses cause tears in the lining of the gut and will give HIV direct access to the blood stream.
- Ensure that they are getting enough water and electrolytes.
- Try to bottle-feed with either formula or goat's milk if available.

Mothers not infected with HIV

CONTINUE to breastfeed

Your body manufactures hormones and antibodies that help the baby fight disease. It is a good way to ensure that your baby continues to be hydrated.

Get to a doctor as quickly as possible

Having a sick baby with a gut problem is very scary for any mother. For mothers living with HIV, this experience can feel worse as she will have to stop breastfeeding her baby. However, this suggestion might not be an option for many mothers without access to formula or clean water. These mothers are faced with the difficult choices of either continuing to breastfeed and risk transmitting HIV to their child or to stop feeding and starve their child. Due to the medical interventions available in the 21st Century, mothers should not have to face this choice. Faith leaders in particular need to actively lobby for access to proper healthcare for all women so that these types of choices become a thing of the past.

Cracked nipples and mouth sores?

If you have cracked nipples or if your baby has sores in his or her mouth, you will have to stop breastfeeding. With cracked nipples, a mother's blood will mix with breast milk, increasing the risk of HIV transmission. If the baby has sores in his or her mouth, you also need to stop breastfeeding. In this case, there is direct access to the blood stream for HIV. Because babies feed so often and for long periods of time, the sores will be exposed to the HIV positive breast milk for a prolonged period. Thus, any HIV neutralising properties that the saliva contains will be overwhelmed by the quantity of HIV in the milk and the prolonged exposure.

CHOICE 2: Breast feeding while under ARV treatment

Note to facilitator:

The section on ARVs is rather dry and factual, and is included simply to provide basic information. Find out about the ARV treatment protocol for mothers in your area before you deliver the information below. Remember that not everyone has access to these drugs.

Breastfeeding and ARVs

If you have access to ARVs, the treatment protocol should be followed. Using ARVs while breastfeeding will vastly reduce the risk of HIV transmission through breast milk. (See following section):

CHOICE 3: Bottle-feed with formula, understanding the safe methods

Using formula milk for mothers living with HIV and their babies is the ONLY way to guarantee that the baby will not get HIV from breast milk. However, you will need the following:

- Access to clean water. You can ensure that your water is clean by straining it through a cloth and boiling it for at least twenty minutes before you use it to make up a formula feed. Even in cities your water supply needs to be clean. If there is any doubt, ensure that you boil it for at least twenty minutes.
- You need to have a steady, reliable water supply. New-born babies need feeding every two hours, and as babies grow, they will need milk feeding between five and six times a day before they are able to take solid food. An erratic water supply or a water supply that is highly labour intensive will not meet the needs of bottle-feeding mothers and their babies.
- You will need bottles and teats and you will need to be able to sterilise them.

CAUTION

One of the leading causes of deaths in Africa for children under 5 is diarrhoea. Diarrhoea is often caused by small water-borne infections that babies and children acquire from unsterilized water and bottles. If you are unable to sterilize your water and bottles, consult your clinic sister for safe breastfeeding advice.

- You will need good access to age-appropriate formula for your baby. Some clinics provide this free of charge. If that is not available, buying the formula can be an expensive outlay for a family. If this is the case, consider breastfeeding or pasteurising your breast milk under the correct supervision.
- Do not dilute any formula feeds. Formula is very specifically designed to give your baby good nutrition in correct dosages. Rather than dilute your formula to make it last longer, you should rather breastfeed, pasteurise your milk or use a milk substitute like pasteurised goat's milk.

For mothers living positively with HIV, formula feeding is the only way to guarantee that your baby will not get HIV from your breast milk. HOWEVER, if you cannot use formula for any reason, there are ways that significantly diminish transmission if you take a few basic precautions. Using Antiretroviral will also ensure that you do not transmit HIV to your baby. If you have access to them, that may be the best option for you.

We hope that this module has given you information about the various choices that you can make around feeding your baby, and, if you are living with HIV, feeding your baby so that HIV transmission is diminished or eliminated. Feeding your baby is not only important in terms of nutrition but also important in terms of your baby's emotional health. Whatever choice you make, or are forced to make, most mothers will do the best for their babies.

References

UNICEF, UNAIDS, WHO, UNFPA (2008): *HIV transmission through breastfeeding: A review of available evidence*. Geneva: WHO

World Health Organization, United Nations Children's Education Fund (2016): *Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV*. Geneva: World Health Organization

Reflection and Notes

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

HIV TRANSMISSION:
OTHER BODILY FLUIDS

THIRD EDITION

HIV TRANSMISSION: OTHER BODILY FLUIDS

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General Understanding

This section is important to lay the groundwork for understanding HIV transmission. Through a combination of choices, we can reduce the risk of transmission of the virus. Ensure that you play the Transmission Game. You may refer back to it later or play it in other sessions. **DO NOT** skip this session as it provides the basis for making accurate, informed choices for one's overall health and wellbeing

Session Objective:	Describe how HIV is transmitted through vaginal fluid and semen
Session Overview:	• Sex and Sexuality • Different types of bodily fluids • How and why HIV is transmitted through bodily fluids • How to prevent HIV transmission through bodily fluids
Key Message:	Breast milk, semen and vaginal/penile fluids have high concentrations of HIV – you can prevent transmission of HIV if you adopt SAFER practices
Biblical Scripture:	*Then Jesus said to them, "I ask you, which is lawful on the Sabbath: to do good or to do evil, to save life or to destroy it?" (Luke 6:9)*
Scripture Emphasis:	Bodily fluids are sacred and carry life like the blood. They can get infected and the idea is for each person to do everything possible to keep these fluids clean and to seek treatment if the fluids get sick and ensure that we don't infect others.
Islamic Scripture:	The messenger of God said. "Islam is clean, so cleanse yourselves, for only the cleansed shall enter Paradise," (At-Tabarani)
Scripture emphasis:	Every person is obliged to seek utmost cleanliness and acquire knowledge on how to prevent HIV transmission through bodily fluids.
Expected Learning Outcomes:	By the end of this session, participants should be able to: Explain how and why HIV is transmitted through contact with vaginal/penile fluids Identify ways of reducing the risks of transmission
Toolkit References:	ARVs Condom use Mutual Fidelity VCT Sterile surgical equipment Male circumcision and cultural scarification Sexually transmitted infections
Time:	1 hour
Resources Needed:	Flip chart paper and pens Equipment and preparation for Transmission Game: • Jars for holding water- one for each participant • Clear vinegar • Baking soda/bicarbonate of soda • Teaspoons Equipment needed for desaturation of barriers of HIV transmission 1. Orange or other citrus fruit 2. Knife 3. Hollow bore needle (if available) 4. A balloon 5. Cotton wool Materials needed for demonstration on viral load • Food colouring • 3 Glass jars • Large glass jar • Water • Spoon • Guest speaker - Person living with HIV (if available)

Note to facilitator:

You will have to plan for this game well beforehand to ensure that you have the right materials. You can get most of the ingredients from a local grocery store, a school, with science laboratory, or a chemist.

This game is very important to play because it shows two things:

1. You cannot "see" the transmission of HIV, you do not know who is living with HIV.

2. It clearly shows how HIV is transmitted to many people even if initially there is only one person infected.

This game primarily focuses on sexual practice, but it is also effective in showing how blood contact can lead to high levels of HIV transmission.

Instructions:

You will need:

- Colourless vinegar
- Water
- Baking powder
- Glasses, or drinking cups
- Teaspoons
- A glass jar for each participant

Give each participant a slip of paper with a role written on it. Instruct them not to tell anyone else what their role is. Three people must be given Role 1. The rest have Role 2 or Role 3.

The instructions for each role are as follows:

Role 1: Your role is to exchange fluids as often as possible with anyone you want. If someone doesn't want to exchange fluids with you, find a way to persuade them. **Your aim is to exchange fluids as often as possible.**

Role 2: Your role is always to say "NO" if someone wants to exchange fluids with you. **Your aim is not to exchange fluids at all.**

Role 3: Your role is to exchange fluids only with your first partner and encourage them to exchange fluids only with you. Say "NO" to anybody else. Try to also prevent your partner from exchanging fluids with anybody else. You may exchange fluids with your partner as often as you want. **Your aim is to exchange fluids with your partner ONLY, whenever you want to**.

- Fill three glass jars half-full with pure vinegar. Give these to the three people who are assigned Role 1. These people will be acting that they are living with HIV. Everyone else receives a glass jar half-filled with plain water.

- Before the game starts use your own two jars to demonstrate how to exchange fluids. As a person sharing fluids, pour all the contents of your jar into the other and give it a good stir. Then return half the mixture to the empty jar. This is considered a complete exchange of fluids.
- Instruct the participants to move around the room playing their role. Give them five minutes to do this.
- When the time is up, take each jar and test it by pouring baking powder into it. Every jar that fizzes indicates that the fluid in it has the HIV.
- Tell the group that you started with three solutions that were HIV positive. Have a discussion about the spread of HIV. Ask how the people who were encouraged to have only one partner, or who said "NO" were persuaded to exchange fluids. If you handle this correctly and appropriately, you can have a very deep discussion on transmission and prevention of HIV. It will be important to bring into this discussion the fact that HIV can only be transmitted through BODY fluids, and even then, only through "high risk" body fluids - these being penile or vaginal fluids, blood and breast milk.

How is HIV transmitted:

Note to facilitator:

This is a quick information session.

High risk:

- *Blood*
- *Milk*
- *Vaginal/penile fluids*

Note that part of the human tragedy is that our most intimate relationships are potentially high risk - our first relationship with our mothers, our adult sexual relationships, and our relationship with humanity by giving blood to save lives.

Effective transmission:

- *HIV must find a way to enter the blood stream*
- *HIV needs to be present in sufficient quantities*
- *Duration of exposure needs to be long enough*

HIV must find a way to enter the blood stream:

The skin – our first protection against HIV

Activity:

You will need:

- *An orange or other citrus fruit. If possible, give each participant a piece of the fruit.*
- *A knife*
- *A hollow bore needle and syringe (if you have access)*

Ask participants to describe the texture of the orange. (Note that an orange most closely resembles human skin. Doctors and nurses begin practising injections on oranges before they are allowed to practice on patients).

The outside of the orange is like a human skin – it forms a barrier against infection, HIV included. The skin is the most effective barrier against the virus.

Now cut the orange. Hopefully some of the juice will spill out. The juice represents blood. Stress that once the skin is broken in some way, the skin can no longer provide a protective barrier. Thus, any open sore or wound provides an opening for HIV to get into the blood stream. Even small cuts will allow HIV to enter the blood stream.

Take the syringe and hollow bore needle and inject it into the orange. Pull some of the juice into the syringe. Take the syringe out of the orange and show people that there is juice both in the syringe and therefore in the needle. This is similar to how blood gets into a needle and syringe from the human body.

Go to someone else's orange (or you can use your own) and inject the contents of the syringe. Again, remove the syringe. There should still be some juice left in the syringe and therefore on the needle. Explain that as unsterilized needles move from person to person, they break the barrier of the skin, and therefore HIV has access to the blood stream.

Note to facilitator:
When this exercise is complete, stress that HIV needs to enter the blood stream in order to infect a person.

Activity:

Ask the group for ways in which HIV cannot get into the blood stream. Write the answers on a flipchart. Try to get a similar list to the one below:

- *Holding hands*
- *Eating off the same plate*
- *Sneezing*
- *Using a toilet*
- *Drinking the same water*
- *Contact with low risk body fluids like tears, sweat, saliva or urine.*

If a person in the group says that you can contract HIV from one of the above methods, refer back to the orange demonstration. Stress that the human skin, just like the skin of the orange, provides an excellent barrier of protection because it is tough, has many layers, and is not easily broken. HIV needs to get through the skin first before it can enter the blood stream, which is difficult.

If people mention kissing or oral sex – put it on the parking lot. The topic will be discussed in the next session.

Our mucous membranes are not as good as skin in providing protection (mucous membrane and skin are part of the same "organ group" – the dermis).

Activity:

You will need:

- *An inflated balloon*

Compare the inflated balloon with the skin of the orange. Ask participants what the differences are and compare their relative toughness. Explain that the balloon is similar to the mucous membranes in your mouth as well as the very porous mucous membranes in the genitals, the anus and rectum. These membranes are easily torn. Pop the balloon at this point for effect.

Ask people to feel inside their mouths, and ask them how this feeling differs from the toughness of the skin. Remind them that the mucous membranes they are feeling are easily broken. Furthermore, the mucous membranes in the genitals, anus and rectum are even more delicate and they tear easily. Thus, exposure in these areas to blood, milk and vaginal/penile fluids can provide direct access for HIV into the blood stream.

These barriers are not as effective as the skin.

What about kissing?

- Information: The mouth is a good barrier against HIV (although not as good as skin) because the mucous membrane is not porous. Furthermore, saliva breaks down HIV – as a result HIV is often not present in saliva.
- You would need to have sores in your mouth (e.g. bleeding gums) to get HIV from kissing.
- There have been no reported cases (in over twenty years of tracking transmission) of a person getting HIV from kissing.
- We spoke earlier of the need for HIGH viral load, or numbers of viruses. Saliva is a very low risk bodily fluid because when HIV is present in saliva it is always in very low quantities.

Enjoy a good kiss and cuddle – it is good for building an intimate relationship and does not transmit HIV.

Sores in the mouth:

If you or your partner have sores in your mouth or on your lips, then you should refrain from kissing. Sores, dental work, or damage to the mouth will lead to blood in the saliva. Blood can have an extremely high concentration of HIV and therefore contact with wounds in the mouth can lead to transmission.

What about oral sex?

This topic is covered in detail in the section on safer practices.

HIV TRANSMISSION – OTHER BODILY FLUIDS

This section is brief since issues of sex and sexuality are covered in other sections of the Toolkit.

Session Objective:	To facilitate learning on HIV Transmission through vaginal/penile fluids.
Session Overview:	• HIV transmission through penile and vaginal fluids • How to reduce the risk of HIV transmission.
Key Message:	• Penile and vaginal fluids have high concentrations of HIV- You can prevent transmission of HIV if you adopt SAFER practices.
Expected Learning Outcomes:	By the end of this session, participants will be able to: • Explain how HIV is transmitted through contact with penile/vaginal fluids transmission • Identify ways of reducing the risks of HIV transmission
Time:	• 1 hour

Note to facilitator:

This section is mainly informative. Note down any questions that people have in terms of transmission as these are dealt with in other sections of the Toolkit.

Remind participants that HIV needs to enter the blood stream to infect a person.

Fluid	High Risk	Low risk
Blood	X	
Penile Fluid	X	
Vaginal Fluid	X	
Breast Milk	X	
Tears		X
Sweat		X
Urine		X
Saliva		X

Low risk bodily fluid:

Saliva:

- There is very little HIV present in saliva. Thus, kissing persons who are living with HIV carries very little risk of infection. There is no known case of infection through saliva.
    - The danger of transmission through kissing arises when people have open sores inside or on their mouths. It is not desirable to kiss under these conditions anyway.
    - Bleeding gums as a result of tooth-brushing generally is not a concern as the mouth heals these small tears within a matter of minutes.
    - Bleeding gums due to a gum infection is problematic as the body has more difficulty healing these wounds. Furthermore, there will be CD4 cells present in these areas trying to control and manage these infections.

Note to facilitator:

When discussing points above, emphasize the potential risk of blood to blood contact with mouth wounds, or semen to blood contact. It is not saliva contact that is important.

Tears and Sweat:

- As with saliva, there are very low levels of HIV present in both tears and sweat. We know that HIV transmission is related to the concentration of HIV in the body fluid concerned. Here the concentration is so low that there is no risk of transmission at all.

It is absolutely safe to hug, hold, wipe away tears, kiss away tears etc. There is no recorded case of any transmission via sweat or tears.

Urine:

- Urine is another body fluid which has very low concentrations of HIV, and has not been known to cause the transmission of HIV. For homecare workers in particular, normal hygiene should be observed while cleaning patients, but the body fluid you should be most careful around from an HIV transmission point of view is blood.

High-risk bodily fluids:

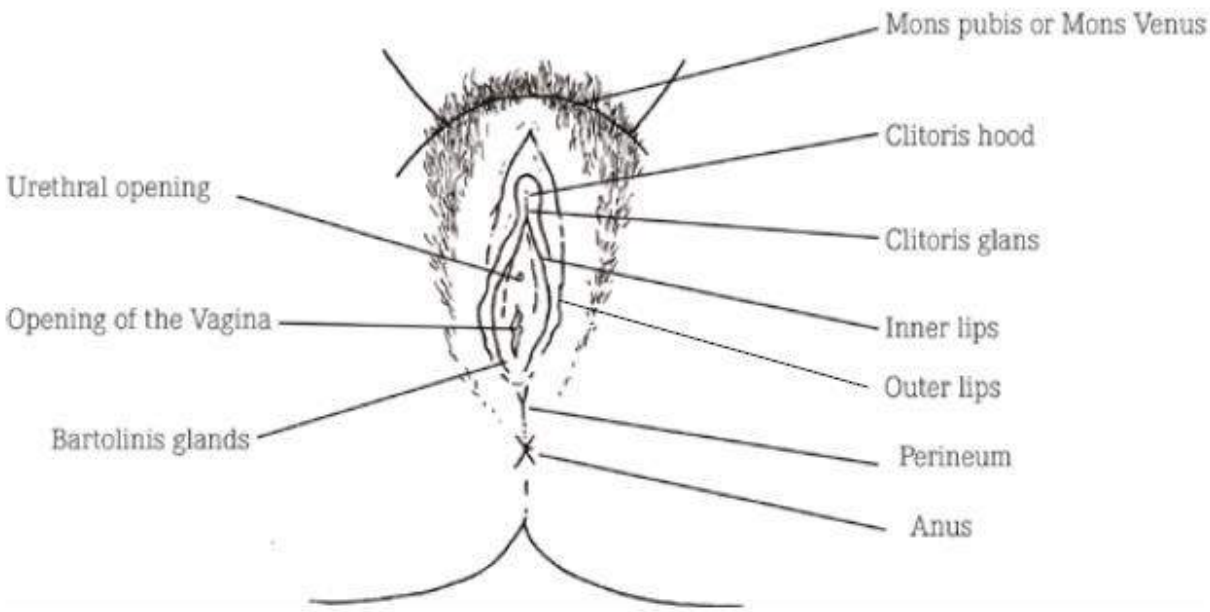
Breast Milk

This is discussed in the module: HIV transmission: Breast Milk in great detail

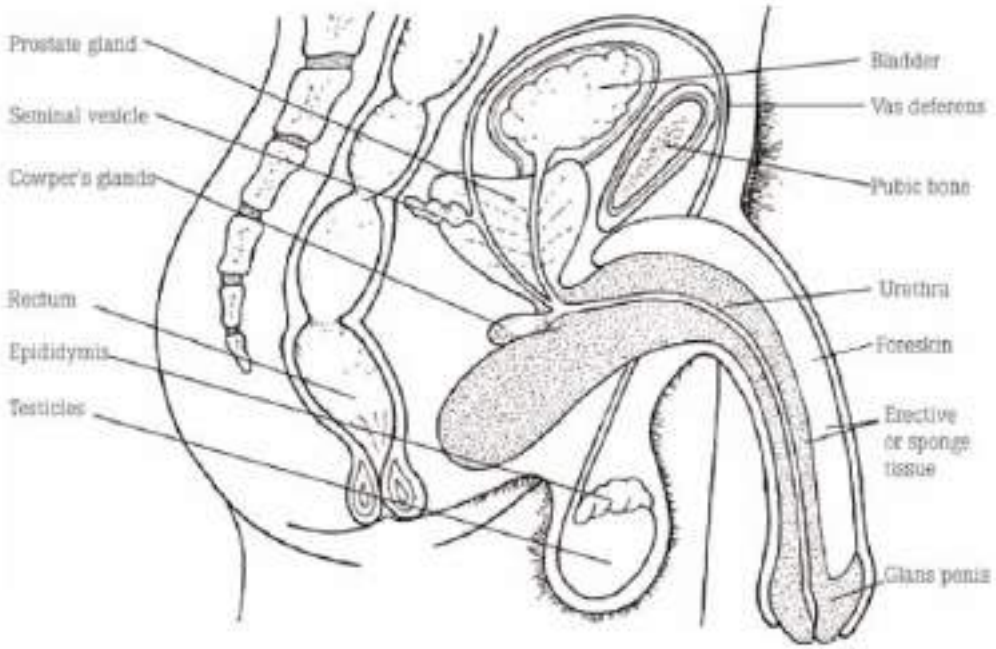
Semen

Seminal fluids carry a large amount of HIV. Semen's method of entry into the blood stream is generally through very delicate parts of the body, which increases risk of transmission.

The mucous membranes of the vagina, rectum and anus:



Female reproductive organs



Male reproductive organs

Vaginal sex:

The vagina and the penis are very delicate parts of the body. The vagina contains natural bodily processes that protect it from infection.

- The vagina constantly produces a mucous lining that protects both the vagina and the uterus.
- The vagina produces mucous during sex that protects the delicate wall of the vagina and cervix and the penis produces semen and other fluids.
- There is a large concentration of immune cells around the vagina, ensuring that the environment is kept clean and infection free.
- During sex, however, there can be microscopic tears to the vaginal wall caused by the friction between the vaginal lining and the penis. These tears give semen direct access to the blood stream and, to some blood stream rich in CD4 cells. HIV positive vaginal and penile fluids carry high risk of transmission.
    - Sex during a woman's menstruation also provides an ideal environment for HIV transmission.
    - Firstly, there is blood involved. If a man has tears on his penis, then there is a high risk of HIV infection.
    - Secondly, during menstruation the lining of the uterus gently tears away from the uterus wall, leading to small tears in the uterus – an area rich in blood supply.

CAUTION!

- Semen stays in a woman's body for between three and five days, which means that there is ample opportunity for infected semen to get into the blood stream.
- Generally, a woman's first sexual experience provides trauma to the vaginal area. There can be severe tears in the vaginal wall and cervix, which lead to a high risk for HIV transmission.
- A woman's cycle provides higher risk periods for vaginal trauma and therefore heightened vulnerability to HIV transmission. After menstruation, the vagina does not secrete a lot of the protective lining. Thus, sex during this period can cause small tears in the vagina for easy access of HIV to the blood stream.
- During pre-menopause and menopause most, women will suffer from severe vaginal dryness. Once again, this causes tears in the lining of the vagina, providing easy access for HIV. During this time, it is advisable to use LOTS of lubricant with the condom, as this will provide more protection and also more pleasure for both parties.

Vaginal and penile fluids:

- Vaginal and penile fluids also have a high HIV content. Sexual transmission is high if there are tears on a penis or during oral sex. The inside of the foreskin as well as the inside of the urethra are also highly sensitive to HIV infection via vaginal and penile fluids.

Anal sex, (both women and men):

This sexual practice is high risk for HIV transmission and other sexually transmitted infections if practiced without the necessary safer practices.

- The anus contains a very thin lining. As a result of diet, stress and tension, and conditions like haemorrhoids, there can be severe tears in the anus which increase the risk of HIV transmission.
- During anal sex the anus does not generally produce a sufficient amount of lubrication, which means that more often than not tears in the anus wall will occur. The anus is much smaller than the vagina and thus the risk of trauma is greater.
- To decrease the risks of HIV transmission use lubrication as well as condoms.

CAUTION!

- Anal sex is often practised by heterosexual couples to prevent pregnancy. Focusing exclusively on pregnancy, they forget the real dangers of HIV transmission as well as other sexually transmitted infections. In parts of Africa where there is an increased focus on virginity testing before marriage, many young girls engage in anal sex with their boyfriends to remain vaginal virgins for the tests before their marriage. Anal sex should always be performed with a well lubricated condom due to the high risks of infection.

A note on sexually transmitted infections

- Common sexually transmitted illnesses will always create tears and wounds in both the vagina and mouth, as well as on the penis or around the anus. The complications of these illnesses are immense, not only in terms of HIV transmission but also to the health of the infected person.
- A SAFER practice is to see a doctor and get appropriate treatment as soon as possible.
- A SAFER practice is to abstain from penetrative sex if you know you have a sexually transmitted disease. Mutual masturbation or solo masturbation are permissible in these circumstances, but it is important to use condoms for mutual masturbation.
- Many people, women in particular, will not know they have a sexually transmitted illness until they are in the severe stages of the infection. If you have sex without a condom you are at risk, which increases the risk of HIV transmission.
- Cervical cancer is widespread in the developing world. It also causes tears in the lining of the cervix providing easy entry for HIV. There are simple tests to detect this form of cancer, but access to such healthcare is not always possible. Always use a condom to prevent not only HIV transmission but also cervical cancer and the transmission of other STIs.

Activity:

You will need:

- *Cotton wool*

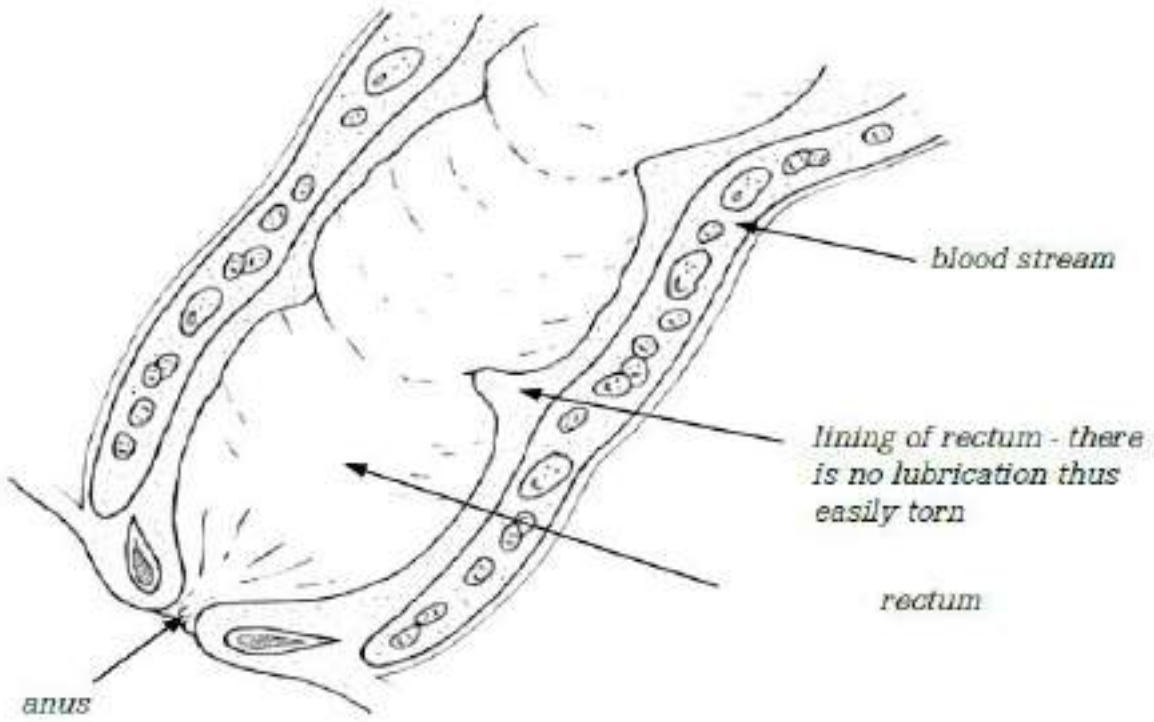
Again, remind people of the difference between the skin and the delicate membranes of the mouth. Explain that the lining of the vagina, anus and rectum are even more delicate than the membrane of the mouth.

Give participants a ball of cotton wool each. Ask them to roll out their balls of cotton wool as thinly as possible. They should notice that the cotton wool becomes damaged it develops small holes and tears in the fabric. Explain that this represents any friction in the vagina, rectum or anus, which can lead to breakages in the mucous membranes. The mucous membranes are easily damaged which provides easy access to the blood stream, and therefore HIV has access to the blood stream.

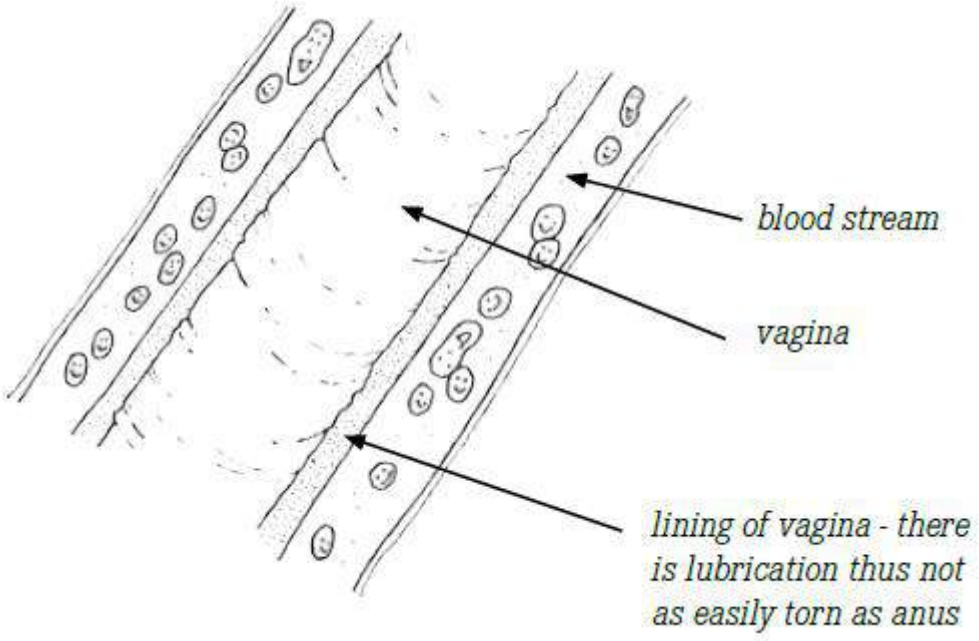
Notes for facilitator:

This illustration is a good way of explaining why HIV can access the blood stream so effectively through the genitals. Explain the drawing carefully to the participants. Note that you will do two drawings; however, the drawings are presented here separately to more clearly take you through the steps when explaining to participants.

Draw the following picture for the participants:
Anus and rectum



Vagina



HIV positive seminal fluid allowing HIV to enter the bloodstream through tears in the rectum or vagina

Explain that in order to infect a person with HIV, one needs to penetrate the mucous membranes of the vagina, anus and rectum where fluids can enter the blood stream. Explain how the skin of the penis is tougher than the membrane of the vagina so risk of transmission to men can be less. The urethra of the penis (this is the small hole at the tip of the penis where urine is excreted) gives access to the same type of membrane for a man, but access is more protected. Within the blood stream, there are specific cells to which fluids will attach themselves—CD4 cells and taxi cells (Langerhans cells).

Ask participants: How does HIV cross the barrier of the mucous membrane into the blood stream? You should get the following answers:
Breaking the membrane through:

- sex
- inserting objects into the vagina, rectum or anus
- dry sex
- sexually transmitted infections that cause sores and tears

HIV

HIV enters the blood stream and attaches itself to the CD4 cells where it begins the replication process. Or, HIV attaches itself to the taxi cells where they are then transported to the lymph nodes where the CD4 cells are manufactured. Here HIV can transfer itself to the newly made CD4 cells and begin to replicate.

HIV needs to be present in sufficient quantities in the blood stream

Activity:

You will need:

- *Food colouring*
- *3 glass jars*
- *Large glass jar*
- *Water*
- *Spoon*

*Pour water in all three of the glass jars. In the first jar put **five** drops of food colouring and stir it up. In the second jar put at least **twenty** drops of colouring. In the third jar put over **fifty** drops of colouring (the colour of the last jar should be very vivid). Request participants to tell you what they observe.*

They should note that the colour becomes more vivid as more food colouring is put into the water. This represents the quantity of the virus in a person living with HIV.

- *The first jar represents a person who is living with HIV who has an undetectable viral load - generally as a result of ARV treatment.*
- *The second jar represents a person who is living with HIV and the viral load is detectable. This is during the phase after the window period and before the CD4 count has reached levels less than 350.*
- *The third represents a person who is in the AIDS phase of the infection, or who is in the window period. The virus simply overwhelms the body's immune system*

Fill the larger jar with water. This represents the blood of a person who has not been infected with HIV.

Discuss this as follows:

- *HIV transmission depends on the quantities of the virus present in the fluid – either blood, breast milk or other bodily fluids.*
- *Take the first small glass jar and tip it into the larger jar. You should notice that the colour of the larger jar is barely changed. This is an example of exchange of bodily fluids where the virus is undetectable. Can you think of examples of where this can happen?*
- *Unprotected sex with a person living with HIV whose viral load is undetectable (See the Christo Greyling story in the condom module).*

CAUTION: This should only be done with close medical supervision

- Does this mean that the virus can be transmitted? We are not sure as we do not know how much HIV is needed to begin the process of replication. This SAFER sexual practice is ALWAYS necessary.
- Take the second small jar and pour the liquid into the large jar. You should notice that the colour is now visible. In the small jar there was enough colouring to dramatically change the colour of the water in the large jar. This exchange of fluids shows that if there is enough HIV present in the blood stream of the first person, it will pass to the second if the conditions are right. The second will then test positive for HIV in six to twelve weeks.

Discussion:

Have a group discussion about these questions:

- *What are the implications of the above for you if you do not have HIV?*
- *What are the implications of the above for you if you do have HIV?*

Final Comment:

Monitoring concentrations of HIV in the blood stream is not a complex process, but getting access to this monitoring can be problematic. So do not take any chances:

- Wear condoms. Do not have unprotected sex, whether you have the virus or not.
- If you are on ARVs, ensure that you are taking them according to the correct protocols.
- If you are breastfeeding, follow the advice given by your clinic sister to minimise the transmission of HIV to your baby. We will discuss how you can do this safely in a later module.
- Kiss, cuddle, hug, eat, bath and live life as normal – a little care will ensure a happy long life.

We do not know how many actual copies of HIV per ml it takes to infect an individual – it could be as low as one but we simply don't know. So always protect yourself, your partner and your community.

Duration of exposure needs to be long enough

We do not know exactly what "long enough" means. We cannot tell people whether you need to be in contact with HIV positive body fluid for five minutes or five hours before infection is said to have taken place. However, what we do know is the following:

- Blood has the highest concentration of HIV. Thus, needle stick injuries, or exchange of blood on a circumcision blade, or intravenous drug users all have a high risk of transmitting HIV.

HIV Transmission: Vaginal and Penile Fluids

- Vaginal and penile fluids are also high risk when it comes to the transmission of HIV. Men and women can get HIV from their sexual partners who are living with HIV because of the high concentration of HIV in the vaginal and penile fluids.
- The penis/vagina are sensitive organs, and during sex there can be lesions on the penis/vagina that will ensure that the HIV present in the penile/vaginal fluids gains direct access to a woman's/ man's blood stream. This can be true even if the woman's vagina is well lubricated during sex.
- Remember that during the menstrual period there is a lot of blood present in a woman's vagina. This mixed with vaginal fluids is a very high-risk concentration of fluid and provides the ideal environment for HIV transmission.
- After sex, vaginal/penile fluids remain on the penis and in the vagina. If there are lesions, there is easy access for HIV into the man's/woman's blood stream from the vaginal/penile fluids.
- A shower after sex does not reduce the risk of HIV transmission.
- Remember the duration of exposure to HIV is a key determinant of transmission.
- Thus, the point of highest risk is during penetration.
- Furthermore, we do not know if blood needs to be exposed to a high-risk fluid for five seconds or five minutes for it to become infectious. The time one takes from the act of having sex to getting into the shower could be enough for transmission to take place.
- A shower to prevent HIV transmission is not an effective prevention strategy. Use a CONDOM.
- The head of the penis, if it is protected by foreskin, is highly sensitive and lesions can easily occur here during sex.
- Any sores on the penis/vagina will present an opportunity for transmission of HIV
- If during mutual masturbation there are wounds on the fingers or in the mouth, these wounds can give HIV from vaginal fluids direct access to the blood stream. One can use a condom on one's fingers. There are special condoms designed for oral sex.

CAUTION

- Male circumcision is currently highlighted as reducing the rate of HIV transmission through sexual intercourse. This is because once the foreskin of the penis is removed the skin on the head becomes tougher and lesions are less likely to occur. However, circumcision does not reduce the risk to zero. Moreover, circumcision needs to be done voluntarily and in a safe way such as Voluntary Medical Male Circumcision.
- During the first six weeks after a circumcision is performed, the wound is very tender. Sex during this period can open a substantial wound on the head of the penis. Thus, any exposure to HIV positive vaginal fluid will result in transmission.
- The penis is still a delicate organ and thus remains vulnerable to lesions during sex even with circumcision.

Therefore, always wear a condom.
Once again- Protect yourself.

Living with HIV

Session Objective:	To help participants explore the feelings, thoughts and challenges faced by Persons Living with HIV.
Session Overview:	This session covers lived experiences of Person Living with HIV
Expected Learning Outcomes:	By the end of this session, participants should be able to explore and share feelings thoughts, and challenges faced by Persons Living with HIV
Time:	1 hour
Resources/Preparation:	Flipchart and markers

Drawing activity on HIV and AIDS

- *Explain the purpose of the session and divide participants in two groups: either separate female and male groups, or mixed groups.*
- *Ask them to discuss in their group what Persons Living with HIV often go through and feel. They must focus on both the positive and negative.*
- *Add: They must then represent this through a drawing.*
- *No word should be used in the drawing except HIV.*
- *In the discussion of the pictures, make sure that you look at both the positive and negative aspects of living with HIV.*
- *Discuss the issue of stigma and the negative effects of it on persons living with or affected by HIV.*

Tips for facilitators

- The drawing exercise is designed to help us reflect on what persons living with HIV go through. It can be used in communities where people are illiterate to help them reflect on the stigma and the way they treat people.
- Please note that if you are not able to get a Person Living with HIV to attend or to source a DVD testimonial from such a person, then this session can last longer so that it deals comprehensively with issues of living positively with HIV.

Points to remember

It is important to handle this discussion with sensitivity and to recognise that there may be people in the group who are living with or affected by HIV personally.

Person Living with HIV (PLHIV) Guest speaker

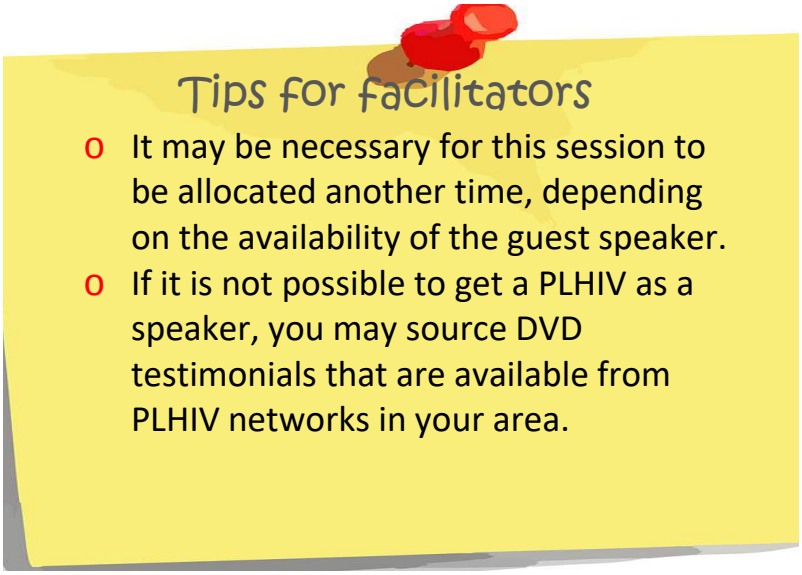
Session Overview:	Participants are addressed by a PLHIV and get the chance to ask questions.
Expected Learning Outcomes:	Participants should be able to share their experience interacting with someone living positively with HIV, and will have had opportunity to ask additional questions.
Time:	1 hour
Resources/Preparation:	Flipchart and markers.

PLHIV Guest Speaker:

Invite a guest speaker who is livingly openly and positively with HIV to address the participants on issues of living with HIV. Allow the speaker to talk for thirty minutes, and then allow time for questions.

Points of remember

This is an important session as it gives the participants a new perspective, and allows them the opportunity to take in new information from different angles.



Explaining HIV to children

Children need hands-on, interactive activities to really understand the nature of HIV. Here are some fun activities. The aim is to get them to understand that HIV is a virus that attacks the immune system. Also, to understand that if they have HIV they need to look after themselves and take their medication when necessary. If children understand the importance of HIV and good HIV management, they can be powerful advocates in families for SAVE practices.

Note that the section on CD4 count and viral load should not be included for children as this makes understanding the virus unnecessarily complicated for them. The essential information they need to know is that HIV attacks the immune system.

Activity:

- *These activities are planned for children aged six to ten. More sophisticated activities can be used for older groups. The children can build bigger models and can get very excited about the whole creating process. This is important because it gives them a sense that HIV can be managed.*
- *Divide the children into groups of between four and six.*
- *Each group is going to build a house. Give each group boxes, glue and crayons. They can also use clay and a variety of grasses and leaves to make their houses. Since they can get very involved and intense in building their houses, give them 45 minutes to complete the task. Encourage them to make their houses as beautiful as possible.*
- *You will need to build your own house – either before or during the activity time. Build it in such a way that it can be taken apart very easily.*
- *Once the houses have been built, ask each child in the group to make four figurines out of clay - a thief, a policeman, a gangster and a superhero. Thus, each child will have his or her own thief, policeman, gangster and superhero. Ensure that you also have one of each.*
- *Once the group has had fun creating them, tell the following story. Let the children help you develop the story.*
- *There is a system inside your body that is very much like your house. It is called the immune system and protects you from germs. If you get sick it helps you get better. You can make it strong with good food, water, sleep and exercise.*
- *Ask the children: Look at the house you have built and tell me what makes it strong?*

- *One day a thief comes into the house and begins to steal things. The thief is called HIV.*
  - *Use the thief you have made to go inside your house and steal something.*
  - *Ask all the children to use their thief to steal something from your house.*
  - *Ask the children: How would you feel if thieves came into your house and stole things?*
  - *Ask the children: What would you do?*
- *As the owner of the house you call the police. The police take a while to come so the thief, HIV, can steal some more of your house.*
- *When the police come – the anti-HIV crime fighting unit – the thief HIV finds it a little more difficult to steal. But he has ways and means. He turns the policeman into HIV too and they both go and steal.*
  - *During this explanation get the police to come and guard the house and then get the thief, the HIV, to whisper in a policeman's ear. Then get the two of them to steal from the house. They should be stealing doors and walls.*
  - *Ask the children: What do you think is happening to the house? They should notice that it is breaking up.*
- *Once the house is very broken, the gangsters arrive. The gangsters are not able to get into the house if it is strong, but the thief, HIV, is stealing the door and the walls. The gangsters come and live in the house. They make fires in the house. They smash the bathrooms. Is there any hope?*
- *Yes – you have a superhero, called ARV, who comes in, chases all the gangsters away and ties up the thieves in the house. It takes some time but he helps the owner to rebuild the house.*
  - *As you are saying this, bring out your superhero and chase the gangsters away, wind up some string around the thief and start to rebuild your ruined home.*
  - *Ask the children: What will happen if the superhero suddenly goes away?*
- *Once you have told the children this story, explain to them the following:*
- *There is a system inside your body that is very much like your house. It is called the immune system and protects you from viruses. If you get sick it helps you get better. You can make it strong with good food, water, sleep and exercise.*
- *If the virus called HIV gets into this house it begins to steal things from the house. It begins to steal things from the immune system.*
- *Even if the immune system calls the police, the thief, HIV, uses them to become thieves as well and then there are more thieves stealing from the immune system.*

- *If there are lots of thieves (HIV) stealing, the immune system gets very weak. When it is weak other viruses, that could not get into our bodies before, are able to get in. These viruses include tuberculosis, flu, chickenpox and thrush. They are the gangster viruses and make a person very, very sick. When this happens, the person's immune system house begins to crumble and we say that this person has AIDS. They will die unless there is help.*
- *We have a superhero whose name is ARV. He is able to tie up the HIV and give the body time to chase the gangsters away. As the immune house is being rebuilt, the person gets well again.*
- *If the superhero ARV goes away, the thieves, HIV, will come again and start stealing again, so it is important that the owner of the house makes sure that the superhero ARV is there every day to protect his house.*

Conclusion:

The final message is that HIV destroys the immune system and that ARV stops the HIV destroying the immune system, allowing the body to rebuild the immune system until a person is well again. Furthermore, ARV needs to continue to be around to protect the immune system from HIV even when the person is feeling well again.

How does HIV get into our bodies?

This is a logical question. Be as honest as possible but only give them as much information as they need. This is generally not a sexual question but one of simple curiosity. We have supplied some activities to help you.

- HIV needs to get into our blood before it can start stealing. These are the ways this can happen
- The first way that HIV gets into our body is a cut in the skin. We have all had cuts, we have all fallen out of trees and fallen over our feet and cut ourselves and we do not have HIV.
- Simply cutting ourselves does not give us HIV. But, if someone is living with HIV and they cut themselves, this blood may be able to give you HIV but only if you have a cut too and your blood mixes. When you do cut yourself, find a grownup to help you.
- Sometimes when you are really sick in hospital and you need more blood, the hospital will give you blood from someone else. Mostly this is not a problem and will help you, but very rarely this blood might have HIV, and then you could get HIV. But there are very clever doctors and nurses who work with blood all day to make sure that if we need it, it will not have HIV in it.

- Never play with needles. Sometimes needles can have blood on them and if we prick ourselves that blood gets into our body. If the blood on the needle has HIV then we will get HIV. But don't worry about needles in hospital. They have been specially cleaned so that there is no blood on them. If you are worried, talk to your doctor or nurse about how they clean needles.
  - Another way to get HIV is when a mummy and a daddy are making a baby. If one of them has HIV they can give it to the other. (Note: for young children you do not need to get very detailed about sex. If they do start asking questions, there are other aspects of the Toolkit that can address these areas. Remember: do not lie and always be age appropriate.)
  - Yet another way to get HIV is when a baby is being born. But our superhero ARV often comes to the rescue and will protect the baby from HIV. Also, ARV can protect mother and baby from getting sick and they can all live good lives together.

One of the key fears of young children is that their parents will die. If you know of a mother living with HIV who has a small child, ask her to come and talk to the children. They can then see that someone's mother has HIV and is healthy. A mother who is living with HIV may also be able to answer children's questions in ways that give them a greater understanding of living with HIV.

SSDDIM for children:

SSDDIM for children is approached in a way that encourages compassion for all. It does not single out persons living with HIV and does not try to create differences in response to sickness. Furthermore, it does not differentiate orphans and vulnerable children from other children. Children may do this naturally and single out ones who are struggling, but this can be very destructive and adults should provide guidelines for children to be compassionate in these situations.

- **Musical hugs:** Play some music and ask the children to run around and give one another hugs. Ask them to try to give everyone in the class a hug, and to count the hugs they give. When the music stops ask them how many hugs, they "collected". At the end of the game explain that you cannot get HIV from hugging people. In fact, we all need hugs - the more hugs we get and give the happier we will all be. (**Note:** This exercise should be optional)
- **You are special:** Sit all the children in a circle and ask them to tell the class why they are special. For example: "My name is Alice and I am special because I can do a cartwheel". When this exercise is finished, stress that we are all special and we all bring different gifts to the world. It is our responsibility to use those gifts, whether we are living with HIV or not.
- *We care:* If any child is absent for a couple of days or sessions, get the class to make a "we care" card. Fill it with drawings, hand prints and anything else that will help the child to feel loved. Any child who is sick or in any way distressed should get one of these cards. This teaches that each child is valuable, special and important. If a child has an HIV-related absence the child will be treated no different to any other child and will feel part of a loving group.
- **Death:** Children are afraid of death, especially their own, or the death of a loved one or care-givers. This is a very hard reality to deal with. Ask someone living with HIV to come and talk to the children about how they are living positively with HIV. Furthermore, do not avoid

questions about death; deal with them honestly and openly as they arise. Refer children who need special care to trained bereavement counsellors who can support them.

EXPLAINING HIV TO TEENS:

Like children, teens need to have practical activities to ensure that they understand the nature of the virus. There is a lot of material that focuses on how HIV is transmitted, especially for teenagers, but it is important that they also understand the nature of the virus.

Activities:

- For a group of teenagers, adapt the activity that is outlined for children. Ask them to make puppets instead of clay models of the thief, the policeman, the gangster and the superhero.
  - Ask the teens to design a puppet show which will explain HIV to younger children. They will gain a lot from this as they will really have to understand the workings of HIV and the immune system to make it simple enough for children to understand.
  - Create an opportunity for the teens to show the puppet show to children.
  - A further idea is to have the puppet show within faith communities so that parents are able to see what their children are learning.
  - Using puppets is a great way to communicate information and get people to have fun at the same time.
- It is important that teens understand the relationship between viral load and CD4 count. The graph that is included at the beginning of this section should be used.
  - Draw the graph in small stages carefully explaining the window period and the gradual rise in the number of viruses in the body.
  - Once the teens have grasped this, move onto the CD4 graph and how the CD4 count rises and declines during the various stages of progression of living with HIV.

SSDDIM for teens

SSDDIM for teens can be complex. It is important to stress a compassionate and caring environment. The section also assumes that a leader is present for groups of teenagers that will encourage mutual friendships and SAFER practices. An adult within the community or teens themselves can provide leadership and guidance.

- Ask a Person who is Living with HIV to come and speak to the teenagers about HIV and how to live positively with it.
- Teenagers often have great fear of dying (as do children). Allow the teens to ask the person living with HIV how the fear of death has impacted their lives.
- Create a compassionate culture by creating groups of peers who care for each other. Encourage these groups to write "get well" messages whenever one of them is sick. If a teen is baby-sitting younger siblings, ask a friend's help. Homework clubs, soccer clubs, netball clubs, etc. are vital in promoting social cohesion. Peers who are friends are less likely to reject each other than peers who do not have close relationships.
- Within teen groups where all the teens know their HIV status, encourage mutual responsibility.
- Create opportunities for them to talk about SAFER practices.
- For those who are living with HIV, try to assure them that they are supported and encouraged to take their medication at the right times. Teens are often more compliant in taking their medication if they know someone cares, not only about the medication but also about their well-being in general.
- Encourage positive friendships among teens, ones that follow SAFER practices, and are supportive and mutually beneficial.

MISACTION

Some parents and caregivers decide not to tell children and teenagers living with HIV about their HIV positive status.

- The first pillar of good HIV management is to ensure a healthy immune system; thus, they need to know about good nutrition, good sleep habits and be encouraged to exercise.
  - Many children and teens are involved with contact sport. If they are injured and there is blood, they need to know how to treat themselves SAFELY for everyone.
- They will also need to monitor their own health for opportunistic infections and even small bouts of flu so that their immune systems can be supported correctly. This support can be through medication or simply having adequate rest. They will need to be in-tune and understand their bodies.
- Once children and teenagers are on medication it becomes important that they know how to take it and why proper adherence to medication is important.
  - They may decide to stop taking their medication because the medication makes them feel sick.
  - They may spend time out of their usual environment and they do not take their medication for a couple of days.
- By encouraging children and teenagers to take responsibility for their health, we empower them to make good decisions when there is either no adult or a well-informed adult looking after them.

- If young people know they are infected with HIV AND they are given information about SAFER practices they will be able to make positive choices around:
  - Managing their sexual health and taking responsibility for that of their partners.
  - Managing medical procedures where they are able to request the right sterile instruments.
  - Ensuring that any rituals around cultural scarification, circumcision or even a simple razor haircut are done SAFELY.

If children and teens know their status and are given good information, we reduce HIV transmission and empower young people to take control of their bodies and to live positively.

Reflection and Notes

Reflection and Notes

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

SAFER PRACTICES

SAFER PRACTICES

THIRD EDITION

Safer Practices

Responsible Sexual Health

Introduction

Activity

- Spend about 20-30 minutes allowing participants to “be” in their bodies.
- Ask participants first to take their shoes off so that they can connect in some way to the earth.
- Depending on the cultural context, ask them to dance, sing, or move around to the music, or do a yoga session which is excellent for increasing focus on their bodies. All these activities help people to release anger, tension and, most importantly, fear.
- When it is over, ask participants how they are feeling. Hopefully they will feel calmer, content, and connected to one another. Ask them to sit for a minute and experience these feelings and quietly hold them.
- If any of the sessions contained in this module gets too heavy, or if there is an increase of fear, ask people to return to the feelings of this activity, or alternately you could repeat the activity. It is amazing how beneficial movement can be.
- ENJOY

Introduction for the facilitator:

Human beings are sexual – this is how we are created. We use our bodies to explore the world in which we live. Our minds are contained in the countless cells and neurons that process stimuli and make us the wonderful individuals' beings that we are. Our sexuality is a celebration of who we are. It is a great gift to be able to express our love for others through the medium of our bodies. Sex with our partners and people that we love, respect and honour is joyous. This module explores sexual practices that honour our own bodies and those of our partners.

Sexual health is the responsibility of the

- Individual,
- Couple,
- Family, and,
- Community

Individual sexuality is influenced by friends, family, the media, etc. Within a faith community, the interpretations of scripture and cultural practice have an influence on how people feel about sex. These feelings in turn influence behaviour. If information about sex is given in a safe and loving environment where the joy of the individual is celebrated, then sex becomes a wholesome, natural behaviour. However, if no information is given, if sex is something we conduct in secret, and/or if sex is conducted in ways that violate ourselves and others, it becomes an act of profound human suffering or violation. Faith communities have a unique opportunity to take responsibility to make sure the correct information about sex is being taught and that it is accessible to all.

The following modules are designed to allow you to interact with participants on a deeper level, ensuring they understand the sexual risks they might be engaging in. It is about rethinking and perhaps changing attitudes to sex that are culturally and doctrinally exclusive. It is about honouring the sexual body and the unique individual inhabiting it.

Section 1 covers the following:

- Abstinence
- Teenage sex and the advantages of delayed first experience of sexual intercourse
- Partner mutual fidelity
- Partner reduction in a responsible way
- Importance of knowing your HIV status

These modules look at how people interact with one another and how relationships work on both personal and community levels. Participants might feel uncomfortable in addressing these issues, but they need to be discussed in an open and non-judgmental environment. Changing individual behaviour is not simple. People can feel like they are being attacked, which is why it is important to provide a safe space for people to feel comfortable discussing such issues. Behaviour will always have stigma attached to it from somewhere: stigma = judgment, which means people put up walls and ignore or avoid change. You need to address these areas of stigma and show that change in behaviour is good and will benefit them as individuals, and the community as a whole.

It is imperative that the facilitator control the levels of fear and anxiety that could arise. If you feel things are getting a little out of hand, return to the activity at the start of the module.

Section 2 of this module is designed to highlight sexual practices that have a role in preventing HIV transmission. The activities allow you to interact with the group and allow them to open up on the issues relating to sex and safer sexual practices. These modules will confront the issues of religion and tradition; therefore, it is important to listen and recognise people's cultures. The module is about learning how we can make changes in our lives to feel safe.

The sections include:

- Condoms
- Mutual fidelity
- Male Circumcision

Covering this topic is a way for people to address their preconceived notions about sex and HIV, allowing the formulation of new ideas. As the facilitator, you must be comfortable addressing these issues. Read through the material first to address any queries you might have before the sessions. It is important to remember we are encouraging people to celebrate themselves and their partners in safer sexual relationships. However, information about safer sexual practices does not encourage promiscuity; it does not encourage people to break all sexual boundaries. In fact, research has shown that information reduces risky behaviours and individuals begin to make healthier sexual choices. Healthy sexual behaviours in happy committed relations in supportive communities is the end goal.

Sharing experiences of sexuality education

Session Objective:	To provide participants with opportunity to reflect on their own sexuality. To get participants to explore the different sources of sexuality information and recognise that different people receive such information at different ages.
Session Overview:	This is a participatory discussion session where participants share experiences first in small groups and then share in the big group about sexuality
Key Message:	Sexuality education is important for building and maintaining self-esteem – we need to take it seriously
Biblical Scripture:	*Or do you not know that your body is a temple of the Holy Spirit within you, whom you have from God? You are not your own, for you were bought with a price. So glorify God in your body (1 Corinthians 6:19-20, ESV)*
Scripture Emphasis:	Our bodies are special dwelling places for the Holy Spirit. Violation of the body, self or other, does not glorify God.
Islamic Scripture:	*The prophet encourages men to ensure that their spouses are adequately prepared and are satisfied in the process of sex (Hadith)*
Scripture emphasis:	God as the Creator has laid down operation rules to be followed in relation to sex and sexual practices. If we do not follow them and go differently then, He says, it is an evil way to follow.
Expected Empowerment Outcomes:	By the end of this session, participants will be able to reflect on both their positive and negative experiences of sexuality education. Participants will understand different sources of sexual information relative to different ages.
Toolkit References:	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Sexually Transmitted Infections • Cervical Cancer and HPV • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	Flipchart and markers.

First Sexuality Information:

- Divide participants into groups of three or four people per group.
- Ask them to think back to the first time they received information on sexuality. They could have received this information from parents, friends, teachers and others.
- Start by sharing your own story as an example to help participants understand what you are talking about.
- Ask participants to focus on the following:
    - What age were you when you first received information on sexuality?
    - Who gave you the information?
    - What message did you get from the information?
    - Ask participants to share this information with each other in their groups.
    - Allocate 15-20 minutes for this part of the exercise.
    - Once groups are finished, get feedback from the participants. You can conduct three quick rounds from the larger group and acquire the details about age, who and what.
    - Write down the information from participants on a flipchart.
    - Remind participants to only talk about their own experiences, unless they have explicit permission from their group members to talk about other people's experiences.

Tips for facilitators

Conclude this discussion by stating that:

- The age at which individuals receive their first information on sex varies.
- People obtain information from various sources; for example, friends, parents, brothers or sisters, aunts, grandparents etc.
- There is a diverse range in terms of when people start to hear about issues related to sex.
- Some messages give a positive image of sex, while others give a negative image.
- Most messages that we hear as we grow up focus on the negative consequences, and there is very little positive information that we hear about sexuality.
- Point out that even within this group we can find a diversity of ages, sources and types of information. It is the same in the communities that we live in. People receive different kinds of information, from different sources, and at different ages.
- It is important to keep this notion in mind when we work with others. Even in a small group, people will be at different levels of knowledge.
- If young people don't get the correct information at a young enough age, they may begin to experiment out of curiosity, or get the wrong information from less dependable sources.
- There is a need to be open about sex and to enable children and young people to receive accurate information to make informed choices in their lives.
- Be aware at this stage of strong messages that come out of the discussion, as you may need to elaborate on some issues.

The Concept of sexuality

Session Objective:	To facilitate a deeper understanding amongst participants of the concept of sexuality and to provide space for participants to reflect on how they view sexuality. To look at sexuality from different points of view.
Session Overview:	This is a brainstorming session.
Session Outcome:	By the end of this session, participants will be able to: • Explain the concept of sexuality in a deeper way than before • Describe positive views of sexuality
Time:	30 minutes
Resources Needed:	• Flipchart or whiteboard and markers

Introducing the session:

- Explain to participants that most of the time when people talk about sexuality, we tend to focus exclusively on the act of sex, but sex is only a small part of the expression of sexuality. Sexuality includes a wide range of aspects, including feelings, emotions, experiences, and consequences.
- In most definitions, there is agreement that sexuality is about the total person from a physical, spiritual, emotional, social, as well as an intellectual point of view. Sexuality includes values, attitudes, beliefs and practices that form part of every individual's life.
- We will focus on the varied aspects of sexuality to better understand it and to explore our own views on sexuality.

Brainstorm around the word "SEX":

- Co-facilitate this exercise so that one person is leading the brainstorming and the other person is writing the issues that come up on the flipchart.
- Write the word SEX in the middle of the flipchart and make a circle around it.
- Ask participants to say what comes to their minds when they see the word SEX. Tell them that there is no right or wrong, or good or bad contributions – all contributions are welcome.
- The lead facilitator must keep good eye contact with the group and encourage contributions.
- Look at each participant and stay a few extra seconds at the ones who seem quiet. Do not force participation, but encourage it and assist participants who might need more time to think.

Group discussion

- Divide the participants into smaller groups of two or three (or ask participants to turn to their neighbour) and ask the smaller groups to come up with four or five words each.
- Give the groups two to three minutes and then make as many rounds as you need, getting one word from each group at a time. Then open the floor again and encourage contributions.
- When you feel that the contributions start to slow down, look at the board and see if there is anything missing.
- Ask questions to encourage the participants to think further. For example, if the word intercourse is there but no other sexual activities, then ask: "**What can we do before intercourse?",** "**And before that?"** Ensure that you cover everything from fantasies, to kissing, to petting, to different forms of penetrative sex and solo-sex.

Wrap up

- Explain to participants that most of the time when people talk about sexuality, we tend to focus exclusively on the external physical organs that distinguish between males and females (This sexual organ is only 1% of the human body) and on the act of sexual intercourse, but sexual intercourse is only a small part of the expression of sexuality. Sexuality includes a wide range of aspects, including feelings, emotions, experiences, and consequences.
- In most definitions, there is agreement that sexuality is about the total person from physical, spiritual, emotional, social, as well as an intellectual point of view. Sexuality includes values, attitudes, beliefs and practices that form part of every individual's life.
- We will focus on the varied aspects of sexuality to better understand it and to explore our own views on sexuality.

Plenary discussion

Allow all participants to come together as one group and ask the following questions:

- What are the most important parts of the body with regard to sexuality?
- What can sex lead to? Include both positive and negative consequences.
- What different sexual identities are there?
- Ensure that both positive and negative feelings and emotions are listed and that the whole body is covered, and include some talk about the words for our sexual organs.
- Ensure that different sexual identities are listed, and include asexuality if it doesn't come from the group.
- Ensure that different positive and negative consequences are mentioned, as well as pleasure and pain, abuse and power, and so on.
- Your flipchart sheet of captured information should resemble the following illustration:

Once you feel that you have a good variety of different aspects, and the participants seem to have run out of contributions, you can stop by saying: "We could probably continue and find even more words, but let's stop here as we already have a good number of things that we can link to sexuality." Mention that sexuality can be about so many things, and it can be different for different people.

Reflection on the brainstorming activity on the word "sex"

In concluding this brainstorming session, mention the following: -

- This exercise gives us many entry points to talk about sexuality, but it also gives us a responsibility to address many different aspects of sexuality.
- As individuals we don't have to identify ourselves with all the words, as we are different and are at different stages in life. Some of us might be sexually active and some might not. Some might be in a relationship, and some might not. Some might have had mostly positive experiences from sex, and some might have had mostly negative experiences. We have been brought up differently; we might have different religions and cultural backgrounds and so we look at sexuality in many different ways.
- The way we look at sexuality also changes over time as we encounter more or new experiences, and as our lives change over time.
- End the session by asking: "If sex can be about so many different things – what is it about for you?"
- Ask the participants to think of about five words that they link to sex. They don't have to share it with anyone, just think about it. Explain that you are not going to do a list of the words chosen. But if you did, you would probably see that some words are more common than others. But you would also see a huge diversity, as we are all different and look at sex in many different ways.

- Link this brainstorm to the next session, "Why people have sex" by saying: "If sex can be about so many different things, another question could be: why do people have sex?"

Brainstorm on "Why People Have Sex?"

- Ask the participants: "*Why do people have sex*?"
- List all the contributions on the flipchart.
- If you feel that some aspects to answering the question in full are missing, use different cues like: "*Why do young people have sex?"; "Can 'benefits' be a reason for having sex?"; "Do people always have a choice when they have sex?";* and so on.
- Having captured all the contributions on a flipchart, point out the diversity of reasons for having sex. You can also add some words that are missing and ask why they didn't come up.
- Note that the reasons why people have sex are different and varied, and may change depending on people and circumstances they face at different stages in life. Some people think that sex is only for reproduction, but that is not true. On the contrary, often we try to avoid having children when we have sex. It is important to be aware that people practice sex for different reasons depending on their circumstances and situations.

Reflective exercise:

- Ask the participants to choose for themselves as individuals: the three most important reasons why they have sex (if they are sexually active) or the three most important reasons why they think that they might have sex in the future. Let them quietly think about it - they do not have to share their thoughts.
- Once again point out that if you did a survey of the participants' responses to the above question, you would probably see a lot of similarities, but you would also see a big diversity in the responses. The reason for this diversity is that we have different experiences of sexuality, and the expressions of our sexuality vary at different stages in our lives.
- Finally, point out that it is important that we become aware of the growth pattern of our own sexuality. As we examine the sexuality of others, we need to avoid judging, stereotyping and (intentionally or un-intentionally) excluding and discriminating against people.

Exploring what controls or influences decisions about sexuality:

- Draw a circle on the flipchart.
- Divide it into three equal parts, and write one word on each part: Physical, Psychological and Social.
- Many factors control sex and the decisions we make regarding it in different circumstances. Our decisions are not based only on instinct or on hormones but are influenced by different factors which can be classified in three categories:
    - Physical (puberty, physical disability, present physical state etc.).
    - Psychological (self-esteem, stress, pressure etc.).
    - Social (how we are brought up, what people say, what is socially accepted; what is culturally accepted, our religion/spirituality say etc.).

- Explain that we can't say exactly how big a space each sector should have since they all interact with each other. Society will influence how we feel on a psychological level; how we feel on a psychological level will influence our physical health (psychosomatic symptoms); and our physical health will influence our mental health.
- Explain that all these issues are linked together. For example, social norms about what we perceive to be beautiful will influence what other people find beautiful.

Concluding task:

Ask the participants to think about which of the three aspects carries more weight in controlling the decisions they themselves make regarding sex.

Ask for a response to the question from two or three participants who feel free to share their personal views with the rest of the group. Point out again the diversity in the answers that have been given. The point is to make participants aware that people are not the same, and we should not impose our own preferences and beliefs on others.

What are the most important parts of the body when it comes to having sex?

- The biggest sex organ is the brain. Everything starts from the brain. It is in the brain that conscious decisions are made and arousal starts before the sexual organ starts responding.
- Sex is also the ability to enjoy the whole body. People need to know when and where they would like to be touched. We can never know what the other person likes until we communicate with that person.
- Sex is also about communicating our needs and wants to the other person. People need to be encouraged to communicate more. As individuals, we like different kinds of things but the gender norms in our society often do not allow us to express our sexuality and sexual desires in an open way.
- Based on the fact that we are different and express our sexuality in different ways, we need to be non-judgmental in order to reach out to people in an effective way.

SEXUALITY AND THE VERNACULAR

Session Objective:	To enable participants, familiarize with words relating to human sexuality which are used (or not found) in local languages
Session Overview:	Language and human sexuality
Session Outcome:	By the end of this session participants would have positive attitudes to use actual words to refer to sexual organs.
Time:	30 minutes
Resources Needed:	Prepared list of words and flipchart

- Explain to participants that when we work with sexuality education, we get forced to use words that are sensitive, and that we are not always comfortable using ourselves.
- It is important to note that when you work with any age group in their local language, these words will have to be said to ensure understanding so that we do not confuse the people that we work with.
- Explain that it is important for us to get used to using these words in a way that is not derogatory, but that ensures that learning is optimised.
- Ask participants to get into groups based on their local languages or locality.
- Explain that their task is to come up with similar words to those listed below in their local language.
- Encourage participants to cover a range of different words, including polite, street, rude, and local words, and different words used by men and boys or women and girls.

Small group sharing:

- Ask participants to get into two to three groups.
- Explain that their task is to come up with similar words to those listed below in their local language. Words which could be considered for this exercise are listed as follows: -
- They must write this up on flipchart paper and be ready to make a presentation

- Vagina
- Clitoris
- Penis
- Glans
- Foreskin
- Masturbation
- Anal sex
- Vaginal sex
- Orgasm
- Ejaculation
- Testicle
- Scrotum
- Oral sex
- Erection
- Lubrication

Facilitator's summary

- It is important to note that when you work with any age group in their local language, these words in the vernacular may have to be used.
- It is important for us to get used to using these words.
- We need to use these words in the vernacular in a way that they are not derogatory but rather enhance communication and learning around sexuality.
- Where words in the vernacular do not exist to describe certain sexual actions, we need to ask the question why? Is such activity foreign to our customs and culture? Is it taboo to make

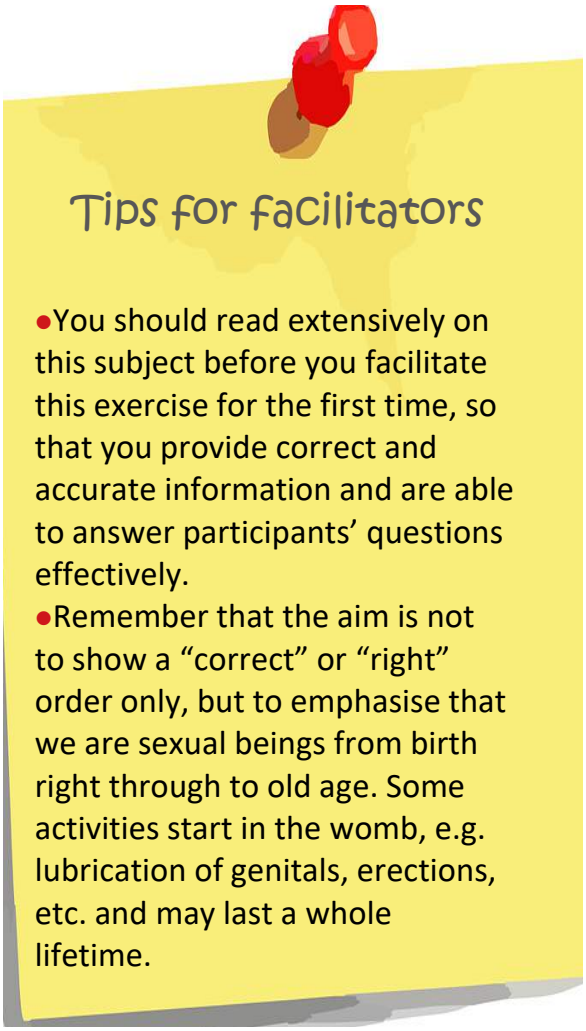
reference to such actions? Are we in denial that such activities are practiced? Should we be introducing words in the vernacular giving recognition to the reality of such practices?

SEXUALITY AND GENDER CONTINUUM

Session Objective:	To explore the development of sexuality and the influence of gender roles from the womb to old age To see how sexuality and gender influence each other
Session Overview:	Development of sexuality and gender
Key Messages:	Culture and biology determine gender and sexuality – an interesting mix
Session Outcome:	By the end of this session participants should be able to: • choose to express their sexuality in different ways – either openly or hidden • demonstrate how culture often assigns specific roles to being female or male • differentiate gender roles from sex roles showing that gender roles assigned to people can differ from those of their sexuality
Time:	1 hour 30 minutes
Resources Needed:	Flipchart and markers Handout - 'sexual and gender continuum'

Sexuality and Gender Continuum:

- You need to create a timeline. Write ages, ranging from zero (in the womb) to seventy +, on pieces of paper and stick them on the wall
- Explain that the numbers represent the different ages in the life of a person.
- Divide participants into small groups of two to three people.
- Distribute the "Sexual and Gender Continuum" handouts
- Ask participants to discuss in their groups where they think the handouts fit in the "life line" on the wall: i.e. at what age would people start doing the activity that is explained in their handouts.
- Once they have decided as a group, they must stand up and stick the activity they have been given on the wall where they feel it applies.
- Give about twenty minutes for participants to do this exercise.
- Once all groups are finished, ask them to explain why they decided to place their handouts where they did.
- Have a general discussion around each of the card placements on the time-line, ensuring that misconceptions are corrected, where necessary.

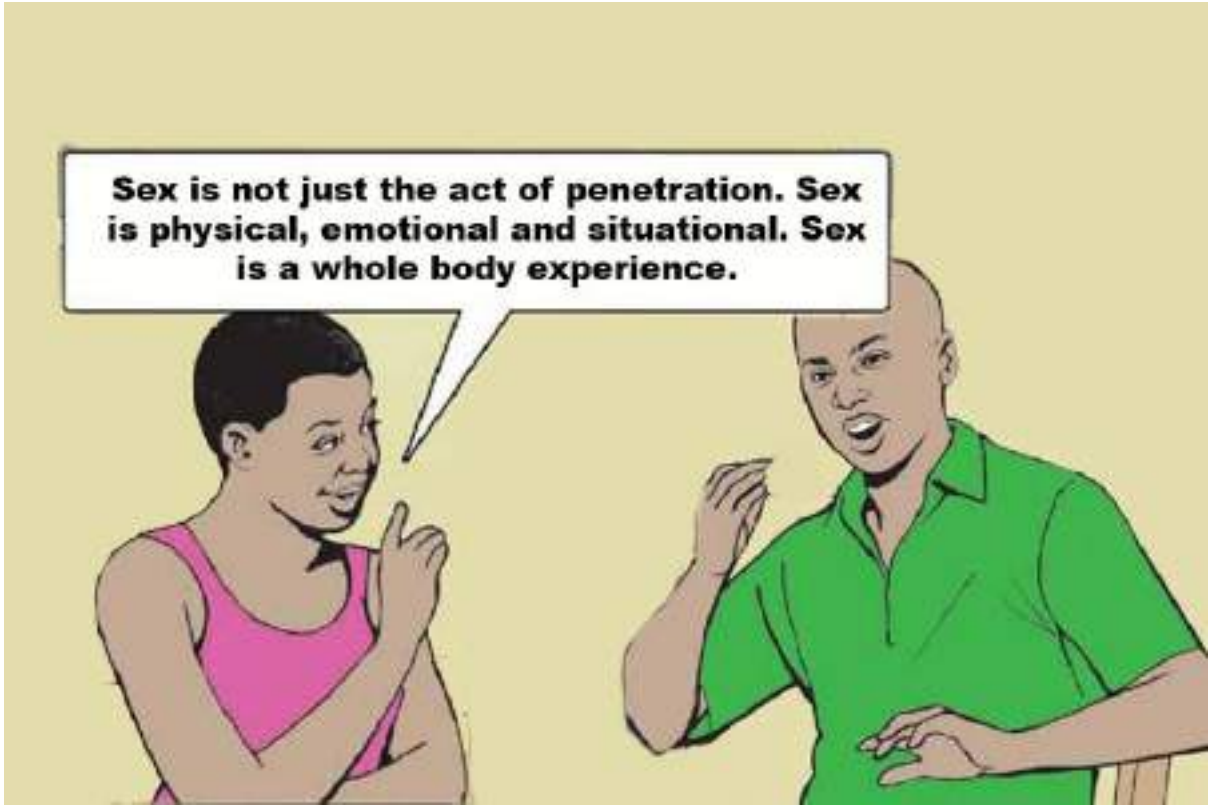


Exploring the sexual anatomy from a pleasure perspective

Session Objective:	To explore the sexual anatomy of a human person from a pleasure perspective, and not from a reproductive aspect.
Session Overview:	Sexual anatomy and human person pleasure
Key Messages:	The whole body was made for sexual pleasure
Session Outcome:	Explain the concept of the whole body engaging in pleasurable sex. Describe the male and female anatomy and the potential for pleasure.
Time:	1 hour
Resources Needed:	Handouts of the male and female sexual anatomy

Introduction of the importance of "WHOLE BODY SEX" approach

When we addressed the question, "What is sex?" we saw that it is not just the act of penetration. Sex is



physical, emotional and situational. Sex is a whole-body experience. Whole body sex is a way in which to explore how your mind and body are connected. You can get pleasure and have a healthy sexual experience without having to engage in the act of vaginal or anal penetration.

During the act of masturbation, the mind is very important. It links your thoughts and emotions to the pleasure you feel in your sexual organs and the sexual release you experience. Although it is a personal experience, the connection and awareness of your body is as important during masturbation as it is in shared sexual experience.

Skin is the most visible and the largest sex organ of the body; the sexual power of the skin is highly under-appreciated. Because your skin is able to react to your mind and your mood, it is an amazing sexual receptor. Discovering your partner's body, with the focus being on the whole body and not just on the genital area, allows for greater connection and intimacy. Stroking, kissing, nibbling and touching your partner can open up a world of sexual pleasure that you would otherwise miss out on if you just concentrated your pleasure on the genitals. Whole body sex engages the mind and the personal connection between you and your partner. It generates greater pleasure and a healthier relationship.

Keep in mind that the body is a unit. For whole body sex to happen the body has to work as a unit, united in its goal for pleasure. This means the mind, hormones and genitals must have good communication: i.e. good communication between all of these facilities leads to whole body and pleasurable sex.

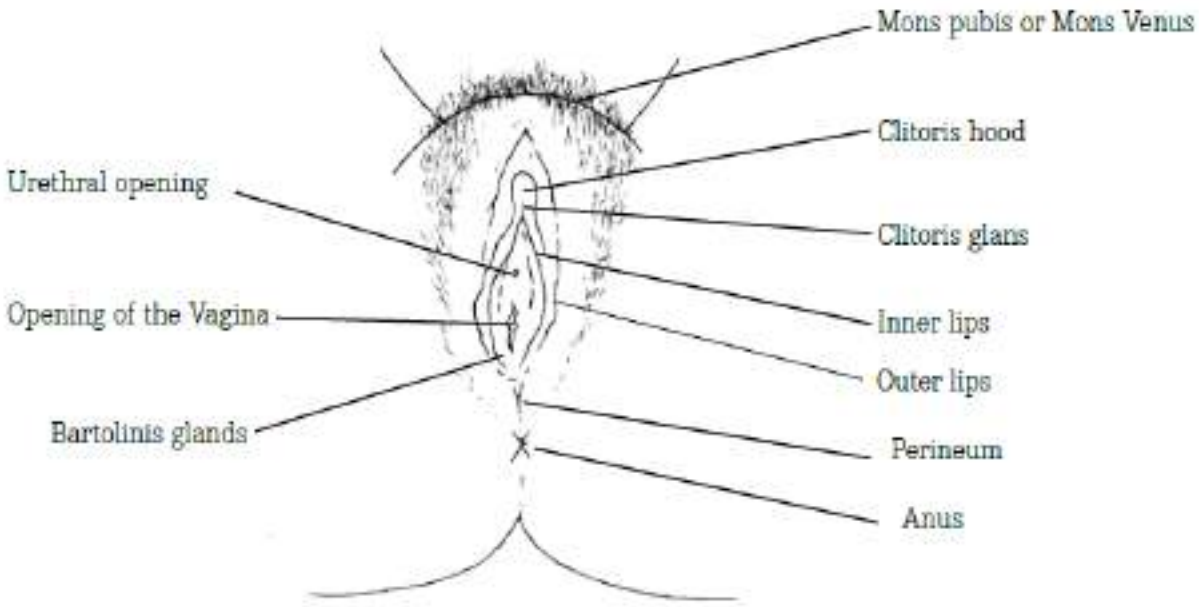
Tips for facilitators

- Make an effort to do your own research on this topic and collect as much information as you can.
- Ensure that you keep the discussion open and allow participants to ask questions and make observations throughout the session.
- In talking about both the female and male sexual organs, emphasise that we are all made from the same parts, i.e. female and male sexual organs only start to develop after week thirteen of the foetus' life in the uterus.

Exploring the female sexual anatomy

- Start with the female sexual organ.
- Distribute the handouts with the diagram of the female sexual organ to all participants.

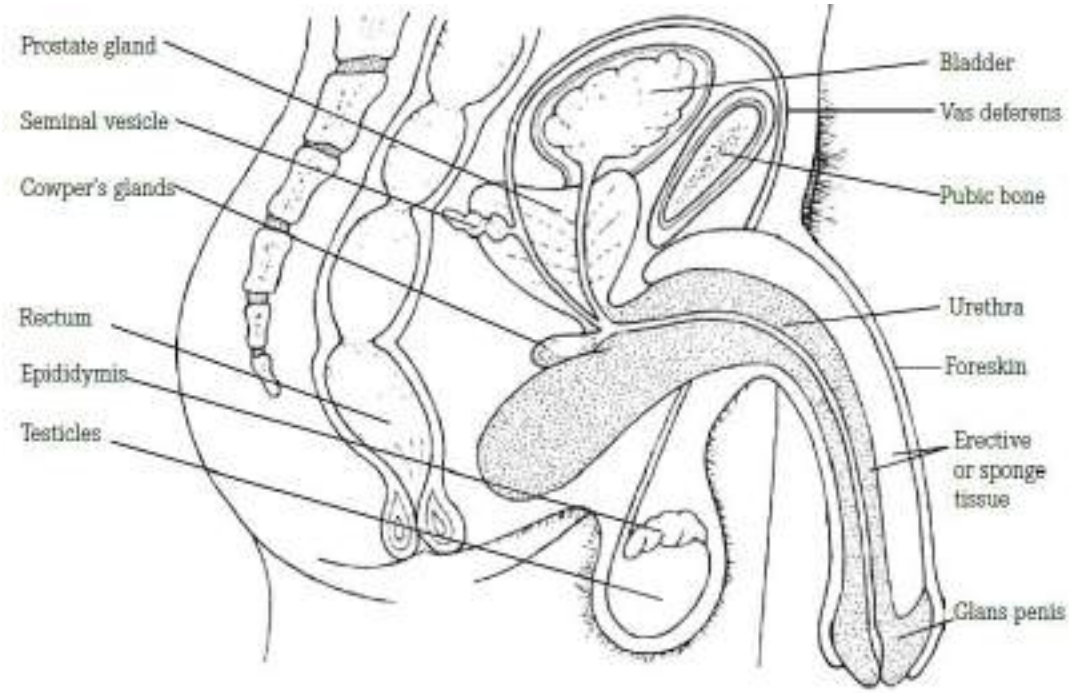
- Using the handouts, talk about each part of the female sexual organ and the role it plays in terms of pleasure.
- Focus on issues relating to masturbation, pleasure, the whole clitoris, including the parts on the inside, the vaginal corona (or the 'hymen') and all the myths about it, Female Genital Mutilations and all issues related to it.
- Allow participants to ask questions during the presentation.



Female anatomy

Exploring the male sexual anatomy

- Once the discussion on the female sexual organ is completed, distribute the handouts with the diagram of the male sexual organ to all participants, and explain the role of each male sex organ part in terms of pleasure.
- Include in the presentation the issue of masturbation, erection and loss of erection, erectile dysfunction, size and shape, semen and sperm production, male circumcision, etc.



Male anatomy

Sexual and Gender Continuum

Are physically able to experience

Sexual pleasure

First erection First lubrication

Able to experience orgasm

Becomes a sexual being

Becomes homo- or bisexual Becomes heterosexual

May play sexual games

Starts to ask questions about sex and sexuality

Get curious about their origin

Asks questions about pregnancies and where babies come from

First kiss

Able to get pregnant

Able to make a girl/woman pregnant

Fantasising about sex

Starts longing for intimacy

Able to get sexually aroused (consciously)

Starts to actively seek information about sex

Starts to masturbate (with sexual fantasies)

May try petting with a partner

First oral sex

First intercourse anal sex

Experiment with different sexual activities

May try homosexual acts

Coming out as a homosexual

May experience erectile dysfunction caused by stress

Menopause

May experience less lubrication and fragile linings in the vagina

May experience erectile dysfunction caused by age

Stops having sex

Starts to get treated according to sex by parents and other adults

Mimics typical male or female behaviour

Learns stereotyped gender roles

Are allowed to play without adult interference (girls)

Are allowed to play without adult interference (boys)

Express them self verbally as a man or a woman

Learns how to behave as a woman or a man

Play family games

Attach importance to having same sex friends

Are able to gain from sexuality education

Attach importance to same sex peers

Likes to dress according to gender

Peer pressure becomes important

Strive for independence

Get married

Becomes a parent

Becomes a grand parent

Knows what it is to be a man or a woman

Getting less influenced by peer pressure

Reflection and Notes

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DELAYING
sexual debut

THIRD EDITION

Delaying Sexual Debut

Session Objective:	Enable participants to learn about the benefits for young people in delaying their first sexual experience.
Session Overview:	This session includes several discussions on how to help teenagers delay their sexual debut. It involves discussions with teenagers about their sex and sexuality and what they would like to know about sex and taking sexual responsibility for themselves.
Key Messages:	Having sex when we are emotionally and physically ready to handle the experience reduces HIV transmission.
Biblical Scripture:	*"Promise me, O women of Jerusalem, not to awaken love until the time is right. Young Women of Jerusalem" (Song of Songs 8:4, NLT)* *"How can a young man keep his way pure? By guarding it according to your word." (Psalms 119:9)*
Scripture Emphasis:	There is a right time for engaging in lovemaking. Young people should make and keep the promise to wait for that time.
Islamic Scripture:	*The Prophet said, "O group of youngsters, whoever amongst you has the means should get married, because it keeps the gaze down the best and it is the most protecting for the private parts. Whoever does not have the means should fast, because that breaks the temptation." (sahih Bukhari)*
Scripture Emphasis:	When the youth have come of age it is important to marry and live decently. This will prevent them from having different

	sexual partners who will raise the risk of infection for sexually transmitted diseases
Expected Learning Outcomes:	• Understand the benefits of delaying sex. • Know where you can get sexual health information for young people. • Better understand how to engage with young people about sex. • Reduce the awkwardness of addressing sex • Understand the pressures young people face. • Cultural/social/economic factors around sex
Toolkit Resource:	• Abstinence • Masturbation • Condoms • VCT • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	Flipchart, Markers.

Note to the facilitator:

Young people naturally think about sex. We are designed to explore who we are as sexual beings. This module deals with how to engage with teenagers about delaying their first sexual experience, and makes it clear why it is beneficial for them to delay their sexual activity. The focus here is on good overall sexual health. There is information about good sexual health throughout the Toolkit so please refer to that if specific questions need to be addressed.

The strength of this module lies in NOT giving the following messages:

- Teenage sex will get you pregnant.
- Teenage sex will leave you with a sexually transmitted infection
- Teenage sex is bad

These messages only serve to make teenagers ashamed of their sexual desires and feelings. We need to communicate healthy messages and, through these, give teenagers the confidence and information to take responsibility for their own sexual health. An example of a positive message would be that delaying their sexual debut is about SAVING sex until they find the right person, they wish to share it with in love, usually within the bounds of a committed relationship.

We are designed to explore who we are as sexual beings.

Studies have been carried out in the United States1 that clearly show that the more accurate information teenagers have about sex, the more responsible they become about their sexual health. They automatically seem to delay their first sexual experience, they have fewer partners and are less at risk for sexually transmitted illnesses and pregnancy.

Discussion:

Either in small groups or in the larger group ask the participants the following:

- *What do you consider to be sex?*
- *When and how did you learn about sex?*

Write as many of the responses down as you can. Then, once the discussions have been completed, classify the responses into good and bad experiences. Also, classify any form of violent sexual experience as extremely damaging ("bad" is simply too mild a word to describe what some people experience). In many contexts you will find that the majority of the participants have had little or no sexual education until they had their first experience.

- *What effect did the way you learnt about sex impact on you?*

Once again you will find quite a lot of negative experiences coming out.

- *What would you do differently to change your own sexual knowledge?*

Activity:

(This activity is included in the Gender and Sexuality module, but this is also including it). It is appropriate for both adults and teenagers, but it is better to have them

Draw a line across a sheet of paper and ask participants to write on it the different stages of sexual interaction from beginning to end. This can be done in the larger group, or in small groups if you feel this is more appropriate.

Give the participants twenty to thirty minutes to complete the exercise. Try to encourage them to think of their own sexual experiences and put in as much detail as possible. Once this has been done, ask the participants the question, "What do you consider to be sex?"

- Interestingly you will find that most adults will talk about sex as kissing, and everything after that is often taboo to speak of.
- Teenagers have a range of responses, but most link sex with the genital regions

Have a discussion about how these understandings about sex affect how we communicate about sex. Look at the different sexual acts and decide about which you would like more information. This may be an appropriate place in the training to address these issues or you may prefer to wait and answer them under the Sex, Sexuality and Gender modules

Activity:

Ask the group to design a simple framework for communicating about sex to others.

- *Who would be the ideal person to talk to about sex?*
- *What would you want to know?*

I lectured at a local school. Afterwards, several young men came up to me and told me that the girls they were having sex with didn't even ask them to use condoms – in fact they had even told these boys, "It's okay – you don't have to use anything." These girls perceived discussing contraception with their boyfriends as putting their worth at stake.

Discussion:

- *What are these teenagers exposing themselves to by engaging in unprotected? sexual intercourse?*
- *These were teenagers from ages thirteen to eighteen. What are the implications of engaging in unprotected sex at this age?*
- *What choices do we have in ensuring that teenagers make sexual choices that protect them? What can we do?*

Notes:

Sex is a normal, natural part of life. As human beings, we have been given a long period of time to prepare our minds, bodies and hearts for the beauty of a positive sexual experience. We need to give our teenagers comprehensive sexual education to ensure they have the knowledge necessary to make informed choices. Shame: A sense of shame about sex and sexuality is reinforced during puberty. If we communicate openly and honestly about sex, about the joy and beauty of it, about the mechanics of it and about the dangers of it, more teenagers would choose to honour sex as sacred. From the Judeo- Christian scriptures:

> How fair and pleasant you are, O loved one, delectable maiden! You are stately as a palm tree, and your breasts are like its clusters. I say I will climb up the palm tree and lay hold of its branches. Oh, may your breasts be like the clusters of the vine, and the scent of your breath like apples, and your kisses like the best wine that goes down smoothly gliding over lips and teeth.
> I am my beloved's, and his desire is for me. Come, my beloved, let us go forth into the fields, and lodge in the villages; let us go out early into the vinyards and see where the vines have budded, whether the grape blossoms have opened. There I will give you my love[1].

This is a challenge to us all to engage in beautiful sexual relationships. If we communicate openly and honestly about sex - the joy, beauty, mechanics, and dangers – teenagers will be more likely to choose to honour sex as sacred.

Social/environmental/economic factors

- The concept that girls should be virgins and boys must have experience. Is this the norm in your culture and how can it be challenged? (Look at concepts of masculinity and femininity and what is associated with these roles).
- Power dynamics; sex in return for something else e.g. money/grades/schooling/job/ clothes/airtime (credit) on cell-phones
- Family situations where sexual abuse is an issue.

Self-esteem/body image/mental health

- Peer pressure and pressure from a partner
- Valuing your body and realising that it is something that has to carry you through life: love yourself
- Self-confidence in yourself and not needing a partner to complete you

Resources

- What sex education are they already having and from where?
- What misinformation are they getting and from where?
- What services for young people are available in the area?
- Understand that young people may be sexually active and they need to be able to speak to someone in a non-judgmental way about it.

Discussion:

Try to get the group to discuss when they debuted and what thoughts they have about it. Do they regret it? Was it a negative or positive experience? How many people are still in relationship with their first sexual partner? How many waited till they were married before having sex? What pressure did they feel under to have sex, and from whom?

- *At what age do they think young people in their community start having sex?*
- *At what age do they think they should start to address the issue of sex with young people? Are there social/economic factors that are pushing young people towards having sex at a young age? If yes, how would they address these issues?*

Supporting Persons Living with HIV

Young people are vulnerable, and a lack of education can put them in harm's way. Is the price of an awkward conversation worth your child's health and the health of others? Young persons living with HIV need to know how they can have sex in a responsible and healthy way, and that they are entitled to the same experiences as everyone else.

Young persons living with HIV in the family need support to show them ways to engage in sex in a safer way, and that sex is not a way in which to seek attention or to act out.

Empowering Communities

Is there a safe space for young people, where they can talk to someone about issues around sex and prevention in a non-disclosure, private environment?

Activity:

- Ask participants how they can design and encourage a space for young people to talk about sex.
- Where? What will it look like? Who will be involved? etc.

Make more information available to young people in places where they are. Open up the lines of communication in a positive way – show that sex is something that requires thought and is a big step. Do not show sex to be a sin.

SSDDIM

If you approach the issues of sex in a way that is judgmental, aggressive, doctrinal and non-approachable then you are reinforcing the concept that SEX = SIN and the cycle of HIV continues. People's attitudes towards sex need to change in a way that helps to create safer behaviour patterns that do not put their health at risk.

By not talking about sex and the issues that surround it, you are creating a wall that drives the issues underground, making it a taboo subject. Stigmas around sex and sexual debut need to be addressed from across the community in order to maintain the safety of young people and the reduction of HIV.

Change is more likely to take place when people see change as a good thing, something that they will benefit from and that is supported by friends, family and the community. People are more likely to resist when they see something as an obstacle, and there is no support and no education available. The key is to work alongside local beliefs, customs and traditions and teach people ways to make practices safer rather than try to abolish them altogether. This approach enables people to embrace safer practices and allows for positive behaviour change rather than fighting something alien and imposed.

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Song of Solomon 7: 6-12

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Reflection and Notes

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ABSTINENCE

THIRD EDITION

Abstinence

Session Objective:	To help participants understand that abstinence is a choice and should be made within a context of good sexual information and support.
Session Overview:	Discussions on the meaning of abstinence and the support that is necessary from communities to help people who have made this choice to live positively.
Key Messages:	Making the choice to abstain from sex needs to happen within an information-rich and supportive community
Biblical Scripture:	*It is God's will that you should be sanctified: that you should avoid sexual immorality; that each of you should learn to control your own body in a way that is holy and honorable (1 Thessalonians 4:3-4).*
Scripture Emphasis:	God's will be that Christians be sexually pure. God created male and female and provided them with the liberty of choosing their partners and to solemnize marriage through invoking His presence in the wedding process to prevent sex outside marriage. The highest risk of HIV transmission is through different sexual activities.
Islamic Scripture:	*For men and women who guard their chastity, and for men and women who engage much in God's praise, for them has God prepared forgiveness and a reward (Quran, 33,35)*
Scripture Emphasis:	One of the noblest characteristics of a Muslim believer is sexual chastity.
Expected Learning Outcomes:	Understand the meaning of abstinence To know abstinence as a choice based on good sexual information
Toolkit Resource:	• The Human Immunodeficiency Virus • Voluntary Counselling and Testing (VCT) • Empowerment

	• HIV and Human Rights
Time:	1 45 min
Resources Needed:	Flip charts, pens, markers

Abstinence does not mean silence on sex. Just because someone chooses abstinence does not mean they should not receive Comprehensive Sex Education.

This module looks at the practice of abstinence. Abstinence is when a person chooses not to engage in sexual activity until they reach their goal – usually marriage. People choose to abstain for many reasons including religious, cultural practices and morals; it is a global practice that is common. People choose to abstain from sex until marriage or till they reach a certain age where they feel they are mentally and physically mature enough to engage in sexual activity. Abstinence can also be a conscious choice for a person who has come out of a relationship, either through a breakdown of that relationship or the death of their partner or spouse. It is a choice that can be made at any age and any time in life – not necessarily just young people. There are many aspects to abstinence that religious leaders must be aware of in order to fully support people who are abstaining.

Abstinence is a brave practice and choice that is often met with fierce resistance. We live in a highly sexualised world, and we face images of sexual content on a daily basis, whether from TV, news, magazines, the internet. This is the case whether one is in an urban environment or a rural one. To choose to guard one's body and refrain from sexual activity is a huge step to take, and a good way to look after yourself. It should, however, be done in conjunction with a comprehensive sexual education. Just because people are not engaging in sexual activity does not mean they need to be silent about it. If sex is treated as a taboo, then it drives conversation and activity underground. Taboo = isolation, and isolation = the potential for dangerous behaviour. If people have broken their vow or had a sexual encounter, they need a safe space to talk about it rather than face a wall of silence and condemnation.

How are you as a religious leader helping to guide and support people on the journey to abstinence?

Abstinence remains the safest of the safer sexual practices in reducing the risk of HIV transmission. However, it does not protect you fully since HIV can be transmitted through other means that are not sexual. Also, once you are in a sexual relationship, even if it is monogamous, your partner may have been sexually active previous to the relationship with you, thereby putting you at risk.

Abstinence does not mean silence on sex. Just because someone chooses abstinence does not mean they should not receive comprehensive sex education.

Other factors to consider:

- A person is not always in control of their own body (rape)
- You might engage in sexual activity for a variety of reasons
- Lack of support
- Lack of sexual education

Discussion:

Are people abstaining in your community? What support and guidance are you offering?

Activity

Read this story out to the group, and then divide the group into smaller groups for discussion. On flipchart paper get the groups to write down what issues they think are important.

Your friend's daughter comes to you for advice. She took an oath to abstain; however, she and her boyfriend got a bit carried away in the moment and they had unsafe sex.

- *What do you do to offer her advice?*
- *What happens to her relationship?*

A boy in your neighbourhood took an oath to abstain but he feels pressure from the rest of his friends to have sex. They tell him he is not a real man, and that he should have sex to show them how much of a real man he is.

- *Does he go out and have sex to prove to his friends his masculinity and virility?*
- *Does he stick to his oath and tell his friends he is a man for sticking to his word?*
- *What advice do you give him when he comes to you for guidance?*

Bring the group back together and have one person from each group report on the discussion.

Note to facilitator

- *Are the young people in your community getting support and counselling while they are abstaining?*
- *How are they setting boundaries if they are in a relationship?*
- *Are they facing peer pressure to engage in sex?*
- *Do they have a place where they can go and discuss issues?*
- *How are you as a community going to address these issues?*

Discussion

As a group, discuss answers to some of the challenges listed below.

- *If you love me, you would have sex with me.*
- *If you don't have experience as a young man you will never be able to satisfy your wife.*
- *If you are not having sex with women, you must be gay.*
- *You are a sexual being! If you don't have sex you are damaging your body.*

References

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Reflection and Notes

Reflection and Notes

Reflection and Notes

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MUTUAL fidelity

THIRD EDITION

Mutual fidelity

Session Objective:	Present mutual fidelity as a SAFE sexual practice To appreciate that each partner has sexual history To discuss the importance of mutual fidelity in prevention of HIV transmission
Session Overview:	Discussions about mutual fidelity as SAFE sexual practice
Key Messages:	You have sex with every single person with whom your partner has sex with.
Biblical Scripture	*Drink water from your own cistern, running water from your own well. Should your springs overflow in the streets, your streams of water in the public squares? Let them be yours alone, never to be shared with strangers. May your fountain be blessed and may you rejoice in the wife of your youth. A loving doe, a graceful deer—may her breasts satisfy you always, may you ever be intoxicated with her love. Why, my son, be intoxicated with another man's wife? Why embrace the bosom of a wayward woman? (Proverbs 5:15-20, NIV)*
Scripture Emphasis	Sexual intimacy should be exclusive to persons. It should not be shared with strangers (outsiders), or other people's spouses.
Islamic Scripture:	*Allah says: "Lodge them (in a section) of where you dwell out of your means and do not harm them in order to oppress them. And if they should be pregnant, then spend on them until they give birth..." (Qur'an 65:6)*
Scripture Emphasis:	We need to ensure that couples live in harmony and trust. The process of marriage should be simplified but spiritually strengthened. Couples have roles with the man taking responsibility of the family and supporting the woman in the process of life.
Expected Learning Outcomes:	• Explain that each person has a sexual history • Discuss why having one partner – whose status is known – is important in preventing HIV transmission • Explain that serial monogamy is not mutual fidelity

Toolkit Resource:	• VCT • Condoms • Sexually transmitted infections • Safer practices
Time:	30 min
Resources Needed:	Flip charts and markers

Activity:

Insert a skit on mutual fidelity – something funny but giving the message that monogamy is good for people, not just because it prevents HIV transmission, but because it provides a good environment for a couple to grow. Furthermore, the message needs to be conveyed that you have sex with every other partner with whom your partner has had sex – so get tested before each new sexual relationship.

Facilitator's notes:

- *Do not be prescriptive about sex before marriage. Most teenagers have had some type of sexual experience ranging from foreplay to penetrative sex. The message that you want to convey is that sex in a positive, mutually respectful and monogamous relationship is sexually healthy and responsible. You also want to encourage people to voluntarily have their HIV status tested as they enter new sexual relationships.*
- *Within some cultural group's polygamy is a culturally acceptable form of sexual expression. It could, in this context, be appropriate to discuss some of the ways polygamous relationships can be conducted safely.*
- *Discuss parallel relationships if appropriate. This would involve, for example, migrant workers who have partners at home and partners in their places of work. Many people see these relationships as being safe and exclusive.*

Level 1: Preventing transmission:

Discussion:

a) Why is it hard to have only one partner?

b) Question: real men have many sexual experiences; real women wait until they are married. How does this impact on sexual relationships?

Facilitator's Notes:

This module relies on 100% truthfulness and trust between each partner. Mutual fidelity means that there are only two people in the relationship and neither are having sexual relations outside of this relationship. Both people should be tested for STIs and HIV so that if they are engaging in unprotected sex, they know their status and they are not putting their partner at risk. Most people will have a sexual past. Testing for STIs and HIV is to ensure that the past does not interfere medically with the current relationship.

The time span of the relationship is important. The term, "serial monogamist" refers to a person who is in a relationship for a short period of time, during which time he or she is faithful. However, the relationship does not last long and then they move on to the next person. Once again testing for STIs and HIV with each person is important.

For people in a long-term monogamous relationship the key is communication - making sure you are on the right path and that you are both happy within the relationship. It is essential to communicate your feelings rather than to seek comfort in the arms of someone else.

Doubts of fidelity:

Is someone cheating?

- *Separation*
- *Travel expectations*
- *Migrant labour*
- *Loneliness of being left at home*

Discussion:

Divide participants into small groups. You may want to further separate these groups by age and gender.

Think of ways in which you can talk to your partner about your sex life. Are they happy with it; are there ways in which they want to change it?

What services are there to support people in long-term relationships?

Level 2: Supporting Persons Living with HIV:

People can have a very long and fulfilling relationship when one or both partners are living with HIV. The dynamics of the relationship are the same. (Having a good relationship with a family doctor is important).

Facilitator's Notes:

- *Polygamous relationships where one or multiple people have HIV can also be safe and healthy. However, because there are many sexual partners in a polygamous relationship, if one person within this relationship is living with HIV the rest will be vulnerable to HIV transmission. Furthermore, the person who is living with HIV is made more vulnerable of reinfection with HIV due to the ability of the virus to mutate rapidly. Thus, SAFER sexual practice should form part of this relationship. It would be recommended that all the people involved in the polygamous relationship knew their status and that SAFER sexual practices were consistent across the whole group.*
- *Multiple concurrent partnerships carry a high risk of HIV transmission. In new sexual relationships, sexual boundaries are often not made clear at the start. Thus SAFER sexual practice could be adopted in one relationship but not in another. Unfortunately, this leads to the increased risk of transmission.*
- *Serial monogamy also increases the vulnerability to HIV transmission. Once again, sexual boundaries can be fluid at the start and end of relationships. Furthermore, partners may be exclusive for a number of years before they break-up and develop new relationships. During this long exclusivity they may have engaged in sexual practices that were not SAFE. Ensure that before you enter a new relationship you know your status and that your sexual boundaries include SAFER sexual practices throughout the relationships.*

References

World Health Organization (1992): *The global AIDS strategy*. World Health Organization. https://apps.who.int/iris/handle/10665/39900

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

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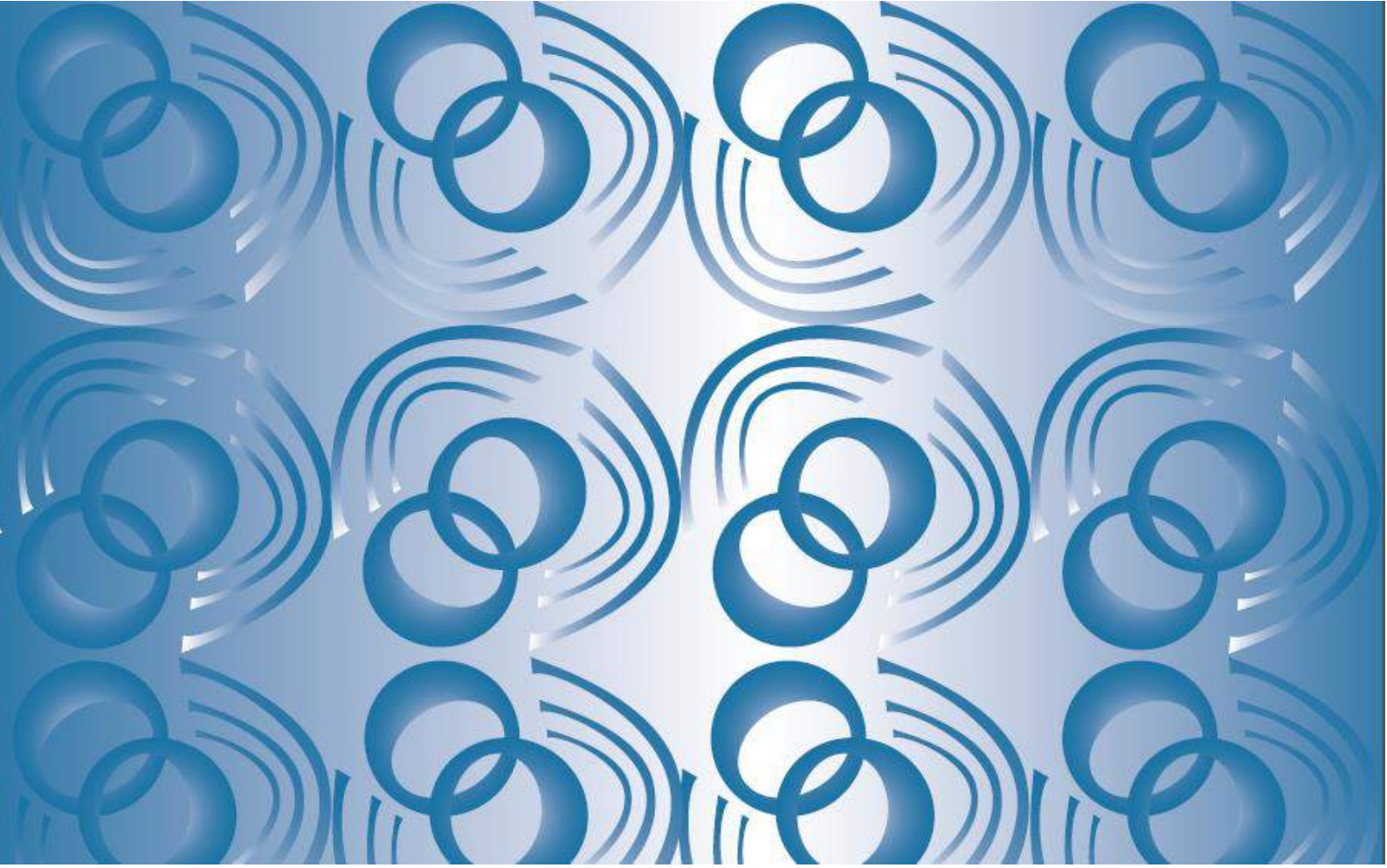


CONDOMS

THIRD EDITION

Condoms

Session Objective:	Present use of condoms as an excellent way of preventing HIV transmission
Session Overview:	Discussions and demonstrations on how to use and dispose condoms correctly.
Key Messages:	No glove no love! Safer sex is great sex!
Biblical Scripture:	*Then Jesus said to them, "I ask you, which is lawful on the Sabbath: to do good or to do evil, to save life or to destroy it?" (Luke 6:9)*
Scripture Emphasis	Sex is socially acceptable in marriage and couples may use condoms for any reason including for infection prevention among both concordant and discordant couples, and for use in child spacing. In many communities, sex outside marriage is not socially accepted. However, those who engage in sex outside marriage should take responsibility and use condoms to reduce the risk of disease transmission to themselves and others.
Islamic Scripture:	*Spend in the Way of Allah and do not cast yourselves into destruction with your own hands; do good, for Allah loves those who do good. (Qur'an 2:195)*
Scripture Emphasis:	Sex is socially acceptable in marriage and couples can use condoms for any reason including concordant and discordant couples use or child spacing and infection prevention. However, those who have sex outside marriage should have the courtesy of reducing the risk of disease transmission to themselves and others
Expected Learning Outcomes:	Individuals will understand why it is important to carry and use condoms in a safe way. • How to use a condom and how to dispose it correctly • Individuals will know where they can obtain condoms. • Individuals will be able to ask for condoms where they are provided for free. • Individuals will be able to ask their partners to use a condom.
Toolkit Resource:	ARVs Sexually transmitted infections VCT
Time:	1 hour 30 minutes

Resources Needed:	• Flipchart • Markers. • Condoms • Demonstrators for condoms (bananas, dildos etc.) • Range of lubricants (Vaseline, K-Y, cooking oil, hand lotion etc.) • Bleach

Facilitator's Notes:

This module is intended to provide people with the knowledge necessary to make informed decisions in practicing safer sex. It is not intended to encourage promiscuity

The history of the condom

- The use of the condom can be traced back to 1000 years BC with the ancient Egyptians.
- The earliest evidence of condom use in Europe comes from scenes in cave paintings at Combarelles in France in 100-200 AD. There is also some evidence that some form of condom was used in Imperial Rome.
- 1500s: The syphilis epidemic that spread across Europe gave rise to the first published account of the condom. Gabrielle Fallopius described a sheath of linen he claimed to have invented to protect men against syphilis. Having been found useful for prevention of infection, it was only later that the usefulness of the condom for the prevention of pregnancy was recognised.
- 1700s: The first published use of the word "condom" was in a 1706 poem. It has also been suggested that Condom was a doctor in the time of Charles II. It is believed that he invented the device to help the king to prevent the birth of more illegitimate children. Even the most famous lover of all, Casanova, used the condom as birth control as well as against infections.
- 1844 - Goodyear and Hancock came up with the process of making rubber more flexible and useful. Some decades later, mass-production of condoms made out of vulcanized rubber began.
- In the 20th century, the labour union in Sweden used condoms to fight against poverty by reducing the number of children being born, and encouraging child spacing to promote women's SRHR.
- The facilitator should add some local condom facts here: where condoms are made, how many are made and distributed in your country each year, etc.

This module is intended to provide people with the knowledge necessary to make informed decisions in practicing safer sex. It is not intended to encourage promiscuity.

Activity:

Ask participants what they already know about condoms, including facts, myths and also their personal feeling about condoms. Do they have a positive or negative association with condoms? Write this information on a flipchart. At the end of the session look at the list again and see if what has changed in what they know, and if there is anything you are now able to cross off the list.

Level: 1 Preventing Transmission:

Facilitator's Notes:

HIV is transmitted through the exchange of bodily fluids. Penile and vaginal fluids have high concentrations of HIV. Furthermore, our genitals and anus are full of blood vessels that are close to the surface, so tears can occur easily, which makes the transmission of HIV and other infections like herpes easy.

Condoms allow people to engage in safer sex with significantly reduced risk of bodily fluids being exchanged, since the condom acts as a barrier (barrier method). Condoms not only help to prevent the risk of contracting HIV but they also help to protect against other sexually transmitted infections (STIs) and unwanted pregnancy. Condoms need to be used correctly and consistently to gain the benefits of good health. To effectively reduce the risk of HIV transmission condoms should be used when having vaginal, anal and/or oral sex. Condoms should also be used on sex toys.

Activity:

The aim of the activity is to demonstrate how to correctly open a condom packet, place it on the demonstrator, remove it, and dispose of it. Divide the participants into smaller groups of four or five. Give condoms to each group and instruct them to allow, each participant to take a turn placing their condom on the demonstrator, while describing the steps to the group. Make sure that there is one condom short in each group. In order to demonstrate the dangers of using faulty condoms, give the participants who did not receive a condom "used" one to place on the demonstrator– i.e. condoms that are sure to tear.

From this activity, discuss the dangers of putting on condoms incorrectly and using damaged or faulty condoms. As the participants have just had the experience of placing a condom on a demonstrator, let most of the suggestions come from them.

Hopefully the groups will identify resistance to condom use as a major topic. It may be that one member of the group simply refused to handle the condom. If that was the case, highlight it as a concern and allow the discussion to continue. You will deal with some of these issues later in the session.
Next give each group two condoms and a range of lubricants including water-based and oil-based ones (Vaseline, K-Y, cooking oil, hand lotion etc.). Ask them to blow up the condoms like a balloon and apply an oil-based lubricant to one and a water-based lubricant to the other. Set a stop-watch and see how long it takes for the condom with the oil-based lubricant to degrade and break. This will illustrate the fact that oil-based is bad for condoms and water-based is good!

Here is another useful demonstration to introduce the subject of "dry sex", and the problems associated with it. Fill a condom with bleach - or any other substance used for dry sex. Make sure to do this over a basin as the bleach will eat through the condom and spill everywhere. This is a good way to start a discussion about dry sex.

Facilitator's Notes

Some further facts that should be raised:

Using condom in a relationship where one or both people are living positively with HIV:
Re-infection is when you are living with HIV but become infected with an additional strain of HIV from someone else who is also living with HIV. This can happen because the virus mutates in different ways in different people's bodies every time it replicates. Consequences of being re-infected can include treatment complications i.e. drug resistance. Drug resistance is the term we use when the virus in a person's body has mutated in a way, which means that the drugs being used to treat them are no longer effective. If a drug resistant virus from one person is introduced, through re-infection, to another person, this can cause resistance to medication and the virus then has the ability to replicate more freely. This will then increase the viral load and a new regimen of treatment will have to be found to counter this. If you are worried or in need of more advice, please see your doctor.

Sex when just one of you is living with HIV
It is important to always use a condom for reducing the risk of HIV transmission. If you are living with HIV, you put your partner at risk of HIV infection if you don't practice safer practices. Furthermore, you could expose yourself to the other infections that come with unprotected sex, like herpes, gonorrhoea, warts etc. These can give you serious health problems, besides being extremely sore and uncomfortable.

Activity:

Get each person to write down the "lines" that men and women use to get each other to have unprotected sex. You may get some of the following:

- *Only promiscuous girls ask men to use condoms*
- *If you loved me, you would not ask me to wear a condom*
- *I will take my penis out before I orgasm*
- *It is not "African" or "Christian" or "right" to wear a condom*
- *My husband won't wear a condom – he says that if I ask him to, I must be living with HIV.*

  My wife says that if I wear a condom, I am being unfaithful.

Facilitator's Notes:

Some of these "lines" can be dealt with in a light-hearted and easy manner. Others, especially the ones about husbands and wives, are much harder. We would suggest that these questions be acknowledged and specifically addressed in the Gender Imbalances session. However, if the group would like to deal with those issues immediately, use some of the activities in the Gender Imbalances section and come back to the rest of the condom section later. Each group will be different when addressing this issue. Also remember if the discussion gets heated, take a break or return to the activity at the beginning of the module.

When working with teenagers:

After the activity and before discussions, get the teenagers to act out the scenarios using the "lines" from the activity. This can be quite fun as they can help each other come up with helpful ways to get out of situations that have become uncomfortable. A discussion around how alcohol and drugs can impair judgement and lead to unprotected sex may be appropriate at this point.

Further issues about living with HIV and having unprotected sex:

If you are trying to get pregnant naturally you would need to have unprotected sex. However, you should ALWAYS seek the advice from a doctor before having unprotected sex. Even here there are ways to reduce the risk of infection: for instance, the partner who is living with HIV can use ARVs; use

enough lubrication; make sure you have foreplay as this stimulates the body to produce natural lubricants and protective mucus.

Does size matter? Yes!!!

Penis size changes from man to man in terms of length, thickness and shape, so you need to wear the correct size of condom. Think of it in terms of gloves for your hands - if they are too small they constrict the blood, hurt and rip, whereas if they are too big they fall off. It is not one size fits all so try a few sizes to see which is best for you.

Size does matter when you are using male condoms. If you use condoms that are too small they may tear, putting you and your partner at risk of STIs and HIV infection. If the condoms are too big they are likely to come off during sex.
***Note:** Condom size is according to the width (thickness) of the penis - not the length!*

What to do if the condom tears or comes off?

If a condom tears or comes off during sex STOP immediately. If you continue you are putting both your partner and yourself at risk! Speak to a medical professional as soon as possible to discuss exposure.
There are two types of condoms; male condoms which are the more common ones, and female condoms. There are different brands of female condoms, for example, Femidom, Care, and Dominique and of male condoms, for example, Durex, Trust and Skyn depending on the country you live in.
A female condom is placed inside the woman's vagina before sex. It is less restricting for males and there is less concern about tearing and coming off during sex.
It is very important to use a condom in anal sex, whether it is between a man and another man or between a man and a woman. Anal sex creates a very high-risk environment for HIV transmission and the transmission of STIs due to the very delicate wall of the rectum that can tear easily. These tears may be very small but they still allow easy access for transmitting the virus. So always use a condom.

Dry sex:

Dry sex is one of the most high-risk sexual activities between a man and a woman. In some African countries women are encouraged to dry out their vaginas before sex so that the man can have greater sexual pleasure (the act of drying out the vagina creates a 'tightness'). This is very dangerous because the lack of vaginal lubrication allows for greater friction, causing tears, cuts and lacerations on the vaginal wall. This is an ideal place for HIV to cross the barrier from one partner to the other. Correct education about sex and condom use allows women and men greater understanding about their bodies and the benefits of using a condom.

Stimulating condom use by making condoms fun

Using condoms can be an enjoyable part of sex and should not be seen merely as a disruption/interruption during sex. Condoms come in different shapes, colours, flavours and textures. Have fun with your partner and find something that you both enjoy and that feels right.

Level 2: Supporting Persons Living with HIV

Just because you are living with HIV does not mean you can no longer have sex or have children. Knowing your status allows you to be in control and protect yourself as well as others. You are entitled to as a healthy and safe a sex life as everyone else.

Knowing your status when it comes to sexual intercourse allows you to be in control, and know your limitations when a condom is not available.

case study

Christo Greyling tested HIV positive back in 1987. At the time he was engaged to Liesel. When he heard that he had tested HIV positive he wanted to break off the engagement, but Liesel would not let him. She insisted on supporting him. They got married in 1988. Sixteen years later, having always practiced safe sex within their marriage, Christo remained HIV positive while Liesel remained HIV negative. Then they heard the effects of viral load on reducing the risk of HIV infection. At the time Christo was just starting ART. When his viral load was low, they got children. Today Liesel remains HIV negative, and their two beautiful daughters are also negative. Christo continues to use ART and manages his HIV status well.

(1 Channels of Hope).

PROVIDED BY CHRISTO GREYLING
WRITTEN BY THE REVEREND FR JP MOKGETHI-HEATH

Empowering Communities

Condom line-up

Session Objectives:	To explore the journey of using condoms from purchasing, storing, using and disposing of condoms. To explore thoughts and feelings about condoms and the technical aspects of using a condom.
Session Overview:	This session involves facilitator-led discussion and an interactive group game on accessing and disposal of condoms.
Key Messages:	Condom use is a SAFER Practice.
Toolkit Resource:	ARVs Sexually transmitted infections VCT
Time:	1 hour and 30 minutes.
Resources Needed:	Printed handouts on the 'Condom line-up', flipchart and markers, condoms, bananas or dildos.

The condom line-up

- Start by talking generally about condoms and their importance in combating the transmission of HIV.
- Explain that the lack of correct and consistent use of condoms for various reasons is a major challenge for HIV prevention.
- Explain that the purpose of the exercise is for us to go through the journey of using the condom, from thoughts and feelings associated with it, to the more technical aspects of using it.
- Before beginning the exercise, write one of the stages of the condom line-up on separate slips of paper. Randomly give each participant one of the slips of paper. (if there are more slips of paper than people let them have two each).
- Explain that they must organise themselves in the chronological order in which they think the "event" they have on their slip of paper should follow.
- Once they have figured that out, they must arrange themselves into a U-shape, with the first person being the first "event", and the last person being the last "event". Give them ten minutes in which to do this.
- Ask participants to think about the possible problems that are associated with their "event" from a gender perspective, and how these could be addressed.
- Ensure that you give time for each "event" to be discussed properly.

Condom line-up sequence of events and points to highlight from the discussion:

No.	MALE CONDOM STEPS	FEMALE CONDOM STEPS
1	Buy/get a condom	Buy/get a condom
2	Store the condom:	Store the condom:
3	Make contact/flirt, show interest	Make contact/flirt, show interest
4	Agree to have sex	Agree to have sex
5	Agree to use condom	Agree to use condom
6	Hugs and kisses	Up to 8 hours before, carefully open the condom
7	Foreplay	Press the inner ring into a figure 8 and insert into the vagina, ensuring that the outer ring stays outside the vaginal opening
8	Erection and lubrication	Hugs and kisses
9	Carefully open the condom	Foreplay
10	Put the condom at the tip of the penis	Erection and lubrication
11	Roll the condom down to the base of the penis	Penetration, ensuring that the outer ring stays outside the vaginal opening
12	Add lubrication	Intercourse
13	Intercourse	Orgasm
14	Orgasm	Male withdraws the penis
15	Hold condom at the base of the penis	Remove the condom from the vagina
16	Withdraw the penis	Dispose of the condom
17	Dispose of the condom	

Tips for facilitators

- The "condom steps" above have been done for both the female and the male condom. It is recommended to focus on just one in a workshop. Doing both may take too much time and be a repetition of some steps.

- If there are enough people, you may divide the group into two and have them simultaneously do the condom line-ups for males and females, but you should ensure that both exercises are discussed thoroughly and equally.

- It is advisable to have at your disposal a wide variety of condoms (different colours, flavours, textures, etc.) for this exercise, so that you may do additional condom demonstrations where participants touch and play with the condoms to get used to them.

End reflections for participants:

- What did I learn?
- What made me feel uncomfortable?
- Have my views on sex changed at all?
- Do I feel shameful about my sex life?
- Am I able to change my behaviour to have safe, fun sex?
- What will I change?

End reflections for facilitators:

- What activities worked, what activities did not work, and why?
- SAFER sex
- Has my attitude to shame and sex changed?

Male condom

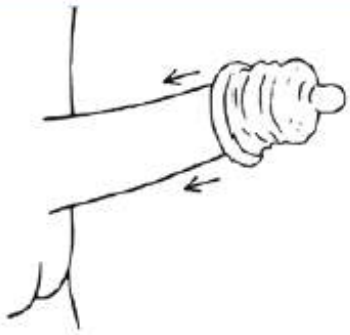
1

Erection

2

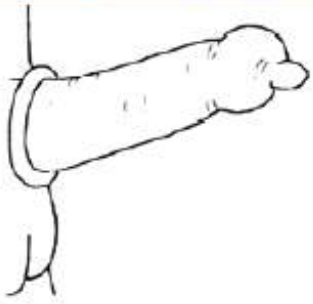
Carefully open the condom

3



Pinch the teat to expel any air and roll the condom down to the base of the penis

4



Hold the condom at the base of the penis. Withdraw the penis and tie condom in a knot. Dispose of condom safely.

Female condom

1

Up to 8 hourse before, carefully open the condom

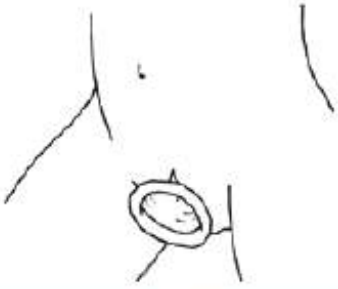
2

Press the inner ring into a figure 8

3

Insert into the vagina, ensuring that the outer ring stays outside the vaginal opening

4



Penetration ensuring that the outer ring stays outside the vaginal opening

Quick reference guide of Do's and Don'ts when using a male condom

DOs	DON'Ts
Before sex • Make sure you are using a good quality condom. • Keep condoms in a cool dry place. • Make sure you are using the right size condom as incorrect size can cause it to either come off or tear. • Before opening the packet check the Use By date. • Use for vaginal, anal and oral sex. • Move the condom to one side inside the packet and carefully tear the edge. • Make sure the condom is not inside-out. • Place the condom over the tip of the penis. • If there is a "well" or teat, squeeze the air out before rolling the condom down to the base of the penis. • If it comes off, replace it with a new condom. **After sex** • Withdraw the penis while it is still erect; hold the base of the condom during withdrawal. • Remove the condom from the penis, making sure you do not spill any fluid. Tie a knot in the end to stop it leaking. • Dispose of condom safely.	**Before sex** • Don't open pack with your teeth. • Don't fill with water to check for holes. • Don't pull the condom on. • Don't store condom in direct sunlight or anywhere on a rough surface as it may damage the condom before use. • Don't use a condom that has had a staple through the packet. • Don't use a condom with an expired date on the packet. **After sex** • Don't dispose in a toilet. • Don't reuse. • Don't wash out. • Don't pass used condom to a friend to use.

Value game: The four corners

Session Objective:	To give participants the chance to reflect on their personal values and to share them with others.
Session Overview:	Participants listen to a short story and then share their views.
Key Messages:	Personal values are important in preventing HIV transmission and AIDS related deaths.
Session Outcome:	By the end of this session, participants should be able to: Explain their personal values and other values that they might want to take up Describe the condom line-up sequence of events
Toolkit Resource:	ARVs Sexually transmitted infections VCT
Time:	15 minutes.
Resources Needed:	Prepare papers with reaction statements written on them to place of the floor or stick on the wall.

The four corners exercise:

- Remind the participants that as part of the rules of any values game, they are required to respect one another's different opinions.
- Explain the specific values game you are going to take them through now.
- Ask people to stand up and come to the centre of the room.
- Then tell present the incidence:

"Imagine you have a 14-year-old daughter. She comes home from school and puts her bag on the table and leaves the room. When you move her bag from the table, it falls and a condom drops out of the bag. What do you think your reaction would be?"

Read out the different reactions, and stick each reaction in a different corner of the room:

- **Corner 1**: Get angry and scold her
- **Corner 2**: Use the situation to talk to her about sexuality, condoms, etc.
- **Corner 3:** You say nothing. You are happy because you know she is caring for herself
- **Corner 4:** Your reaction is not one of these three
- Repeat the story and the different reactions.
- Ask participants to go and stand at the corner that indicates their reactions.

Tips for facilitators

Remember the rules and guidelines on how to facilitate values games, as contained in the introduction to this manual.

- Allow participants to discuss their opinions in their group.
- Encourage everyone in each group to speak
- Ask two or three people from each small group to share their personal values.
- Ask if anybody would like to change and move to another position after listening to others.
- Thank participants for sharing their values.

Our community does not have access to condoms:

Activity:

Have a discussion around the following topics:

- *There is access to condoms but we are simply too embarrassed to go and collect them.*
- *We have no clinic.*
- *We are Christian, Muslim… condoms are sinful.*
- *My Church does not allow the use of condoms.*

Allow as many other topics to come up for discussion.

Facilitator's Notes:

Once again, these topics can bring up some really deep-seated hurts and fears. Be gentle, park what is necessary and take breaks.

Ideas for required action:

- Although universal access to condoms has increased, availability and access to condoms can still be a problem for some individuals.
- Communities should be aware of where they are able to obtain condoms for free and where they can be purchased. If they are not available, then this allows you to look into the issues that are affecting their availability.
- Brainstorm ways of making condoms available.
- Brainstorm ways of making condom use more widespread and acceptable.

PEOPLE HAVE SEX!!! They may not talk about it but it is happening. It is important to spread the word about safer sex in the community and make a space available where people can come and talk and ask questions without feeling judged. Once again everyone has the right to say NO to sex if a condom is not available.

SSDDIM
Focus on shame and sex

Discussion:

Shame: *Why do you think having sex is considered to be shameful?*
Condom sex may be considered to be shameful - why do you think that is so?

Facilitator's Notes:

The ABC approach of Abstain, be faithful, use a Condom in some countries has had the letter D added for Die because the approach is not encouraging safer sexual practices and is driving the topic of sex underground. People have sex, but the lack of a safe environment to talk about sex means that issues are not addressed. The message of SEX = SIN has permeated community perceptions, putting people's lives at risk. SSDDIM reduces the effectiveness of education on safer sex and does not allow people who are living with HIV to live openly or even have a healthy sex life. Also, SSDDIM reinforces the idea that people who are living with HIV should hide away. We want to break this idea and show that people need to come together as a community, whether they have tested HIV negative or HIV positive, and talk openly and truthfully about sex and how they can protect themselves and others.

References

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UNAIDS (2004): *Making condoms work for HIV prevention: Cutting-edge perspectives*. Geneva: UNAIDS

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

MALE

Circumcision

THIRD EDITION

Male Circumcision

Information in this module also applies to cultural scarification

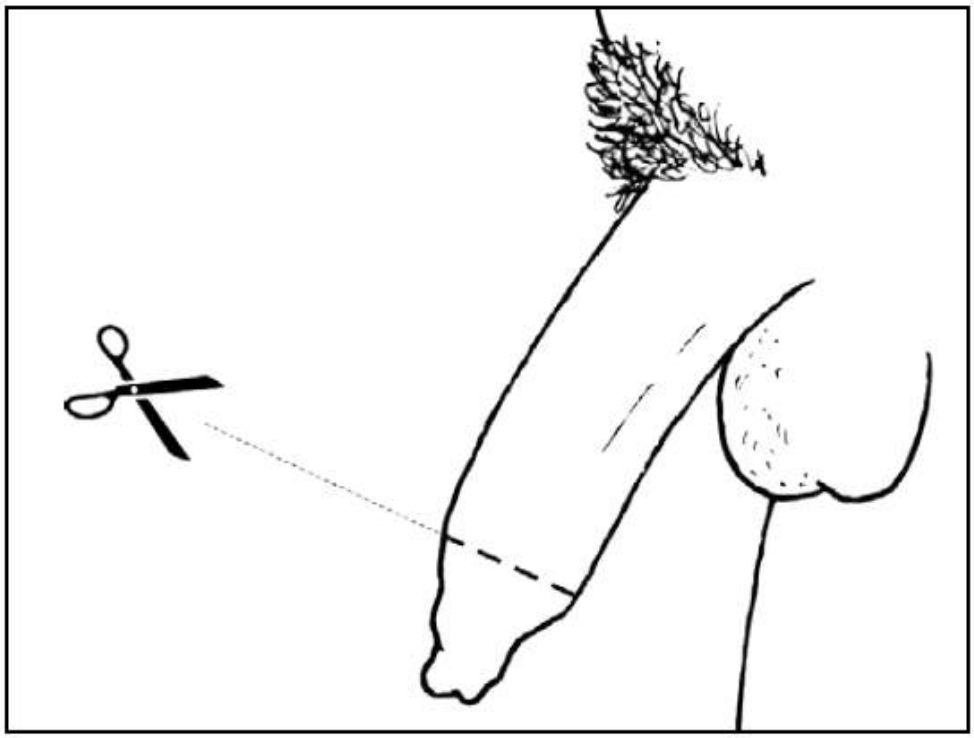
Session Objectives:	Enable learning on why male circumcision needs to be done with sterile equipment Provide opportunity to talk to young men about why circumcision is useful in HIV transmission and prevention
Session Overview:	Discussions and planning around encouraging circumcision to be used as a positive practice
Key Messages:	Circumcision can be used to educate young men into SAFER sexual practices but must be done with other SAFER sexual practices that are of benefit to them and their sexual partners.
Biblical Scripture:	*I have come that they may have life, and have it to the full. (John 10:10 b)*
Scripture Emphasis	Male Circumcision when done safely saves lives. And anything that is known to save lives is recommended.
Islamic Scripture:	*The Prophet was quoted saying: "five things are fitra: circumcision, shaving pubic hair with a razor, trimming the mustache, paring one's nails and plucking the hair from one's armpits" (Sahih Bukhari and Muslim).*

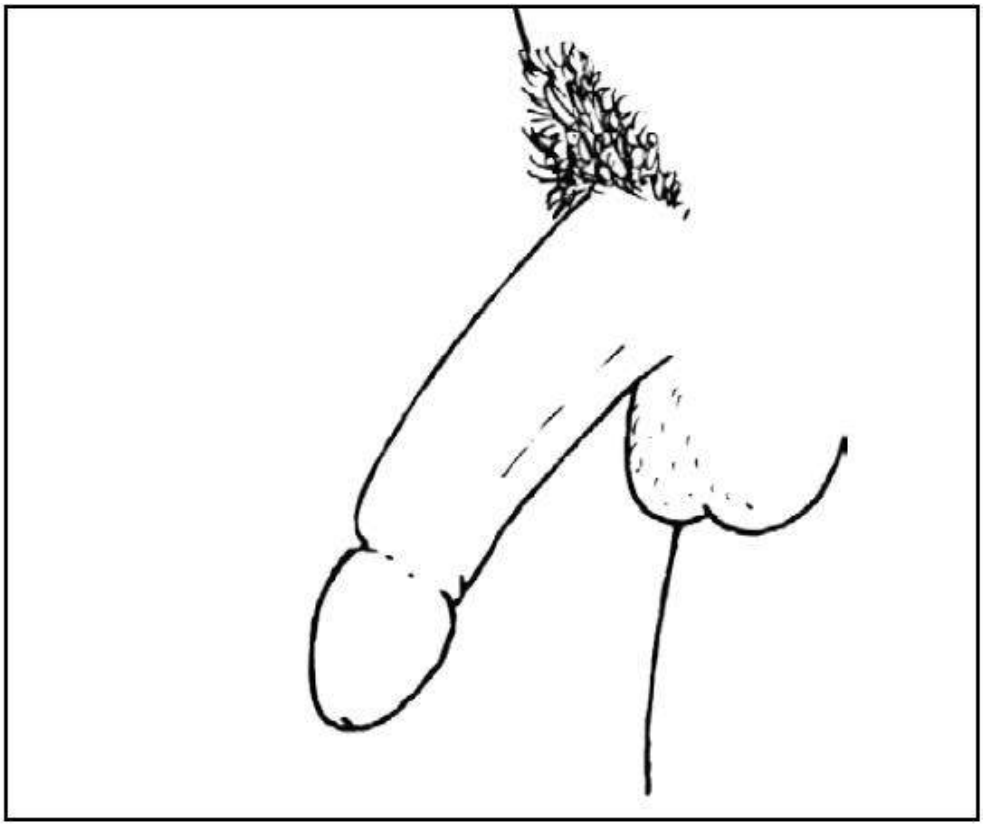
Scripture Emphasis:	Male circumcision is well recognized and accepted in Islam. This is often done on the seventh day after birth if the child was born healthy. The recent observation that the foreskin in males increases the risk of HIV infection is well appreciated.
Expected Learning Outcomes:	• Explain the importance of safe and sterile circumcision • Explain why circumcision needs to be part of a comprehensive prevention method. • Explain the importance of circumcision as part of holistic sex education • Explain the importance of circumcision as a human rights issue. • Demonstrate confidence to know and ask for sterile equipment. • Discuss male circumcision as part of a cultural and religious practice that can be adapted and changed in response to changing times without losing the essence of the practice.
Toolkit Resources:	HIV transmission Condom use Sterile medical instruments STIs VCT
Time:	45 minutes
Resources Needed:	Flipcharts, pens, markers

Introductory Cycle

It is important that male circumcision and cultural scarification is respected as part of the culture and tradition of a group. However, stress that this needs to accommodate the reality of HIV. Asking schools to adapt traditional practice without losing the essence of the practice is important. Furthermore, this can be used as an opportunity within the schools to talk about other safer practices like condom use and voluntary counselling and testing. It is also important to communicate the fact that men in communities need to take sexual responsibility.

Male Circumcision





Facilitators notes:

Changing the practices about male circumcision can encounter resistance because it can be seen as an attack on the prevailing culture. Thus, the following can be valuable assets when you deal with this topic:

- *Respected leaders in the community who promote the use of sterile instruments for both circumcision and cultural scarification to talk to the group about how it enhances the traditions.*
- *Revisit the game on HIV transmission so that people can see how quickly HIV may spread.*
- *You can take time to discuss the inner significance of the initiation rites, and write them where people can see them during other discussions.*

Level 1: Preventing transmission:

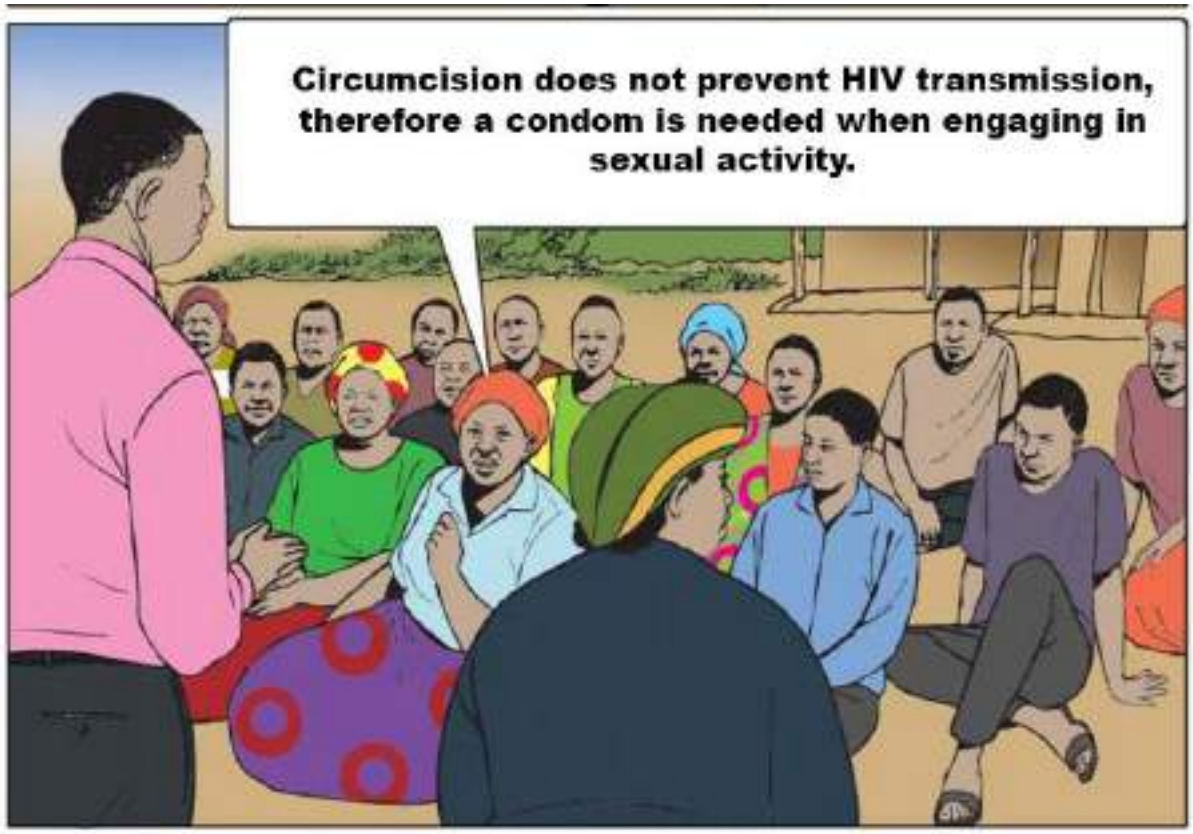
The practice of male circumcision happens in many cultures across the globe and it happens at many different ages, from birth through to teenage years. The procedure can be done for many reasons - medical, cultural and religious. The practice needs to be recognized as part of a culture and needs to be carried out in a safe way so that young boys don't get infected with HIV.

What is Male Circumcision?

- It is a procedure in which some or all of the foreskin of the penis is removed with a blade.

Discussion:

- *What practices within initiation schools can contribute to either the prevention or transmission of HIV?*



- **Initiation schools:** Gatherings of young men under the guidance of elders. During the school's young men are taught what their roles and responsibilities will be as men, and they will undergo a circumcision ritual to signify that the boy has become a man. These schools are found across the globe.

Facilitator's Notes:

Prevention:

- *Accurate education about safer sexual practices during the initial phases of the initiation.*
- *Creating understanding around culturally accepted sexual practices that prevent HIV transmission.*
- *Education around what it means to be a man within the community in terms of interaction with women and children.*
- *Looking at the realities of migratory practices within the community and how safer sexual practices within cities prevent HIV transmission in communities.*
- *The use of single sterile blades for each individual boy.*

Transmission risks:

- *No education around safer sexual practices.*
- *The practice of using the same blade to circumcise or scarify many boys.*
- *No education about the risks and dangers of having unprotected sex when the circumcision wound is still healing.*
    - *An open wound, particularly in the genital area, is a perfect environment for HIV transmission. A wound that has not healed creates a large surface area for HIV to reach the blood stream easily. Furthermore, it also places the person concerned at risk of transmission for other STIs. This will further increase the risk of HIV transmission.*

Benefits of male circumcision:

- *Opportunity to provide young men with good sexual education and help them to an understanding of sexual responsibility.*
- *Circumcision has been shown to reduce the transmission rate of HIV from women to men during vaginal sex. This is because the foreskin is a delicate organ and tearing can occur during vaginal sex.*

CAUTION: Circumcision does not prevent HIV transmission, therefore a condom is needed when engaging in sexual activity.

Supporting Persons Living with HIV:

Male circumcision lowers the risk of contracting HIV via the penis during vaginal sex, but it does not eliminate the chance of transmission. Male circumcision must be part of safer sexual practices, including using condoms. Knowing your status allows you and your partner to make safer choices.

Discussion:

Should young men who are living with HIV still undergo the ritual of circumcision or cultural scarification?
If we exclude boys who are living with HIV from this ritual, how does that affect them and what is the impact on the family and community? SSDDIM

Facilitator's Notes:

Circumcision for young men living with HIV:

- *Make circumcision safe for all young men.*
- *In a community that practices circumcision we cannot discriminate between boys who are living with HIV and those who are not.*
    - *Not all people know their status – in excluding the boys who are known to be living with HIV there is no guarantee that those not excluded are not living with HIV. Excluding people does not prevent transmission - it leads to denial.*
    - *Exclusion leads to stigma, shame, discrimination and denial.*
- *Boys living with HIV have a compromised immune system. However, there are a number of other factors that will compromise the immune system - from the common cold to lack of sleep. Thus, good medical care needs to be given to all the boys. This would include good wound hygiene, adequate amounts of sleep and very good nutrition.*

Empowering communities

Discussion:

What can we as a community do to make the practice of circumcision safe for our young men as well as for us as a community?
An important point that you would want to make is that a circumcision school is an opportunity for good sexual education.
It is also an opportunity for education around gender relationships. Perhaps suggest that elements of this Toolkit be used in the circumcision schools.

Phido or child circumcision:

In some faith communities, circumcision is practiced on male babies. This is particularly so for both Muslim and Jewish communities. Medical science shows us that this remains the most effective age at which to circumcise boys from the perspective of preventing the transmission of HIV. This is because the body heals very quickly at this age, and there are enough years during which the penis head can harden and become tougher before the boys become sexually active. This means a greater protection against slight tears or lesions in the skin of the penis, thus reducing the risk of HIV transmission.

SSDDIM (Stigma, Shame, Denial, Discrimination, Inaction, Misinformation)

Boys and men should not be excluded from participating in this tradition because they are living with HIV; their status only emphasises the needs for greater understanding and reinforces the need for use of sterile equipment.

Using sterile instruments allows you to maintain your cultural practices, while doing them in a way that protects and minimizes future harm to the community.
Circumcision schools run well and within the cultural traditions provide ideal opportunities for education and awareness.

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Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

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FEMALE

genital mutilation

THIRD EDITION

Female Genital Mutilation (FGM)

THE INFORMATION IN THIS SECTION IS TAKEN FROM THE WHO WEBSITE

GRAPHIC DESCRIPTION INCLUDED

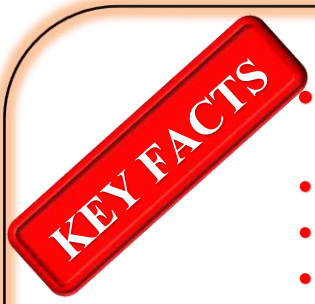
Session Objective:	Introducing the risks of FGM for HIV transmission
Session Overview:	Main purpose to provide information, with a key focus on post circumcision complications and how these increase HIV transmission
Key Messages:	FGM is a practice that increases HIV transmission
Biblical Scripture:	*I have come that they may have life, and have it to the full. (John 10:10 b)*
Scripture Emphasis	FGM has been shown to cause harm to a woman's body. The integrity of the body is required as a matter of faith.
Islamic Scripture:	*The Prophet SAW said "Do no harm to yourself and don't harm others." (Ibn Majah)*
Scripture Emphasis:	Muslims discourage people practicing any act that may be harmful to their body
Expected Learning Outcomes:	By the end of this session participants should be able to explain the risks of FGM and HIV Transmission

Toolkit Resources:	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	30 minutes
Resources Needed:	Flipcharts, pens, markers

Note to facilitators

This is an information session, which will inform people about a practice that is still current across the globe, but is seen to be a breach of human rights. This session highlights the increased vulnerability to HIV transmission that can occur as a result of this practice.

Female Genital Mutilation (FGM) is when there is intentional partial or full removal of the external female genitalia. This is done for cultural reasons - not medical.



- Female Genital Mutilation (FGM) includes procedures that intentionally alter or injure female genital organs for nonmedical reasons.
- It is mostly carried out on young girls between infancy and age fifteen.
- The procedure has no health benefits for girls and women.
- Procedures can cause severe bleeding and problems urinating, and later, potential childbirth complications and new born deaths.
- An estimated 200 million girls and women worldwide are currently living with the consequences of FGM.
- In Africa an estimated 92 million girls from ten years of age and above have undergone FGM.
- FGM is internationally recognized as a violation of the human rights of girls and women.

Female Genital Mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending to childbirths. Increasingly, however, FGM is being performed by health care providers.

FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life, when the procedure results in death.

Female Genital Mutilation (FGM) is when there is intentional partial or full removal of the external female genitalia.

Procedures

FGM is classified into four major types.

1. **Clitoridectomy:** partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. **Excision:** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. **Infibulation**: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.
4. **Other**: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

No health benefits, only harm

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus and sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include:

- recurrent bladder and urinary tract infections;
- cysts;
- infertility;
- an increased risk of childbirth complications and new born deaths;
- The need for surgeries later. For example, the FGM procedure that seals or narrows a vaginal opening (type 3 above) needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks.

Who is at risk?

Procedures are mostly carried out on young girls sometime between infancy and age fifteen, and occasionally on adult women. In Africa, about three million girls are at risk of FGM annually.

Over 200 million girls and women worldwide are living with the consequences of FGM. The practice is most common in the western, eastern, and north-eastern regions of Africa, in some countries in Asia and the Middle East, and among certain immigrant communities in North America and Europe.

In 28 African countries, about 55 million girls below the age of 15 have experienced or are at risk of experiencing FGM.

Cultural, religious and social causes

The causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities.

- Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice.
- FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido, and thereby is further believed to help her resist "illicit" sexual acts. When a vaginal opening is covered or narrowed (type 3 above), the fear of pain of opening it, and the fear that this will be found out, is expected to further discourage "illicit" sexual intercourse among women with this type of FGM.
- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are "clean" and "beautiful" after removal of body parts that are considered "male" or "unclean".
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups. Sometimes it has started as part of a wider religious or traditional revival movement.
- In some societies, FGM is practiced by new groups when they move into areas where the local population practice FGM.
- Many mothers introduce their daughters to FGM in fear that if their daughters do not undergo FGM their chances of marriage within that community are reduced.

FGM and HIV

INERELA+ wants to highlight the issues surrounding FGM in terms of increased danger of HIV transmission.

FGM interferes with a woman's body and the natural functions of the body – lack of natural lubrication means more friction when engaging in sexual activity. This increases the rate of HIV transmission. Also due to opening and closing of the vaginal opening there is increased damage and tearing which once again can increase during sexual activity, thereby increasing the chance of HIV transmission.

FGM is not a safer sexual practice

If a woman is living with HIV and has undergone FGM the chance of transmission of HIV to the child during birth is greatly increased. Due to the damage of the female genitals and the stress that they

undergo during birth, the increase in vaginal tearing and transmission of HIV to the child is dramatically increased.

Once again if a woman is living with HIV and has undergone FGM, her immune system is compromised due to the vulnerability to viral/bacterial infections.

The high risk of vaginal tearing also increases the risk of HIV transmission for the man concerned during sexual intercourse. The additional friction can cause tears in the skin of the penis, and the high chance of bleeding introduces another "high risk" body fluid in terms of HIV transmission.

International response

In 1997, the World Health Organization (WHO) issued a joint statement with the United Nations Children's Emergency Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of FGM. A new statement, with wider United Nations support, was then issued in February 2008 to support increased advocacy for the abandonment of FGM. The 2008 statement documents new evidence collected over the past decade about the practice. It highlights the increased recognition of the human rights and legal dimensions of the problem and provides current data on the frequency and scope of FGM. It also summarises research about why FGM continues, how to stop it, and its damaging effects on the health of women, girls, and new born babies.

Since 1997, great efforts have been made to counteract FGM, through research, work within communities, and changes in public policy. Progress at both international and local levels includes:

- wider international involvement to stop FGM;
- the development of international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGM; and
- In some countries, decreasing practice of FGM, and an increasing number of women and men in practising communities who declare their support to end it.

Research shows that, if practising communities themselves decide to abandon FGM, the practice can be eliminated rapidly.

WHO response

In 2008, the World Health Assembly passed a resolution (WHA61.16) on the elimination of FGM, emphasizing the need for concerted action in all sectors - health, education, finance, justice and women's affairs.

WHO efforts to eliminate female genital mutilation focus on:

- Advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM within a generation;
- Research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM;
- Guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone FGM procedures.

WHO is particularly concerned about the increasing trend of biomedical trained personnel performing FGM? WHO strongly urges biomedical health professionals not to perform such procedures?

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UNICEF (2013): *Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change*. New York: UNICEF

Reflection and Notes

Reflection and Notes

SAVE

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A Practice Guide to the SAVE Prevention Methodology

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SAFE

surgical practices

THIRD EDITION

Safe Surgical Practices

Session Objective:	To enable learning on the need to use Sterile Medical Instruments to prevent HIV transmission
Session Overview:	Examples of medical instruments; Why sterilize medical instruments
Key Message:	Clean is not enough – sterile for us
Biblical Scripture:	*After all, no one ever hated their own body, but they feed and care for their body, just as Christ does the church— (Ephesians 5:29)*
Scripture Emphasis	People should take care of their bodies
Islamic Scripture:	*The Prophet SAW said: 'God loves a servant who when performing a task does so skillfully.' (Al Bayhaqy)*
Scripture Emphasis:	It is important that those who are involved in surgical operations must ensure the safety of the patients or clients.
Expected Learning Outcomes:	• Individuals will understand why it is important to use properly sterilised instruments for all medical procedures. • Individuals will understand why even minor medical procedures need sterile instruments. • Individuals will understand how to deal with minor wounds and abrasions in a safe manner. • For people who use drugs, using sterile syringes is vital.

Toolkit References:	• Male circumcision • Female genital mutilation • Blood transfusions • PEP • Nutritional support
Time:	30 minutes
Supporting Documentation:	HIV strategic plan for the country concerned

Level 1: Preventing transmission:

It would be helpful to show participants a sterile pack of syringes and blades. Any pharmacy should be able to supply them, or ask your local clinic to donate one.

- HIV is transmitted through the exchange of high-risk bodily fluids including blood. If unsterile equipment is used to draw blood in any way, there is the risk of various infections, including HIV.
- The chance of HIV spreading through unsterile instruments is real. Doctors and nurses who are pricked by needles or cut by blades that have already been used must be given immediate Post Exposure Prophylaxis (PEP) for HIV.
- Re-using blades for shaving hair and beards also carries the risk of HIV transmission.
- Ensure that the barber soaks blades in a sterile solution before each new haircut.
- Clinics have been known to repeatedly use the same needle for immunizations and taking blood.
    - Insist that if a nurse or doctor is going to inject you or your child, they wash their hands, put on gloves and open the instruments in the sterile pack in front of you. If they do not do this, do not receive the injection.
    - Follow the same practice when a nurse or doctor is taking blood.
    - Previously used blades also carry a risk of transmitting HIV. Once again, insist that a blade that will be used to lance a boil or to perform a circumcision is opened in front of you before it is used, and that the person performing the procedure washes hands and uses gloves.
- Circumcision schools have been known to repeatedly use the same blades or spears for circumcision. This practice endangers the lives of the initiates and has caused death.
    - Using a previously used blade for circumcision carries a higher risk of infection than a needle stick because the surface area to which the blade is exposed is considerably greater. The same caution applies for cultural scarification.
    - Culturally, young men who have gone through circumcision are encouraged to engage in sex. If the circumcision wound has not healed properly the risk of HIV transmission is significantly increased.
- The risks of HIV transmission through used blades during female genital mutilation are considerable.
    - This is due to the great surface area that is excised and the great trauma to the genitals. Due to this trauma bleeding is extreme and thus increases the risks of transmission.

- Furthermore, because of the severe trauma to the genitals the risks of HIV transmission during sex at any age are dramatically increased. During each sexual encounter there will be tearing of the vagina, there could be open wounds that have not healed and thus provide easy entry for the virus. Practices that require the re-stitching of the vulva in particular provide a great traumatized surface area for infection as well as prolonged exposure to semen.

Level 2: Supporting Persons Living with HIV

Persons living with HIV who have developed AIDS are more susceptible to opportunistic infections that are introduced by the use of unsterile equipment. All of the above precautions apply.

It is important to highlight that the body is put under stress when infections are introduced or when undergoing surgical procedures of any kind (including circumcision and scarification).

- If you are being vaccinated, ensure that YOU know that the vaccine is safe for Persons Living with HIV (for instance yellow fever vaccination should not be given to people with a CD4 count of less than 500). If you are unsure or do not trust the information you have been given, do not be bullied into the procedure. It is your right to refuse treatment!
- COVID-19 vaccines are safe and recommended for Persons Living with HIV irrespective of their CD4 count.
- Ensure that sterile equipment is used, especially when blood is being taken for testing. Your biggest risks are the opportunistic infections such as Hepatitis A, B or C. These are generally hard to treat and can become more dangerous if you are living with HIV, challenging the liver's ability to process ARVs.
- If you need to undergo a medical procedure, make sure you are working with a doctor who understands HIV.
- If you need surgery or are being circumcised, you will need to increase the amount of good nutrition that you are eating. Increase your intake of fresh fruit, vegetables, and herbs. Ensure that you are able to have adequate rest. Use a mosquito net in malaria areas as you do not want the added stress on your body of malaria in addition to the recovery from surgery.
- If you do get sick seek medical care as soon as possible.

Empowering Communities

- Often people who live in rural areas and people who are poor do not have access to the right health care environments to ask for sterile equipment. This can fall under a "wish list" of things that the community needs rather than a reality that they can access. Explore ways that the community can lobby for sterile instruments.
- If necessary, people can form a lobby group together with others and go together to hospitals and clinics to demand good quality care. It is important to emphasise that everyone must be aware of what sterile equipment looks like, and that sterile packs should be opened in front of a patient.
- Circumcision and cultural scarification can be difficult areas to confront because of cultural taboos. However here are some ideas:
    - Ensure that every person knows how great is the risk of HIV infection when using unsterile procedures. Their children can die as a result.

- It is generally the elders of a community who uphold the traditions. If a community can convince the holders of the tradition in particular to change the mechanics of circumcision, rather than changing the ethic and tradition, this would go a long way to preventing the transmission of HIV. Try to explore ways how this can be done.
- There are often government sponsored training initiatives for circumcision practitioners that teach the proper use of sterile equipment.
- Government may be able to supply the necessary sterile instruments.
- Cultural practices could be expanded to include each initiate bringing their own blade.

Female genital mutilation is often more severe and traumatic than male circumcision.

- In terms of the risks of HIV transmission and supporting young girls who are living with HIV, note that FGM increases vulnerability. Once again, the holders of the tradition, especially the grandmothers of the community, need to have the right information so that, while the ethic of the tradition can be preserved, the practice can be changed. If this is a serious issue for the community you are working with, it would be important to have lengthy discussions around the subject.

SSDDIM

- Unsterile equipment is dangerous for ALL people. It would be wrong to offer sterile instruments to persons living with HIV only.
- Youngsters living with HIV should not be discriminated against in terms of attending initiation schools. Relatively speaking many individuals do not know their status so inevitably there will be initiates who are living with HIV but they do not know. Excluding youngsters who are living with HIV from initiation rites not only reinforces stigma and shame but does NOT reduce the risk of HIV transmission. Using sterile equipment and basic safe medical practices, such as washing hands and using gloves, is the only way to prevent transmission.

Reflection and Notes

Reflection and Notes

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access to TREATMENT

THIRD EDITION

Access to treatment

Antiretroviral Therapy
What is it and how does it work?

Session Objective:	To enable learning on what antiretroviral therapy (ART) or simply Antiretrovirals (ARVs) are and how and why ARVs work
Session Overview:	Discussions and demonstrations on Antiretroviral Therapy What is it and how does it work?
Key Message:	ARVs prevent HIV from replicating and therefore prevent one from being infected with HIV or keeps the HIV viral load low.
Biblical Scripture:	*"Is there no balm in Gilead? Is there no physician there? Why then is there no healing for the wound of my people?" (Jeremiah 8:22, NIV)* ***"****I counsel you to buy from me gold refined in the fire, so you can become rich; and white clothes to wear, so you can cover your shameful nakedness; and salve to put on your eyes, so you can see." (Rev. 3:18)*
Scripture Emphasis:	The availability of ART is a God-given solution. Religious leaders should advocate for access, and encourage adherence
Islamic Emphasis:	*The Prophet SAW said 'Seek treatments servants of God. There is no disease that Allah has created, except that He also has created its treatment' (Sahih Bukhari)*
Scripture Emphasis:	God is in control of all world phenomena including health diseases and cures. Scientists who discover medicines are with

	God's support. It is with the acceptance of God's bounty that we should seek treatment.
Expected Learning Outcomes:	By the end of this session, participants will be able to: • Explain the HIV virus and how it affects the body's immunity • Illustrate how ARVs work • Explain why good nutrition, the right amount of sleep and exercise are important.
Toolkit References:	HIV transmission
Time:	I hour
Resources Needed:	Flipchart paper, pens; glass jar; different coloured marbles or clay Read the story on antiretrovirals and make the 5 superheroes

Antiretroviral Therapy (ART)

Facilitator's notes:

This can be a difficult section because in certain situations ART is not available. Thus, it may seem that you are offering people a means to save their lives without them being able to access it. In these situations, you need to discuss ARVs in a way that encourages people to advocate for ARVs in their communities. Everyone in the community needs to be part of this advocacy, including those who have developed AIDS, those who are living with HIV and those who are HIV negative.

Stress that ARVs inhibit the virus's ability to replicate itself, meaning that over time the body's antibodies are able to reduce the viral load which allows the immune system to recover. However, while taking ARVs one still needs to support the immune system through proper health care practices and good nutrition.

What can antiretroviral therapy do for you?

Discussion:

Ask the group the above question – "What can ARVs do for you?" You should expect answers in the following categories:

- *Category 1 – they prolong life and restore people to wellness.*
- *Category 2 – they allow the immune system to recover, thus AIDS-related infections do not happen.*
- *Category 3 – they improve the quality of life for Persons Living with HIV*
- *Category 4 – they reduce the impact of HIV on the community.*

Stigma:

During the discussion, you may get some of the following questions:

Our communities do not have access to clean drinking water, electricity, proper basic health care.
So why should we worry about access to ARVs?
Why not just let persons living with HIV die?

This could initiate a discussion on human rights. In such a discussion emphasise that when we compromise on human rights for one person, we compromise on our own human rights as well. While everyone has needs which may not be met, we must continue to advocate for everyone's basic rights - the right to life, the right to healthcare, and the right to be treated equally like other human beings.

- *Refer to the four categories above: Category 1: in prolonging life, you have more people who are able to work within the community and for the community.*

- *Category 4: The tragedy of HIV is that its greatest prevalence is in ages 15 to 35, which are very productive years. This is the time that professional people are coming into their own. By having access to ARVs, communities can benefit from the services of these professionals for longer.*

Our communities suffer from other diseases like malaria and TB also – we need to focus on these diseases as well as on HIV.

- *Category 2: Malaria and TB can severely compromise the immune system of a Person Living with HIV. By getting access to ARVs these infections can be reduced,*

- *Category 4: When communities have access to ARVs they often get access to other healthcare initiatives as well, such as good TB and malaria care. This benefits the whole community.*

- *HIV co-infections with TB and malaria remain some of the most critical issues which communities have to deal with. The emergence of HIV has led to the re-emergence of TB. Unless we get HIV under control, we will not be able to control TB.*

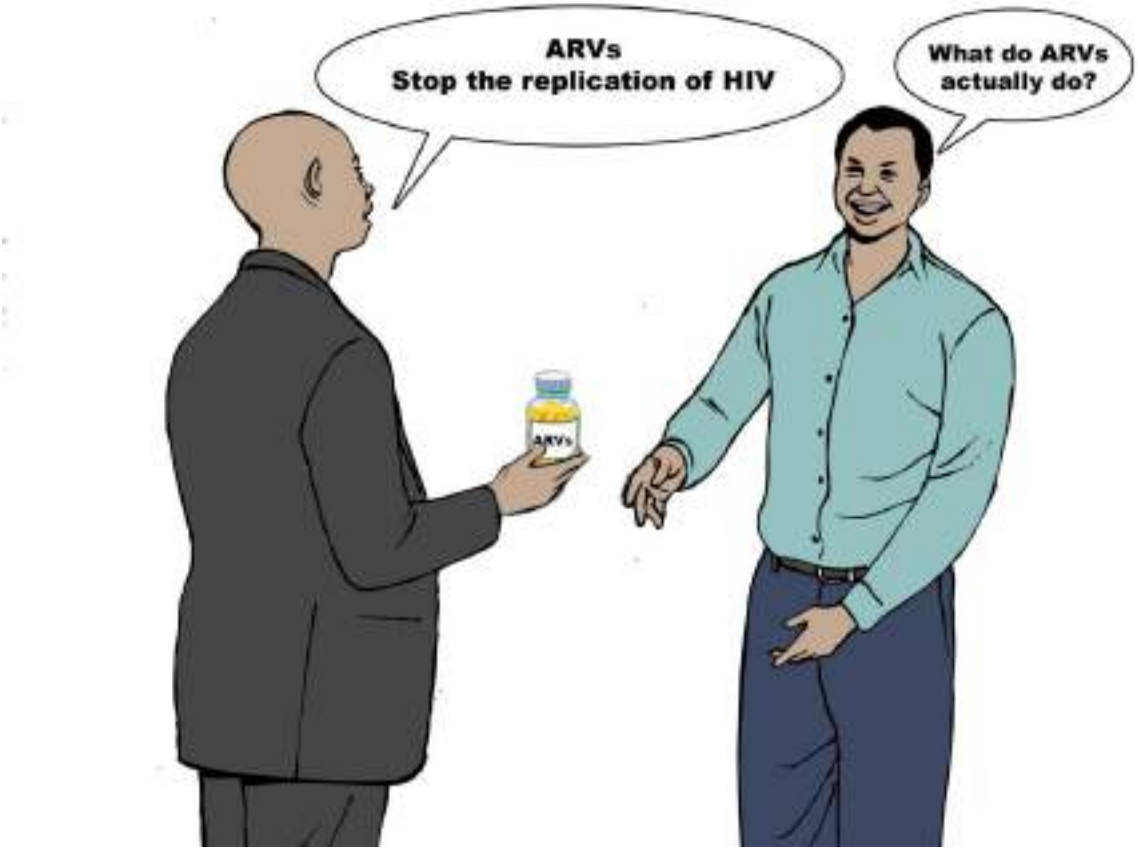
What do ARVs actually do?

Facilitator's notes:

Refer back to the section on HIV and remind people about the thief, the gangster and the superhero.

ARVs: Stopping the replication of HIV

The aim of antiretrovirals is to stop the replication of HIV. There are six different families or types of ARVs, and there are currently over thirty different antiretroviral drugs available for use in the fight against HIV. Availability and access to these drugs is improving all the time and there is continuous research into better, more effective and less toxic drugs. Unfortunately, these drugs do not eradicate HIV. HIV has the ability to find places in the body to hide. Thus, if ARV treatment is stopped, or taken incorrectly, the HIV comes out of these hiding places (sanctuary sights) and starts replicating again.



Each of the different families of ARV is explained below. For a more detailed list of ARVs please refer to the ARV appendix.

Think of ARVs as different types of superheroes – they work together to ensure that HIV is in no way able to replicate.

Level 1 ARVs: Prevent HIV from entering a CD4 – The superheroes that prevent HIV and the CD4 cell from shaking hands.

In order for HIV to enter a CD4 cell, the cell and the HIV need to shake hands. HIV has special proteins that exactly fit into the protein receptors on the CD4 cell, much like a thief with a key to the locked doors of a house. Once the thief has gained entry, he can begin stealing. Thus, this type of superhero stops HIV from using its lock- picking system to enter the CD4 cell

Level 2 and Level 3 ARVs: First level of prevention of getting HIV to stop the process of replicating. This superhero confuses the "brains" of HIV.

Once HIV enters the CD4 cell it disintegrates, leaving only its own nucleus and a strand of genetic material – RNA. Think of this as the thief entering your house, standing in the living room, looking around and deciding what to steal. The second type of superhero prevents the brain from communicating with the thief's body so it cannot move and thus cannot steal. These types of ARV effectively prevent the HIV nucleus (or "brains") from telling the HIV-RNA (the body) what it needs to do, and stops the thief's body from being able to move.
Thus the CD4 cell contains HIV material that is useless. Eventually the CD4 cell will get old and die and the body will get rid of it in the normal way. No new HIV has been produced.

Level 4: Second level of prevention to stop the process of replicating. This superhero stops HIV from actually stealing from your house.

Once HIV has entered the CD4 cell, and the nucleus is able to communicate with the RNA, the HIV-RNA changes to DNA. This sounds very complicated but it is easy to think about it in our thief analogy. We have the thief in the house, his brain has communicated with his body and his body is going towards the security system in order to dismantle it so that he can steal freely in your house. The thief now knows what he needs to do.

Coming back to a more scientific explanation: In our bodies we have long strands of information that tell the body how we grow. This information determines factors like eye colour, hair colour or whether we are prone to heart disease. These strands of information are in every cell in our body. These strands are called DNA. HIV has something a little similar. Because HIV is not as complicated as our own bodies it has a small strand of information called RNA. This RNA, or HIV strand of information, needs to change into DNA information so that it can "talk" to the DNA of the human CD4.

Going back to the thief – the thief is now able to move around your house and is able to communicate with your family which is in your house. This fourth type of ARV, or superhero,

prevents this from happening. It is as if the thief thinks he can tell your family members to help carry out the stolen goods, but finds that he cannot. He is completely stuck.

Level 5: Preventing HIV from using the DNA of the human cell to make the RNA and nucleus of HIV. The fourth superhero effectively prevents the thief from packing the stolen goods into bags to carry out.

Think about what has happened. The thief has come into your home, has been able to approach your family members and ask them to gather all the things he wants to steal, BUT he is not able to deal with them. He can just stand there, looking around. In the body HIV cannot use the DNA of the CD4 cell to make HIV-RNA and nucleus. The CD4 cell, as is the natural way of things, dies and the bits and pieces of HIV are removed from the body.

Level 6: Preventing HIV from leaving the CD4 cell. This superhero blocks the door of the house so that once HIV has been able to replicate it cannot leave the CD4 cell.

Back to the thief analogy:

The thief has entered the house, has been able to get your family to help him gather everything he wants to steal, has packed everything in bags, ready to go, but cannot get out of the house.

We hope that you have been able to understand the above analogy. However here are the most important points to take away with you:

- The several different ARV types work in different ways to stop HIV replication.
- Most people will be on a combination of three types of medication to completely stop HIV at different points in its journey through the CD4 cell. These combinations might be from one family of ARVs or a combination of different families of ARVs.
- Keep taking your ARV medication as missing a dose, or deciding to not take another because you feel sick, or have run out of medication and cannot get to the clinic, can give space for the replication of HIV to start again. As it is explained in the drug resistance section, this can be very dangerous to your health.

Note to facilitator:

You can be quite creative in your explanation on the work of ARVs. You can use clay models of the different superheroes and create interesting characters for them. You can use the drawing that we have provided. We hope that the thief analogy helps you to understand what is happening in the body.

Questions that the group may ask:

If I am on ARVs, do I still have HIV?

- Researchers and scientists are still searching for a way to cure HIV infection completely. HIV hides in different places in the body. If ARV treatment is withdrawn, the hidden HIV can begin to replicate.
- Thus, you still have HIV even though your viral load (or number of viruses measured per millilitre of your blood) is so low it cannot be detected in your blood.
- You can still transmit HIV because one of the hiding places for HIV is in the testicles or ovaries. Furthermore, if your immune system is depleted for any reason- from a simple cold, a major illness, or the stresses of pregnancy - HIV can begin to replicate again.
- Keep your immune system healthy and ensure that you are always practising SAFER sex.

If I choose to take an HIV test, will the result be negative?

- No is the short answer. You will always have several types of HIV antibodies in your blood. Any of the tests for HIV will detect antibodies and not the HIV itself. Essentially these tests are designed to see if you have an immune response to HIV.
- If you are living with HIV, you will always test positive for HIV

Is it true that if I am on ARVs I cannot be re-infected with HIV?

- The short answer is, once again, no. HIV is a virus which mutates very quickly in the body as it replicates itself. This means that if you are exposed to HIV a second or a third time, the chances that the HIV you are being exposed to is different from the one you have already is almost 100%. This can then mean that you have more than one strain of HIV in your body at the same time, which in turn will speed up the disease progression. Your ARV regimen may not target the second type of HIV that you get. Furthermore, as explained in the drug resistance section, you can develop drug resistance and a new strain of HIV may overwhelm your system so that HIV begins to replicate again.

If I am on ARVs, does it mean that I will not die of AIDS-related illnesses?

- Fortunately, this is true for most people; however, it is not true for all.
- Some people will start ARVs too late in the AIDS cycle for them to help the immune system recover. The body is simply too overwhelmed. Even in some of the top hospitals around the world, people still die of AIDS-related illnesses because they do not access treatment on time, or have developed drug resistance.
- Some people have bodies that do not react well to the drugs and there is not much that can be done, except good care as they face the prospect of AIDS.

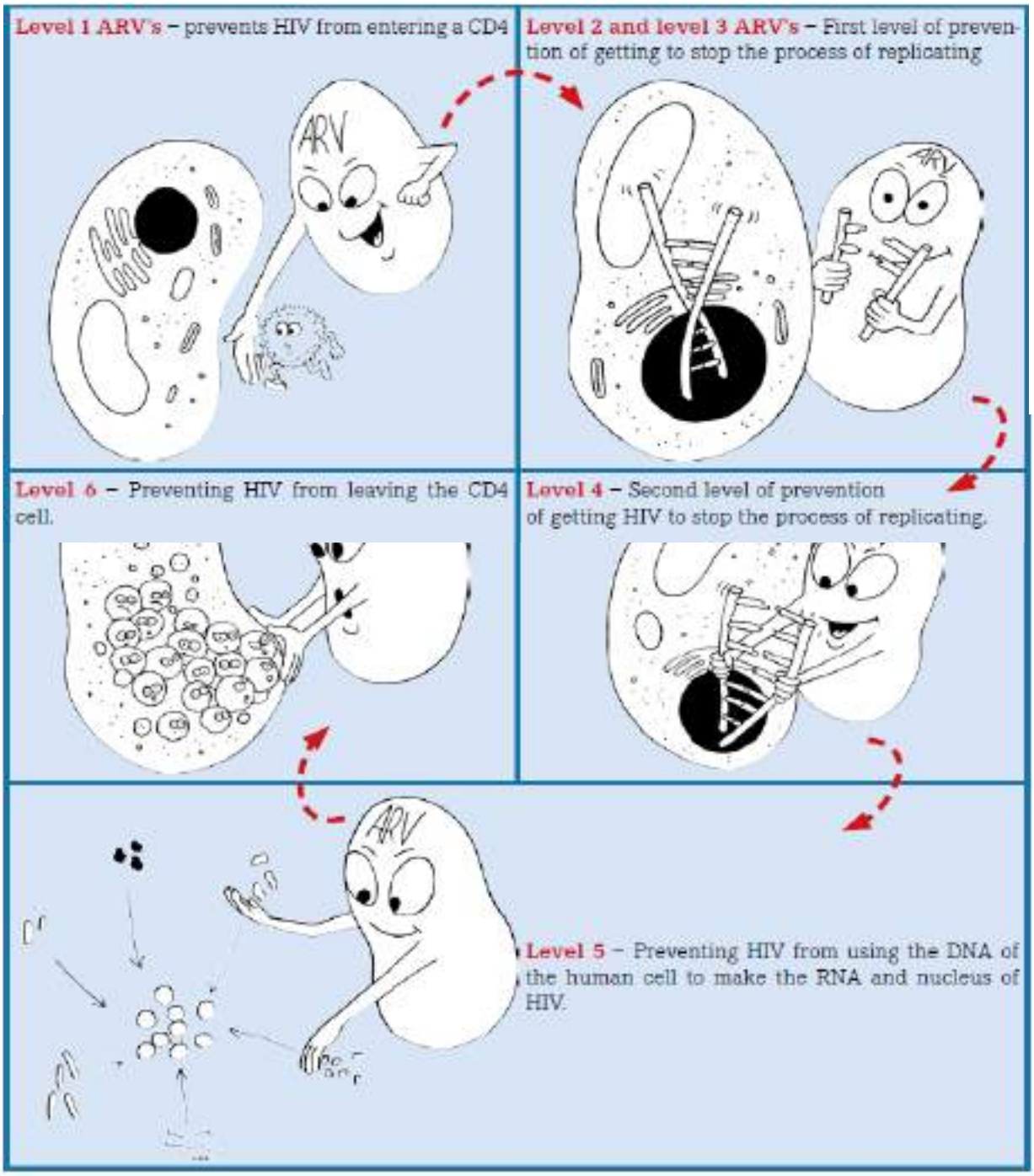
- Other people do not have access to the right combination of ARVs for their bodies. Therefore, even though they may be on ARVs, they are not effective.

Group Work

The facilitator may divide the participants into groups to respond to the following questions. Each group will report in plenary.

- What is the most important message that you are taking away from this session?
- How will you take this lesson into your community?

This diagram is one that explains briefly how the six different types of drugs attack HIV.



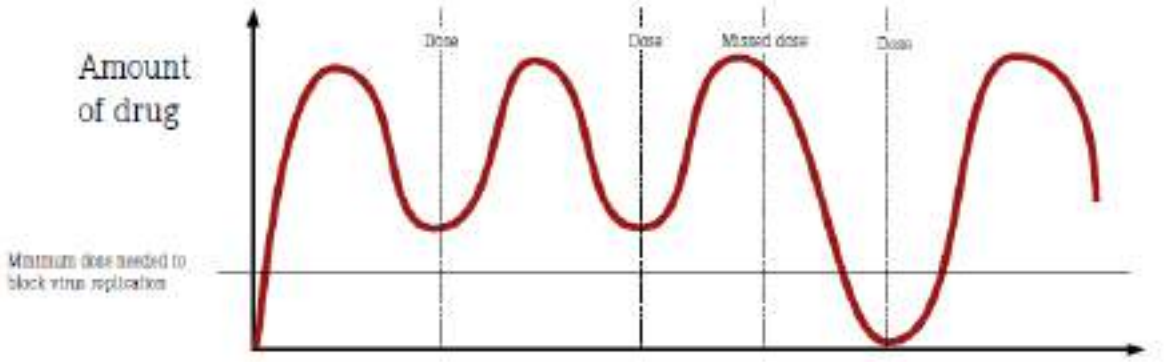
Note to facilitator: Please read and understand this section before presenting it to participants.

Adherence to ARVs

ARVs work in a very specific way. They do not kill HIV and they do not support the immune system - they simply interfere with the ability of the virus to replicate (make copies of) itself. This in turn means that the body's immune system has the opportunity to systematically produce antibodies that kill the virus, without the virus replicating faster than the antibodies can kill them. This will mean that, very slowly, the immune system will have the opportunity of regenerating, or being restored to its original level.

For the ARVs to work, there needs to be a certain concentration of them in the blood. Doctors have determined what this level is, and the dosage which is prescribed is designed to keep the level of ARVs in the blood above that critical level. All medication which we take is processed by the liver. It then gets passed into the blood, and the amount of "drug" or medicine in the blood will rise rapidly. The blood continually passes through the kidneys whose job is to remove all impurities. They will have identified medicine as an impurity. This means they will systematically go about removing medicine from the blood, so the level of medicine in the blood will gradually decrease after its initial peaking. This is why the next dose of the medicine needs to be taken, to make sure that medicine goes into the body faster than the body can clean it out.

The level of ARVs determined by doctors as necessary for interfering with the ability of the virus to replicate is critical. If the level of the ARVs in the body drops below this level, it gives the virus the opportunity to produce more viruses, and some of these may be resistant to the medication being used. This would mean that even though you continue taking your ARVs, they are not able to stop those viruses replicating. This is called drug resistance. One of the main ways the level of the drugs in the body can fall below the necessary level is if you are not taking the ARVs at the prescribed time. Most ARVs need to be taken either every 12 hours or every 24 hours, depending on the instructions given by your doctor. If you go beyond the 12 or 24-hour period this means the level of the ARVs in the blood will fall below the critical level, and drug resistance can develop. If this happens once or twice it is probably not critical, but if your adherence (taking medicine on time every time) falls below 90% you are in great danger of developing resistance. Other factors can be if you have problems with your liver, in which case the liver cannot process the ARVs fast enough to keep the level high enough in the blood.



Side-effects

The information contained in this section should not be generally taught, but is made available so that facilitators can answer questions which may arise on the use of ARVs. The intention is not to frighten people, but to give accurate information in a clear, factual way.
Like all medications, ARVs contain toxins. It is these toxins in ARVs which interfere with the ability of the virus to replicate. While it would be very easy to kill the virus with a variety of different substances, the trick is to do so without killing the body the virus is in! Mostly our bodies are easily able to cope with the toxins in ARVs. It can, however, take our bodies some time to get used to the ARVs and many people can experience side effects when starting them. For most people these side effects will disappear after four to six weeks, and thereafter they will not feel any effect except a gradual increase in health and vitality. (This is obviously a good thing!) Sometimes the side effects can continue longer. In addition, for some people who use ARVs over a long period of time, side effects develop over time.

Common side effects to starting ARVs are dizziness, nausea, diarrhoea, loss of appetite and strange dreams or hallucinations. Sometimes early side effects can also be skin itches or rashes. With some medications particularly, the rashes need to be shown to a doctor as soon as possible.

Longer term side effects of using ARVs can include the reshaping of the body as fat cells can move around from one part of the body to another. This can result in the enlarging of the neck or the development of a hump on the back. Other long-term side effects can include the development of rashes. When these occur, they should always be shown to a doctor. In addition, if you develop stiffness in all your joints or muscles you should speak to your doctor about this. Another long-term side effect of using certain ARVs can be the loss of feeling in feet or hands. This would only happen after the hands or feet have first become extremely sensitive and painful to the touch. This can usually be managed either by changing medication or regularly massaging the hands and feet. With some ARVs people can also experience an increase in blood cholesterol levels. This can be serious if not treated properly.

Many of the newer ARVs being developed have fewer side effects than some of the older ones. While there are side effects to using ARVs, there are obviously more serious effects to not using

them, namely that there will be no stopping the ability of the virus to replicate in the body, causing lasting damage.

Group Work

The facilitator may divide the participants into groups to respond to the following question. Each group will report in plenary.

- Why is it important to adhere to ARVs?

Drug resistance:

Activity:

Play the children's game – broken telephone.

Get all the participants to sit in a circle and whisper a message in one person's ear - something like "HIV causes AIDS". That person has to whisper this message into the ear of the person next to him/her, and so on until the message has gone around the whole circle. The last person to get the message must say it out loud. You will be surprised at how the message changes as it moves around the circle. Do this a couple of times and let the participants have fun with the messages and the distortions.

There are a couple of rules of the game.

- *Whoever is passing on the message needs to whisper it into the ear of the person next to them.*
- *They must say the message once only – they cannot repeat it.*
- *They must say the message very fast.*

Explain that the above game shows how HIV makes copies of itself. The basic structure remains the same but because it makes between 1 and 10 billion copies of itself daily, mistakes are made. This is similar to the mistakes that the group made in transmitting the messages.

CAUTION:

If you are taking ART and decide, for whatever reason, not to take your medication, the virus will get another opportunity to start replicating again. As described above, this gives the virus an opportunity to further mutate and drug resistance results.

Once you are using ART stay on ART, take it religiously and at the correct times. Not doing so may cost you your life.

Deciding on a drug regimen

- All ARV regimens need to be prescribed by a doctor. In many primary health care facilities nurses have been trained to prescribe the appropriate drug therapies.
- However, if you are not happy with the care you are receiving you do have a right to seek out other doctors or nursing professionals.
- If you need ARVs you will start your treatment when your CD4 count is at 350 or below. This is your first line treatment and, if you adhere to the proper protocols, this could be the drug regime that you will take for the rest of your life.
- CD4 counts are not available everywhere. If you suspect that you are infected with HIV, always get yourself tested. The only way to make sure of your HIV status is by getting tested. Don't guess! Positive or negative! Find out through a test and know. Many medical professionals have enough experience to decide when treatment should commence even if a CD4 count is not available.
- You need to be ready to commit to therapy – you have a right to choose not to start ARVs. Before deciding, make sure you speak to someone who is using ARVs to find out what the benefits and challenges have been for them.

Group Work

The facilitator may divide the participants into groups to respond to the following question. Each group will report in plenary.

- How can communities strengthen or support access to treatment HIV-related illnesses and STIs?

Mother-to-child transmission: brief explanation

In this manual, mother-to-child transmission of HIV is discussed fully in the transmission section. Here are the key messages to be found in that section:

- If a mother is living with HIV, her baby does not necessarily have to be living with HIV
  - there are effective ways to stop mother-to-child transmission.
- Access to the correct care for mothers living with HIV before the birth of a baby is very important in preventing transmission. In fact, good antenatal care for every mother is essential.
- ARVs are vital in the prevention of mother-to-child transmission during the birthing process. This is an important advocacy issue if this is not available in your community.
- Mother-to-child transmission during breastfeeding is not inevitable. There are a number of choices for women in feeding their babies safely.

A woman who is living with HIV does not necessarily give birth to a baby who is infected with HIV. With the right support and information, we can completely eliminate this mode of transmission. We need healthy moms and healthy babies to grow healthy communities.

Nevirapine: A special note

Anti-HIV Nevirapine drug (NVP) or simply Nevirapine is possibly the best-known ARV because it is used extensively for inhibiting mother-to-child transmission.

Nevirapine works, like all other ARVs, to prevent HIV replication within the CD4 cell. It does this at the stage where the HIV nucleus needs to communicate with the HIV-RNA. Basically, it ensures that when the HIV thief is in your house it is paralysed.

This ensures that the viral load of the mother who is living with HIV is at least low, or undetectable. This reduces the probability of HIV being transmitted to the baby during birth and breast feeding. Mothers living with HIV will generally continue to take Nevirapine, or an equivalent drug, along with other ARVs after the birth of the baby. The baby will also get its own dose of Nevirapine after birth.

A baby can only be tested for HIV antibodies at about 15 – 18 months. Why?

- Remember that testing for HIV is NOT testing for the presence of the virus itself. It is a test for HIV **antibodies** in the blood that your own body has manufactured.
- Antibodies for HIV in the baby's system would be as a result of the mother's anti- bodies, rather than those made by the baby. Thus, a baby could test positive for HIV BUT this would not be because of their own HIV antibodies.
- The only way to test a baby to see if they will test positive for HIV is to do a viral load test (CD4 count). This can be done from the time of the baby's birth, meaning that if the baby tests positive for HIV, treatment could be started early. Viral load tests are not available everywhere. If this test is not available where you live, advocating for it can save many lives, particularly of babies before the age of eighteen months.

SSDDIM

SSDDIM: Discrimination:

In the taking of ARVs it is very important to keep the level of drugs constant in the body, thus people who are taking ARVs follow a very strict regime where they have to take the drugs at certain times every day.

In relation to this, the head of the United States Agency for International Development (USAID), Andrew Natsios, made some of the most unreflective – and rightly infamous – comments. In testimony before the US Congress in June 2001 he stated that treatment with Antiretrovirals was impossible for Africans "because of conflicts, because of the lack of

infrastructure, lack of doctors, lack of hospitals, lack of clinics, lack of electricity; Africans he claimed 'don't know what Western time is..."1.

Ironically, when ARVs were introduced into Africa the first trials showed that Africans had a much higher adherence rate than people in either America or Europe. Discrimination on the basis of race or nationality had, in this case, meant that millions of people in Africa had died of AIDS-related illnesses before the medication was made available to them.

Taking drugs is not shameful; it is life enhancing and life-saving.

Nutritional support for persons taking ARVs

Session Objective:	To enable learning on the importance of good nutrition that supports the immune system
Session Overview:	Focus on the elements of good nutrition. Discussions on various aspects of food security
Key Message:	Support your immune system by making healthy food choices
Expected Learning Outcomes:	Explain what types of food are necessary to support a healthy immune system Discuss the importance of food security and food allocation in terms of preventing HIV transmission
Toolkit References:	HIV transmission
Time:	I hour

Importance of good nutrition

- Good nutrition is important for all people. For Persons Living with HIV it becomes vital that they eat a good, balanced, healthy diet because this is what builds and supports the immune system.
- Good nutrition helps the body process the various medications that are necessary to live positively with HIV.

- Proteins:

- Proteins are important building blocks in the body. They are involved in nearly every bodily process and are important components of the immune system.
- If you are eating too little protein, the body will use muscle to keep the various processes within the body going. This causes damage to muscles as well as organs.
- If you are living with HIV make sure that you have a good source of daily protein.
- Good sources of protein include eggs, soya products, nuts, dairy products or meat. This will protect your organs from being damaged and will ensure that your immune system is healthy and keeps functioning.

- Carbohydrates
- Essentially, carbohydrates give you energy; however, there is a right and a wrong way to eat carbohydrates:
    - Avoid high sugar foods. We should all avoid the high sugar foods such as sweets, cakes, biscuits and cool drinks. If you are living with HIV these sugary foods are definitely not good for you. Avoid consuming them as much as you can. If you are prone to thrush do not eat sugar in any form. Thrush uses sugar to grow, so if you are fighting a thrush infection you are feeding the thrush with the sugar rather than destroying it.
    - Eat as much complex carbohydrates as you can. The following are especially good – oats, brown rice, sweet potatoes, barley and beans or lentils. Beans and lentils are good since they are relatively cheap, are high in fibre and can be easily disguised in food for children
    - Eat a variety of fruit and vegetables. Because these are high in fibre, they support your digestive system and they make tasty snacks.

- **Fats**
    - This is the major source of the body's energy storage. Once again, there are good and bad fats.
    - Good fats protect the heart and the blood vessels. These fats are found in nuts and seeds, cold water fish like salmon, and in avocado pears
    - Bad fats are found in fatty meat, poultry with skin, butter, whole-milk dairy foods, and coconut and palm oils. These can cause cardiovascular disease. Although you do not need to cut these foods out completely, you do need to try to limit the amount that you eat.
    - Some ARVs have the effect of medication-related high cholesterol. This means that an individual runs a high risk of cardiovascular disease and heart-failure. If you are taking one of these medications, you will be told exactly what you can and cannot eat by your clinic sister or doctor in terms of fat intake.
- **Vitamins and Minerals**
    - These are substances that we get from our food that help the chemical processes in the body and are vital to a healthy body.
    - We get most of our necessary vitamins and minerals from fresh fruit and vegetables.
    - If you are able to afford a supplementary vitamin, check with your doctor or nursing sister about the one that is right for you. For example, pregnant and lactating women need different supplements to those given to children or adults.

- Herbal products can also be problematic, so before you take herbal supplements check with your doctor.

Any do's or don'ts?

- There are things which you will eat in your home and region which people elsewhere may not eat. This does not make them wrong to eat.
- Nature is full of wonders we have not even begun to understand, and much of which we have already forgotten! Speak to people who are knowledgeable about the properties of plants in the area where you live. They will be able to give you advice on what you could eat which will stimulate the immune system.
- Follow the universal truths of hygiene with food – wash your hands before preparing food; don't let food stand uncovered for long periods before you eat it; if something you are eating makes you feel bad in any way, leave it out of your diet.
- Eat from all food groups, eating well is one of the most wonderful ways of staying healthy.
- Nutrition is part of healthy living, but it is not the only part. Nutrition is like the top of a table, without it there is no table, but just as importantly a table needs legs. The four legs of the healthy living table are:
  - Social integration and support
  - Physical exercise and wellbeing
  - Emotional health and wellbeing
  - Spiritual health and support

If one of these legs is missing, the table will be less stable but will still stand; if two legs are missing the table will break.

SSDDIM

Discrimination

Activity:

Often people in food insecure areas have a cultural system that divides food as follows: Men and older boys will always get first helpings of food; the children will get next and the women and girls will get what is left/

- *If a person is living with HIV how would this system affect them?*
- *What would the effect of having a poor diet be on someone who is living with HIV?*

Note to facilitator:

- *One of the questions you might get is, "Why give a dying person a scarce resource like food?" Explain that people live with HIV for a long time. Helping them protect their immune system with a good balanced diet ensures that they can contribute to the household economy for many years to come.*
- *ARVs are essential in halting the progression of HIV infection to AIDS. Ensure that you stress how vital this is. If a community does not have access to this type of health care, encourage them to keep lobbying for it.*

Activity:

If a community does not have access to ARVs, help them to design an advocacy strategy to lobby government for access. Warn them that this is a long and hard task but persistence is the key. If they are able to get other communities to lobby with them this will make a stronger voice for change.

Inaction:

Communities that are food insecure have limited choices. Education and work opportunities are very limited. Persons who are living with HIV, have a compromised immune system and the progression from HIV to AIDS will be faster. Furthermore, food insecurity limits people's options, making high risk occupations like migrant labour or sex-work an alternative option. Both carry risk of HIV transmission. Food security is a key element in having no person die of AIDS-related illness.

We cannot be food insecure – we cannot let people go hungry – what are we going to do about it?

Activities:

- If we are a food insecure community what can we do to enhance our food security and thus improve everyone's nutritional status?
- If we are not a food insecure community how can we reach out to individuals and other communities who are food insecure?
- Using community projects such as soup kitchens, school feeding schemes and community gardening, how can we educate people on the importance of good nutrition for everyone, and also the importance of good nutrition for persons living with HIV?

An example: During food distributions in Zimbabwe in the early 2000s, youth groups got together and performed HIV awareness plays while people were waiting for their rations. Furthermore, during breakfast at school feeding programmes, these groups would also perform HIV awareness plays specifically for junior school children.

WHAT CAN YOU DO?

References

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Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

Pre-exposure Prophylaxis & Post-exposure Prophylaxis

THIRD EDITION

Pre-exposure Prophylaxis & Post-exposure Prophylaxis

PREVENTIVE ARVs: Information contained is used and adapted with permission from: Centre for Interfaith Action on Global Poverty (CIFA), 2013. CIFA individuals (former): Katie Taylor, Benjamin Bechtolsheim, and Jonathan Amgott.

Session Objective:	To facilitate learning on PrEP and PEP as HIV prevention strategies and how these may be used as SAFER practices in preventing HIV (re) infections and AIDS.
Session Overview:	• PrEP & PEP are SAFER Practices • PrEP may be used by women and men to prevent HIV infection BEFORE a high HIV-Infection-risk-sexual encounter • PEP may be used by women and men to prevent HIV infection AFTER a high HIV-Infection-risk sexual encounter or practice, for example, needle stick injury • PrEP & PEP do not prevent the transmission of other STIs. • PEP is a SAFER Practice that can be used after a high HIV infection-risk-sexual encounter or a needle stick injury
Key Messages:	PrEP and PEP are SAFER Practices as they prevent HIV (re) infections and AIDS related deaths. A person's choice of action needs to be SAFE and EFFECTIVE.
Biblical Scripture:	*"Is there no balm in Gilead? Is there no physician there? Why then is there no healing for the wound of my people?" (Jeremiah 8:22, NIV)* ***"****I counsel you to buy from me gold refined in the fire, so you can become rich; and white clothes to wear, so you can cover your shameful nakedness; and salve to put on your eyes, so you can see." (Rev. 3:18)*
Scripture Emphasis:	PrEP and PEP are known to save lives. And anything that is known to save lives is recommended.

Islamic Emphasis:	*"Spend in the way of Allah and do not put yourself into destruction and do good. Of course, Allah loves those who do good (Qur'an 2: 195)*
Scripture Emphasis:	We are all responsible to ourselves and to God in all areas of life including our health. We should not put our lives in danger.
Expected Learning Outcomes:	By the end of this module, participants should be able to: • Describe the proper use of PrEP as SAFER Practices that women and men can use to prevent HIV infection before a high-risk sexual encounter • Explain the proper use of PEP as SAFER Practice that individuals can use to prevent HIV infection after a high-risk sexual encounter or high-risk injury like a needle stick injury • Explain that neither PrEP nor PEP can prevent the transmission of other STI. • Illustrate situations in which PrEP or PEP may be administered to people for prevention of HIV transmission • Describe the side effects of PrEP • Explain precautions to take while taking PrEP medication
Toolkit References:	• Safer Practices Modules • Access to Treatment • VCT • Empowerment and Human Rights Advocacy
Time:	I hour
Resources Needed:	Flip chart & Pens; Expertise from a healthcare worker; Scissors, glues, paper, paints, magazines (these are for an optional exercise)

Note to facilitator:

Before starting this module do some research as to what PrEP and PEP options are available in your local area, where and how much they cost.

This module is intended to provide information on the use of Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP).

Note to facilitator:

Glossary of terms and some definitions:

Pre *– means before*

Post *– means after*

Prophylaxis*: is a biological term and means a specific action that an individual may take to prevent an infection, in this case an HIV infection.*

Exposure: *in this case it means a practice that predisposes one to a high probability of being infected with HIV.*

PrEP

Activity: Case study

Anna and her boyfriend, Husky, had been together for some time. She had always suggested that they go for HIV testing before things got more serious between them. Husky dodged the subject for a while citing his fear for needles and hospitals. She assured that she would support him. After a long wait, they visited a VCT and were counselled and tested. Manna tested HIV negative while her boyfriend tested HIV positive. The healthcare provider took time to counsel them. Manna shared that she loved her boyfriend and would like to continue living with him. However, she was worried about their sexual life in future as a discordant couple. She feared that she would contract HIV. She also expressed their risk of not having children or having children who test HIV positive. The healthcare provider explained that there are drugs that help discordant couples lead normal lives, enjoy healthy sex and get children who are not infected with HIV. She advised that while Husky would need ART to control his viral load, Manna would need to take PrEP to protect herself from HIV infection.

Note to Facilitator:

This case may be used in groups or in pairs to facilitate learning about PEP. Alternatively, depending on the size of the group, it may be read aloud and discussed in plenary.

What is PrEP?

PrE stands for Pre-Exposure and P stands for Prophylaxis. Prophylaxis is another word for PRE-VENTION, meaning that PrEP helps to prevent HIV.

Pre-Exposure Prophylaxis (PrEP) is the use of antiretroviral (ARVs) drugs by people who are HIV-negative but are at a high risk of HIV infection in order to reduce their risk of infection. PrEP may be taken by men or women as an oral tablet or by women as a gel-infused vaginal ring. While PrEP is already approved and available in some countries it continues to undergo clinical testing and regulatory approval by the majority of countries.

You may also come across the scientific term microbicides. This covers compounds that can be applied inside the vagina or rectum that attacks microbes to protect against sexually transmitted infections (STIs) including HIV.
How to pronounce: my-crow-bus-ides.

Why use PrEP?

PrEP is one of the best biochemical interventions for preventing hetero-sexual HIV transmission. However, it is important to note that PrEP is only one method of preventing HIV infection. There is a whole range of SAFER practices.

Microbicides focus on the prevention of sexual transmission of HIV but could also help those who inject drugs. It looks to protect both men and women, and is intended for people who are at a high-risk level of HIV infection.

Throughout the Toolkit there are modules that cover safer practices, however PrEP is cutting edge in the way that it is a medication that addresses the vulnerability of people to HIV infection. This can be particularly important for women in certain contexts:

- Women may not be able negotiate condom usage
- The fidelity of their partner is questionable
- They don't have control over their own bodies
- They are economically vulnerable
- They are subject to gender inequality

The key advantage of PrEP in these circumstances is that women do not have to negotiate condom use with their partners in order to prevent HIV infection.
PrEP allows women to have a privately controlled prevention method. Women would be able to make informed decisions and take preventative steps for themselves. This could happen with or without the expressed consent of their partners. This allows women greater control and independence over their bodies, spirit and health. Recognising a woman's right to choose what happens to her body and understanding her rights to choose is very important.

PrEP is also a prevention method for men such as Men who have Sex with Men (MSM), an at-risk population. Much like with women, it allows an individual man to have control over his sexual health and rights.

How PrEP works

The drug works by preventing HIV from replicating in the body. In this case, it acts as a catalyst and accelerates the production of anti-bodies that fight disease-causing germs and bacteria. After contact with the virus, tenofovir and emtricitabine block the enzyme that the virus requires for cell multiplication. When used correctly, PrEP eliminates the risk of an individual contracting HIV when exposed to it.

PrEP may be administered in different ways:

- Orally (through the mouth)
- Inserted into the vagina or rectum,
- or applied to the surface of the vagina or the rectum

Therefore, PrEP is administered in different forms:

- Gel
- Cream
- Sponge
- Ring
- Contraceptive
- Non-contraceptive
- Film
- Foams
- Tablet
- Rectal suppositories
- Syrup

The drugs may be taken in the dose of one tablet once per day or regularly for the duration that a healthcare provider advises. But one can take PrEP on need-basis that is only if they plan to engage in sexual intercourse that has high risk of transmitting HIV infection.

The active ingredient in all types of PrEP is an antiretroviral medication (ARV) – the same thing that is being used to treat persons living with HIV.
There are different ways in which the PrEP could act to reduce the risk of HIV infection:
PrEP could:

- Create a physical barrier
- Enhance the existing vaginal and rectal defences
- Strip pathogens of outer covering
- Inhibit HIV replication (after it has entered a cell)

Approaches to HIV Risk Reduction

There are many ways to prevent HIV or reduce one's risk of becoming infected with HIV. Most of these methods can be used together, in collaboration with one another, in order to reduce one's exposure to and risk of testing HIV positive. This combination of options is referred to as the approaches to HIV risk reduction. Individuals can pursue the combination of strategies that best addresses their particular needs and risk profile.

Key Facts

- PrEP must be taken according to how it is prescribed in order to be most effective.
- PrEP is not 100% effective and should be used in conjunction with other risk-reduction strategies (e.g. condoms).

- PrEP is a way to preserve health and wellness.
- Consistent use = efficacy
- Vaginal and rectal medications can NOT be interchanged. Oral syrup cannot be taken vaginally or rectally.

The Research

An international clinical trial of 24070 men using the daily combination of tenofovir and emtricitabine (Truvada conformation) reduced the risk of acquiring HIV by 44%. The trial was made up of MSM and transgendered women, a group considered to be at high risk for infection. The following conclusions have been drawn from this research:

1. PrEP is an additional HIV prevention strategy and can, and in some cases should, be used alongside other prevention methods.
2. People that have high risks of HIV infection should have access to PrEP.

The WHO mentions MSM and transgender women as populations that would benefit from increased access and use of this prevention methodology.

More information:
http://www.nejm.org/doi/full/10.1056/NEJMoa1011205

KEY TERM:
A sero-discordant couple is a couple where one person is HIV-positive and the other is HIV-negative.

Access

Microbicides are not yet available but research is ongoing. We hope that microbicides are available in the next few years.

Access to PrEP tablets will be determined by whether you need a prescription to purchase the medication or whether you are able to buy it over the counter as you can with condoms. Allowing the medication to be easily accessed will provide the greatest decrease in HIV infections.

Above all it needs to be SAFE, EFFECTIVE and AFFORDABLE.

Health and wellness = we don't just mean NOT being sick; we mean being physically, mentally and spiritually well. As people of faith, we think about the whole person.

What to do before beginning PrEP treatment

It is important for patients to be tested before taking the drugs since if they are living with HIV, taking the tablet exposes them to a possibility of experiencing drug resistance hence may make the drug less helpful.

Patients should also get the input of a healthcare professional before they begin treatment.

Side effects

The most common side effects are headaches, nausea and dizziness. They are estimated to clear within a week. If one experiences persistent side effects, they should consult their healthcare provider.

Situations in which one is allowed to use PrEP

- Patients are expected to seek this treatment if they are at risk of contracting the virus. Some of the situations considered in this case are:
    - If one is having intercourse with an infected person
    - If an individual has more than one sexual partner
    - If one is involved in sharing needles with an infected person
    - If one has other STIs like herpes
    - If one is planning to get pregnant by an infected person, they will need to take the medication during pregnancy and breastfeeding
    - If you had been on PEP but report continued risk behaviour or have used PEP on multiple occasions
- If one falls in any of these categories, they should consult a healthcare provider before they consider taking this medication.
- While taking this medication, an individual need to visit their healthcare provider every three months for (Center for Disease Prevention and Control, 2021):
    - Follow up visits
    - HIV tests
    - Prescription refills
- One can start and continue taking PrEP without in-person visits to the provider through the introduction of tele-medicine. This allows phone or video consultation with the healthcare provider and mail-self-testing that allows one to order a toolkit required for testing needed to start or continue taking the medication.

Some reasons for stopping PrEP medication

(Center for Disease Prevention and Control, 2021):

- If your risk of HIV transmission becomes low due to life adjustments

- If you do not want to take the pill as often as described or you often forget to take them
- If side effects from the medicine interfere with your life
- If blood tests indicate that you are reacting to the drugs negatively

Note: If one had stopped taking the drugs and would like to get back to them, they repeat the steps needed for people taking the treatment for the first time as indicated above. PrEP is to be taken by people with ongoing risk of HIV transmission. Those who would like to take it after exposure to the virus once need to talk to their healthcare providers about taking of PrEP.

PEP

Activity: Case study

Kay was walking home from work at night when a group of men approached and grabbed him. One of the men held his mouth tightly so that he could not scream. They carried him into a bush. The men sodomized him in turns. At some point, he lost consciousness. It was not until morning that he regained consciousness. He was in a sorry state. His clothes were torn and full of dry blood from his anus. He tried to stand up but he could not. His whole body was in pain. He crawled towards the road hoping to find some help. Fortunately, two ladies drove by almost immediately and stopped to help. After Kay narrated his ordeal, the ladies took him to the nearest hospital. At the hospital, he was screened and tested for HIV and other STIs. Although he tested negative for HIV, the doctor told him that he would need to take PEP as he may have been exposed to the virus. She also told him that it was good that he had come to the hospital within 72 hours because PEP is most effective if taken within this time frame. She explained that he might experience a few side effects of the drug like nausea and headache. If this happens, he should say so and the side effects would be addressed medically. Then the doctor referred him to an office in the hospital that would help him report the case of sexual assault to the police.

Note to Facilitator:
This case may be used in groups or in pairs to facilitate learning about PEP. Alternatively, depending on the size of the group, it may be read aloud and discussed in plenary.

Post Exposure Prophylaxis (PEP)

Post exposure prophylaxis is the administration of certain antiretroviral therapy after an individual has been exposed to a situation where HIV transmission can occur.

Such exposure can happen in the following situations:

- If one is sexually assaulted
- If one has sexual intercourse with their partner who is living positively with HIV and a condom broke
- If an individual shared needle, syringes or any other sharp objects with a person who is living positively with HIV, for example to inject drugs into one's system
- If one is cut or stuck with a needle that was used to draw blood from a person who may have HIV infection
- If an open wound, came in direct contact with body fluids of someone who might be living with HIV
- It is important to get on the PEP treatment as fast as they can. The treatment should be taken daily in the required dose for a period of 28 days.

Healthcare workers are evaluated for PEP if they are exposed after:

- getting cut or stuck with a needle that was used to draw blood from a person who may have HIV infection
- getting blood or other body fluids that may have lots of HIV in their eyes or mouth
- getting blood or other body fluids that may have lots of HIV on their skin when it is chapped, scraped, or affected by certain rashes.

The risk of getting HIV infection in these ways is extremely low -fewer than one in one hundred- for all exposures.

The most common use of PEP is in the prevention of Mother-to-Child transmission. This is where both the mother and the baby are given antiretroviral drugs after birth to prevent HIV transmission.

Furthermore, PEP is given to breastfed babies to prevent transmission via breast milk.
PEP can also be used to treat people who may have been exposed to HIV during a single event unrelated to work (e.g., during episodes of unprotected sex, needle-sharing injection drug use, or sexual assault).

Guidelines for prescription of PEP

Following research, HIV and sexual health doctors across the United Kingdom have come up with guidelines to be used to determine when PEP may be used as an option to prevent sexual transmission of HIV. These guidelines take into account factors such as:

- The type of sex (or other activity) one had to assess the amount of risk one may have been exposed to during the activity. One would also agree to be tested again after completing PEP medication and may need to be tested for other STIs before getting PEP if they are found to have been highly exposed to them. Some of the sexual activities that may lead to high risk are:
    - Receptive anal sex-this is when one acts as the "bottom" in lay mans' language, during sexual activity with someone who is known to have HIV. It is more common among MSM
    - Incentive anal sex-this applies to men who act as the "top" during sex with men who are living with HIV
    - Receptive vaginal sex-PEP is recommended for women who may have had sex with men who are living with HIV
    - Incentive vaginal sex-it is also recommended for men who may have had sex with women who are living with HIV
- Details of the source partner (the person you may have contracted the virus from). If the person is known to be taking their medication as prescribed and found to have low viral loads, then there was a low risk of HIV transmission therefore no need for PEP

Note: PEP is not recommended in circumstances such as oral sex, semen splashes on the skin or eyes, bites from people or needle injury in the community because the risk of infection in these is very low or absent.

Keep in mind that PEP:

- should be administered to patients only after a possible exposure to HIV
- should only be used in uncommon situations right after a potential HIV exposure: it may not be a safe choice for people who are frequently exposed to HIV
- does not act as a substitute to other HIV prevention measures
- is not a substitute for other proven HIV prevention methods, such as correct and consistent condom use or use of sterile needles for injection.
- is not 100% effective. Therefore, you should continue to use condoms with sex partners while taking PEP and should not use abrasive equipment, such as injections and razor blades, that has been used by others. This will help avoid spreading the virus to others if you become infected.
- is most effective if it is administered within 72 hours from the moment of exposure to HIV. It is important to start a 28-day course of ARVs within the first 72 hours after exposure. The medications stop the virus from replicating in your system. If you seek help after the third day of exposure, the administration of PEP at this point will not prevent transmission.

If you believe you have been exposed to high-risk fluids in an environment that is conducive to HIV transmission get the required help as soon as possible.

Steps to take:

- See a doctor immediately (within 72 hours of exposure)
- Start a course of PEP
- Take the full course of ARVs as prescribed by a doctor for 28 days.

It is important to note the following (Asserias, 2022):

- PEP is administered to patients only after a possible exposure to HIV
- PEP does not act as a substitute to HIV prevention measures
- PEP may not be a safe choice to people who are frequently exposed to HIV
- If going through repeated exposure to HIV infection, it is important to consult your healthcare provider on the use of PEP

Drugs used for PEP

PEP consists of three anti-HIV drugs from diverse classes. The most recommended is the administration of a fixed-dose combination tablet that has emtricitabine and tenofovir disoproxil from the NRTI class along with raltegravir (otherwise known as Isentress) from the intergrase inhibitor class (Asserias, 2022).

How does PEP work?

PEP works by preventing the virus from replicating after exposure. It causes the HIV cells to die within a short period reducing the chances of HIV taking over an individual's body.
It is important to incorporate other HIV prevention measures like engaging in protected sexual intercourse, not sharing needles and others mentioned in a previous module even while taking these drugs.
It is also important to note that PEP may interact with other drugs and this may affect a recipient and that is why it is important to notify your healthcare provider on this before you begin taking PEP.

Side effects of PEP

Like other antiretroviral therapy, PEP may cause side effects like prolonged headache, diarrhoea and nausea in some people. For most people, these are treated easily and are no cause for alarm.

> **Note:** If you are taking PEP and experience a persistent side effect that bothers you, it is important to talk to your healthcare provider.

There are chances that one may have taken PEP and still test positive for HIV. In such a situation, counselling before one start taking ART will be provided by a healthcare worker. The available treatment methods render HIV manageable as they suppress the virus leading to

an undetectable viral load and enabling thousands of PLWHIV to live longer and healthier lives.

If one has used PEP severally, they may consider using other HIV prevention measures like condoms, PrEP and other safe sexual practices as mentioned in a previous module as PEP should only be used during emergencies. According to Asserias (2002), this most likely occurs if:

- One fails to start PEP Medication in required time as mentioned above.
- One misses a PEP dose or does not finish the 28-day course.
- One has a HIV strain that is resistant to the drugs used for PEP.
- One still engages in unprotected sex, shares needles or continues exposing themselves to the virus.

Estimated cost for PEP

Depending on the reason for the prescription, one may qualify for free or low-cost PEP medication. Some of the reasons for low cost or free PEP include the following:

- If one has been a victim of sexual assault
- If one is exposed to HIV through their work their health insurance or workers' compensation can pay for PEP
- If one is unable to pay for PEP through insurance coverage or on their own, they can apply for free PEP medicines through medication assistance programs

The facilitator may share on available medication assistance programs in the local community and/or ask participants to share.

References

Asserias C. (2022): Post-exposure Prophylaxis (PEP). Aidsmap.https://www.aids.com/about-hiv/pst-exposure-prophylaxis-pep

WHO (2016): *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection*. Geneva: WHO.

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

SEXUALLY TRANSMITTED INFECTIONS

THIRD EDITION

Sexually Transmitted Infections

Facts on STIs:

Session Objective:	To enable participants, familiarise with issues relating to STIs in relation to HIV/AIDS prevention.
Session Overview:	Facilitator-led session with a simulation game on nature, causes, symptoms, and prevention of specific STIs in relation to HIV and AIDS.
Key Messages:	When someone has a STI the chances for HIV transmission are increased.
Biblical Scripture:	*"In all cases involving serious skin diseases, be careful to follow the instructions of the Levitical priests; obey all the commands I have given them." (Deuteronomy 24:8, NLT)*
Scripture Emphasis:	Appropriate care should be taken to reduce the spread of infectious diseases, including STIs
Islamic Emphasis:	*"And spend in the way of Allah and do not throw (yourselves) with your own hands into destruction (by refraining). And do good; Indeed, Allah loves the doers of good."*
Scripture Emphasis:	God is Merciful and calls on us to do good at all times.
Expected Learning Outcomes:	By the end of this session, participants should be able to explain how STIs promote HIV transmission and AIDS-related deaths.
Toolkit References:	• Access to Treatment • Antiretroviral therapy • PrEP • PEP • Cervical Cancer and HPV

	• Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	45 minutes
Resources Needed:	Flipchart and markers, 'transmission game' index cards.

When someone has an STI the chances of the HIV transmission are increased.

Tips

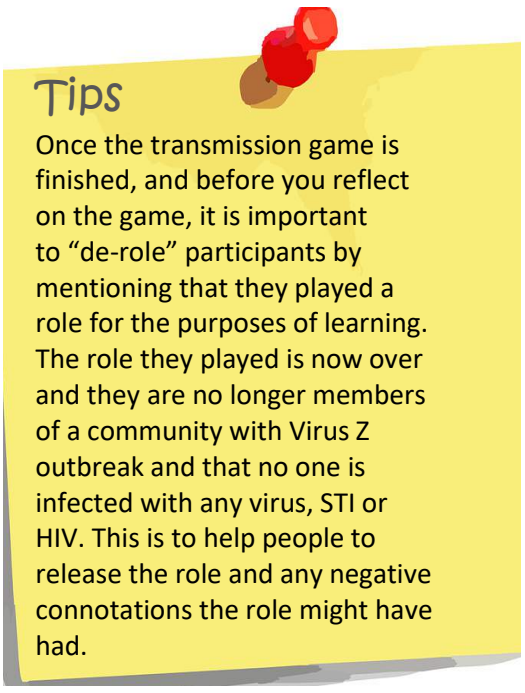
- This session requires some technical knowledge about STIs and HIV.
- If you feel challenged in leading this session, try to secure the input of a knowledgeable "outside" person who could be invited to facilitate just this session.
- Also note that one or two persons participating in the workshop may have technical knowledge and work experience on issues relating to HIV and other STIs. If needed, draw on such expertise and experience from within the group.
- Use the session to highlight the symptoms and options available to treat various STIs.

Transmission of HIV and other STIs

Session Objective:	To facilitate learning on how STIs including HIV are transmitted
Session Outcome:	By the end of this session, participants will be able to explain how STIS are transmitted.
Key Message:	When someone has a STI the chances for HIV transmission are increased.
Session Overview	This session involves participants in a simulation game
Time:	30 minutes
Resources Needed:	Flipchart and markers, 'transmission game' index cards.

The transmission game:

- Prepare index cards before the game begins.
- There should be enough cards for all participants except three of them.
- All, except three of the cards, should remain blank.
- Of these three cards, one should have the letter Z written on it, and the other two should have the word “glove” written on them.
- Fold all the cards and staple them shut, if possible.
- Explain to participants that they live in a small village where there is a virus called Virus Z. The only way to get infected with this virus is if you shake hands with a person who is infected.
- Give all, except three participants, an index card and a pen or pencil.
- Ask them not to open their cards until you instruct them to do.
- Now ask them to walk freely around the room, greeting others with a handshake.
- When they greet someone, they must get that person to write their name on the outside of the index card. Once they have five signatures, they must sit down.
- The three participants who did not receive any index cards can walk around and greet people, but should NOT shake hands with anybody and should NOT have their names written on any card.
- Once all the participants are seated, ask them to open their index cards.
- Ask the person who has the letter Z written on their card to stand up. This is the person infected with Virus Z.
- Then ask all those who have this person’s name on their cards to stand up. These people may have been infected with HIV
- Now ask those with a glove on their index cards to sit. These people were saved from getting infected as the Virus cannot pass through a glove.
- Now ask anyone who shook hands with anyone who is still standing to stand up. Again, those with a glove may sit down. These people were also infected with Virus Z.
- Point out that those people who did not shake hands with anybody and did not have their names written on any cards are completely safe from Virus Z because they abstained from shaking hands with anyone.
- Ask the participants to look at how many people are still standing. This illustrates how quickly and easily STIs can spread from one person to the next.
- Lead a discussion on how Virus Z can be likened to many different STIs, and the “glove” can be likened to condoms.



- Explain the link between STIs and HIV infection; the fact that STIs increase the chance of infection with HIV. Explain that the wounds related to many STIs create an ideal opportunity for HIV infection.

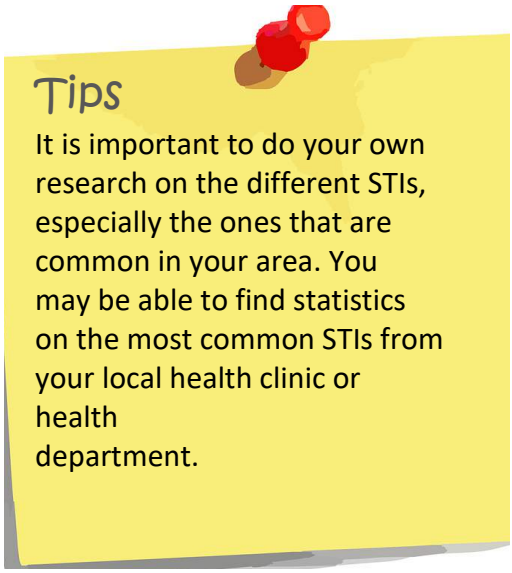
Note: At the end of the game, it is important to clarify that HIV is not transmitted by shaking hands. In this game, shaking hands is merely symbolic of the different ways in which HIV is transmitted. You might want to repeat the different ways through which HIV is transmitted.

Points to remember

Ensure that the discussion at the end of the game focuses not only on HIV, but on other STIs as well.

FACTS ON STIs, HIV AND AIDS

Session Objective:	To facilitate learning on facts on HIV and other STIs.
Session Outcome:	By the end of this session, participants will be able to describe facts on how STIs including HIV are transmitted.
Session Overview	This session involves participants in written brainstorming, followed by a facilitator-led lecture and discussion.
Time:	2 hours and 30 minutes
Resources Needed:	Flipchart and markers,



Individual exercise on STIs

- Write the different STIs on different pieces of paper and give each to one participant.
- Ask each person with a piece of paper to go up to the board and write down everything they know about the STI that is written on the paper.
- It can be any number of things related to the STI, including symptoms, if it is curable or not, and any other additional information on the STI.
- After they have finished, look at each one and discuss them at length. Use the notes in the handouts (or refer to the internet for more information).

Points to remember

Highlight Chlamydia as an STI, as it is spreading rapidly but is currently not prioritised as a concern in many parts of the world, especially in Africa.

VALUES GAME

Session Objective:	To help participants to explore their own values with regards to issues related to, and attitudes towards persons living with HIV
Session Outcome:	By the end of this session, participants will be able to question and/or affirm their own values and attitudes to persons living with HIV.
Session Overview	In this session, participants listen to a story and then they have to decide how they would react if they were one of the characters in the story
Time:	30 minutes
Resources Needed:	Prepared story.

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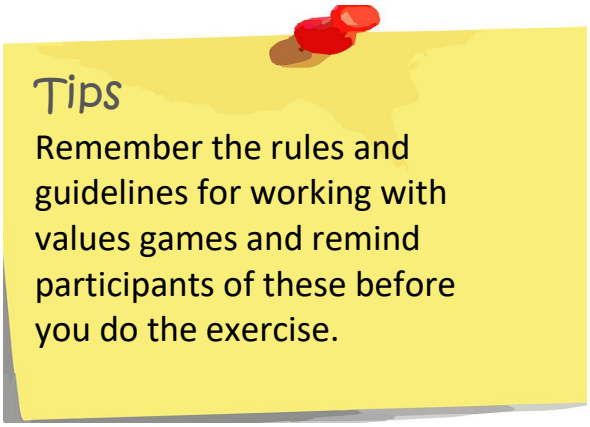
Story-telling exercise:

- Tell the following story to the participants:
- Imagine you are single and you are longing to meet someone. You go out one evening and you meet someone you are attracted to and he or she is also attracted to you. After dating for some time, you find each other in your partner's room, petting, cuddling and kissing. Your partner says "please stop I have something to tell you; I am living with HIV". What do you think your reaction will be at that very moment? The options are:
    - Get up and leave;
    - Believe in safe sex so continue and use a condom;
    - Believe you are immune to HIV infection so continue and have unprotected sex;
    - Would not have continued further than petting, cuddling and kissing anyway;
    - Agree to abstain from sex
    - Any other reaction.
- Repeat the story and explain the different options once again and ask people to move to the option they would choose.
- Once they have made their choice, ask them to talk with others in their corner, saying why they choose that option.
- Once they have spoken in their groups, open the discussion for everyone to explain their choices.



- Ask two or three people from each group to share their personal values about what is presented in the story.
- Remind participants that they may change their stance if they wish, after hearing other people's arguments.
- Thank all participants for sharing.

Is there a HIV Vaccine?

From the beginning of our knowledge of HIV, scientists have been searching for a possible vaccine for HIV. There is interesting research in this area but a safe vaccine is a still in the test phase.

List of infections

(Information provided by Terrence Higgins Trust)

Gonorrhoea

Gonorrhoea is an infection caused by bacteria that lives in the urethra in men or in the vagina in women, as well as in the throat or the anus and rectum.

Symptoms

In men, symptoms of gonorrhoea can be:

- drops of white or green liquid on the end of the penis (a discharge)
- pain when passing urine
- itching in the anus or rectum.

In women, symptoms of gonorrhoea can be:

- white or green liquid discharge from the vagina
- pain when passing urine
- itching in the anus or rectum.

However, many men or women who have gonorrhoea do not have any symptoms.

How it is transmitted

You can get gonorrhoea by having sex with someone who already has it. It is most easily passed on through penetrative vaginal and anal sex without a condom, although it can also be transmitted on fingers from one person's penis or vagina to another.

A pregnant woman who has gonorrhoea can pass it on to her baby when during birth.

What can I do if I think I have gonorrhoea?

If you think you have gonorrhoea, visit a health clinic as soon as possible.

Testing

The doctor or nurse will test you for gonorrhoea by taking a small urine sample or collecting some discharge with cotton wool or a swab:

- In women, swabs are usually taken from the cervix (entrance to the womb) and urethra.
- In men, swabs are usually taken from the tip of the penis.
- In both men and women, swabs may also be taken from the throat or the rectum.

Having a swab taken is not painful, although it may be uncomfortable. The samples are then tested for gonorrhoea.

Treatment

It is usually easy to get rid of gonorrhoea with antibiotics. Your doctor may ask you to return later to check that the gonorrhoea has gone.

Why get treated?

It is important to get rid of gonorrhoea because if it stays in your body it can lead to serious health problems, including:

- Pelvic inflammatory disease (PID) in women, where the fallopian tubes are infected, become inflamed and can cause infertility (stopping a woman from being able to have children).
- Inflammation of the testicles in men which can cause infertility (stopping a man from being able to have children).

Protect yourself and others

If you have gonorrhoea it is best to tell your partner or anyone else, you have had sex with recently so that they can get a check-up. Remember that until the gonorrhoea is treated, and you have taken all the antibiotics prescribed by a doctor, you can still pass it on to anyone you have sex with.

Using a condom can help protect against getting gonorrhoea. Remember too that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Chlamydia

Chlamydia is a common infection caused by bacteria and is easy to pass on. The bacteria live in the urethra in men or in the vagina in women, as well as in the throat or rectum.

Symptoms

In men symptoms of chlamydia may be:

- drops of white liquid on the end of the penis (a discharge)
- pain when passing urine

In women symptoms of chlamydia may be:

- white liquid discharge from the vagina
- pain when passing urine
- pain in the lower abdomen
- pain during sex.

However, most men or women who have chlamydia do not have any symptoms.

How it is transmitted

You can get chlamydia by having sex with someone who already has it. Chlamydia is most easily passed on through penetrative anal and vaginal sex without a condom, although it can also be transmitted on fingers from one person's penis or vagina to another.
A pregnant woman who has chlamydia can pass it on to her baby during birth.

What can I do if I think I have Chlamydia?

If you think you have chlamydia visit a health clinic as soon as possible.

Testing

The doctor or nurse will test you for chlamydia either by taking a urine sample or a small sample of your discharge with cotton wool or a swab:

- In women, swabs are usually taken from the cervix (entrance to the womb) and urethra.
- In men, swabs are usually taken from the tip of the penis.

Having a swab taken is not painful although it may be uncomfortable.

The samples are then tested for chlamydia.

Treatment

It is usually easy to get rid of chlamydia with a course of antibiotics, but you have to take all the medications you are given to clear the infection. Once you have taken the medications the doctor may ask you to return to check that the chlamydia has gone.

Why get treated?

It is important to get rid of chlamydia because if it stays in your body it can lead to serious health problems, including:

- pelvic inflammatory disease (PID) in women, where the fallopian tubes are infected, become inflamed and can cause infertility (stopping a woman from being able to have children)

- ectopic pregnancies (pregnancy outside the womb) in women if they have chlamydia when they are pregnant
- inflammation of the testicles in men which can cause infertility (stopping a man from being able to have children).

Protect yourself and others

If you have chlamydia it is best to tell your partner or anyone else that you have had sex with recently so that they can get a check-up. Remember that until the chlamydia is treated, and you have taken all the antibiotics, you can still pass it to any person that you have sex with. Using a condom can help protect against getting chlamydia. Remember too that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Genital Herpes

Genital Herpes is a very common infection caused by a virus called the Herpes Simplex Virus (HSV). This virus is similar to the one that causes cold sores around the mouth. Most people who have HSV do not have any symptoms, or do not recognise the symptoms because they are so mild. Therefore, many people who have HSV do not know that they have it.

Symptoms

Symptoms of Herpes, which can appear anywhere from a week to a few years after getting the virus, can be:

- Feeling achy and hot, as if you have a cold or the flu
- Small blisters or sores, often around the penis or vagina, which can be painful and can make it hurt when passing urine.

If someone has Herpes, they can get symptoms or outbreaks a number of times. Usually people feel most unwell during the first outbreak.

Many people only ever have one outbreak: after that their bodies stop future outbreaks happening.

How it is transmitted

HSV is transmitted through skin-to-skin contact, so sex, particularly penetrative vaginal and anal sex, is the main way that it is passed on. It can also be transmitted through other forms of sex.

What can I do if I think I have Genital Herpes?

Testing

The doctor or nurse will test you for HSV by taking a small sample of discharge with cotton wool or a swab. They can only test for HSV when there is a sore present to swab. Having a swab taken is not painful. The samples are then tested for HSV.

Treatment

There is no treatment that will get rid of HSV from your body. If you have a particularly severe outbreak of Herpes you may be given tablets which can help it to clear up quicker. However, rest and looking after yourself is probably the best way to help you get better. Some people find that they get outbreaks when they:

- Are tired or stressed
- Have not been eating well
- Have been drinking a lot or not taking as much care of themselves as usual.

Many people who have Herpes feel they can lessen the chances of getting an outbreak by avoiding or reducing the things that may bring it on.

Protect yourself and others

If you have HSV it is best to tell your sexual partner or anyone else, you have had sex with recently so that they can get a check-up.

Using a condom can help protect against getting HSV. Remember too that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Hepatitis

Hepatitis means “liver inflammation”. It is caused by a virus. Several kinds of hepatitis virus can infect the liver, but the most common are the hepatitis A, B and C viruses.

Types of Hepatitis

Hepatitis can be categorized as either acute or chronic.

Acute Hepatitis

Acute hepatitis occurs suddenly or gradually, but in either case it is short-lived, usually lasting less than two months. For someone with acute hepatitis, liver damage is usually mild.

On rare occasions, acute hepatitis can be fatal. In some circumstances, acute hepatitis can progress to chronic hepatitis.

Chronic Hepatitis

Chronic hepatitis persists for long periods of time and is classified as either chronic persistent or chronic acute. Chronic persistent hepatitis is usually mild and progresses slowly. However, it can become severe, and progress to chronic acute hepatitis. As liver damage becomes more extensive and severe, chronic acute hepatitis can cause cirrhosis, most often resulting in liver failure and even death.

Viral causes of Hepatitis

There are seven viruses that are known to cause hepatitis. These are designated by the letters A to G. However, the cause of some hepatitis is still unknown, leading scientists to believe there are other viruses that are yet to be discovered.

The three most common viral forms of hepatitis are:

- Hepatitis A
- Hepatitis B
- Hepatitis C.

The other forms of Hepatitis - D, E, F and G - are rare.

Non-specific urethritis (NSU)

Non-specific urethritis is the inflammation of a man's urethra. The urethra is the tube down the middle of the penis that carries urine out of the body.

Non-specific urethritis can be caused by:

- A bacterium, the most common one being chlamydia
- Slight damage to the urethra or the end of the penis
- Chemicals, such as those in soap powder, which may irritate the urethra.

Symptoms

Symptoms of NSU may be:

- Drops of white liquid at the end of the penis (a discharge)
- A burning pain when passing urine and feeling the need to urinate more than usual.

Most men who have NSU do not get any symptoms.

How it is transmitted

You can get NSU through having sex. It is most easily passed on through penetrative vaginal or anal sex without a condom, although it can also be transmitted on fingers from the vagina to the penis.

What can I do if I think I have NSU?

Testing

The doctor will test you for NSU by taking a small sample of the discharge with cotton wool or a swab. Swabs are usually taken from the tip of the penis. Having a swab taken is not painful but it may be uncomfortable.

The sample will then be tested for NSU.

Treatment

If you have NSU it is usually very easy to get rid of it with a course of antibiotic tablets, but you have to take all the tablets to cure the NSU.

Why get treated?

It is important to get rid of NSU as, in some rare cases, if it is untreated it can lead to other health problems. It can infect the testicles and make it difficult for a man to impregnate a woman.

Protect yourself and others

Using a condom can help protect against getting NSU. Remember too that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Syphilis

Syphilis is an infection which is caused by a bacterium. It is most easily passed on through penetrative vaginal and anal sex without a condom.

Symptoms

There are a number of symptoms of syphilis, which show up at different stages in the infection. The symptoms are the same for men and women.

Early symptoms

About three weeks after infection with syphilis, one or more sores may appear on the body, usually around the penis or vagina. Anytime from a few weeks to a few months later a rash may appear: these small spots don't itch. At the same time other sores may appear and the person may feel unwell, often as if they have a very bad cold. During this time the person is very infectious.

In these early stages the syphilis is usually easy to treat.

Later stages

When syphilis is not treated and it stays in the body. It can lead to much more serious health problems later in life. These can include:

- Heart problems
- Eyesight problems, and,
- Problems with the nervous system.

It is still possible to get rid of the syphilis during this stage, but sometimes the serious problems do not go away.

What can I do if I think I have Syphilis?

Testing

The doctor will test you for syphilis with a simple blood test. If you have a sore on your body they will swab this with a cotton wool stick. They will also examine you. None of these tests will be painful but some may be uncomfortable. The samples will then be tested for syphilis.

Treatment

If you have syphilis it is usually easy to get rid of it with a course of antibiotics, taken as either tablets or injections. But you have to take the full course to clear the syphilis. Once you have taken the antibiotics you will need to return to the doctor to make sure the syphilis is cleared.

Protect yourself and others

You will need to tell your partner or anyone else you have had sex with as soon as possible that you have been diagnosed with syphilis so that they can get checked out too. It is important to get rid of the Syphilis early on as it can lead to serious health problems if left untreated.

Using a condom can help protect against getting syphilis. Remember too that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Genital Warts

Genital warts are small fleshy lumps that can appear around a man's penis and testicles, a woman's vagina or around the anus. Genital warts are caused by a virus called human papilloma virus (HPV). It is one of the most common sexually transmitted infections.

You can have HPV and not get genital warts. There is another type of HPV that causes warts that you might find elsewhere on your body, such as your hand.

Symptoms

Genital warts do not usually hurt. They include:

- itching, and,
- a little bleeding from warts inside the vagina or anus.

How it is transmitted

Genital warts are spread by close skin-to-skin contact. Sex, especially penetrative anal and vaginal sex, is the main way that warts are passed on. If you have sex without a condom with someone who has genital warts, you may get the virus that causes warts

Warts cannot be transmitted through toilet seats or swimming pools. Also, as the warts on your hands are a different type to genital warts, they cannot be passed from someone's hand to your genitals.

What can I do if I think I have genital warts?

Testing

The doctor or nurse can usually tell whether you have warts just by looking. However, for accurate results, the doctor may:

- Conduct a pelvic examination using a pap test to check for cervical changes caused by genital warts in women
- Use blood tests to check for other STDs that are associated with genital warts, and,
- Conduct an anal examination using a device called an endoscope to check for warts inside the anus.

These tests do not hurt at all but may be uncomfortable.

Treatment

Occasionally warts go away by themselves. However, it is best not to rely on this but to get help from a doctor. The doctor may treat them by:

- Treating them with Trichloroacetic acid (TCA)
- Applying podophyllin cream or paint, or,
- Freezing them with gas (which is a bit like dry ice).

These methods are not painful and will gradually clear the warts.

Sometimes you may have to visit the doctor a number of times over a few months for treatment until the warts have gone.

Why get treated?

Some types of HPV are associated with cancer of the cervix. Lately, there is a vaccine against these called HPV vaccine that is freely given to adolescent girls in many hospitals. Older women may also be vaccinated after tests indicate that they do not have any STIs or/and cancer of the cervix. Otherwise, women aged 20 and above are encouraged to have a regular cervical pap smear annually or once in two years depending on the recommendation of their doctors.

Protect yourself and others

Using a condom can help protect against getting genital warts. Remember also that using a condom will help protect you against getting or passing on other sexually transmitted infections.

Pubic lice

Pubic lice are tiny insects or parasites that are about the size of the head of a pin. They are also called “crabs” because of what they look like.

Pubic lice live in pubic hair, which is the hair around the penis and the vagina. They are also sometimes found in other body hair such as on the legs, under arms or on the stomach. They do not live in the hair on your head.

Symptoms

Signs and symptoms of pubic lice can be:

- Itching in the areas where the lice are living
- Black powder, which is their droppings, in your underwear
- Little round spots, which are their eggs, fixed on your hairs.

Some people notice the lice themselves but usually they are too small to see.

How they are passed on

Pubic lice are passed on by close skin-to-skin contact, often during sex, although they can also be passed on by other close contact, such as sharing a bed. You cannot get lice from lavatory seats or by simply sharing a chair with someone.

What can I do if I think I have pubic lice?

Testing

The doctor or nurse can tell whether you have lice just by looking: often they will use a microscope to do this.

Treatment

The doctor will give you some lotion to apply on the pubic area to get rid of the pubic lice. You can apply the lotion at home and this does not hurt. You will usually have to apply the lotion every day until the lice have gone. The doctor may ask you to return for a check-up to make sure the lice have all been killed.

Sometimes you will still itch for a time after the lice have gone. The doctor can give you a lotion to help stop this.

You should wash the bedclothes you slept in, any towels you have used and any clothes you have worn while you had the lice to make sure you get rid of them.

Inform your sexual partner

If you have pubic lice it is best to tell your sexual partner or anyone else you have had sex with recently, or been in very close contact with, so that they can get a check-up.

References

WHO (2014): Sexually transmitted infections. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/112323/WHO_RHR_14.10_eng.pdf . Accessed on 23rd May 2022.

UNAIDS/WHO: *Sexually transmitted diseases: policies and principles for prevention and care*. Geneva: WHO. https://data.unaids.org/publications/irc-pub04/una97-6_en.pdf. Accessed on 23rd May 2022

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

CERVICAL CANCER & HPV VACCINE

CERVICAL CANCER & HPV VACCINE

THIRD EDITION

Cervical Cancer & HPV Vaccine

Session Objective:	To enable learning about cervical cancer and promotion of HPV Vaccine as a SAFER Practice
Session Overview:	• Cervical cancer, a preventable disease • Causes and risk factors of Cervical Cancer • HPV Vaccine and other ways of preventing cervical cancer • Cervical cancer and HIV
Key Message:	A person's choice of action needs to be SAFE and EFFECTIVE.
Biblical Scripture:	*"Is there no balm in Gilead? Is there no physician there? Why then is there no healing for the wound of my people?" (Jeremiah 8:22, NIV)* ***"****I counsel you to buy from me gold refined in the fire, so you can become rich; and white clothes to wear, so you can cover your shameful nakedness; and salve to put on your eyes, so you can see." (Rev. 3:18)*
Scripture Emphasis:	HPV Vaccine is known to save lives. And anything that is known to save lives is recommended.
Islamic Emphasis:	*Narrated by Usamah Bin Shareek (may Allah be pleased with him): 'I was with the Prophet (PBUH), and some Arabs came to him asking, "O Messenger of Allah, should we take medicines for any disease?" He said, "Yes, O You servants of Allah take medicine as Allah has not created a disease without creating a cure except for one." They asked which one. He replied "old age." (Sahih Bukhari)*
Scripture Emphasis:	Whatever medicine that can relieve a sick person it should be used. Cancer is a chronical illness that is known to cause much morbidity or mortality. The vaccine that prevents the disease should be encouraged.
Expected Learning Outcomes:	By the end of this session, participants will have acquired: • Discuss the causes, risk factors of and how to prevent cervical cancer • Explain the importance of promoting the HPV Vaccine and reduce the risk of cervical cancer among women

Toolkit References:	• Access to Treatment • Antiretroviral therapy • Sexually Transmitted Infections • Cervical Cancer and HPV • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights •
Time:	1 hour
Resources Needed:	Flipchart and markers, 'transmission game' index cards.

"*It makes no sense to save a woman's life from AIDS, only to let her die from treatable or preventable cancer*," President George W. Bush, October 2015

Cervical cancer is a leading cause of death among women. In 2020, an estimated 604 000 women were diagnosed with cervical cancer worldwide and about 342 000 women died from the disease in Sub-Saharan Africa, Melanesia, South America, and South-Eastern Asia.

The main cause of cervical cancer is Human Papillomavirus (HPV). HPV is a common virus that is passed from one person to another during sex. At least half of sexually active people will have HPV at some point in their lives, but few women will get cervical cancer.

The most common symptoms of cervical cancer are: bleeding between periods, bleeding after sexual intercourse, bleeding in post-menopausal women, discomfort during sexual intercourse, vaginal discharge with a strong odour, vaginal discharge tinged with blood, and pelvic pain. However, these symptoms can have other causes, including infection. Anyone who experiences any of these symptoms should see a doctor.

Risk factors of cervical cancer

- Having many sexual partners or becoming sexually active early
- Smoking: This increases the risk of cervical cancer, as well as other types.
- A weakened immune system due to HIV or AIDS or organ transplant
- Long-term use of some common contraceptive pills
- Sexually transmitted diseases (STD) such as Chlamydia, gonorrhoea, and syphilis

Prevention of cervical cancer.

A number of measures can help reduce the chances of developing cervical cancer:

- Vaccination against cervical cancer using Human papillomavirus (HPV) vaccine.
- Safer sex: The Human Papillomavirus (HPV) vaccine only protects against two HPV strains. Other strains can cause cervical cancer. Using a condom during sex helps protect from HPV infection.
- Regular cervical screening might help a person identify and deal with signs of cancer before the condition develops or spreads far. Screening does not detect cancer but indicates changes to the cells of the cervix. These changes accurately detect risk of cervical cancer.
- Having fewer sexual partners: The more sexual partners a woman has, the higher the risk of transmitting the HPV virus becomes.
- Delaying first sexual intercourse: The younger a woman is when she has sexual intercourse for the first time, the higher the risk of HPV infection becomes. The longer she delays it, the lower her risk.
- Avoid smoking: Women who smoke and have HPV face a higher risk of developing cervical cancer than people who do not

Symptoms

In its initial stages, cervical cancer has no signs or symptoms. Once it is developed, symptoms include:

- Vaginal bleeding after intercourse
- Abnormal Vaginal discharge with foul odour
- Pelvic pain during intercourse

Treatment

Cervical cancer treatment options include:

- Surgery
- Radiotherapy
- Chemotherapy
- Or a combination of these

Deciding on the kind of treatment depends on several factors, such as the stage of the cancer, as well as age and overall state of health. Treatment for early-stage cervical cancer, when the cancer remains within the cervix, has a good success rate. The further a cancer spreads from its original area, the lower the success rate tends to be.

Cervical cancer and Persons living with HIV

Cervical cancer is the most common cancer among women living with HIV. The likelihood that a woman living with HIV will develop invasive cervical cancer is up to five times higher than for a woman who is not living with HIV. Equally, the risk of contracting HIV is almost doubled among women who are infected with HPV. The World Health Organization therefore recommends cervical cancer screening for women living with HIV at the time of HIV diagnosis, regardless of age, with re-screening every 3 years following a negative result.

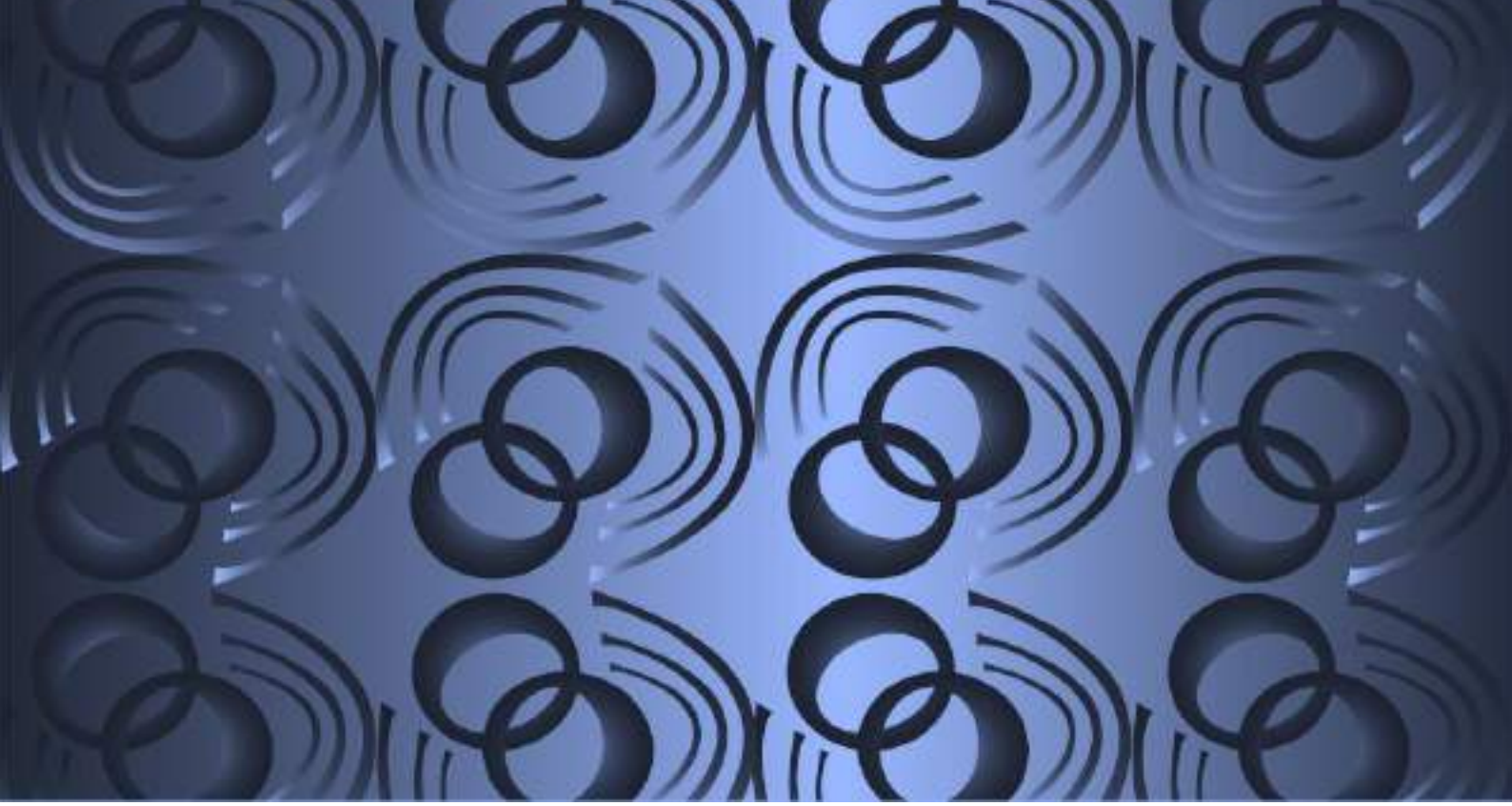
References

UNAIDS (2018): *Cervical cancer and HIV- two diseases, one response*. Geneva: UNAIDS

UNAIDS (2016): *HPV, HIV and cervical cancer: Leveraging synergies to save women's lives*. Geneva: UNAIDS

Reflection and Notes

Reflection and Notes



EPIDEMICS AND HIV

THIRD EDITION

Epidemics and HIV

Session Objective:	To enable learning on how the epidemics (illustrated by Ebola and COVID-19) affect persons living with HIV.
Session Overview:	What is COVID-19/Ebola? How is COVID-19/Ebola transmitted and prevented Common Symptoms of COVID -19/Ebola COVID- 19 /Ebola and persons living with HIV
Key Message:	Every person has a right and a responsibility to seek healthcare and to adopt positive health seeking behaviour more so for Persons Living with HIV and other chronic illnesses.
Biblical Scripture:	*"Dear friend, I pray that you may enjoy good health and that all may go well with you, even as your soul is getting along well." 3 John 1:2*
Scripture Emphasis:	Good health is paramount as one seeks spiritual wellbeing. Seeking medical help is important to ensure good health, including COVID-19 vaccination.
Islamic Emphasis:	*The Prophet (PBUH) said: "There are two blessings which many people do not appreciate: Health and leisure."* *"O You servants of Allah take medicine as Allah has not created a disease without creating a cure except for one."* *They asked which one. He replied "old age." (Sahih Bukhari)*
Scripture Emphasis:	The Prophet talked of Taun that had killed many people in the early days and he recommended that those who are in the affected villages should not get out of it and those who are out should not get in until the epidemic is controlled.
Expected Learning Outcomes:	By the end of this session, participants should be able to: • Explain how COVID-19/Ebola are transmitted, prevented and treated • Illustrate how COVID-19/Ebola relate to HIV • Explain the vulnerability of persons living with HIV and other chronic illnesses
Toolkit References:	• Access to Treatment • Antiretroviral therapy • Sexually Transmitted Infections • Voluntary Counselling and Testing (VCT) • Empowerment

	• HIV and Human Rights
Time:	1 hour
Resources Needed:	Flipchart and markers

EPIDEMICS AND HIV & AIDS

An epidemic is an infectious disease that spreads widely in a community at a particular time. Persons Living with HIV and AIDS are at a higher risk being infected with epidemics than the general population. This is because of their reduced immunity since HIV affects the immune system. For this reason, Persons Living with HIV should carefully protect themselves from infections at all times and more so whenever there is an epidemic. For the same reason, persons living with HIV and AIDS get sicker than the general population once infected by an epidemic. Therefore, they should seek medical care immediately they suspect or realize that they are infected. They should not try to self-medicate because this may not work and also because if they are on antiretrovirals, they need a doctor to prescribe the right drugs. Some drugs used to treat epidemics can be dangerous if used together with antiretrovirals. This section of this Toolkit focusses on Ebola and Covid-19 to illustrate these points

The Coronavirus Disease of 2019 (COVID-19)

> ***This crisis is a wake-up call to do things differently. We need a recovery based on economic and social justice since response gaps in pandemics, whether HIV or COVID-19, lie along the fault lines of inequality.***
>
> António Guterres United Nations Secretary-General

The Coronavirus Disease first detected by the World Health Organization in 2019 in Wuhan City, China is a communicable disease that is caused by the SARS-CoV-2 virus. The disease quickly spread to all countries worldwide. COVID-19 is a respiratory illness with human to human transmission. It is spread by respiratory droplets (sneezing and coughing), hand to hand contact and touching surfaces which are contaminated, and with airborne transmission being a possibility. COVID-19 cause slight respiratory illness and those infected may recover without needing special medical attention. However, some patients may become extremely ill and could require special medical attention especially elderly persons and those with pre-existing medical conditions such as cardiovascular disease, diabetes, cancer, HIV & AIDS.

Symptoms

On average it takes 5–6 days from when someone is infected with the virus for symptoms to show. However, it can take up to 14 days.

Most common symptoms:

- Fever or chills
- Cough
- Shortness of breath or difficulties breathing
- Tiredness
- Loss of taste or smell

Less common symptoms:

- Sore throat
- Headache,
- Aches and pains,
- Diarrhoea,
- A rash on skin,
- Discoloration of fingers or toes, and,
- Red or irritated eyes

Serious symptoms:

Difficulty breathing or shortness of breath

Loss of speech or mobility

Confusion and chest pain

What can I do if I think I have contracted COVID-19?

Seek immediate medical attention if you have serious symptoms.

Always call before visiting your doctor or health facility.

People with mild symptoms who are otherwise healthy should manage their symptoms at home.

How to prevent COVID-19

People infected with COVID-19 should not be stigmatized and discriminated. They should be respected and supported. They are human like everyone else and governments should protect the human rights and dignity of those affected by COVID-19. Besdies, they are part of the solution. The experience learned from the HIV epidemic can be applied to fight against COVID-19. As in the AIDS response, governments should work with local communities to find local solutions. Key populations should not be stigmatized or discriminated as a result of COVID-19 pandemic.

How to prevent infection

Everyone, including people living with HIV, should take the recommended precautions to reduce exposure to COVID-19:

- Regular and thorough hand washing with soap and water or alcohol-based hand rub.

- Maintain at least 1 metre distance between yourself and anyone who is coughing or sneezing.
- Avoid touching your eyes, nose and mouth.
- Cover your nose and mouth with a mask
- Make sure that you, and the people around you, follow good respiratory hygiene—cover your mouth and nose with your bent elbow or tissue when you cough or sneeze and dispose of the used tissue immediately.
- Isolate if you feel unwell. If you have a fever, cough and difficulty breathing, seek medical attention and call in advance. Follow the directions of your local health authority.
- Vaccinate against COVID-19

Note:

Some of the above measures may not be applicable in certain places because of:

i) Weak healthcare systems,

ii) Overcrowding especially in informal urban settlements

iii) Overcrowding in public transport systems

iv) Lack of clean water and sanitation,

All leaders including religious leaders and all persons of good will should support local solutions that work and help manage COVID-19.

COVID- 19 and People Living with HIV

People Living with HIV are at an increased risk of more severe outcome from COVID-19 compared with other people. As everyone else they should observe strictly COVID-19 prevention protocols. In addition, regardless of their CD4 or viral load they should be vaccinated against COVID-19 because the potential benefits outweighs potential risks.

COVID-19 vaccine and HIV

Before vaccines are licensed for scale up, global and national regulatory authorities review data and ensure they are safe. No safety or efficacy data have emerged to cause worry that People Living with HIV are at any greater risk from COVID-19 vaccines than anyone else.

COVID-19 vaccine significantly reduces the risk of severe disease and death for everyone including People Living with HIV. Until the level of the virus has fallen very low in the population due to large scale vaccination, everyone should continue observing COVID-19 prevention protocols even after vaccination. There is therefore need for continued advocacy so that no one is left behind and that national vaccination programmes do not exclude people from key populations, who may have limited access to health services.

Note:

Vaccination against COVID-19 will not reduce illness or deaths from other causes. People living with HIV should therefore continue with antiretroviral therapy, which not only keeps people healthy but also prevents ongoing transmission of HIV. As in most vaccines, COVID-19 has mild side effects such as generalized malaise, mild fever and typically sore arm. Serious side effect rarely occurs.

References

UNAIDS. (2021). *COVID-19 and HIV: What People Living With HIV need to know about HIV and COVID-19*. Geneva: UNAIDS

USAID. (2021). Breaking down barriers to achieving HIV outcomes. *Global AIDS Strategy 2021-2026*, 44-46.

EBOLA VIRUS DISEASE (EVD)

What is Ebola?

Ebola Virus Disease (EVD), or simply Ebola, is a deadly disease with occasional outbreaks that occur mostly on the African continent. Ebola most commonly affects people and nonhuman primates (such as monkeys, gorillas, and chimpanzees). It is caused by an infection with a group of viruses within the genus *Ebolavirus*. Ebola virus was first discovered in 1976 near the Ebola River in what is now the Democratic Republic of Congo. Since then, the virus has been infecting people from time to time, leading to outbreaks in several African countries. Scientists do not know where Ebola virus comes from. Based on similar viruses, they believe Ebola is animal-borne, with bats or nonhuman primates being the most likely source. Infected animals carrying the virus can transmit it to other animals, like apes, monkeys, duikers and humans.

How is Ebola Transmitted?

The virus first spreads to people through direct contact with the blood, body fluids and tissues of animals. Ebola virus then spreads to other people through direct contact with body fluids of a person who is sick with or has died from Ebola. This can occur when a person touches these infected body fluids or objects that are contaminated with them. The virus then gets into the body through broken skin or mucous membranes in the eyes, nose, or mouth. People can get the virus through sexual contact with someone who is sick with or has recovered from Ebola. The virus can persist in certain body fluids, like semen, after recovery from the illness.

Signs and Symptoms

Signs and symptoms may appear anywhere from 2 to 21 days after contact with the virus, with an average of 8 to 10 days. The course of the illness typically progresses from “dry” symptoms to wet symptoms.

Dry Symptoms

Fever

Abdominal Pain

Severe Headache and muscle/joint pain

Weakness and fatigue

Sore throat

Wet Symptoms

Diarrhoea

Vomiting

Bleeding from various body openings

Prevention

When living in or traveling to a region where Ebola virus is potentially present, there are a number of ways to protect yourself and prevent the spread of Ebola.

- Avoid contact with blood and body fluids (such as urine, faeces, saliva, sweat, vomit, breast milk, amniotic fluid, semen, and vaginal fluids) of people who are sick.
- Avoid contact with semen from a man who has recovered from Ebola, until testing shows that the virus is gone from his semen.
- Avoid contact with items that may have come in contact with an infected person's blood or body fluids (such as clothes, bedding, needles, and medical equipment).
- Avoid funeral or burial practices that involve touching the body of someone who died or is suspected to have died from Ebola.
- Avoid contact with bats, forest antelopes, and nonhuman primates (such as monkeys and chimpanzees) blood, fluids, or raw meat prepared from these or unknown animals (bush meat).

These same prevention methods should be used when living in or traveling to an area experiencing an Ebola outbreak. After returning from an area experiencing an Ebola outbreak, people should monitor their health for 21 days and seek medical care immediately if they develop symptoms of Ebola.

Ebola Virus Disease and HIV

Persons Living with HIV are particularly vulnerable to Ebola virus infection. This is because patients with compromised immune systems experience a more difficult recovery.

Ebola Virus Disease Vaccine

The U.S. Food and Drug Administration (FDA) approved the Ebola vaccine rVSV-ZEBOV (called Ervebo®) on December 19, 2019. This is the first FDA-approved vaccine for Ebola. This vaccine is given as a single dose vaccine and has been found to be safe and protective against *Zaire ebolavirus*, which has caused the largest and deadliest Ebola outbreaks to date.

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Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

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MENTAL HEALTH AND HIV

THIRD EDITION

Mental Health and HIV

Session Objective:	To enable learning on issues of mental illnesses and their relationship with HIV and AIDS and the need for access to treatment.
Session Overview:	What is mental health, Key facts about mental illnesses, Classifications of mental illnesses, Mental Health Illness stigma and discrimination, Mental Health and HIV and AIDS, Treatment options for PLWHIV experiencing mental illness and Promoting good mental health among PLWHIV, Important points.
Key Message:	Mental health illnesses are treatable and/or manageable. Therefore, you and I should not fear persons living with these illnesses but should care for and support them to live positively.
Biblical Scripture:	*Be anxious for nothing, but in everything by prayer and supplication, with thanksgiving, let your requests be made known to God; and the peace of God, which surpasses all understanding, will guard your hearts and minds through Christ Jesus*. (Philippians 4:6-7, NKJV)
Scripture Emphasis:	God's will be for His people to enjoy peace of mind as they cast their burdens to Him, because he cares!
Islamic Emphasis:	*'Abdullāh ibn 'Amr (may Allah be pleased with him) reported that the Prophet (may Allah's peace and blessings be upon him) said: "Those who are merciful will be shown mercy by the Most Merciful. Be merciful to those on the earth and the One in the heaven will be merciful to you."* - [At-Tirmidhi - Abu Dawood - Ahmad]
Scripture Emphasis:	There are many types of mental illnesses and different causes as well. Mental illness is like any other illness. Caring for persons with mental illness is emphasised in both the Qur'an and the Sunnah of the Prophet.
Expected Learning Outcomes:	By the end of this course, participants will be able to: • Describe mental health • Explain the bidirectional relationship between mental health and HIV

	• Understand the importance of caring for and supporting persons living with mental health • Suggest ways in which individuals, families and society can promote good mental health among PLWHIV
Toolkit References:	• Modules on Stigma, Shame, Denial, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • PrEP • PEP • Sexually Transmitted Infections • Cervical Cancer and HPV • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	Flipchart and markers

Tips to facilitator

This unit should not be presented word for word. It is important that you, the facilitator, read and understand the subject of mental health so that you focus on issues that are relevant to your participants particularly on mental health and HIV in the context of SSDDIM.
The participants could share a lot on experiences and stories from their local communities including the stigmatizing terms given to persons with mental illnesses. Then you can use these stories to bring home some of the points in this session.

What is Mental Health?

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004). There can be no health without mental health. This is because mental health is the basis

for the well-being and effective functioning of individuals in all other spheres of life including physical, psychological, social, cultural, and spiritual. Mental health is not merely the absence of a mental disorder; it is a state of balance, both within the individual person and with the entire environment. In spite of the centrality of mental health in holistic health and wellbeing, and although mental disorders are the leading cause of disabilities globally, mental health receives inadequate attention.

Key facts about mental illnesses

- Mental illness is NOT one disease. There are many mental illnesses
- Many people suffer from different mental illnesses. It is estimated that every 1 in 4 people in the world suffer some form of mental disorder.
- These are classified as depression, bipolar disorder, schizophrenia and other psychoses, dementia, and developmental illnesses including autism.
- Generally, mental illnesses present as abnormal thoughts, emotions and behaviours as people interact with themselves, with other persons and with their entire environment.
- It is possible to successfully prevent many mental illnesses such as depression.
- It is possible to successfully treat mental illnesses and ways to manage them.
- Prevention, management and treatment of mental illnesses require good access to mental health care and social services including psychosocial support.
- In low- and middle-income countries (LMIC) 80% of the people do not receive care in prevention, management or treatment of mental illnesses.
- The burden of mental illnesses worldwide keeps growing due to social, cultural, economic, political, and health challenges. For example, with the outbreak of COVID- 19 in December 2019, mental health enormously increased.
- Mental illnesses have negative effects on the individual person, their family and their society at large in all spheres of life including social, economic, physical, and educational, among others.

Key facts about mental illness in relation to HIV

- According to a study done in Zambia by WHO consultant, Melvyn Freeman, 85% of pregnant women living with HIV and AIDS had episodes of severe depression and frequent suicidal thoughts
    - Studies also indicate a prevalence of suicidal thoughts and depression among AIDS orphans in Eastern and Southern Africa

- Caregivers of PLWHIV are also more likely to experience mental health illness in form of anxiety, chronic stress and depression among others. This may negatively impact on them, their families and prevent them from providing care where needed
- PLWHIV are more likely to develop Altered Mental Status (AMS) due to the nature of the disease, a lower immunity and complicated medical regimens among others
- Research indicates that HIV can lead to the shrinkage of the brain structures involved in learning and processing of information
- Patients living with HIV are more likely to develop schizophrenia compared to those who do not have the virus

Classifications of mental illnesses

i) Depression

This is the most common mental illness and the major cause of disabilities in the world. Approximately 264 million people suffer from depression. More women than men suffer depression.

A person suffering from depression will manifest continued

- sadness
- poor appetite
- loss of interest in everything including what they previously enjoyed doing,
- feelings of guilt
- Feelings of poor self-image
- feelings of low self-worth,
- interrupted sleep or appetite
- tiredness, and,
- poor concentration

Additionally, they may complain of multiple physical pains which have no apparent physical cause. Depression may be long-lasting or recurrent. It impairs the normal day to day functioning of people and could lead to suicide. There is mild, moderate and severe depression depending on the level of these manifestations.

PLWHIV are likely to experience severe depression:

- as a result of a reaction to the diagnosis and sometimes,
- because depression may be as a side effect of the disease. PLWHIV suffering from depression are more likely to engage in risk-taking behaviour like substance abuse which may harm them

The good news about depression is that it can be successfully prevented through psychotherapy and prevention of what triggers it

more. They are also more likely to be care-free and have multiple sexual partners or engage in drug-induced sex exposing themselves to the risk of reinfection.

Moreover, mild and moderate depression may be successfully treated with talking with the patient to create awareness on what may be triggering the symptoms and addressing it (cognitive behaviour therapy) or/and to replace the symptoms with positive emotions, positive thinking, and positive acting (psychotherapy). However, moderate and severe depression may require use of drugs called antidepressants.

Please note that in mild and moderate depression, antidepressants are used only after the talking therapies have failed. Besides, they should not be used in children (even when they have severe depression) and with adolescents, they should be used with a lot of caution because they can lead to negative side effect including addiction.

To manage depression, events that trigger it would be identified and prevented, talking therapies applied, and social networks activities restored and sustained. In moderate to severe cases, antidepressants may be used but with a lot of caution to avoid addiction and other negative effects.

ii) Bipolar disorder

This is the second most common mental disorder. It affects about 45 million people globally. It manifests in bouts of overexcitement on one extreme and depression on the other. In between the two extremes, they will manifest normal moods. Overexcitement will present in display of excessive happiness or anger, over-activity, elevated self-image and therefore elevated self-importance, rapid speech, and reduced need for sleep. Some people may not manifest depression so that they swing between normal moods and overexcitement. These too are classified as having bipolar disorder.

As with depression, bipolar disorder may be successfully prevented, treated, and managed. Effective treatments are available for the treatment of the acute phase of bipolar disorder and the prevention of relapse. Both talking therapies and medicines may be used.

ii) Psychoses

Psychoses, for example schizophrenia, are severe mental illnesses. The conditions affect the person's capacity to think, feel, talk, perceive themselves, and act normally. Persons living with psychoses hear, see or feel things that do not exist (hallucinations) and having false beliefs or perceptions (delusions). For example, one can think and claim that he is the Pope when clearly, he is not. These conditions make it difficult for people to live normally. In most situations, schizophrenia begins in late adolescence or early adulthood.

Sadly, such people suffer stigma and discrimination in society. Others may be denied their human rights, for example freedom and right to work. This makes life even more difficult for them.

Yet, the conditions may be successfully managed using medicines and psychosocial support. About 20 million people across the globe live with psychoses.

- HIV and psychosis

New-onset psychosis is a serious complication of HIV infection that develops more in those with weaker immunity. The occurrence of first-episode psychosis in PLWHIV is associated with delusions resulting from paranoia. They are estimated to range from less than 1%to as high as 15%. The main cause of this condition has not yet been agreed upon but it is heavily associated with drug and substance abuse, cognitive impairment, dementia and untreated HIV infection.

Research indicates that PLWHIV are six times more likely to have schizophrenia compared to those without the virus. When these two conditions couple up, they may hinder the treatment process. Patients suffering from schizophrenia possess an increased mortality rate. Healthcare workers are less likely to take them seriously or respond to their concerns. They are also lees likely to comply with their medication which may distort their adherence to ART and lead to advanced effects later.

iii) Dementia

Dementia is the second commonest mental disorder in the world; about 50 million people have dementia. As people grow old, their ability to think slowly declines as their brains age and become less effective in remembering, understanding, calculating, learning, and judging, among other thinking processes. Typically, dementia presents similarly but far beyond what happens with normal ageing. In most cases, this decline in thinking may be preceded or accompanied by lack of control of emotions (for example, one can start crying excessively for no apparent reason) language, and actions.

Diseases and injuries of the brain such as stroke and Alzheimer's disease lead to dementia. Unfortunately, at the moment, there is no treatment to manage or cure dementia. However, a lot can be done to improve the quality of life of persons living with dementia through social support.

- AIDS Dementia Complex (ADC)/HIV-associated Dementia (HAD)

This is most common among persons with advanced HIV infection. Symptoms may include brain inflammation, change in behaviour, gradual decline in cognitive function such as memory loss and the inability to concentrate. ADC can lead to death if left untreated. However, this condition is rare in incidences where ART is being adhered to.

Note: Milder forms of cognitive issues as a result of HIV infection are normally reported during the course of ART. These are referred to as HIV-associated neuro-cognitive disorder (HAND).

iv) Developmental illnesses

Some mental illnesses usually begin at childhood and may persist into adulthood. They are presented as lack of or delay in development of intellectual ability and other abilities related to the normal functioning of the central nervous system. Children Living with HIV (CLWHIV) are more likely to develop developmental delays, brain lesions and slower growth compared to their counterparts.

The most common of these developmental illnesses is autism. The conditions present in impaired thinking and acting in relating with other people, impaired communication skills including language, and an exaggerated interest in a few activities so that they do these activities repetitively. This affects their daily lives negatively.

Social support, particularly family care and support is very important for the health and wellbeing of persons living with developmental disorders. Therefore, the community has a central role to play in protecting the rights and needs of persons living with disability.

The community at large has a role to play in respecting the rights and needs of people with mental illnesses.

v) Anxiety disorders

These refer to a group of mental illnesses that lead to constant fear and overwhelming anxiety. Women are more likely to experience anxiety due to their hormonal composition. Men are less likely to experience this condition due to a higher amount of testosterone. Examples of anxiety disorders include panic attacks, Obsessive Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). Different types of anxiety may be triggered by different experiences. Generally, anxiety may be cause by the following:

- Certain personality traits like feeling uncomfortable with certain things or people

- Stressful events and experiences in childhood or adulthood
- Family history of anxiety or other mental health conditions
- Physical conditions like unusual heart rhythm

Some symptoms of anxiety are listed below:

- Shortness of breath
- Heart palpitations
- Flashbacks
- Feeling panic, fear and uneasiness
- Inability to stay still and remain calm
- Insomnia

PLWHIV are also likely to develop and experience anxiety disorder. The most common forms of anxiety are General Anxiety Disorder (GAD) and Panic Disorder (PD). An increase in HIV symptom count is more likely to increase incidences of GAD among patients. Conditions like PTSD are closely linked to faster progression of HIV/AIDS. Patients with this condition have also been found highly unlikely to follow dose instructions and this may affect their adherence to ART.

Mental Health Illness stigma and discrimination

Across the world, persons living with ill mental health are stigmatized. This is because there is lack of knowledge about the mental conditions. Therefore, there are many misconceptions and negative attitudes about the causes of mental illnesses and how these may be treated. For example, many people in Africa think that mental health illnesses are possessions by evil spirits caused by witchcraft. Therefore, they think everyone who has a mental illness has psychoses and this cannot be treated. Others think that mental illnesses are infectious, that is, they can be transmitted from one person to another. Therefore, they will fear associating with any person living with such illnesses.

Important to note:

- There are many kinds of mental health illnesses;
- Mental illnesses are not infectious;
- All the different illnesses are may be effectively treated or managed.

This means that **we should not fear persons living with mental illnesses**. We should care for and support them to treat or manage the conditions.

Mental health and HIV

According to UNAIDS (2020) there is a bi-directional relationship between HIV and mental health. This means that HIV infection could lead to mental health conditions and mental health conditions could lead to HIV infection.

At the onset of HIV treatment, one is given antiretroviral therapy (ART), a combination of antiretroviral drugs that are still foreign to the body at that time. The immune reconstitution done as a result of this in their first weeks and months of ART may affect the brain and cause AMS. This is why there are side effects within the first 4 to 6 weeks. Later however, the body get used to these drugs.

Persons who are living with mental illnesses are at a greater risk of HIV infection because they may not make safe decisions. For example, they are more likely to engage in unsafe sex for lack of information. At the same time, they are more vulnerable to sexual abuse than persons who have good mental health.

On the other hand, persons living with HIV are at a greater risk of mental health illnesses because they suffer a lot of stress. Depression and anxiety are the most common mental health conditions found among persons living with HIV. This is because HIV is chronic but also because persons living with HIV may be suffering from stigma and discrimination. Many cases of suicide (caused by extreme untreated depression) are associated with HIV.
PLWHIV are also likely to develop and experience anxiety disorder. The most common forms of anxiety are General Anxiety Disorder (GAD) and Panic Disorder (PD). An increase in HIV symptom count is more likely to increase incidences of GAD among patients. At the moment, ART has not proven to be beneficial in reducing these incidences.

Conditions like PTSD are closely linked to faster progression of HIV/AIDS. Patients with this condition have also been found highly unlikely to follow dose instructions and this may affect their adherence to ART.

How HIV/AIDS affects the nervous system.

HIV does not directly affect the nervous system but exposes them to risk through infecting the glia cells, responsible for shielding and supporting the neurons. It also triggers the damage of

the central nervous system (CNS), that is the brain and the spinal cord. This may be manifested through mental issues such as:

- Confusion and forgetfulness
- Inability to pay attention
- Mood disorders (anxiety and depression)

Due to a lower immune system, HIV and AIDS may also lead to *herpes zoster virus, which* can affect the brain system and functions. Lower immunity may also cause CNS lymphomas, cancerous tumours that begin in the brain or may be as a result of cancer spread from other parts of the body. It may lead to seizures, paralysis and mental deterioration among others.

COVID-19, HIV and mental health

With the onset of COVID-19, cases of depression have increased especially among persons living with HIV. This is because persons living with HIV and other chronic infections have greater risk of being infected with COVID-19 and of dying from the infection. Yet, in many countries in Africa, like Kenya, "The COVID-19 response in Kenya has no formal mental health response plan." (Jaguga & Kwobah, 2020).

However, COVID-19 has led to many digital innovations for mental health by community health workers, non-specialists and peers especially for young people. According to Roland (2020) this digital revolution promises increased access to affordable, available, scalable, and desired mental health services.

Treatment options for PLWHIV experiencing mental illness

There are still no laid-down treatment plans that are solely meant for PLWHIV. For now, treatment plans and options mainly involve treatment specified for the mental illness one has and that of ART.
As explained above, ART is advantageous in reducing the occurrence of mental illness such as HIV-associated dementia.

Promoting good mental health among PLWHIV

Good mental health makes people reach their goals, make healthy life choices, develop and maintain healthy relationships and cope with stress.
Poor mental health affects this. However, it is not a substitute for mental illness. A person with poor mental health my not be mentally ill and vice versa.
Ways in which good mental health can be promoted in PLWHIV include:

- A conducive environment in which PLWHIV can share their thoughts and feelings with their healthcare providers
- Healthcare providers also need to closely investigate if ART is affecting their patient's health and address the matter where they can
- They can also refer them to a therapist or counsellor
- Healthcare workers can encourage PLWHIV to join support groups
- PLWHIV should get adequate sleep, maintain a balanced diet and do regular exercise

Important notes

The following are important notes to remember:

- Mental illnesses are illnesses just like any other.
- The conditions are **treatable and manageable.**
- Persons living with mental health illnesses have greater risk of HIV infection
- Persons living with HIV have greater risk of depression and anxiety.
- You and I should avoid fear which leads to stigma and discrimination of persons living with HIV and/or mental health illnesses.
- You and I have a major role to play to care and support persons living with HIV and/or mental health illnesses for them to lead normal lives like everyone else.
- Persons living with HIV have greater risk of depression and anxiety.
- You and I should avoid fear which leads to stigma and discrimination of persons living with HIV and/or mental health illnesses.
- You and I have a major role to play to care and support persons living with HIV and/or mental health illnesses for them to lead normal lives like everyone else.

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Reflection and Notes

Reflection and Notes

SAVE

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VOLUNTARY COUNSELING AND TESTING (VCT)

Introduction to VCT

SECOND EDITION

Introduction to VOLUNTARY COUNSELLING AND TESTING

Session Objective:	To facilitate learning on Voluntary Counselling and Testing
Session Overview:	Discussion on interventions that would make VCT popular for all people at different times
Key Message:	Know your HIV status – it could save your life
Biblical Scripture:	*"When a person has a swelling or a scab in the skin on his body that turns white in appearance and appears to be more extensive than skin deep, he is to be brought to Aaron the priest or to one of his sons among the priests. The priest is to examine the skin rash on the body. If the hair on the skin rash has turned white and its appearance is deeper than the skin of his body, it's an infectious skin disease…" (Leviticus 13:2-3, NIV)*
Scripture Emphasis:	The scriptures teach that the status of a disease needs to be ascertained by competent authorities, so that appropriate action is taken to help affected individuals. It is important for one to know his or her HIV status
Islamic Emphasis:	*"So by mercy from Allah, [O Muhammad], you were lenient with them. And if you had been rude [in speech] and harsh in heart, they would have disbanded from about you. So pardon them and ask forgiveness for them and consult them in the matter. And when you have decided, then rely upon Allah. Indeed, Allah loves those who rely*

	[upon Him]." (Qur'an 3:159)
Scripture Emphasis:	The Qur'an encourages Muslims to decide their affairs in consultation with each other. This is in the form of counseling where one gets solutions to problems and in this case to know your status which ends up with treatment or skills to prevent infection.
Expected Learning Outcomes:	By the end of this session, participants should be able to: • Explain what isVCT • Promote VCT Use community resources to make VCT accessible
Toolkit References:	• HIV transmission • ARVs
Time:	1 hour
Resources Needed:	Flipchart paper and pen

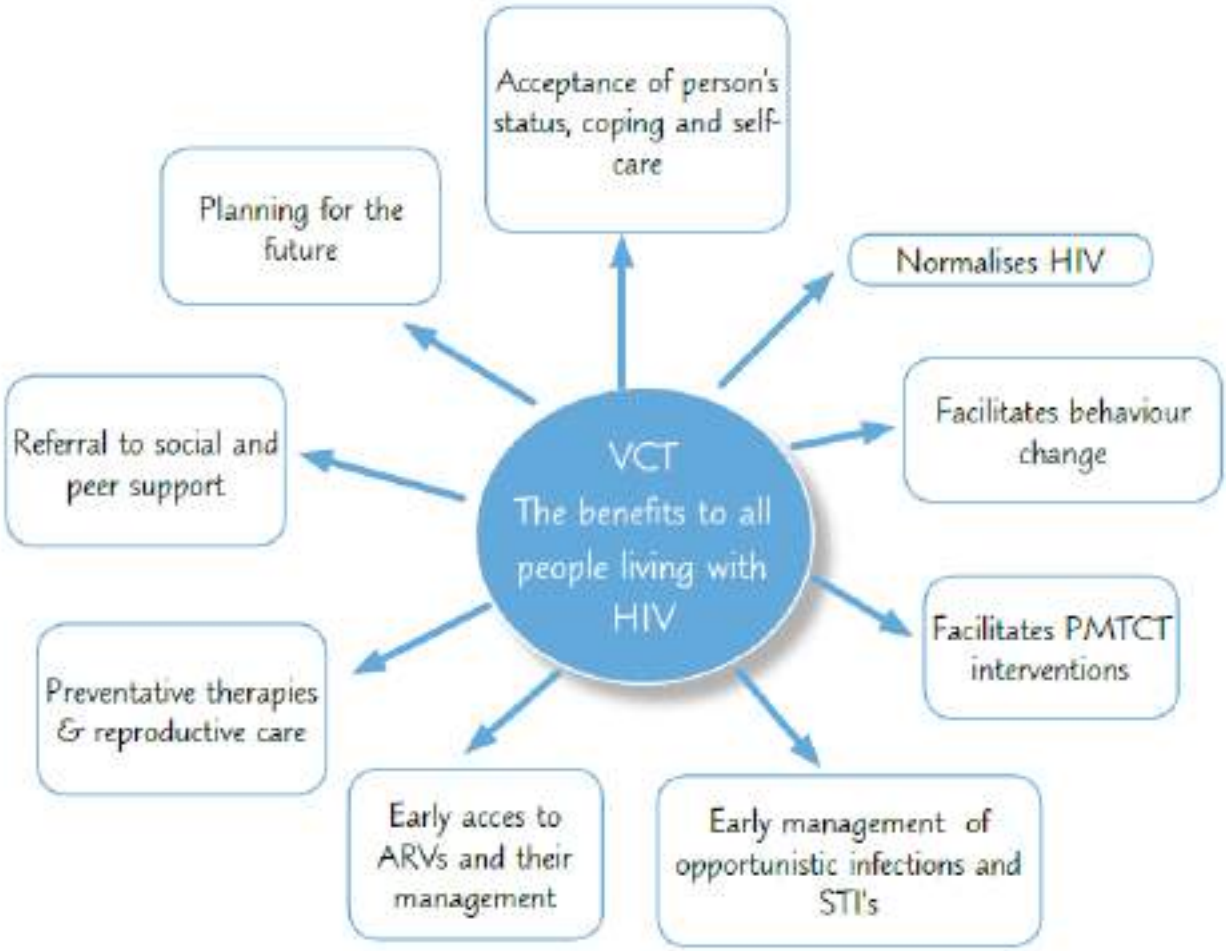
The Purpose of Voluntary Counselling and Testing

Discussion:

What is Voluntary Counselling and Testing?

Note to Facilitator:

Explore this topic for about 10-15 minutes. You are trying to find out what participants know about VCT.



Adapted from VCT Toolkit Family Health International September 2002

VCT consists of three components: pre-counselling, testing, and post-test counselling. Each of these will be highlighted in the modules that are being included.

personal story

In 2007, I was pregnant with my second child. I asked my doctor if I could have an HIV t during the pregnancy to ensure I was not HIV positive. Given that I am a middle-class, whi South African, she assumed that the risk of HIV transmission was non-existent. Statistically I fall into one of the low risk groups for HIV transmission. But statistics are for groups of people and not for individuals and I, as an individual, could have HIV because I had unprotected sex with my husband. The doctor even said to me, "You are not at risk so why do you need one?" She even went on to say that in her practice she had only ever encountered three women who were living with HIV– I would be the fourth if I tested positive. She was very reluctant to order the test until I reminded her that I had a blood transfusion during the birth of my daughter 18 months previously.

I had not tested for HIV after the transfusion because blood transfusion in South Africa follows strict international protocols. I did not think I was at risk. Thinking back now, I realise how irresponsible I had been. Even the small chance of getting HIV through the transfusion should have led me to a testing centre so that I knew my status. I breastfed my precious little girl for a year and I put her at risk for HIV by ignoring VCT. If I was living with HIV, I would have transmitted HIV to her - something that I could have prevented.

My doctor only agreed to order the HIV test when I reminded her of the blood transfusion. The fact that I had unprotected sex with my husband was ignored. No counselling was given either by her or by the nurse that took the blood. They did an ELISA test (HIV antibody test) that takes a couple of days to process. I could only imagine what would have happened if I had tested HIV positive. My marriage may have fallen apart as the two of us would have fought about how I had contracted HIV.
Even though I knew the risk of HIV was small, I was still worried. A week later, I phoned her for the results. She said, "I didn't phone you because I knew you were not HIV positive." I now go and have an HIV test every year on principle. I am always at risk, although the risk may be low. I am faithful to my husband and I trust that he is faithful to me. Yet there are many other people who are more at risk than I am and they receive the same treatment that I experienced from my doctor - no counselling and the dismissal of the real fears that we all have about living with HIV.

V J MICHAEL: PERSONAL STORY

Studies show that if the counselling aspect of VCT is poor, people are hesitant to go for testing. One of the strengths of faith-based organisations is that there are usually good counselling services available. If people want to have an HIV test, they can go to these counsellors in areas where other counselling is poor or non-existent. Furthermore, this can protect confidentiality because individuals will use those counsellors for many things, not just counselling for VCT. In training counsellors in a faith-based context, the SAVE Toolkit can be useful because it provides a lot of information, not only on HIV but on various aspects of individual and social development as well.

The counselling process in VCT should not be taken lightly and can and often does form the foundation for people living positively– both those who are living with HIV and those who are not.

Fears that surround VCT:

There are a number of fears that surround the test itself. The first is confidentiality. As is highlighted in the confidentiality section, it is really only for a select group of people that true confidentiality exists. In some countries there are even laws that force people to get tested and disclose their status to their employers. In South Africa migrant mine workers from other countries had to test annually and disclose their status.

A second fear arises from discrimination when having the test. If, for example, union structures in the work place do not support VCT, then many people will choose not to have the test for fear they will be discriminated against. In workplaces, unions and senior management need to be key supporters of any drive for VCT to clearly show that there is no discrimination. Leadership in undergoing VCT is vital.

Thirdly, people who do not have access to ARVs generally feel less motivated to get tested.

The consequences of having the HIV test, beyond merely dealing with the physical progression of the infection, can have a severely negative effect on the uptake of VCT. People fear stigma, discrimination, violence and rejection by partners, families or communities.

Women especially fear, and often experience, violence and rejection from their partners or husbands, which makes them reluctant to get tested. High quality counselling is imperative.

Currently there is a realisation that more people need to be counselled than only the person testing for HIV. A couple will need to be counselled if one of them is tested positive in the relationship. Families need counselling on how to deal with the implications of a beloved family member living with HIV. Children need counselling on living with parents or siblings with HIV. Everyone needs support, and faith-based communities provide an ideal platform to reach all these different people.

Challenge:

Use the SAVE Toolkit as an education tool in your faith community, encouraging as many people as possible to have an HIV test – even those people who feel that they are not at risk. Think about how to do this so that everyone feels supported.

How would you try to ensure confidentiality? If this is impossible, how would you provide support to people with a recent HIV diagnosis in a public space?

If access to ARVs is problematic, how can you as a community advocate for VCT and link it to advocacy around access to ARVs?

Who are the important community leaders who would have to be part of a VCT initiative?

Conclusion

VCT is a powerful tool in helping individuals and communities deal with the realities of HIV. High quality counselling is the key to success. This must not be neglected as part of a VCT programme in any context.

Testing for HIV

When testing for HIV, we are not testing for the virus BUT for the antibodies the body produces to fight HIV. This poses one big problem. It takes time for the immune system to manufacture antibodies. This is known as the window period. Remember, during the initial stage of infection, your viral load is very high so ensure that you always use SAFER practices. If you believe that

you are at risk ensure that you do TWO tests, one as soon as possible and another three months after.

Accuracy:

The various tests for HIV antibodies are highly (98.4%)1 accurate. Tests are generally done to test for antibodies in saliva and then confirmed by a blood test. If both tests confirm HIV antibodies the person is diagnosed as being HIV positive.

In less than 1% of cases one of the tests will indicate that HIV antibodies exist but they are not really there. This is known as a false positive, and would usually occur when the body is fighting some other infection and many antibodies are being produced (e.g. a person has flu at the time of going for an HIV test). This is one of the reasons why two tests are used.

Furthermore, in less than 1% of cases the tests will indicate that HIV antibodies do not exist when there is HIV in the blood stream. This is known as a false negative. Once again, this is why two tests are done.

CAUTION

If you believe that you have been exposed to HIV get tested at least twice. The first test should be as soon as you can. Sometimes the immune system is very sensitive and the antibody tests can detect antibodies within twenty-five days of infection. Get tested again about six weeks after exposure, then again (if possible) at three months. Remember, whether you believe you have been exposed to HIV or not, ensure you use SAFER practices. Even if you do not think you are living with HIV, use SAFER practices. Prevention is ALWAYS better than cure!

VCT – Confidentiality

Session Objective:	To encourage confidentiality during VCT
Session Overview:	Discussion on interventions that would make VCT popular for all people at different times
Expected Learning Outcomes:	By the end of this session, participants should be able to: • Explain the difficulties in maintaining confidentiality • Use community resources to make VCT a reality.
Toolkit References:	HIV transmission • ARVs
Time:	1 hour
Resources Needed:	Flipchart paper and pen

"The whole village knew that people would be coming to test." he told me. "The previous week, the young counsellors had been all around the village telling everyone.
"They came the next Saturday to set up their testing centre at the school.
Many, many people came to test, including young people and not such young people. And to know who was living with HIV and who was not, you just had to stand and watch."
"For what?" I asked.
"For how long the people stand. You see, there is counselling before the test and counselling after the test. The counselling before the test is the same for everybody - a few minutes. But the counselling after the test -, for some it lasts two minutes but for others it is a long, long, time. They don't come out for maybe half an hour, or even an hour. And then you know.
"By the time the day ended, the whole village knew who had tested HIV positive"
"The whole village?"
...Such information is not easily absorbed. In the weeks and months that followed those who had tested positive were silently separated from the rest of the village. They were watched. Nobody told them they were being watched. Nobody said to their faces that their status was common knowledge. But everything about them was observed in meticulous detail: whether they coughed, or lost weight, or stayed at home; whether they boarded a taxi, and if so, whether the taxi was going to the clinic; above all, with whom they slept. These observations were not generous; they issued from a gallery of silent jeerers[1]

Notes to the facilitator

Possibly the only place that Voluntary Counselling and Testing (VCT) is confidential is in large cities where people tend to be anonymous. In small villages and communities, as described above, it will be more challenging to keep one's HIV status secret. Thus, as part of a VCT initiative this understanding needs to be an integral part of encouraging people to test. It also needs to inform the way in which we help people to accept their HIV status and, for those who are living with HIV, find ways of helping them to move through stages of disclosure, and living positively. It would be useful to refer back to the section on stigma, particularly self-stigma, and the effect it can have on people. People choose not to test because of the silent jeerers.

SSDDIM:

Once someone's status is known within a community, they have to deal with the underlying SSDDIM that causes the very people who are part of their communities to watch and wait and condemn. It is in this setting that people of faith are called on not to condemn, are asked not to be part of the silent jeerers, and are challenged to be part of healing SSDDIM.

Discussion:

Individuals are like onions

- For this session you will need paper to draw diagrams, or you can draw the diagrams in the sand.
- This is a learning session where you, as the facilitator, will do most of the talking but be prepared for questions.

At the centre of any decision to undergo VCT is an individual. It is here that we begin to wrestle with fear: fear that we will test positive for HIV, fear of what others will think, fear of the effect on our families and loved ones, fear of the effect that HIV will have on our lives. From this fear comes shame: shame of who we are as sexual beings, shame for our sexual behaviour, shame for bringing the disease on ourselves, shame that we have disappointed our families.

The second layer of the onion is the people that we love: immediate family, partners and children. The decision of the individual very much depends on the reactions of the people closest to them. If these people are supportive; if the individual knows he or she will be accepted and supported by this first inner circle, then the fear will be reduced. However, if the individual fears what will happen if they test positive for HIV: that he or she will be beaten, thrown out of their home, or lose their employment, then they will in all probability not get tested.

The fear of facing living with HIV alone is enough to lead to denial. Furthermore, knowing that a likely consequence of disclosing an HIV positive status is discrimination, people will often rather choose not to know their status. Thus

individuals can die, sometimes in the care of those they love where everybody knows their status, but because there is no confirmation, they do not necessarily have to face stigma or discrimination. This choice is often easier – the choice to die rather than living with it.

The next layer of the onion is the community. The community norms and standards govern how we interact with each other.

Write down following questions and use them as a basis for discussion:

1: How does my community respond to VCT and those who are confirmed to be living with HIV?

2: Do we want to reduce the fear that individuals experience when the opportunity for VCT is presented?

3: What can we do as a community to reduce the fear of knowing your status?

Notes to the facilitator:

At the end of this session the aim is to get something very concrete that the participants can do to reduce the fear around "knowing your status". Campaigns can be effective in some contexts but are often very impersonal and do not address individual and community fears directly.

Some further comment on faith leadership

SSDDIM is the greatest obstacle against people who want to know their status. There will always be those in communities that believe that sex outside of marriage is taboo.

They will regard people with HIV as bringing condemnation upon themselves, and therefore not worthy of help. Many people who hold these views have mind-sets that can only be changed through a personal experience of HIV. Their contribution to learning about HIV can be negative. However, their fear needs to be addressed in a compassionate and caring manner.

The emphasis of the Toolkit is compassion, and for many VCT, as scary as it is, is a start of a long journey of compassion. This compassion needs to start with being compassionate with ourselves. All faiths teach a deep reverence for life. "Knowing your status" is an important step, perhaps the most important step, in preventing HIV transmission, and giving people living with HIV the opportunity to live full wholesome lives. It is the first step in the challenge for both persons who are living with HIV and those who are not to take up the challenge to embrace SAFER sexual practice.

Question: How can people of faith support VCT?

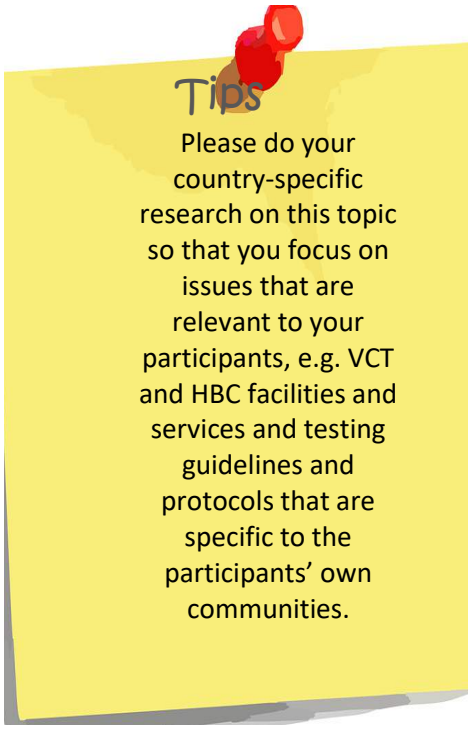
Ask participants to think about this question as we explore the issues around VCT. It is a question that we will ask again at the end of the modules on VCT.

Statement to finish the session on VCT.

If you test positive for HIV you can be helped to live positively, information can be given about how to live long healthy lives; if you test HIV negative, you can be given information about how to stay negative, and about how to help Persons Living with HIV be part of a loving community; if you are HIV ignorant you remain a danger to yourself and those you love

VCT and home-based care

Session Objective:	To facilitators participants to explore the issue of VCT and home-based care and support
Session Overview:	This session involves participants brainstorming and a facilitator-led discussion.
Expected Learning Outcomes:	By the end of this session, participants will be able to distinguish between myths and perceptions on one hand and facts about VCT and home-based care on the other.
Time:	30 minutes
Resources Needed:	Flipchart and markers. Read up on VCT and home-based-care in your locality.



Brainstorming session on VCT and Home- based Care (HBC):

- Ask participants to brainstorm what they know about VCT and home-based care.
- Ask participants if they want deeper knowledge on the issue.
- Have a general discussion and ensure that misconceptions are corrected and myths are dispelled.

Points to remember

- Emphasise the importance of early and regular testing in the discussion on VCT.
- Talk briefly about what should be done about the fact that young children have to take on the role of care-givers in many situations, and ways to ensure that this is corrected in the communities.

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Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

EMPOWERMENT

SEX, SEXUALITY AND GENDER

THIRD EDITION

Sex, sexuality and gender

Session Objective:	To enable learning on the differences and relationships between sex, sexuality and gender.
Session Overview:	Discussions and activities around sex, sexuality and gender
Key Message:	We are all different – we are all the same
Biblical Scripture:	*For God gave us a spirit not of fear but of power and love and self-control. (2Tim 1:7)*
Scripture Emphasis:	Scripture teaches against fear in favour of love and self-control.
Islamic Emphasis:	*"Whoever, male or female, does good deeds and is a believer, then such people shall enter Paradise, and they shall not be wronged in the least." (Qur'an 4:124)*
Scripture Emphasis:	God awards with equity to all persons for the good they do without any discrimination; Islam recognizes gender values when a common belief of Gods bounty is when man is blessed with a well-mannered spouse which ensures a stable family
Expected Learning Outcomes:	By the end of this session, participants should be able to: • Explain an individual's own sex, sexuality and gender. • Explain how and why our differences are good and wholesome • Discuss gender as a socio-cultural construct and therefore gender is dynamic

Toolkit References:	• Safer Practices Modules • Access to Treatment • VCT • Empowerment and Advocacy
Time:	1 hour
Resources Needed:	Flipchart paper and pen

Recap on 'sex', body parts, emotions, activities.

We are not promoting one sexuality over another we are explaining the spectrum of sexuality that exists.

Sexual identity and sexual diversity:

Present the following information as an information session. It is important to differentiate between "sexual activities" and "sexual identity":

- *Sexuality* covers both activity and identity.
- *Sexual identity:* reflects "who we are, what we feel, how we look at ourselves. It refers to the ability to fall in love with and/ or be attracted to someone";
- *Sexual activities reflect* "how we express our sexuality in actions with ourselves and others".

The different sexual orientations can be distinguished as follows: -

Define language at the start of the session to make sure people understand the terms and the language that is appropriate for this section.

Asexual:	Asexual people do not have sexual feelings or do not desire to have sex, although they have the ability to be sexually attracted to or fall in love with other people.
Bisexual:	The ability to be sexually attracted to or fall in love with both male and female persons.
Gay:	A male person who is sexually attracted to or falls in love with another male person
Heterosexual	The ability to be sexually attracted to or fall in love only with a person of the opposite sex.
Homosexual:	The ability to be sexually attracted to or fall in love with other male persons if you are male, or other female persons if you are female. Both lesbian and gay persons are referred to as homosexuals.

Intersex:	Intersex persons are born with more than one sexual organ. It is possible for one of the organs to be more dominant than the other, or for one to be totally hidden while the other is visible. It is also possible for both male and female sexual organs to be totally visible and fully developed. This is frequently addressed surgically, with parents choosing the physical sex for their child. A major challenge can be if the parents choose a physical sex which is different from the child's emotional sex.
Lesbian:	A lesbian is a female homosexual person, that is, a female who is sexually attracted to females.
MSM	Men who have sex with men
Transsexual:	A transsexual is someone who feels they are born in a wrong body: e.g. someone who on the outside physically identifies as a female but otherwise feels like a male person. In this case, a male is trapped in a female body. Females may also feel trapped in a male body. It is possible to have operations to change the physical sex to suit the inner feelings.
WSW:	Women who have sex with women

For some people, sexuality may not be static. They can go through a period of life, where they are mostly attracted to people of the opposite sex and then change later in life. Some female or male persons can have sex with a person of the same sex without necessarily considering themselves as homosexual. Persons can also practice same sex as a substitute for heterosexual intercourse if the opportunity for heterosexual activity is lacking (prisoners for example).

We are all sexual beings with a sexual identity to one degree or another. This module is about discovering what people are afraid to talk about in terms of their own sexuality and the sexuality of others, and to discover the challenge people face in discovering their sexuality on a personal and societal level. It will also provide you with useful information to use if you are approached about issues of sexual orientation during your facilitation, youth group, service etc. It is about breaking down the barriers within your community and allowing everyone to have a voice and a safe, violence-free life. It is designed to help dispel the myths that surround different sexual identities, as these myths can often be the source of stigma and discrimination used to repress people who are seen to be different and on the outside of society.

Attraction:

Everyone is different - from the way they look to the way they think and feel. People approach situations in different ways: some are more logical and others more creative. This is what makes us such interesting and diverse people. The same applies to people's sexual identity - everyone is different.

Let us look firstly at the spectrum of attraction. Imagine it is a straight line with 0 at one end representing heterosexuality, 10 at the other end being homosexuality, and 5 indicating bisexuality.

0----------5----------10

During the course of a person's life they will be able to plot their sexuality on this line, and it will vary according to age, situations and environments. The main difference between people is that they will strongly associate with one end of the spectrum compared to the other, showing how they regard their sexual identity. This line is just a way to picture sexuality: it is not set in stone for everyone. Some people find their sexuality to be very fluid and they will place themselves all over the spectrum, while other will be more definite.

Sexuality Spectrum – a little deeper

A question which almost always arises in relation to sexual orientation: "Is it nature or is it nurture?" Both will affect a person in their development, but sexual orientation itself is always determined by the biology with which we are born. When looking at nature, there are many factors which will affect both our gender and sexual orientation. These include genes, chromosomes and hormones. Every person will have a very different and individual mix of these.

As we look at the diagram of the spectrum of gender and sexual orientation, one side is masculine and the other side is feminine. People below the line in the diagram have a male anatomy and people above the line have a female anatomy. Let us look at the bottom section of the diagram. The diagram shows men across the spectrum from masculine to feminine. This in itself does not determine sexual orientation. Quadrant 1 is, however, where you will find most men would find themselves. The narrow ends show that very few men would be extremely masculine or extremely feminine. The majority are found in the circle in Quadrant 1.

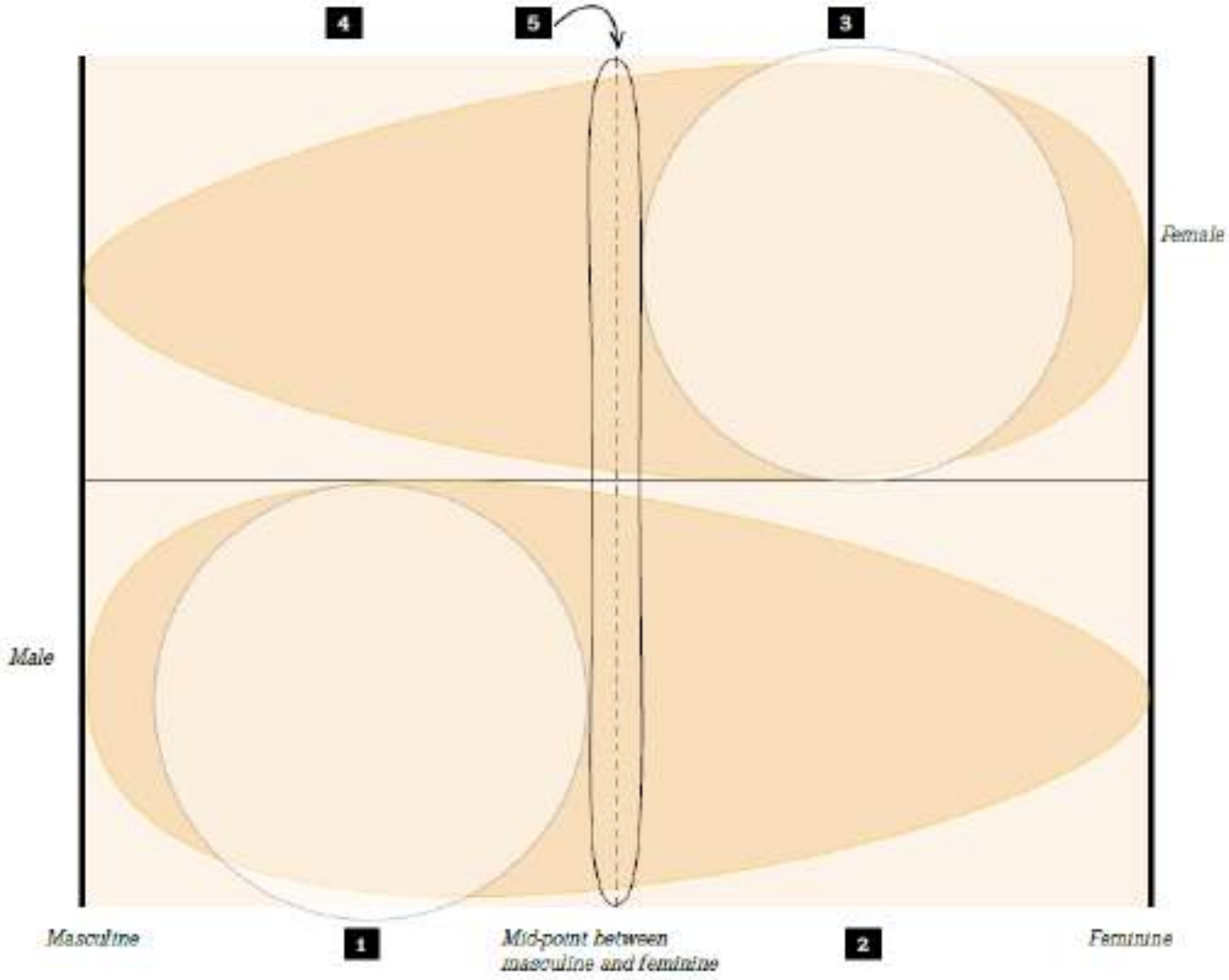
People who are born somewhere in the middle, i.e. surrounding the midpoint between masculine and feminine, may be more likely to be bisexual, but this is only a generalisation. In the same way men born on the more masculine end of the spectrum would predominantly be heterosexual, but could as easily be homosexual in sexual orientation.

Men born in Quadrant 2 might be more likely to have a homosexual orientation but could as easily be heterosexual. If we are born with a strong homosexual orientation there is nothing in our nurture that will be able to change that. In the same way if we are born with a strong heterosexual orientation there is nothing in our nurture that could change that. The same

principles apply in understanding the diagram when approaching the issue of sexual orientation for women.

The diagram shows how people's attributes will fall within a spectrum, and this can be influenced by the environment within which they are raised. This will however not change the base nature with which we are born. Sexual orientation is not something that can be changed, but various people may choose to live a different sexual orientation to the one they have. This could be because of societal pressure, extreme prejudice in a society or negative sexual experiences.

The majority of homosexual men and women were born and raised in heterosexual families. It is their biology that determines their homosexuality. Nurturing and environment can impact strongly the way in which a person's character and expression are developed, but will not, be able to change the sexual orientation they are born with. In the same way, the majority of children raised in homosexual families will tend to be heterosexual if that is their biological make-up. The sexual orientation of parents cannot determine the sexual orientation of children.



For personal reflection (not to be shared with the group): Ask participants how they see their sexual orientation changing over time on their own timeline?

The majority of people will identify themselves as heterosexual. This is seen as the norm in culture, society and religion. The difficulty is that anything that occurs outside of the "norm" is seen as wrong, abnormal, and sinful.

Society is male dominated on the whole; we are patriarchal, and our morals for living a long and healthy life stem from our various religious upbringings and cultural norms. We are expected to walk the same line as everyone else. Is it wrong to go against this? Is embracing your sexuality, whether it is heterosexual or alternative, wrong? Am I normal? Is it something you are born with? Is it something you can change? Does God see it as sinful or does God embrace everyone?

These are just some of the questions people face when approaching the issue of their sexual orientation, and it is often hard to produce answers when challenged because each person is on a path of discovery and self-realization – which can make it hard to put into words.

Language game

Session Objective:	Facilitating familiarization with words relating to human sexuality which are used (or not found) in local languages
Session Overview:	Small group discussion and facilitated report-back
Time:	1 hour
Resources Needed:	Small group discussion and facilitated report-back

This activity is meant to show how labelling people can do harm and create barriers with community.

Language is very important when approaching the issue of orientation because much of the language used can be stigmatising and discriminating. This is language that we use in our day to day lives but we have to know what is appropriate to use so that we do not offend or alienate anyone. Language can be strong in its intent and very hurtful; we want everyone to discover what is good and what is negative language.

- Explain to participants that when we work with sexuality education, we have to use words that are sensitive, and which we are not always comfortable using ourselves.
- It is important to note that when you work with any age group in their local language, these words will have to be said to ensure understanding and not confuse the people in the group.

- Explain that it is important for us to get used to using these words in a way that is not derogatory, but that ensures that learning is optimised.
- Ask participants to get into groups based on their local languages or locality. (Only if it is not a community-based workshop).
- Explain that their task is to come up with similar words to those listed below in their local language.
- Encourage participants to cover a range of different words, including polite, street, rude, and local words, and including different words used by men and boys or women and girls.

On separate sheets of paper write the term:

- Gay
- Lesbian
- Man
- Woman
- Bisexual
- Transgender

Note to facilitator:

New terms emerge all the time so you may research for more terms and also discuss with participants to add to this list in your context.

Spread these sheets of paper around the room and leave a marker pen with each sheet. Break the group into smaller groups. The intention is for them to rotate between all the sheets writing all the names they know for the terms at the top of the page. Let them know that in this activity they are free to write any word, even if it is not generally considered acceptable, and they can use their own language.

Once the sheets of paper are full, bring the group back together. Now take one sheet to the front and place it so that everyone can see what is written on it.

Ask these questions:

- Are these terms/names positive or negative?
- Are they offensive?
- Do they stigmatise?
- What do you think is the appropriate term to use (the only appropriate one is the one at the top of the page)?

Follow this procedure for all of the sheets.

Behind closed doors

Sexual activity does not define one's sexual orientation, as people are open to experiences that can be a one-off or a time of discovery. As young people grow up and interact with their sexual feeling, they may have sexual encounters with their friends, including someone of the same sex. This encounter does not define their sexual orientation. It is just an experience in their sexual development. This may also happen during adulthood. Once again, just because a person has a sexual experience that is outside of the norm for them, it does not mean their orientation has changed. This could just be an experience for experience's sake.

Discussion pairs

The facilitator may request participants to work in pairs to respond to the following. A few of the pairs may share their responses with the whole group.

"I don't hate you; I just hate what you're doing."

How does this statement make the person feel?

Activity: *Draw the following grid on a blank page of flipchart:*

Sexual Activity	Hetero-Sexual Couple	Homosexual		Bisexuals
		Lesbian Couple	Gay Couple	
Kissing				
Foreplay				
Vaginal Sex			X	
Anal Sex				
Flirting				
Oral Sex				
Phone Sex				

X= the only no

- *Ask participants to brainstorm a range of sexual activities that are being*

practiced among couples. Capture these activities on the left hand column of the matrix, titled "Sexual Activity." Their responses should identify and include the following broad spectrum of sexual activities: kissing, hugging, foreplay, same-sex, toy-sex, masturbation, vaginal sex, anal sex, cyber-sex, phone sex, oral sex, petting, stroking, dry sex, wet sex, etc.

- *Having identified a number of these sexual activities, go through the*

matrix with the participants and 'tick off' activities that each couple can do.

- *When you have completed the ticking off, ask the participants what*

  they can conclude about the patterns / results of exercise.

Facilitator's summary:

- It is important to point out that the differences in what people do with their partners is much bigger on an individual level than between people of different sexual orientations. For example, not all gay couples practice anal sex and yet some heterosexual couples do.
- There are more similarities in these couples than differences in terms of the different types of sex that they practice. The only type of sex that gay men do not practice is vaginal sex because they do not have a vagina.
- Explain that regardless of where we place ourselves on the identity continuum, we may at times try different activities because we are curious and want to experiment to find out about what we really like.
- We can try different activities and practice same-sex sexual activities without identifying ourselves as lesbian or gay.
- People throughout the world and history have been practising same-sex and opposite sex activities.
- The words homosexuality, bisexuality and heterosexuality are invented words that people started using about a hundred years ago. Words are sometimes problematic as they do not capture all the diversity of human sexual activities.
- All our sacred texts or holy books predate the invention of these words. References to homosexuality, as an example, in any sacred text is therefore imposed by a later translation.
- It is important to respect people's identity and not to judge people based on what is considered "normal" or "abnormal". All people irrespective of their sexual identity/ orientation have feelings and references.
- Sexuality is an integrated part of our identity. Everyone has the right to his or her own identity. It is important to note that some people are asexual, which means they do not have any sexual feelings. But these people can fall in love, and do enjoy some sort of intimacy and closeness.
- The stigma and discrimination of lesbian, gay, bisexual, transsexual, and intersex people often force people to live a double life. This is risky behaviour in terms of vulnerability to HIV infection and can cause mental damage for the individuals concerned.

Exploring sexual identity and gender roles in society

Session Objective:	To introduce the concept of gender and to explore the difference between gender and sex.
Session Overview:	This session is a facilitator-led interactive presentation on sex and gender
Time:	1 hour
Key Message:	Sex is biological – gender is socio-cultural

Expected Learning Outcome:	Compare gender roles and sex roles
Resources Needed:	Flip-chart, markers

Exploring sexual identity and gender roles in society:

Group Work (30 minutes):

- *Divide participants into groups of four.*
- *Ask two groups to focus on the concept of "masculinity", and two groups to focus on the concept of "femininity".*
- *The group focusing on masculinity will answer the following questions:*
  - *"How does society perceive manhood and the*
  - *"What makes a man a man in today's society?"*
- *The group focusing on femininity will answer the following questions:*
  - *"How does society perceive femininity and the role of women today?" or*
  - *"What makes a woman a woman in today's society?"*
- *Give groups thirty minutes to discuss these questions.*
- *Ask each group to capture their discussions on a flipchart.*

Report back *(60 minutes):*

Ask a representative of each group to present their discussions to whole group.

Tips for facilitators

The aim of this session is to create a shared understanding of the concept of sex and gender; and sex roles and gender roles. Emphasise the concept of men's involvement and women's empowerment, and the fact that gender roles play themselves out in specific contexts, times and cultures. Ensure in your presentation that these issues come out clearly.

A journey to your youth

(NB: THIS IS AN EXERCISE FOR ADULTS ONLY)

Session Objective:	To provide participants with the opportunity of remembering their youth as the beginning of the process of exploring their own sexuality.
Session Overview:	In this session the facilitator takes participants on a journey back into their youth through a story-telling exercise, where participants close their eyes and relive a day in the life of their youth.
Time:	1 hour

Introduction:

As an introduction to this session, explain the following to the participants: -

- We all have a lot of memories, good and bad, from our adolescence, even though we tend to forget or to hide them. We might think we have forgotten, but with a little help we can revisit our feelings from that period in life. It is too easy to adopt an adult perspective on sexuality and to neglect thoughts of longing, being vulnerable, love at a distance, affection and falling in love that we experience as adolescents.
- When working with sexuality education, we have to remember that love and emotions of different kinds are as important to talk about and validate as talking about physical sex, reproduction and other factual issues.
- Stories about love, mixed emotions and feelings; good times and bad times; good choices and terrible choices; and success and failure also help us to identify ourselves with the situation of being an adolescent today. This will in turn assist us to open up for a more personal approach when sharing experiences on love and sex, and to talking about sexuality with our children.
- As adults working with young people, we have an advantage if we get involved in the realities of the adolescents, understanding their lives, thoughts and feelings.
- If we can meet adolescents at their level, by remembering our own teenage period of life, we might get closer to communicating effectively with them.

Activity

- *Ask the participants to sit as comfortably as possible on their chairs and to close their eyes. You can help people to relax by asking them to take a deep breath and then exhale slowly.*
- *Inform the participants that you are going to provide them with an opportunity to remember their youth, especially when they began exploring their own sexuality, their physical attraction and emotional feelings for another person.*
- *Inform the participants that you are going to lead them in a reflection focussing on a time when they were young. It is an ordinary day during the middle of the week.*
- *Read the narrative in a slow and meditative manner providing participants a chance to create their own images and to remember their thoughts and feelings as the narrative is being read. Having already familiarised yourself with the narrative, pause after every statement or question and between every memory point. Explain to the participants that it is okay to "jump" from one memory to another if it is impossible to visualize or associate with the story being read.*

The narrative: An ordinary day in the middle of the week

I would like you to go back in your memories to when you were between the ages of thirteen and nineteen years old, to a time when you had just started to think about love and sexuality.

- Where did you live?
- Remember the house or the place where you lived (hut, boarding school etc.).
- Think about your family or the people that you shared the place with.

You wake up in the morning:

- Look around, who else is sleeping in the room?
- Pretend that you're sitting on your bed – what can you see?
- Posters, furniture's and so on
- You get up and get dressed.
- What was the first thing you used to do in the mornings?
- If you used to eat breakfast, who else was eating together with you?
- What did you eat?

You get ready for going to school:

- What was the last thing you used to do before you left your home or the place you stayed at?
- Who did you usually say goodbye to?
- How did you go to school: By foot? By bicycle? By bus?
- Did you meet someone on your way: Who?
- Did you talk to someone on your way: Who?
- What did you usually talk about?

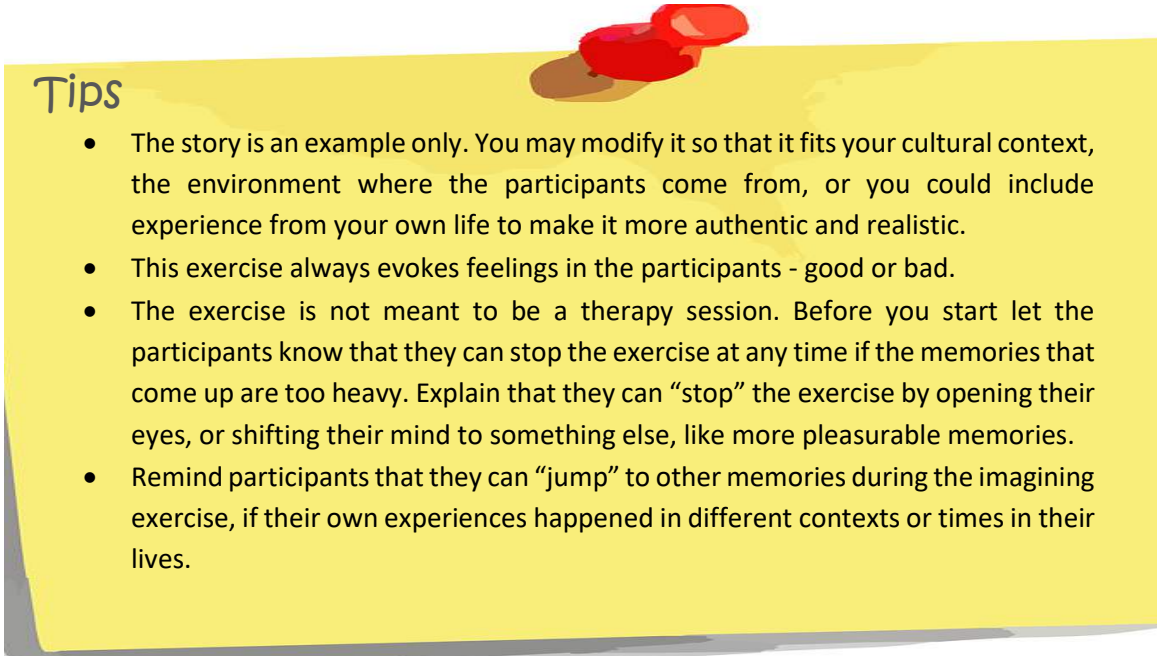
In school, you recognise someone you are very fond of:

- Who was this person?
- What are your feelings for this person? Is it someone you have fallen in love with from a distance? A dear close friend with whom you have fallen in love? Did you desire intimacy with this person? Did you want to spend long moments together with this person? Did you want to reach out and gently touch this person?
- Were you able to communicate your affection with this person? Maybe, you were afraid to communicate your feelings? What would you have liked to say to this person? What eventually gave you the confidence to say something or share your feelings with this person? What did you say? What did he or she say?
- Stay in this moment for a while

You can now bring your mind back to the room. Once again be conscious of who is sitting around you.

Reflection after "The story"

1. After the exercise, ask participants how they experienced the meditation.
2. Emphasise that sharing is not compulsory and participants should share only what they feel comfortable sharing. Linking sexuality and gender to HIV prevention amongst children and teens



Linking sexuality and gender to HIV Prevention amongst children and teens

Session Objective:	To discuss with participants the link between sexuality, gender and HIV prevention
Session Overview:	This is a facilitator-led session
Session Outcome:	By the end of this session, participants would be able to illustrate the link between gender, sexuality and HIV prevention.
Time:	30 minutes

Introduction

Explain to the participants that in order to be able to work with HIV prevention effectively, we need to start with our own process of self-reflection We need to question and interrogate our own values, traditions and attitudes so that when we work with others, especially children, we are able to help them make informed decisions about their lives.

A human-rights based approach

In working with children and teens we need to take into account a human-rights based understanding of how we approach the prevention of the transmission of HIV. Fundamentally, human rights recognise that all people, irrespective of who they are or where they live, are entitled to a certain standard of well-being – material as well as spiritual. It recognises that many people across the globe are unable to live within the standards that have been set due to several factors, including poverty, being part of a marginal group, living in a food insecure region, being a victim of war, to name a few.

Over a number of years, we have begun to recognise that children and teens, particularly due to poverty, need special care and attention. However, that care and attention needs to empower children and teens to take responsibility for their own decisions, and empower adults to support those decisions. In terms of the prevention of HIV transmission this means the following:

- Good, comprehensive sex education so that children and teens are able to understand and take responsibility for their sexual health.
- Encouraging children and teens to understand sexuality and gender issues that contribute to HIV transmission.
- Reducing community vulnerability to food and other livelihood insecurities that can result in children and teens being vulnerable to abuse and exploitation. In these situations, high risk sexual behaviour can result in high levels of HIV trans- mission.

A human-rights approach when dealing with children and teens is often hard for adults. It requires increased dialogue and increased openness. In dealing with the prevention of HIV transmission, it involves discussing subjects with which we may be uncomfortable, such as masturbation, homosexuality, condoms usage etc. It also involves children and teens making choices with which we as adults may not agree, and over which we have very little power.

However, in preventing the transmission of HIV this is vital:

- Children and teens need to be encouraged to identify ways in which they are vulnerable to HIV transmission, and these areas given special attention in any training that is done. The SAVE Toolkit has a number of ideas of how this can be done. This includes looking at sexuality broadly, activities related to condom use and discussions on cultural practices and addressing inhibiting factors to abstinence etc. The SAVE Toolkit also uses the methodology of seeking to find from those you are addressing what their specific vulnerabilities to HIV are, and working on addressing these as a first priority.
- In recognising ways in which they are vulnerable to HIV, children, teens and adults can jointly work together to decrease this vulnerability. This can be through challenging social norms, changing cultural practices or the establishment of peer support groups that promote SAVE and anti-SSDDIM messages.

Points to remember when using a human-rights based approach in discussing gender and sexuality:

- The majority of cases of HIV-transmission, new infections as well as re-infection, occur through sexual activity and reproduction.
- So, working with HIV prevention necessarily involves working with people's sexuality. This includes exploring sexual practices and behaviour as well as the longing for love, sex and intimacy. It means working with our beliefs, myths and values about love, sex and gender. It is also about working with expectations, hopes and fears on how we as individuals will be able to discover our own sexuality and love and how we can express our love and/or sexuality in interaction with others.
- Working with sexuality means working with issues of identity, as sexuality is an integral part of every individual's personality and identity. Sexuality is not only about knowledge and facts; it is also very much about basic questions such as: Am I good enough? Who am I? Am I normal? Will I find someone to love and someone who will love me? What does sex feel like? What is love actually about? There are many other related aspects that individuals will ask themselves.
- Important aspects to keep in mind for all sexuality education are gender issues, sexual identity (homo-bi-hetero) and transsexuality issues, ethnic and religious issues, socio-economic and class issues, issues of physical and psychological abilities and disabilities, and finally the issue of age. In a human-rights based approach, sexuality education should be realistic and inclusive – not exclusive.
- Furthermore, it is important to have a Human Rights perspective and to work with SRHR in issues related to sexuality, gender and HIV.

Tips

- Ensure that you have internalised the information for yourself prior to the group session, so that you do not read through it but rather talk confidently about these issues to ensure understanding by participants.
- Remember to focus on human sexuality, and the fact that we need to start with ourselves in this process.
- Emphasise the issue of gender roles in this session.

  Remember to offer the opportunity to participants to open up and share as much as possible, but they can determine their own limits in terms of how much they want to share their personal experiences.

Activity:

Break into small groups of three or four:

1. *For adults: Based on what you have heard about Children's Rights, how do you feel you could use this information to prevent HIV transmission amongst children and teenagers? Be very specific and try to commit yourself to doing something. Remember that there needs to be inclusion of children and teenagers.*
2. *For children and teenagers: Based on what you have heard about Children's Rights how do you feel you could use this information to prevent HIV transmission amongst your peers? Are you able to challenge some of the factors in your community that contribute to your vulnerability to HIV transmission? How could you do this?*

Give them about fifteen to twenty minutes to discuss, and then ask the small groups to give feedback to the larger group.

If you have done work with groups of adults and children and teenagers, it could be appropriate to get the groups together to discuss their conversations. From these conversations could develop exciting com- munity initiatives for reduction of vulnerability to HIV transmission.

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

GENDER AND SEXUALITY EXPLORED

THIRD EDITION

Gender and sexuality explored

Session Objective:	To enable deeper learning about gender dynamics and how-to breakdown and understand the core elements.
Session Overview:	Gender dynamics and core elements
Key Message:	Inclusivity is the only way to hear all voices and implement personal and social change.
Biblical Scripture:	*"There is neither Jew nor Gentile, neither slave nor free, nor is there male and female, for you are all one in Christ Jesus" (Galatians 3:28, NIV)* "*So God created man in his own image, in the image of God he created him; male and female he created them.*" (Genesis 1:27)
Scripture Emphasis:	In God's eyes all persons are created in the image of God. We should treat each other with respect, dignity and justice regardless of our differences in sex, gender, age, or any other variable.
Islamic Emphasis:	*"Surely, Muslim men and Muslim women, believing men and believing women, devout men and devout women, truthful men and truthful women, patient men and patient women, humble men and humble women, and the men who give Sadaqah (charity) and the women who give Sadaqah, and the men who fast and the women who fast, and the men who guard their private parts (against evil acts) and the women who guard*

	(theirs), and the men who remember Allah much and the women who remember (Him) - for them, Allah has prepared forgiveness and a great reward." (Qur'an 33:35)
Scripture Emphasis:	Both men and women are equal in the sight of God. They are both judged by their actions
Expected Learning Outcomes:	Describe how gender is socially constructed. Critique assumptions about gender.
Toolkit References:	• Sex, sexuality and gender module • Gender Based Violence • FGM
Time:	2.5 hours
Resources Needed:	Markers Flip-chart paper

Note to facilitator

You must have first done the module sex, sexuality and gender before taking the group into this module as it provides a deeper understanding of gender and sexuality. People must first be on track with terms and have a general understanding.

Gender and sexuality

This module seeks to explore the key concept of gender and the issues that surround it. Gender is not something that we think about on a day-to-day basis but it is something we deal with every day. Whether it is how we see other people or how they see us. By understanding gender dynamics, we can begin to explore how we can relate to people differently. We can begin to understand why gender matters when people relate to each other. We can begin to explore the boundaries that have been imposed on women and men. In doing this we can begin to be more inclusive of gender differences within our own sphere of influence.

What is Gender?

How do we determine gender? Historically we have assigned gender to babies based on what is seen between their legs at birth "Congratulations it's a boy/girl", but this may not reflect their sense of "self" as they grow and develop into a person. Gender is not inherently connected to one's physical anatomy.

Biological sex = Nature

Gender = Culture

With modern technology, new parents can often know whether they are having a boy or a girl before they are born. It is often, from this moment that we begin our gender journey. Friends and family buy pink clothes for girls and blue for boys. Gender is taught to us as we grow, from the toys we are given to play with to the colours we are allowed to wear, to the games we are allowed and encouraged to play. We are open to influence from family, community, religion and media, this is known as social conditioning. If we do something that goes against the gender, we are assigned we are told that this is not the correct behaviour, people keep us in check, in line with what is expected. This is all done at an early age as a child develops and these concepts of gender are embedded in their identity. The concept of gender will change from culture to culture, country to country, however the dominant understanding is “male” and “female”. Furthermore, there are quite rigid ideas and norms about how “female” people and “male” people interact with their world.

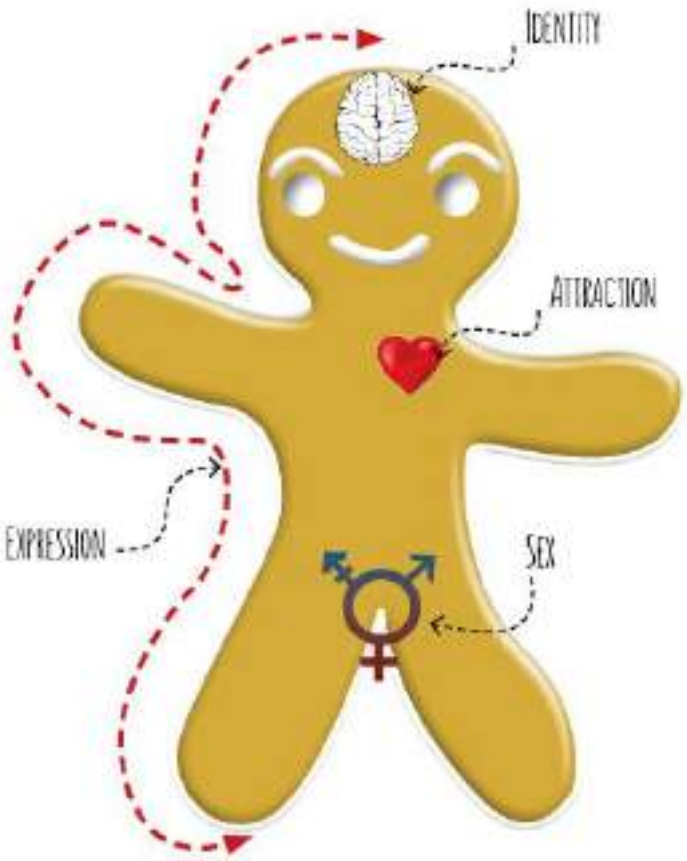
Gender is a social construct and we expect people to comply with what we deem appropriate behaviour, only when someone goes against the norm do, we look at gender in a specific way and start to ask questions.

The global population now stands above 7.9 billion. We commonly only have two terms for gender to categorise billions of people, does this seem adequate?

Question

Have you ever questioned your gender? Most people will answer NO, however, there are people that will answer yes and that is why we need to address the topic of gender.

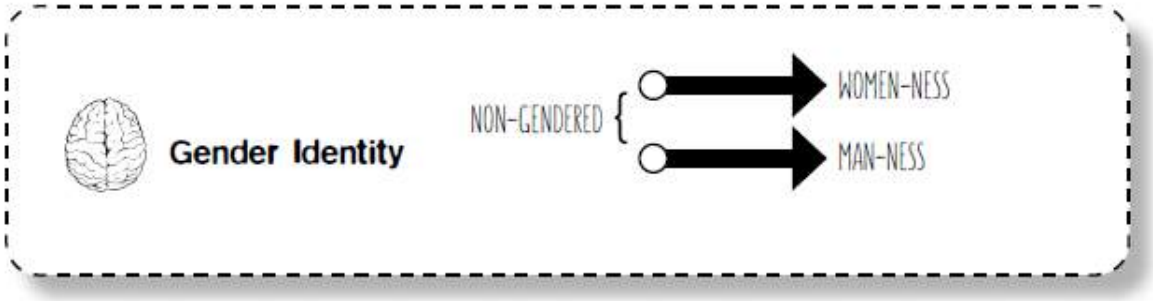
Below is the Gengerbread person; we shall use this as an introductory guide to understanding gender in the larger picture, a picture that is more inclusive of ALL people. Gender can be seen massive spectrum, which is larger, more dynamic and more interesting than the binary construct of "male" and "female", and it continues to grow.



(Lager copy available at the back of the module)

Understanding the Genderbread Person:

Gender identity: who you think you are

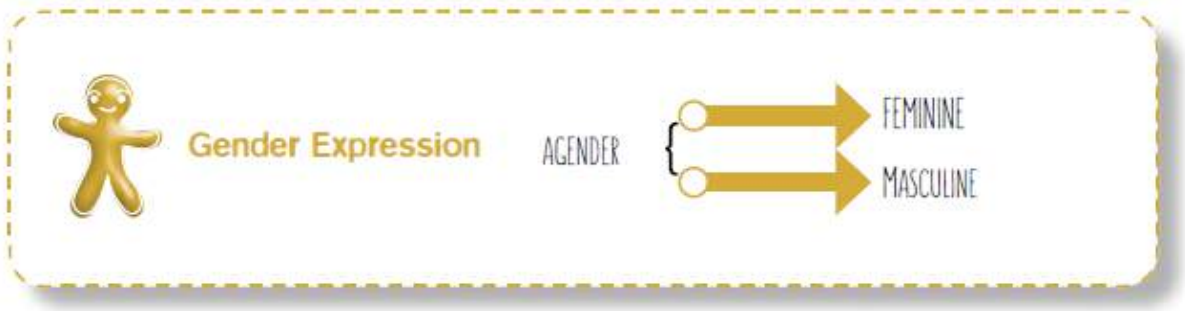


On the left of both continua we have "nongendered," which, you guessed it, means existing without gender, and on the right, we have "woman-ness" (the quality to which you identify as a "woman") and "man-ness" (ditto, but with "man"). Below we have some examples of possible

plots and possible labels for those plots. Examples of common identities that aren't listed include agender, bigender, third-gender, and transgender.

Gender identity is all about how you think about yourself. It's about how you internally interpret the chemistry that composes you (e.g., hormone levels). As you know it, do you think you fit better into the societal role of "woman" or "man," or does neither ring particularly true for you? That is, do you have aspects of your identity that align with elements from both? Or do you consider your gender to fall outside of the gender norms completely? The answer is your gender identity. It has been accepted that we form our gender identities around the age of three and that after that age; it is incredibly difficult to change them. Formation of identity is affected by hormones and environment just as much as it is by biological sex. Oftentimes, problems arise when someone is assigned a gender based on their sex at birth that doesn't align with how they come to identify.

Gender expression: how you demonstrate who you are



On the left of both continua we have "agender," which means expression without gender ("genderless"), and on the right sides we have "masculine" and "feminine." Examples of different gender expressions and possible labels are below. "Androgynous" might be a new word, and it simply means a gender expression that has elements of both masculinity and femininity.

Gender expression is all about how you demonstrate gender through the ways you act, dress, behave, and interact—whether that is intentional or unintended. Gender expression is interpreted by others based on traditional gender norms (e.g., men wear pants; women wear dresses). Gender expression is something that often changes from day to day, outfit to outfit, and event or setting to event or setting. It's about how the way you express yourself aligns or doesn't with traditional ways of gendered expression, and can be motivated by your gender identity, sexuality, or something else completely (e.g., just for fun, or performance). Like gender identity, there is a lot of room for flexibility here. It is likely that your gender expression changes frequently without you even thinking about it.

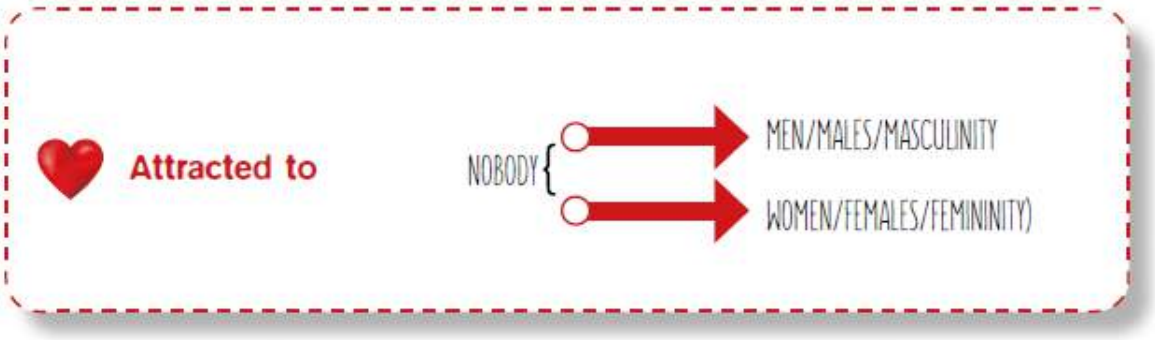
Biological sex: the equipment under the hood

On the left we have "asex," which means without sex, and on the right, we have "female-ness" and "male-ness" (both representing the degree to which you possess those characteristics). In the examples below, you see a new term, "intersex," which is a label for someone who has both male and female characteristics. You also see two "self ID" (self-identification) labels, which represent people who possess both male and female characteristics but identify with one of the binary sexes.

Biological sex refers to the objectively measurable organs, hormones, and chromosomes you possess. Let's consider biological sex in the ultra-reductive way society does: being female means having a vagina, ovaries, two X chromosomes, predominant oestrogen, and the ability to grow a baby in your abdominal area; being male means having testes, a penis, an XY chromosome configuration, predominant testosterone, and the ability to put a baby in a female's abdominal area; and being intersex can be any combination of what I just described.

In reality, biological sex, like gender identity and expression, for most folks, is more nuanced than that. Someone can be born with the appearance of being male (penis, scrotum, etc.), but have a functional female reproductive system inside. There are many examples of how intersex can present itself.

Attraction: who you are romantically and sexually into



On the left we have "nobody," meaning no feelings of attraction. On the right we have "men/males/masculinity" and "women/females/femininity." Examples below include "pansexual," which is attraction to all genders ("gender-blind"); "asexual," someone who experiences no (or little) sexual attraction (but might still experience romantic/ other attraction); and "bisexual," a person attracted to people of both their gender and another gender.

Sexual orientation is all about who you are physically, spiritually, and emotionally attracted to (so really, you could plot three points on each of those continua, if you wanted to get really specific), and the labels tend to describe the relationships be- tween your gender and the gender types you are attracted to.

If you are a man and you are attracted to women, you are straight. If you are a man who is attracted to men and another gender, you are bisexual. And if you are a man who is attracted to men, you are gay. This is the one most of us know the most about. We hear the most about it.

Interestingly enough, pioneering research conducted by Dr. Alfred Kinsey in the mid- twentieth century uncovered that most people aren't absolutely straight or gay/lesbian. Instead of just asking "Do you like dudes or chicks?" He asked people to report their fantasies, dreams, thoughts, emotional investments in others, and frequency of sexual contact. Based on his findings, he broke sexuality down into a seven-point scale (see below), and reported that most people who identify as straight are actually somewhere between 1 and 3 on the scale, and most people who identify as lesbian/ gay are between 3 and 5, meaning most of us are a little bisexual.

0—Exclusively Heterosexual
1—Predominantly heterosexual, incidentally homosexual
2—Predominantly heterosexual, but more than incidentally homosexual
3—Equally heterosexual and homosexual
4—Predominantly homosexual, but more than incidentally heterosexual
5—Predominantly homosexual, incidentally heterosexual
6—Exclusively Homosexual

PUTTING IT ALL TOGETHER: INTERRELATION VS. INTERCONNECTION

The four things presented above are certainly interrelated, they are not interconnected. What does that mean?

Gender identity, gender expression, biological sex, and sexual orientation are independent of one another (i.e., they are not connected). People's sexual orientation doesn't determine their gender expression. And their gender expression isn't determined by their gender identity. And their gender identity isn't determined by their biological sex. Those things certainly affect one another (i.e., they are related to one another), but they do not determine one another. If someone is born with male reproductive organs and genitalia, he is very likely to be raised as a boy, identify as a man, and express his masculinity. We call this identity "cisgender" (when your biological sex aligns with how you identify), and it grants a lot of privilege. It's some- thing most of us who have it don't appreciate nearly as much as we should.
What do we mean by "sex" and "gender"?

Sometimes it is hard to understand exactly what is meant by the term "gender", and how it differs from the closely related term "sex". "**Sex**" refers to the biological and physiological

characteristics that define men and women. "**Gender**" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women. To put it another way: «Male» and «female» are sex categories, while «masculine» and "feminine" are gender categories.

How to be a Trans* Positive Ally

Trans* positive tips!

Respect someone's gender identity

Address the individual as they wish to be addressed, using the name and the pronouns they prefer. Also remember that not all gender non-conforming people identify as transgender, some may identify as Genderqueer, androgynous, or other labels – respect their choice. (Example: Jane has been your friend since grade school. However, Jane would like you to now use the name Jimmy and male pronouns.)

Use their preferred name and pronouns and if you make a mistake do not over apologize just follow the mistake with the correct name or pronoun and move on.

In trainings when making nametags for everyone:

> **Name: (this is the name you wish to be called)**
> **Pro-noun (the pronoun you would like people to use)**

Making nametags this way makes it clear for everyone in the group and allows people to get comfortable with using non-traditional/non-binary pro-nouns when referring to someone.

Respect individuals' privacy.

Many transgender people are not "out" about their transgender status. **Do not out them**. When a transgender person tells you of their transgender status, they are trusting you with personal information, to tell others without their approval of it is a betrayal of their trust. No transgender person is obligated to reveal their status as transgender; keeping one's trans- status to one's self is not hiding anything. Do not refer to people in the past tense unless you are sure you can use their current name and pronoun, when in doubt, bring it all to the present tense.

Do not make a transgender person feel fake

Do not refer or compliment a transgender person for looking like a 'real man' or a 'real woman' or say things like 'you look so natural'. Though you may mean well using terms 'real' or 'natural' can make transgender people feel or think you believe them to be fake or unnatural. Good rule of thumb:
Do not make any comments or compliments to a transgender person that you wouldn't also make to a non- transgendered person.

Do not assume transgender people have a choice

Do not assume someone is transgender by choice. Although trans people must make a decision to go through hormone replacement therapy or seek medical transitioning they did not choose to be transgender.

Do not assume that transgender people are queer or kinky

Do not assume that a transgender person is gay or bisexual, though they are incorporated under the umbrella of LGBTQI+, many transgender people are straight. Do not assume that a transgender person is promiscuous or fetishist. **Gender identity is not the same as sexuality**.

Don't not ask about their 'real name' or 'what their genitals look like'.

Ready to expand your vocabulary?

Facilitators note:

Vocabulary is essential to understanding and exploring LGBTQIA+ issues. Be sure that you're comfortable explaining the words that you share with your participants.

Using the correct part of speech for certain words is crucial. Some words are not encouraged for use in their noun form and should exclusively considered adjective only words. Other times a word can be both a noun and an adjective and be perfectly affirming. What's important to remember is when in doubt, adjectives are safer. They add on an aspect of someone's identity rather than reducing them to a single identity. Example: It feels different when you say, "Meg is a blonde," vs. "Meg is blonde." So, keep in mind some words are adjective only, and if you're in doubt, adjectives are the way to go!

These definitions and terms change (sometimes quite rapidly), don't be alarmed if you haven't seen a term before or have heard a different definition, they evolve and shift often. They are all to be considered "working" definitions.

For some of these terms their connotations are just as important as their denotations - so be sure to pay attention to not only what they mean, but how they are received.

Gender terms:

- Agender - (noun) a person with no (or very little) connection to the traditional system of gender, no personal alignment with the concepts of either "man" or "woman," and see themselves as existing without gender (sometimes called Gender Neutrois, gender neutral, or genderless).
- Androgyny/ous – (adj) (1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of "intersex" to describe a person with both female and male anatomy.
- Androsexual/Androphilic – (adj) attraction to men, males, and/or masculinity.
- Asexual – (adj) having a lack of (or low level of) sexual attraction to others and/or a lack of interest or desire for sex or sexual partners.
    - Asexuality exists on a spectrum from people who experience no sexual attraction or have any desire for sex to those who experience low levels and only after significant amounts of time, many of these different places on the spectrum have their own identity labels.
    - Asexuality is different from celibacy in that it is a sexual orientation whereas celibacy is an abstaining from a certain action.
    - Not all asexual people are a romantic.
- Bigender – (adj) a person who fluctuates between traditionally "woman" and "man" gender-based behaviour and identities, identifying with both genders (and sometimes a third gender).
- Bicurious – (adj) a curiosity about having attraction to people of the same gender/ sex (similar to questioning).
- Biological Sex – (noun) a medical term used to refer to the chromosomal, hormonal and anatomical characteristics that are used to classify an individual as female or male or intersex. Often abbreviated to simply "sex".
    - Often seen as simply a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics, itis more accurate to view this as a spectrum (which is also more inclusive of intersex people as well as trans*-identified people)
    - Is commonly conflated with gender.
- Cisgender – (adj) a person whose gender identity and biological sex assigned at birth align (e.g., man and male-assigned).
- A simple way to think about it is if a person is not trans*, they are cisgender.
- "Cis" is a latin prefix that means "on the same side [as]" or "on this side [of]."
- Cisnormativity – (noun) the assumption, in individuals or in institutions, that everyone is cisgender, and that cisgender identities are superior to trans* identities or people. Leads to invisibility of non-cisgender identities.
- Cissexism – (noun) behaviour that grants preferential treatment to cisgender people, reinforces the idea that being cisgender is somehow better or more "right" than queerness, or makes other genders invisible.
- Fluid(ity) – generally with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that is a fluctuating mix of the options available (e.g., man and woman, bi and straight)
- FTM / F2M – abbreviation for female-to-male transgender or trans- sexual person.

- Gender Binary – (noun) the idea that there are only two genders – male/female or man/woman and that a person must be strictly gendered as either/or.
- Gender Expression – (noun) the external display of one's gender, through a combi nation of dress, demeanour, social behaviour, and other factors, generally measured on scales of masculinity and femininity.
- Gender Fluid - (adj) gender fluid is a gender identity best described as a dynamic mix of boy and girl. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more man.
- Gender Identity – (noun) the internal perception of a one's gender, and how they label themselves, based on how much they align or don't align with what they understand their options for gender to be.
- Generally confused with biological sex, or sex assigned at birth.
- Gender Normative / Gender Straight – (adj) someone whose gender presentation, whether by nature or by choice, aligns with society's gender-based expectations
- Genderqueer - (adj) is a catch-all term for gender identities other than man and woman, thus outside of the gender binary and cisnormativity (sometimes referred to as non-binary). People who identify as genderqueer may think of themselves as one or more of the following:
  - both man and woman (bigender, pangender);
  - neither man nor woman (genderless, agender);
  - moving between genders (genderfluid);
  - third gender or other-gendered; includes those who do not place a name to their gender;
  - having an overlap of, or blurred lines between, gender identity and sexual and romantic orientation.
- Gender Variant – (adj) someone who either by nature or by choice does not con- form to gender-based expectations of society (e.g. transgender, transsexual, inter- sex, gender-queer, cross-dresser, etc.).
- Intersex – (adj) someone whose combination of chromosomes, gonads, hormones, internal sex organs, and genitals differs from the two expected patterns of male or female. Formerly known as hermaphrodite (or hermaphroditic), but these terms are now considered outdated and derogatory.
  - Often seen as a problematic condition when babies or young children are identified as intersex, it was for a long term considered an "emergency" and some- thing that doctors moved to "fix" right away in a new-born child. There has been increasing advocacy and awareness brought to this issue and many individuals advocate that intersex individuals should be allowed to remain intersex past infancy and to not treat the condition as an issue or medical emergency.
- Metrosexual – (noun & adj) a straight man with a strong aesthetic sense who spends more time, energy, or money on his appearance and grooming than is considered gender normative.
- MTF/ M2F – abbreviation from male-to-female transgender or transsexual person.
- Passing – (verb) (1) a term for trans* people being accepted as, or able to "pass for," a member of their self- identified gender/sex identity (regardless of birth sex).
- (2) An LGB/queer individual who is believed to be or perceived as straight.

- While for many trans* people this considered to be a positive experience and allows them to reveal their trans* identity only at their own discretion, for many queer individuals passing is not a positive experience as it may feel invalidating or make them feel invisible within their own community.
- Preferred Gender Pronouns (PGPs) – (noun) a phrase used as an affirmative way of asking someone how they would like to be referred to (common examples: she/ her/hers, he/him/his, they/them/ theirs, ze/zir/zirs).
- Trans* – (noun) an umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. Trans* people may identify with a particular descriptive term (e.g., transgender, transsexual, gender- queer, FTM).
- Transgender – (1) An umbrella term covering a range of identities that transgress socially defined gender norms; (2) (adj) A person who lives as a member of a gen- der other than that expected based on anatomical sex.
    - Because sexuality labels (e.g., gay, straight, bi) are generally based on the relationship between the person's gender and the genders they are attracted to, trans* sexuality can be defined in a couple of ways. Some people may choose to self-identify as straight, gay, bi, lesbian, or pansexual (or others, using their gender identity as a basis), or they might describe their sexuality using other- focused terms like gynesexual, androsexual, or skoliosexual.
- Transition(ing) – (noun & verb) this term is primarily used to refer to the process a trans* person undergoes when changing their bodily appearance either to be more congruent with the gender/sex they feel themselves to be and/or to be in harmony with their preferred gender expression.
- Transman – (noun) An identity label sometimes adopted by female- to-male transgender people or transsexuals to signify that they are men while still affirming their history as females. (sometimes referred to as transguy) Transsexual
    - (noun & adj) a person who identifies psychologically as a gender/sex other than the one to which they were assigned at birth. Transsexuals often wish to trans- form their bodies hormonally and surgically to match their inner sense of gender/ sex.
- Transvestite – (noun) a person who dresses as the binary opposite gender expression ("cross-dresses") for any one of many reasons, including relaxation, fun, and sexual gratification (often called a "cross-dresser," and should not be confused with transsexual).
- Transwoman – (noun) an identity label sometimes adopted by male- to-female transsexuals or transgender people to signify that they are women while still affirming their history as males.
- Two-Spirit – (noun) is a term traditionally used by Native American people to recognize individuals who possess qualities or fulfil roles of both women and men.
    - Being "two-spirit" was traditionally considered an honour, and a mark of wisdom, instead of being viewed as a stigma that it is in other cultures.
- Ze / Hir – alternate pronouns that are gender neutral and preferred by some trans* people.
    - Pronounced /zee/ and /here/ they replace "he" and "she" and "his" and "hers" respectively.
    - Alternatively, some people who are not comfortable/do not embrace he/she use the plural pronoun "they/their" as a gender-neutral singular pronoun.

Phew… that is a lot of information to take in.

Activity: First Impressions of LGBTQIA+ People

Materials	• Flip-chat paper • Markers
Time:	40 minutes

Answer the following questions to the best of your ability; this can be done as a group discussion, if the group is large break people into smaller groups:

1. *How and when did you come to learn that not all people are straight or cisgender?*
2. *Where did most of the influence of your initial impressions/understanding of LGBTQIA+ people come from? (e.g., family, friends, television, books, news, church)*
3. *Who is the first gay or lesbian character (TV, Film, Book, etc.) you experienced? What was the portrayal like? (e.g., healthy, accurate, exaggerated, negative)*
4. *Were your first impressions of LGBTQIA+ people mostly living with HIV, mostly not living with HIV, or something else?*
5. *How have your impressions/understanding of LGBTQIA+ people changed or evolved throughout your life?*

Breaking the myths!

The Top 7 Things to Unlearn about LGBTQIA+ People

1. You can't spot a gay person by the way they dress or act.
2. Being LGBTQIA+ is not a mental illness, or psychiatric condition.
3. HIV/AIDS is not an LGBTQIA+ disease.
4. Lesbians do not really just need the "right man" to set them "straight." Gay men do not really just need the "right woman."
5. Gay men are not paedophiles, and LGBTQIA+ people aren't trying to brainwash everyone to be gay. Straight people are the ones making all the gay kids.
6. LGBTQIA+ people are not unhealthy/unfit parents.
7. Things are not equal for LGBTQIA+ people in the world (not even in the United States), and even though it is "getting better," there is still a long way to go before LGBTQIA people have the same rights and protections as straight/cisgender people.

Sexuality

Putting the shoe on the other foot. It's time to reflect. These questions are designed to spark:

Discussion:

At what age did you realise you were straight?
When did you come out to your friends and family as being straight? Think of a situation in your life where you have been discriminated against for being straight? What were you denied?

Much in the same way gender is a vast spectrum of terms so is sexuality. You can get lost in the alphabet soup of definitions, LGBTIPQA…

A new way of approaching the issue of sexual orientation is to look at all: Sexes, Sexual Orientations, Gender Identities and Expressions (SSOGIE), it is a more inclusive terms for the massive spectrum that is sexuality. As we saw above your sexuality is based on who you are attracted to emotionally, physically and spiritually. Lesbian, Gay and Bisexual refer to sexual orientation terms whereas Transgender and Intersex refer to Gender identity. SSOGIE is a term that is able to cover all aspects as leaves no one out. It allows space for all diversity.

In the module Safer Practices, we saw the exercise that allowed us to explore the reasons why people have sex, we saw that there are so many reasons, and one of the conclusions drawn is that engaging in sex with someone of the same sex does not classify you as being "gay". Sexual orientation runs deeper than the physical. We need to look beyond what people do and look at who they are.

What's the difference between "homosexual" and MSM?

As we have seen from the text above a person who identifies as "homosexual" is a person who is attracted to someone of the same sex on a physical, emotional and spiritual level. Men who have sex with men (MSM) are male persons who identify as heterosexual (straight) but engages in sexual activity with other men for a variety of different reasons. As we have seen in past modules, people have sex for many reasons, from money to exploitation. The two terms are not interchangeable as they are very different, one must be careful when assigning a term without checking with the person in question first. Ask them, how do you identify your sexuality? They do not need to give you a response but if they do, please respect it.

Facilitator's note:

Below is a comprehensive list of terms that can be used classify sexual orientations or terms that are associated with sexual orientation, please note this list is not conclusive and will continue to grow as our understanding of sexuality grows. You do not need to learn all these terms but it is good to have them to refer to.

List of terms:

LGBPTTQQIIAA+: any combination of letters attempting to represent all the identities in the queer community, this near-exhaustive one (but not exhaustive) represents Lesbian, Gay, Bisexual, Pansexual, Transgender, Transsexual, Queer, Questioning, Intersex, Intergender, Asexual, Ally

Advocate: a person who actively works to end intolerance, educate others, and support social equity for a group

Ally: a straight person who supports queer people

Androgyny: (1) a gender expression that has elements of both masculinity and femininity; (2) occasionally used in place of "intersex" to describe a person with both female and male anatomy

Androsexual/Androphilic: attracted to males, men, and/or masculinity
Asexual: a person who generally does not experience sexual attraction (or very little) to any group of people
Bigender: a person who fluctuates between traditionally "woman" and "man" gen- der-based behaviour and identities, identifying with both genders (and sometimes a third gender)

Binary Gender: a traditional and outdated view of gender, limiting possibilities to "man" and "woman"

Binary Sex: a traditional and outdated view of sex, limiting possibilities to "female" or "male"

Biological sex: the physical anatomy and gendered hormones one is born with, generally described as male, female, or intersex, and often confused with gender

Bisexual: a person who experiences sexual, romantic, physical, and/or spiritual at traction to people of their own gender as well as another gender; *often confused for and used in place of "pansexual"*

Cisgender: a description for a person whose gender identity, gender expression, and biological sex all align (e.g., man, masculine, and male)

Cis-man: a person who identifies as a man, presents himself masculinely, and has male biological sex, often referred to as simply "man"

Cis-woman: a person who identifies as a woman, presents herself femininely, and has female biological sex, often referred to as simply "woman"

Closeted: a person who is keeping their sexuality or gender identity a secret from many (or any) people, and has yet to "come out of the closet"

Coming Out: the process of revealing your sexuality or gender identity to individuals in your life; often incorrectly thought to be a one-time event, this is a lifelong and sometimes daily process; not to be confused with "outing"

Cross-dressing: wearing clothing that conflicts with the traditional gender expression of your sex and gender identity (e.g., a man wearing a dress) for any one of many reasons, including relaxation, fun, and sexual gratification; often conflated with transsexuality

Drag King: a person who consciously performs "masculinity," usually in a show or theatre setting, presenting an exaggerated form of masculine expression, often times done by a woman; often confused with "transsexual" or "transvestite"

Drag Queen: a person who consciously performs "femininity," usually in a show or theatre setting, presenting an exaggerated form of feminine expression, often times done by a man; often confused with "transsexual" or "transvestite"

Dyke: a derogatory slang term used for lesbian women; reclaimed by many lesbian women as a symbol of pride and used as an in-group term

Faggot: a derogatory slang term used for gay men; reclaimed by many gay men as a symbol of pride and used as an in-group term

Female: a person with a specific set of sexual anatomy (e.g., 46, XX phenotype, vagina, ovaries, uterus, breasts, higher levels of oestrogen, fine body hair) pursuant to this label

Fluid(ity): generally, with another term attached, like gender-fluid or fluid-sexuality, fluid(ity) describes an identity that is a fluctuating mix of the options available (e.g., man and woman, gay and straight); not to be confused with "transitioning"

FTM/MTF: a person who has undergone medical treatments to change their biological sex (Female to Male, or Male to Female), often times to align it with their gender identity; often confused with "trans-man"/" trans-woman"

Gay: a term used to describe a man who is attracted to men, but often used and embraced by women to describe their same-sex relationships as well

Gender Expression: the external display of gender, through a combination of dress, demeanour, social behaviour, and other factors, generally measured on a scale of masculinity and femininity

Gender Identity: the internal perception of an individual's gender, and how they label themselves

Genderless: a person who does not identify with any gender

Genderqueer: (1) a blanket term used to describe people whose gender falls out- side of the gender binary; (2) a person who identifies as both a man and a woman, or as neither a man nor a woman; often used in exchange with "transgender"

Gynesexual/Gynephilic: attracted to females, women, and/or femininity

Hermaphrodite: an outdated medical term used to describe someone who is intersex; not used today as it is considered to be medically stigmatizing, and also misleading as it means a person who is 100% male and female, a biological impossibility for humans

Heterosexism: behaviour that grants preferential treatment to heterosexual people, reinforces the idea that heterosexuality is somehow better or more "right" than queerness, or ignores/doesn't address queerness as existing

Heterosexual: a medical definition for a person who is attracted to someone with the other gender (or, literally, biological sex) than they have; often referred to as "straight"

Homophobia: fear, anger, intolerance, resentment, or discomfort with queer people, often focused inwardly as one begins to question their own sexuality

Homosexual: a medical definition for a person who is attracted to someone with the same gender (or, literally, biological sex) they have, this is considered an offensive/stigmatizing term by many members of the queer community; often used incorrectly in place of "lesbian" or "gay"

Hypersex(ual/-ity): a sexual attraction with intensity bordering on insatiability or addiction; recently dismissed as a non-medical condition by the American Psychiatric Association when it was proposed to be included in the Diagnostic and Statistical Manual of Mental Disorders version 5.

Intersex: a person with a set of sexual anatomy that doesn't fit within the labels of female or male (e.g., 47, XXY phenotype, uterus, and penis)

Male: a person with a specific set of sexual anatomy (e.g., 46, XY phenotype, penis, testis, higher levels of testosterone, coarse body hair, facial hair) pursuant to this label

Outing [someone]: when someone reveals another person's sexuality or gender identity to an individual or group, often without the person's consent or approval; not to be confused with "coming out"

Pansexual: a person who experiences sexual, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions

Queer: (1) historically, this was a derogatory slang term used to identify LGBTQIA+ people; (2) a term that has been embraced and reclaimed by the LGBTQIA+ community as a symbol of pride, representing all individuals who fall out of the gender and sexuality "norms"

Questioning: the process of exploring one's own sexual orientation, investigating influences that may come from their family, religious upbringing, and internal motivations

Same Gender Loving (SGL): a phrase coined by the African American/Black queer communities used as an alternative for "gay" and "lesbian" by people who may see those as terms of the White queer community

Sexual Orientation: the type of sexual, romantic, physical, and/or spiritual attraction one feels for others, often labelled based on the gender relationship between the person and the people they are attracted to; often mistakenly referred to as "sexual preference"

Sexual Preference: (1) generally when this term is used, it is being mistakenly interchanged with "sexual orientation," creating an illusion that one has a choice (or "preference") in who they are attracted to; (2) the types of sexual intercourse, stimulation, and gratification one likes to receive and participate in

Skoliosexual: attracted to genderqueer and transsexual people and expressions (people who aren't identified as cisgender)

Straight: a man or woman who is attracted to people of the other binary sex than themselves; often referred to as "heterosexual"

Third Gender: (1) a person who does not identify with the traditional genders of "man" or "woman," but identifies with another gender; (2) the gender category avail- able in societies that recognize three or more genders

Transgender: a blanket term used to describe all people who are not cisgender; occasionally used as "transgendered" but the "ed" is misleading, as it implies some- thing happened to the person to make them transgender, which is not the case

Transitioning: a term used to describe the process of moving from one sex/gender to another, sometimes this is done by hormone or surgical treatments

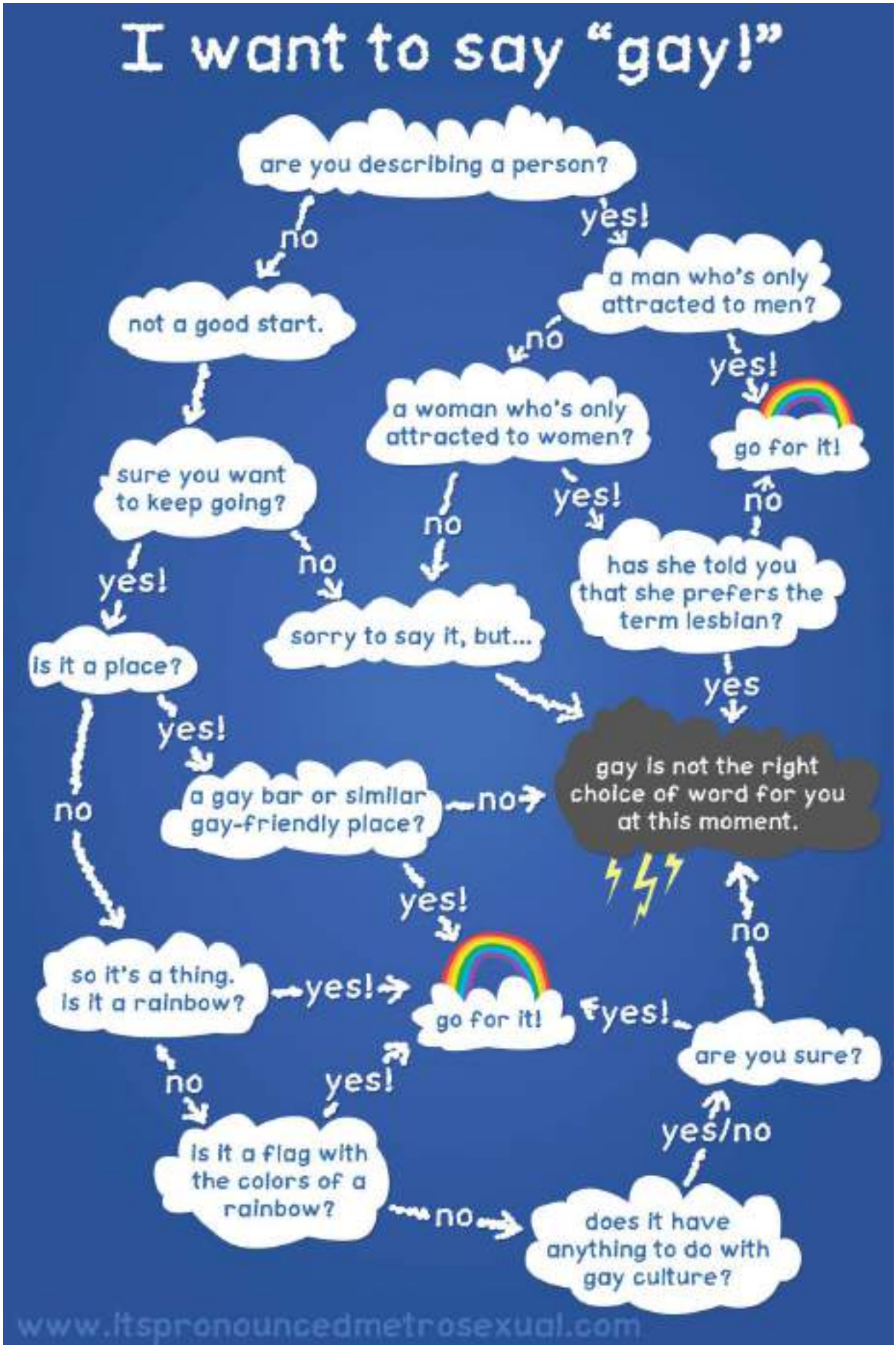
Transsexual: a person whose gender identity is the binary opposite of their biological sex, who may undergo medical treatments to change their biological sex, often times to align it with their gender identity, or they may live their lives as the opposite sex; often confused with "trans-man"/" trans-woman"

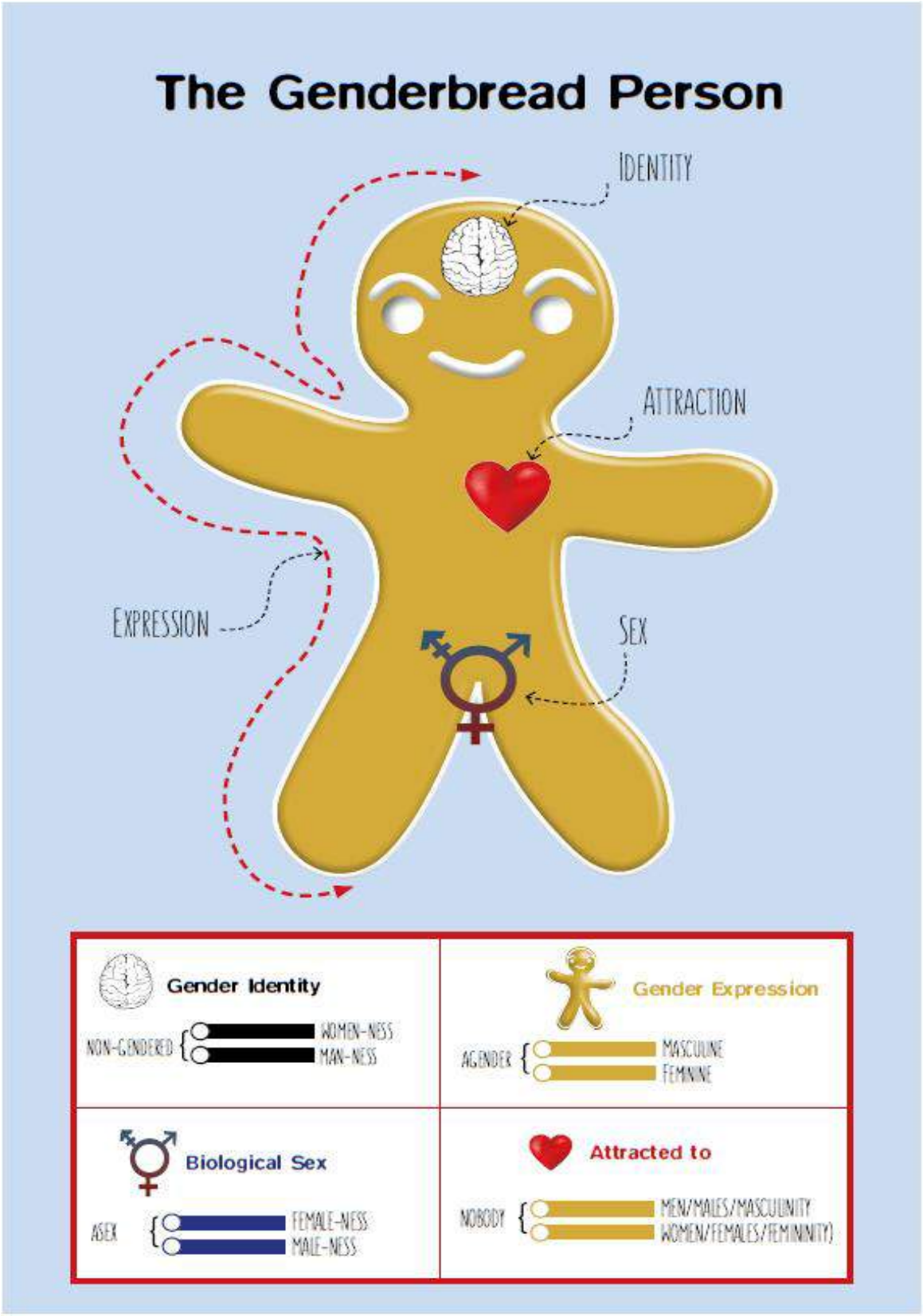
Transvestite: a person who dresses as the binary opposite gender expression ("cross-dresses") for any one of many reasons, including relaxation, fun, and sexual gratification; often called a "cross-dresser," and often confused with "transsexual"

Trans-man: a person who was assigned a female sex at birth, but identifies as a man; often confused with "transsexual man" or "FTM"

Trans-woman: a person who was assigned a male sex at birth, but identifies as a woman; often confused with “transsexual woman” or “MTF”

Two-Spirit: a term traditionally used by Native American people to recognize individuals who possess qualities or fulfil roles of both genders


I want to say "gay!"
are you describing a person?
no
yes!
not a good start.
a man who's only attracted to men?
no
yes!
a woman who's only attracted to women?
go for it!
sure you want to keep going?
yes!
no
no
yes!
no
has she told you that she prefers the term lesbian?
sorry to say it, but...
is it a place?
yes
yes!
no
gay is not the right choice of word for you at this moment.
a gay bar or similar gay-friendly place?
no
yes!
no
so it's a thing. is it a rainbow?
yes!
go for it!
yes!
are you sure?
no
yes!
yes/no
is it a flag with the colors of a rainbow?
no
does it have anything to do with gay culture?
www.itspronouncedmetrosexual.com



MEN/MALES/MASCULINITY WOMEN/FEMALES/FEMININITY)

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

GENDER

A LOOK AT THE DEEPER ISSUES

THIRD EDITION

Gender – a look at the deeper issues

Some of the following material was adapted (with permission) from the One Man Can Manual produced by SONKE Gender Justice.
Also: information on transformative masculinities taken from **"Contextual Bible Study Manual on Transformative Masculinity"** pages 10-12. Published by the Ecumenical HIV and AIDS Initiative in Africa (EHAIA), a programme of the World Council of Churches (EHAIA), Harare Office.
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Session Objective:	To enable learning about the complex issues that lie within gender and how they are all connected together.
Session Overview:	Complex issues within gender
Key Message:	Working together we can break the cycle
Biblical Scripture:	*"There is neither Jew nor Gentile, neither slave nor free, nor is there male and female, for you are all one in Christ Jesus" (Galatians 3:28, NIV)* "*So God created man in his own image, in the image of God he created him; male and female he created them.*" (Genesis 1:27)
Scripture Emphasis:	In God's eyes all persons are created in the image of God. We should treat each other with respect, dignity and justice regardless of our differences in sex, gender, age, or any other variable.

Islamic Emphasis:	*"Surely, Muslim men and Muslim women, believing men and believing women, devout men and devout women, truthful men and truthful women, patient men and patient women, humble men and humble women, and the men who give Sadaqah (charity) and the women who give Sadaqah, and the men who fast and the women who fast, and the men who guard their private parts (against evil acts) and the women who guard (theirs), and the men who remember Allah much and the women who remember (Him) - for them, Allah has prepared forgiveness and a great reward." (Qur'an 33:35)*
Scripture Emphasis:	Both men and women are equal in the sight of God. They are both judged by their actions
Expected Learning Outcome:	Discuss the importance of and how to include men in the movement for change and how to move forward as a united community
Toolkit References:	• SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	30 minutes
Resources	Cases for study

Facilitators note:

This module has a key focus on men and their role within society. Allow men the safe space to be open and honest, remember it is a no judgement space. Men are often left out of the discussion when addressing gender issues. We need to include them in order to help effect change.

Introduction to the module

This module seeks to explore the deeper issues that are attached to the role gender plays in our lives and how it can negatively impact our community. We shall look closely at the impact of gender roles and how societal pressure and expectations can do more harm than good. We will look at how transformative masculinity can help to break the cycle and help to implement change. How working with men can have a greater positive impact on them leaving them on the margins. We are not trying to silence men and take away the value they bring to the community, we are trying to enhance their sense of self-worth after the negative gender norms, myths are broken.

This section is intended to be a resource for those working with men and boys on issues of human rights, gender, health, sexuality and violence but it can also be used in a mixed setting. The module is intended to encourage men to reflect on their own experiences, attitudes and values regarding women, gender, domestic and sexual violence, HIV and AIDS and human rights, so that they can take action to help prevent domestic and sexual violence, reduce the spread of HIV and the impact of AIDS, and promote gender equality.

Case study

South Africa has amongst the highest levels of domestic violence and rape of any country in the world. Research conducted by the Medical Research Council in 2004 shows that every six hours, a woman is killed by her intimate partner. This is the highest rate recorded anywhere in the world. Violence against women in South Africa is a violation of women's human rights. Even though domestic and sexual violence are so widespread, arrest and conviction rates for perpetrators are amongst the worst in the world. In South Africa, it is estimated that only 10% of rapes are actually reported. Even more shocking is that, according to an October 2008 report from Tshwaranang Legal Resources and the Centre for the Study of Violence and Reconciliation, only 4.1% of reported rapes lead to conviction. This violence and the unequal power it reflects between men and women is one of the root causes of the rapid spread of HIV in South Africa. Almost one-third of sexually experienced women (31%) reported that they did not want to have their first sexual encounter and that they were coerced into sex. As a result, young women in South Africa are much more likely to be infected than men and make up 77% of the 10% of South African youth between the ages of 15-24 who are infected with HIV.

In some countries men are socialised into violence and commit the vast majority of violent acts. Men can learn violence as a result of experiencing it in childhood or as adults. But violence is a learned behaviour that can be unlearned. **Men can choose not to behave violently toward women, children, and other men.** Saying that men choose to use violence, rather than that men lose control and become violent, is the first step in holding men accountable for their decisions and actions. This principle of accountability is central to any programme focused on stopping gender-based violence. Choosing not to use violence and to live in equal relationships with women will involve men in **"breaking the gender rules"** and they need support as well as the pressure of accountability to do this. Support from women and other men can help men break the gender rules and end gender-based violence.

While many men and boys do worry about the safety of women and girls – their partners, sisters, mothers, girlfriends, wives, co-workers, neighbours, classmates and fellow congregants – and want to play a role in creating a safer and more just world, they often do not know what to do about it. As gender roles continue to change, a growing number of men are realising that relationships based on equality and mutual respect are far more satisfying than those based on fear and domination.

Men have many roles to play in stopping the violence. In their official capacity as community leaders and decision-makers, men can set the policies and budgets that can provide more help to prevent and intervene in cases of violence. As family and community members, men can intervene with perpetrators to stop the violence and can provide support to those children with whom they are in contact. Men can also serve as role models of gender equality for other men and can work with women as allies for gender equality.

Guiding Principles:

- Domestic violence and dating violence is everyone's business-it is not a "private matter". Too many people still say that domestic and sexual violence are private matters and argue that "it is not my business to intervene". Sexual and domestic violence are, of course, all of our business. Violence affects all of us and we each have a role to play in stopping it. There are many opportunities in our daily lives to take action when we witness someone being mistreated, disrespected or abused. We have to find the courage to act on our convictions that violence is wrong.

- There are no accurate stereotypes when it comes to men's violence against women. Domestic violence and sexual violence against women occur in all communities regardless of race, class and religious upbringing.

- **No one is safe until everyone is safe.** If violence against one group or individual goes unchallenged, then it allows violence to be justified against all of us. We all have a responsibility to ourselves and to each other to take a stand against violence. **Remember, silence can be interpreted as approval.**

- There are lots of reasons why dating violence, sexual violence and domestic violence are issues that boys and men should care about and take action to prevent. Men are often deeply affected by dating violence and domestic violence-as individuals by the pain suffered by victims they know and care about- their daughters, mothers, sisters, friends, colleagues, and as a group, by the fear and suspicion all men encounter as a result of violence committed by other men. Increasingly men are recognizing this and choosing to play a critical role in constructing a healthier world for women and men, free of violence and founded on principles of equity and compassion.

- Violence is learned; it can be unlearned. No one is born violent or abusive. These behaviours are learned and they can be unlearned. We can work together to promote the changes needed to build healthy relationships and healthy communities where we do not have to fear violence or worry about our loved ones.

- Violence is a choice and is a strategy for gaining power and control. Violent and abusive behaviours are strategies used to gain power and control over others. People who become violent may try to excuse their behaviour by saying that they "lost control", "couldn't stop themselves", "snapped", or "blacked out". In reality, people who commit acts of domestic violence do know how to manage their anger. After all, they rarely assault their bosses or their co-workers. And when they do use violence, they are often careful not to leave bruises in visible places.

- Always promote victim safety and perpetrator accountability. Domestic and sexual violence have devastating impacts on millions of women each year. Addressing this problem requires protecting victims from abuse and holding perpetrator's ac- countable for their actions. Counselling services for victims and abusers can help people heal from past abuse and learn to live violence-free lives.

- Make sure the group (when talking about issues) is safe for all participants. In almost any group there will be people whose lives have been affected by dating, sexual or domestic violence. Chances are that you will have members in your group who have witnessed or experienced violence at home or in a dating relationship. Be aware that these members may feel self-conscious, ashamed, or worried that they will be singled out in the group. Allow members to share as much or as little as they wish about their experiences. Invite members to speak with you privately after group sessions if they choose. Remind all members of their group agreements including confidentiality.

- Model equality in the group with equitable gender dynamics between facilitators, staff and group participants. Group participants will learn about healthy relationships from the activities and from their relationship with you and the other participants. Therefore, the facilitators must model the behaviours promoted in this programme by being fair and respectful at all times. The facilitators must never harm or intimidate a group member or allow any other member to do this in the group. If conflict occurs, the facilitator must deal with it in a firm but non-abusive manner.

Understanding Patriarchy, Power, Privilege & HIV

Patriarchy is a system of government or society where the men are the primary authoritative figures. Men can be in charge of political leadership, moral authority, social privilege and in control of property. This leaves women marginalised and without a voice. Women are made and seen as subordinate to men. Women's roles can be seen to be to bear children, look after children, the home etc. Their worlds are confined to what is mandated by men.

What is "transformative masculinities"?

"Transformative masculinities" speaks about the endeavour to generate masculinities that transform the world into a gender-equitable community". (Redemptive masculinities, p.8).

"Transformative Masculinity": Summarising the Concept

In different parts of the world, men have emerged as the gender that is mostly responsible for perpetrating sexual and gender-based violence. In addition, men are more likely to have multiple concurrent partners, thereby increasing their partners' (and their own) vulnerability to HIV. It is therefore critical to work with boys and men to change harmful perceptions of what it means to be men.

"Transformative Masculinity" seeks to challenge boys and men to contribute towards more helpful and life-giving ideas about what it means to be men. The idea is to challenge negative and harmful ideas of what a "real man" is. In many cultures, ideas relating to a "real man" suggest that a "real man" is one who:

- uses force and violence in relationships
- is rough, tough and insensitive
- does not recognise the human rights of women
- does not show any feelings/emotions (especially in public)
- does not accept the leadership of women

- accepts the use of language that denigrates/reduces the stature of women
- has sex with as many women as possible
- must always be in control; is possessive and dominating
- is exceedingly competitive and does not fail
- is addicted to work.

These (the list could be extended) assumptions and practices have led men to carry many heavy burdens. They have also caused a lot of harm to women. It is therefore vital for men to be empowered and liberated from oppressive notions of what it means to be a man. "Transformative masculinity" seeks to encourage boys and men to embrace more harmonious and tolerant ways of being men. The concept has been adopted to motivate boys and men to be "born again" in relation to their interpretation of who they are and how they relate to women, children and other men.

The overall aim is to contribute towards the multiplication of "gender equitable men" in our communities. These are boys and men who:

- Are caring and sensitive
- Respect women, children and other men
- Are faithful in relationships
- Grant their partners space to be independent and to grow
- Use dialogue, not violence, to resolve conflict
- Use respectful language towards women, children and other men
- Avail their time to children
- Avail equal opportunities to women and men
- Are willing to share responsibilities and chores in the home
- Accept the leadership of women and young people
- Actively promote the leadership of women and young people
- Challenge sexual and gender-based violence whenever they encounter it.

The Role of Religious Leaders in Promoting Transformative Masculinity

Religious leaders play an important role in promoting transformative masculinity. To begin with, religions have tended to support or to justify the abuse of power by men. Many men, including those who are not actively religious, appeal to sacred texts to justify why they should dominate women. Some perpetrators of sexual and gender- based violence maintain that religion has accorded them the right to do as they please with women. Religious leaders can help to challenge such abuses of religion by challenging men to be more sensitive and caring.

Religious leaders can promote transformative masculinity in the following ways:

- Leading lives that demonstrate the values of transformative masculinity (as summarised above)
- Using the pulpit to challenge men within the faith community to uphold the values of transformative masculinity, utilising existing structures and institutions (Sunday school, Youth/Men's/Women's groups) to instil ideals of transformative masculinity
- Harnessing examples of transformative masculinity from sacred texts, inviting non-governmental organisations that work with boys and men to promote transformative masculinities within their communities
- Utilising material (books, pamphlets, short movies, music, etc.) on transformative masculinity to increase awareness

- Reaching out to boys and men that are not members of their communities with messages of transformative masculinities, i.e., engage in outreach activities
- Maximising on special days such as Fathers' Day to promote transformative masculinity.

TEXT ABOVE TAKEN FROM "CONTEXTUAL BIBLE STUDY MANUAL ON TRANSFORMATIVE MASCULINITY" PAGES 10-12

This imbalance of power between women and men affects all aspects of men and women's social roles and sexual lives. Many of the conditions that allow HIV to spread result from a systematic misuse of male power and range all the way from interpersonal violence and coercion to institutional abuse: there is a continuum between women's
lower status, men's sexual entitlement, men's violence against women and women's inability to make and act on reproductive health choices because of a lack of access to economic power and proper healthcare. **To prevent HIV from spreading further, we need to create a more equal balance of power between men and women,** we need to make sure that individuals understand and work towards this change, and we need to change the institutions that should help us stop HIV and protect those who are already infected.

In order to make a difference to HIV it is important to talk about both the big, institutional picture and the small, intimate one: we need to carefully examine the connections between economic, political, social and sexual kinds of power. This analysis can help in identifying ways to balance the power between women and men in sexual relations by balancing power in the economy, community and family more equally.

Learning from men who have been role models

Activity

Session Objectives:	• *Invite men to talk about positive experiences with men and in so doing, set a tone for the workshop that encourages men to participate actively and to reflect on their own lives.* • *Promote the notion that men can play an important role in promoting gender equality by identifying gender equitable men who have served as role models*
Resources needed:	• *Flip-chart, masking tape* • *Brightly coloured 8 by 11 pieces of paper* • *Enough markers for all participants to use*
Time:	*30-45 minutes*

Activity

Steps

- *Ask participants to think of a man they know who is or was a role model to them.*
- *Ask participants to identify the qualities this man possessed that made him a role model.*
- *Ask participants to write two qualities that describe their male role model on a piece of coloured paper and attach it to the wall.*
- *Encourage those who are comfortable doing so to draw a simple sketch of this person on the same piece of paper.*
- *Ask how it feels to have the qualities and sketches up on the wall.*
- *Encourage them to see this as a way to bring these people and their qualities into the room.*
- *Ask if anyone has a hard time identifying a male role model. Ask the group how it makes them feel to not be able to identify male role models and why they think so many men have a hard time identifying male role models.*
- *If it is difficult for participants to name male role models, explore their reactions. Ask what thoughts or emotions come up in response to not being able to name a man. Quite probably they will feel sad, angry, surprised. Note their reactions.*
- *Ask men to identify ways in which they serve as role models and to whom.* Ask what qualities they would like to develop and how they plan on doing this.

Facilitators Notes

Many participants may have a hard time identifying positive male role models, some participants may have had absent and often abusive fathers so tread carefully. Explore with the group what effect they think "father absence" or violent fatherhood has had on contemporary society.

to the list of positive qualities and help the group see that most of these qualities have to do with being responsible, respectful, compassionate, caring, dependable etc. Point out that these qualities are not the standard ones that people associate with men. Those are usually qualities like "strong, dominant, successful, independent, tough" etc. Make the point that the qualities they identified in their role models are the ones that society really values. Encourage them to think about what they need to do to honour their role models and to serve as role models themselves.

Act Like a Man, Act Like a Woman

Activity

Session Objectives:	• *To recognize that it can be difficult for both men and women to fulfil the gender roles that are present in society.* • *To examine how messages about gender can affect human behaviour, and influence relationships between men and women.*
Resources needed:	• *Flip chart paper, Markers*
Time:	• *2 hours*

KEY POINTS

The messages that men get about "acting like a man" include:

- *Be tough and do not cry*
- *Be the breadwinner Stay in control and do not back down*
- *Have sex when you want it*
- *Get sexual pleasure from women*

These messages and gender rules about "acting like a man" have the following effects in men's lives:

- *Men are valued more than women.*
- *Men are afraid to be vulnerable and to show their feelings.*
- *Men need constant proof that they are real men.*
- *Men use sex to prove that they are real men.*
- *Men use violence to prove that they are real men.*

The messages that women get about "acting like a woman" include:

- *Be passive and quiet*
- *Be the caretaker and homemaker*
- *Act sexy, but not too sexy*
- *Be smart, but not too smart*
- *Follow men's lead*
- *Keep your man – provide him with sexual pleasure*
- *Don't complain*

Steps

1. Ask the participants if they have ever been told to "act like a man" or "act like a woman" based on their gender. Ask them to share some experiences in which someone has said this or something similar to them. Why did the individual say this? How did it make the participant feel?
2. Tell the participants that we are going to look more closely at these two phrases. By looking at them, we can begin to see how society can make it very difficult to be either male or female.
3. In large letters, print on a piece of flip chart paper the phrase "Act Like a Man."
4. Ask the participants to share their ideas about what this means. These are society's expectations of who men should be, how men should act, and what men should feel and say. Draw a box on the paper, and write the meanings of "act like a man" inside this box. Some responses might include the following:
   - Be tough. • Do not cry. • Yell at people. • Show no emotions. • Take care of other people. • Do not back down. • Be the boss • Earn money • Have more than one girlfriend/ spouse • Travel to find work

5.Once you have brainstormed your list, initiate a discussion by asking the following questions:
   - How does it make the participants feel to look at this list of social expectations?
   - Can it be limiting for a man to be expected to behave in this manner? Why?
   - Which emotions are men not allowed to express?
   - How can "acting like a man" affect a man's relationship with his partner and children?
   - How can social norms and expectations to "act like a man" have a negative impact on a man's sexual and reproductive health?
   - Can men actually live outside the box?
   - Is it possible for men to challenge and change existing gender roles?
6. Now in large letters, print on a piece of flip chart paper the phrase "Act Like a Woman." Ask the participants to share their ideas about what this means. These are society's expectations of who women should be, how women should act, and what women should feel and say. Draw a box on the piece of paper, and write the meanings of "act like a • • woman" inside this box. Some responses may include the following:
   - Be passive. • Be the caretaker. Act sexy, but not too sexy. • Be smart, but not too smart. • Be quiet. • Listen to others. • Be the homemaker • Be faithful • Be submissive

7. Once you have brainstormed your list, initiate a discussion by asking the following questions:

These messages and gender rules about "acting like a woman" have the following effects in women's lives:

- Women often lack self- confidence.
- Women are valued first as mothers and not as people.
- Women depend on their partners.
- Women have less control than men over their sexual lives.
- Women are highly vulnerable to HIV and AIDS and to violence.
- Can it be limiting for a woman to be expected to behave in this manner? Why? What emotions are women not allowed to express?
- How can "acting like a woman" affect a woman's relationship with her partner and children?
- How can social norms and expectations to "act like a woman" have a negative impact on a woman's sexual and reproductive health?
- How can social norms and expectations to "act like woman" have a negative impact on a woman's economic independence? (given that it is not expected of a woman to leave home and seek employment or other economic opportunities)
- Can women actually live outside the box?
- Is it possible for women to challenge and change existing gender roles? Could you see this community having a female leader?

8. Ask participants if they know men and women who defy these social stereotypes. What do they do differently?

9. How have they been able to challenge and redefine gender roles?

10. Ask if any of the participants would like to share a story of a time, they defied social pressure and rigid stereotypes and acted outside of the "box". What allowed them to do this? How do they feel about it?

11. Close the activity by summarizing some of the discussion and sharing any final thoughts. A final comment and questions could be as follows:

- The roles of men and women are changing in many societies. It has slowly become less difficult to step outside of the box. Still, it can be hard for men and women to live outside of these boxes. The roles of men and women are changing in many societies. It has slowly become less difficult to step outside of the box. Still, it can be hard for men and women to live outside of these boxes.
- What would make it easier for men and women to live outside of the boxes? - How can you support this change? - How can government support this change? - How can community leaders support this change?
- How can workplaces support this change?

Gender and Violence

Violence against women and girls is a cause and consequence of HIV infection. It is one of the key drivers behind the increasing number of women and girls living with HIV and AIDS. Young women are especially at risk, as a result of sexual violence, trafficking for sexual exploitation, child marriage and other harmful practices. Coercive sex increases the risk of contracting the virus as a direct result of physical trauma, injuries and bleeding.

The subordinate position that many women and girls hold within their families, communities and societies restricts their access to information about sexual and reproductive health and their use of health-care services. Fear of violence makes many reluctant to be tested or treated, and inhibits their capacity to negotiate safer sexual practices.

Women living with HIV may be marginalized, abandoned by their families or partners, thrown out of their homes, beaten, and even killed. They have faced forced sterilization and abortion, denial of treatment, and disclosure of their status to partners without their consent. Stigma prevents many from seeking even basic medical care where violence is linked to HIV.

Violence is neither blind nor random; its purpose is to control and manipulate. Violence is a tool of oppression used to claim and reinforce power and control. Gender-based violence can be defined as any form of violence that results from and contributes to gender inequality. Most people who use violence are men, and most victims of violence are women. We sometimes think of physical violence and aggression in individual terms, as a result of anger or a bad temper. But men's interpersonal violence takes place in a larger system of male violence. The purpose of this system is to maintain the current gender order, in which men have power over women.

This section provides an understanding of different forms of gender-based violence with particular focus on:

- The impact of gender-based violence on men, women and children;
- The gendered nature and purpose of men's violence against women;
- The role of violence in maintaining inequality;
- Skills and tools for stopping one's own violence; and
- Strategies for engaging men to respond to violence.

Key Objectives

Through the activities in this section we aim to:

- Educate participants about the difference between sexual consent and coercion.
- Challenge the notion that "no" ever means "yes".
- Remind participants that rape is a criminal offence carrying a lengthy sentence.
- Encourage participants, particularly men to take a stand against gender- based violence and for gender equality in their personal lives and in their communities.
    - Support participants, particularly men, to challenge the notion that domestic and sexual violence are personal matters and support them to act against abuse when-ever they see it or know of it.

This workshop aims to foster positive action and change and empower participants to become change agents in their own lives and community. This section aims to encourage action at different levels such as:

At the environmental level taking action to:

- Encourage participants to support and hold accountable their government officials and service providers – especially the police and health service providers– to enforce laws relating to violence against women.
- Encourage participants to educate and involve key stakeholders such as local political leaders, religious and traditional leaders, teachers etc.
- Mobilise community action against gender-based violence
- Facilitate access to support services and programmes for survivors of gender- based violence and other kinds of violence;

At the broader structural level taking action to:

- Demand that laws related to violence against women are fully enforced.
- Pressure for implementation of Africa-wide commitments to prevent gender-based violence.

Understanding the range of violence

People usually think of violence in terms of physical violence, but there are other forms of violence that are used to harm people and maintain power over them. Violence can also be psychological, sexual, emotional, or material (in terms of economic violence). It involves not only direct force, but also threats, intimidation and coercion. Violence does not have to be direct to be effective. The threat of violence has a devastating impact on lives and the choices and decisions people make.

Violence is an everyday experience for many people, especially women. Much violence is not even defined as a problem, but rather is accepted as a normal part of life. Street-level sexual harassment of women is one form of everyday violence that is not only widespread but also widely ignored. Everyday violence also includes the violence in relationships, especially those between young women and much older men. The power inequalities of both gender and age, and frequently economic status, within such relationships make violence almost an inherent part of them.

The reality and extent of violence is often minimized or denied. Some people may blame “bad” men for the violence, but say that it has nothing to do with them; others may blame women or argue that violence is justified. These attitudes are dangerous to women because they diminish the seriousness and pervasiveness of violence and allow it to continue. But there is no excuse for violence.

Men are, of course, negatively affected by domestic violence and rape as well. Boys who live in homes where their fathers abuse their mothers are often terrified by their fathers and the violence they commit; as a result, they can experience problems with depression, anxiety and aggression that interfere with their ability to pay attention at school. Similarly, all men are affected when women they care about are raped or assaulted.

Men's violence against women does not occur because men lose their temper or because they have no impulse control. Men who use violence do so because they equate manhood with aggression, dominance over women and with sexual conquest. Often, they are afraid that they will be viewed as less than a "real" man if they apologise, compromise or share power. So instead of finding ways to resolve conflict, they resort to violence.

These definitions of manhood are a recipe for disaster. They lead to high levels of violence against women and they also contribute to extremely high levels of men's violence against other men.

Impacts of violence

Women are the main victims of male violence, and their lives are damaged and destroyed in many ways by the range of men's violence. Men are also the targets of male violence, especially those who do not stick to the gender rules. Men who have sex with men are often the targets of male violence, for instance, because they break a perceived belief that says that men must only have sex with women. Gender-based violence victimizes all men, because it limits their ability to express all of themselves and their potential for healthy relationships with women, children and other men. Children, too, are heavily impacted by the physical, emotional and sexual violence of men in the home.

Dealing with gender-based violence

It is important to stress the value of a rights-based approach when dealing with gender-based violence. It is important to be specific about the rights of men, women, and children in relation to gender-based violence.
These rights include:

- The right to sex free from coercion or violence
- The right to life;
- The right to dignity;
- Freedom of movement and association;
- The right to decide where, when and under what conditions to have sex;
- The right to decide on the number and spacing of children.

A key principle of this rights-based approach is the indivisibility of rights – rights are inviolable: to be fully human, we need to have all of our rights recognized at all times. Violence is against the law, and anyone who witnesses violence has an obligation to do something about it.

Violence against Women in Daily Life

Activity

Session Objectives:	*Better understand the many ways in which women's (and men's) lives are limited by male violence and/or the threat of men's violence, especially sexual violence Identify some actions they can take to prevent violence against women*
Resources needed:	*Flip-chart paper, marker pen*
Time:	*90 min*

Steps

1. Draw a line down the middle of a flip chart paper from top to bottom. On the one side draw a picture of a man and, on the other, a picture of a woman. Let the participants know that you want them to reflect on a question in silence for a moment. Tell them that you will give them plenty of time to share their answers to the question once they have thought it over in silence

Ask the question:

- *What do you do on a daily basis to protect yourself from sexual violence?*
- *What do you lack in order to be able to protect yourself?*

2.Ask the men in the group to share their answers to the questions. Most likely none of the men will identify doing anything to protect themselves. If a man does identify something, make sure it is a serious answer before writing it down. Leave the column blank unless there is a convincing answer from a man. Point out that the column is empty or nearly empty because men don't usually even think about taking steps to protect themselves from sexual violence.

3. If there are women in the group, ask the same questions. If there are no women, ask the men to think of their wives, girlfriends, sisters, nieces, mothers and imagine what these women do on a daily basis to protect themselves from sexual violence.

4.Once you have captured ALL the ways in which women limit their lives to protect themselves from sexual violence, break the group into pairs and tell each pair to ask each other the following question – explain that each person will get five minutes to answer the question:

- *What does it feel like to see all the ways that women limit their lives because of their fear and experience of men's violence?*

5.Bring the pairs back together after 10 minutes and ask people to share their answers and their feelings. Allow plenty of time for this discussion, as it can often be emotional. Then ask each pair to find two other pairs (to form groups of 6 people) and discuss the following questions (write these out on newsprint) for 15 minutes:

- *How much did you already know about the impact of men's violence on women's lives?*
- *What does it feel like to have not known much about it before?*
- *How do you think you were able to not notice this given how significant its impact on women is?*
- *How does men's violence damage men's lives as well?*
- *What do you think you can do to change this situation and to create a world in which women don't live in fear of men's violence?*

Bring the small groups back together after 15 minutes and ask each group to report back on its discussion. Write down the groups' answers to the last question on the Action Chart. Sum up the discussion, making sure that all the key points are covered.

Facilitator's Notes

This activity is critical for setting and establishing a clear understanding of the extent and impact of men's violence against women. Be sure to allow ample time! This activity works best in mixed gender workshops where the ratio of men to women is reasonably balanced . But it can be included in any workshop.

If men are defensive, make sure to look more closely at their reactions. Make it clear that You are not accusing anyone in the room of having created such a climate of fear. Remind the group that you are trying to show how common and how devastating violence against women is.

Some people have strong emotional reactions to this activity. These reactions can include anger, outrage, astonishment, shame, embarrassment, defensiveness, amongst others. As workshop participants show their feelings, let them know that their reaction is normal and appropriate. Many people are shocked and become angry when they learn about the extent and impact of violence against women. Remind them that anger can be a powerful motivating force for change. Encourage them to identify ways to use their anger and outrage usefully to prevent violence and to promote gender equity.

Be aware that some men may think that they need to protect women from violence. If some men in the group say this, remind the group that it is important for each of us to be working to create a world of less violence. Men and women need to work together as allies in this effort. The danger of saying that it is up to men to protect women is that we take away women's power to protect themselves.

Key Points

Sexual violence and the threat of violence is an everyday fact for women. Sexual violence against women is a huge problem globally, across all sectors of society. This violence against women damages women's lives in many ways. Because men do not live with the daily threat of sexual violence, they do not realise the extent of the problem that women face. Men usually do not understand how actual and threatened sexual violence is such a regular feature of women's daily lives.

Men's lives are damaged too by sexual violence against women. It is men's sisters, mothers, daughters, cousins and colleagues who are targeted by this violence – women that men care about are being harmed by sexual violence every day. Social acceptance of this violence against women gives men permission to not treat women as equals and makes it harder for men to be vulnerable with their partners, wives and female friends.

Gender, HIV and AIDS

This section examines the relationship between gender, HIV and AIDS. It pays particular attention to:

- Gender and the burden of care and support;
- Men's low use of HIV services;
- The HIV vulnerability of women as related to their work and living conditions.

This section shows that men's attitudes and practices very often increase women's vulnerability to HIV. It calls for urgent attention to be paid to engaging men in trying to change both the gender and structural dynamics compromising the health of both women and men.

Key Objectives

In this section we aim to:

1. Encourage participants, particularly men, to use health care services, especially HIV services such as HIV testing and treatment and to join support groups for psychosocial support.
2. Encourage participants to use condoms correctly and consistently every time they have sex – including in non-monogamous, long-term relationships.
3. Encourage participants to decrease the numbers of concurrent sexual partners they have and advocate HIV testing before each new sexual relationship.

We aim to foster positive action and change and empower participants to become change agents in their own lives and community. This section aims to encourage action at different levels such as:

At the environmental level taking action to:

- Hold local stakeholders such as police, health service professionals and local leaders to their promises.
- Encourage community leaders to speak about gender-based violence and HIV

- Ensure that health services are accessible and friendly to men as well as to women, citizens, migrants and refugees alike.

At the broader structural level taking action to:

- Advocate for full access to treatment for all who need it – including full enrolment in prevention of mother-to-child transmission (PMTCT) programmes.
- Advocate for improvements in health care services and increases in the number of health care personnel.
- Encourage national governments to create a task force on men and HIV services, to dramatically increase the number of men using these services.
- Advocate for prevention activities.
- Encourage roll out of evidence-based methods to prevent HIV infection.

Key Points

Women face more risks of HIV than men because of their bodies. Women are more likely than men to get HIV from any single act of sex because semen remains in the vagina for a long time after sex, thus increasing the chance of infection. There is also more virus in penile fluids than in vaginal fluid. The inside of the vagina is also thin and is more vulnerable than skin to cuts or tears that can easily transmit HIV/STIs. The penis is less vulnerable since it is protected by skin.

Very young women are even more vulnerable in this respect because the lining of their vagina has not fully developed. Forced sex also increases the chance that the vagina will tear or cut. As with STIs, women are at least four times more vulnerable to infection. Women often do not know they have STIs as they often show no signs of disease. The presence of untreated STIs is a risk factor for HIV.

Women face more risks of HIV than men because they lack power and control in their sexual lives. Women are not expected to discuss or make decisions about sexuality; this is a man's job. The imbalance of power between men and women mean that women cannot ask for, let alone insist on using a condom or any form of protection. Poor women may rely on a male partner for their livelihood and, therefore, be unable to ask their partners or husbands to use condoms or refuse sex even when they know they risk becoming pregnant or infected with an STI/HIV. Many women have to exchange sex for material favours. This could be as blatant as sex workers, but also includes women and girls who exchange sexual favours for payment of school fees, rent, food or other forms of status and protection.

The many forms of violence against women (as a result of unequal power relations) mean that sex is often forced which is itself a risk factor for HIV infection. Women who must tell their partners about STIs/HIV may experience physical, mental, or emotional abuse or even divorce. Women may give in to their partner's wishes to avoid being yelled at, divorced, beaten, or killed.

Men take more risks with HIV because of the way they have been raised to think of themselves as men. Men are encouraged to begin having sex as early as possible, without being taught about caring for themselves, thereby increasing the possible time for them to be infected. A sign of manhood and success is to have as many female partners as possible. For married and unmarried men, multiple partners are culturally accepted. Men can be ridiculed and teased if they do not show that they will take advantage of all and any sexual opportunities.

Competition is another feature of living as a man, including in the area of sexuality – competing with other men to demonstrate who will be seen to be the bigger and better man. Another sign of manhood is to be sexually daring, which means you do not protect yourself with a condom, as this would be a sign of vulnerability and weakness. Many men believe that condoms lead to a lack of pleasure or are a sign of infidelity and promiscuity. Using condoms also goes against one of the most important signs of manhood - having as many children as possible.

Men are seeking younger partners in order to avoid infection, on the other hand, women are expected to have sexual relations with or marry older men, who are more likely to be infected.
(ADDITIONAL SOURCE: WHO FACT SHEET NO 242, JUNE 2000 – WOMEN AND HIV/AIDS.)

Impacts of HIV and AIDS

Activity

Session Objectives:	• *Understand better the personal impacts of HIV and AIDS* • *Be able to identify roles that men can play in reducing the impact of HIV and AIDS*
Time:	• *1 hour 25 minutes*

Steps

1. *Divide the participants into pairs, and have them sit next to each other. Ask each person in the pair to speak for 2 minutes in answering the following question; after 2 minutes, ask the second person in the pair to speak:*
    - *If you had HIV, in what ways would it change your life?*
2. *Then ask the pairs to take turns in answering the following questions, allowing each person 4 minutes to do so:*
    - *What would be the most difficult part about being infected with HIV? Why?*
    - *If you had HIV, what changes would you want to make in your romantic and intimate relationships?*
3. *Bring the group back together and lead a general discussion using the following questions:*
    - *How did you feel answering the questions?*
    - *How do Persons Living with HIV that you know or hear about deal with living with the virus?*
    - *How do people who do not know their HIV status think about what life would be like if they were infected with HIV?*
4. *Explain that you want to look more closely at the differences be- tween the impacts of HIV and AIDS on women and on men. Divide the participants into two groups. Ask the first group to discuss what it is like as a woman to live with HIV and AIDS and how women are affected by HIV and AIDS. Ask the second group to discuss what it is like as a man to live with HIV and AIDS and how men are affected.*

5. Allow 30 minutes for this group work and then bring the groups back together. Ask each group to present the highlights of their discussion. Then lead a discussion using the following questions:

- *What are the main differences between women and men in terms of living with HIV and AIDS? What are the main differences between women and men in terms of being affected by HIV and AIDS?*
- *How can men get more involved in caring for people who are living with HIV and AIDS and reduce the burden of care that women carry?*
- *What other roles can men play in reducing the impact of HIV and AIDS on women and on other men?*

Make a note of any action suggestions and sum up the discussion making sure that the key points are covered.

Facilitator's Notes

This activity can be very personal and emotional. There may be participants in the group who are living with HIV or who have close friends or family members who are living with HIV and AIDS. Remind the group that it is OK to pass on a question and encourage the participants to only share the information that they feel comfortable sharing.

If the participants do not feel comfortable talking about this in pairs, another option is to ask individuals to think about the first set of questions on their own and then go on to step 3.

Remember that men's and women's experience of HIV and AIDS will also be affected by age, class, caste, ethnic and other differences.

Key Points

Women are more heavily affected by HIV and AIDS than men. They are responsible for the health care of all family members. Care is only one of the many activities that women must do in working to support and take care of the family. This care is provided free but it has a cost! During illness or caring for ill people, women cannot do their other work and this has a serious impact on the long-term wellbeing of the household. Women bear a burden of guilt of possibly infecting their children. Living with the discrimination and stigma increases stress. Care does not end with the death of the husband/child/sister

Women are often blamed for not having cared for the husband enough, some even accused of being a witch. Care of orphans lies with grandmothers and aunts. Women careers are often test positive for HIV themselves.

Gender roles affect the way that men deal with HIV and AIDS. Gender roles can harm the health and wellbeing of men living with HIV. For instance, research has shown that even when men might want to participate in care and support activities, they may choose not to because of fears that, if they did, other men might ridicule them for doing women's work. Similarly, gender roles encourage men to think of seeking help as a sign of weakness. This discourages men from getting tested, using ARVs or from using support groups. This belief can also limit the amount of support men provide to others dealing with HIV and AIDS. These same gender roles also increase the likelihood that, instead of seeking support, men might rely on alcohol, drugs or perhaps even sex to deal with feelings of despair and fear.

Just like women, men too can play a greater role in reducing the impact of HIV and AIDS. We need to work with men to help them and challenge them to get more involved in care and support activities. Men can also talk with the women in their lives about sharing the tasks in the family or household more equally so that the burden is not all on women. Men have a critical role to play in supporting other men to deal with HIV and AIDS, both emotionally and practically.

References

UNAIDS (2014): *Unite with women unite against violence and HIV*. Geneva: UNAIDS
UNAIDS and The African Union (2015): *Empower young women and adolescent girls: Fast-tracking the end of the ADS epidemic in Africa*. Geneva: UNAIDS.

Reflection and Notes

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

GENDER-BASED VIOLENCE

THIRD EDITION

GENDER-BASED VIOLENCE (GBV)

Session Objective:	To enable learning on GBV; its various forms of manifestation; GBV and epidemics including COVID-19 and HIV; how the management of GBV can help in prevention of HIV and AIDS related deaths
Session Overview:	• Definition of GBV • Explanation of various forms of GBV • The relationship of GBV, Ebola, COVID-19 and other epidemics to HIV infection and AIDS death • The management of GBV in HIV prevention
Key Message:	Preventing GBV can reduce HIV (re)infections and AIDS-related deaths
Biblical Scripture:	*Let your gentle spirit be known to all men. The Lord is near*. (Philippians 4;5, NASB)
Scripture Emphasis:	Gentleness is a virtual encouraged by the Bible. This gentleness should be shown to all.
Islamic Scripture:	*The Believers, men and women, are protectors one of another: they enjoin what is just, and forbid what is evil: they observe regular prayers, practice regular charity, and obey Allah and His Messenger. On them will Allah pour His mercy: for Allah*

	is Exalted in power, Wise. (Qur'an 9 :71) *"O believers treat women with kindness even if you dislike them; it is quite possible that you dislike something which Allah might yet make a source of abundant good* (Qur'an 4:1)
Islamic Emphasis:	God created men and women as equal and made them tribes and nations for purpose of recognizing one another. Roles and responsibility are determined by traditions and culture.
Scripture Emphasis:	Both men and women are equal in the sight of God. They are both judged by their actions
Expected Learning Outcomes:	By the end of this module, participants will be able to: • demonstrate knowledge on the various forms of GBV and how they can be manifested • describe how GBV, HIV, COVID-19 and other epidemics may lead to HIV infection and AIDS death • prevent and manage GBV to reduce HIV transmission
Toolkit References:	• Introduction to SSDDIM • Modules on Stigma, Shame, Denial, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • PrEP • PEP • COVID-19/Ebola Epidemics • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour 30 minutes
Resources Needed:	Survivors of GBV; A resource person such as service providers and people who interact with victims and survivors of GBV; Case studies; Group activities; Documentaries on GBV; Two foolscaps; A pen; Scissors; Basket/box A projector; A computer; Felt pens; Manila paper; A stand

Activity:

Group Work: The Power walk-facilitator notes

On a piece of paper, write a few characters that could be male, female and of gender minority groups. Cut out the paper according to the characters enlisted and place those papers at a separate point. You can have characters like: a gay commercial sex worker, a lesbian woman, a cis gender woman, a transgender woman, a PLWD (woman), a male cross dresser and an intersex person

On a separate page, write a few statements that may reflect incidences of gender violence or discrimination against members of the above groups. Some of the incidences to include:

- *Can easily walk at night without fear of being attacked based on their gender or gender Identity-* ***Answer****-none*
- *Possesses socially acceptable traits outlined for their specific gender -****Answer****-cis gender woman**
- *Is easily misunderstood as an attention Seeker-****Answer****- lesbian woman, a male cross dresser, a gay commercial sex worker, a transgender woman*
- *Can easily express their sexuality without fear of Judgment-****Answer****- none*

Ask volunteers to come in front of the group for the sake of this activity

Place the previously cut papers on a central place and ask the members to randomly pick a piece for themselves

Afterr that. Ask them to stand on a straight line, at the same starting point and explain the rules of the game to them. That you will read out a few statements and those that feel that their character would be affected by that need to move forward. It is important to note that every character will react differently in different situations and that some of them may not move at all or may move a few steps compared to others

Once the exercise is over, ask each member to share their reasons for each reaction to your statement then expound on your explanation after they are all through.

What is of GBV?

Gender-based violence refers to harmful acts directed to an individual or group on the basis of their gender (Collins, 2013). It was originally perpetrated by men against women but with time, it has grown to include harsh treatment to individuals and groups based on their sexual and gender identity and their sexual orientation. At the moment, victims of GBV Include men who do not conform to societal gender expectations and some who conform to them.

Note to facilitator:

You should have done the task ahead of this session so that you can comfortably repeat it with the participants.

For this activity you will need:

- *A projector*
- *A computer*
- BBC Documentary: Kenya's Hidden Epidemic - BBC Africa Eye documentary - Bing video accessible with internet or pre-downloaded and saved
- *Felt pens*
- *Manila paper*
- *A stand*

Task:

Watch the BBC documentary on the prevalence of GBV in Kenya. Kenya's Hidden Epidemic - BBC Africa Eye documentary - Bing video *It explains a few forms of GBV and its effects. Ask participants to tell you some of the manifestations of GBV that they have seen on the documentary. Write them on a chart and go back to them as you facilitate participants to discuss each of the different forms of GBV and the relationship between GBV prevention and HIV transmission.*

Forms of GBV

GBV can be manifested in multiple ways. The following are forms of GBV:

- **Physical violence-** this entails the use of physical force to hurt or cause harm to someone else. It may be manifested through serious and minor assault, restriction of individual movement and homicide
- **Sexual violence**-a sexual act performed on an individual without their consent. It can be in form of rape or sexual assault
- **Psychological violence**-any act that causes psychological torture to an individual. It can take the form of coercion, blackmail, verbal insults or harassment
- **Economic violence-** this is fuelled by behaviour that aim at making an individual suffer financially. It can be manifested through property damage, restricting one's access to financial resources and failure to meet financial responsibilities as agreed upon

Some forms of GBV may occur at the same time or lead to others, for example, physical violence may cause psychological trauma to victims with time. Sometimes violence may be manifested in places and situations that are most unlikely like at home, online platforms, and among intimate partners. It is important to note that factors like inequalities experienced by someone due to their race, ability, age, social class, religion, social class and religion may fuel GBV. This means that some gender minority groups are more likely to face multiple forms of violence. (At their own free time, participants may watch Prevalence of GBV among Women with Disabilities - The Documentary Part 1 - YouTube)

Note:

It is important to note that GBV can be manifested and multiplied as a result of structural inequalities such as societal norms, attitudes and stereotypes on gender and violence against women. This makes it important to include **institutional/structural violence** that entails the discrimination of women in economic, social and political life while attempting to justify the occurrence of violence against women in our societies.

How to manage and prevent GBV in order to prevent HIV transmission

Some prevention and management measures for this include the following:

- Interventions that address factors that lead to increased exposure of women to HIV transmission like substance abuse and violence
- Interventions that promote positive relationship and parenting skills, conflict resolution
- Programs on guidance on drug and substance abuse
- Violence prevention messages
- Engagement with children in activities that promote the end of GBV and speak of the harm caused by GBV, gender roles, consent and traditional beliefs that easily promote HIV/AIDS and GBV
- Creating awareness on HIV transmission, GBV and substance abuse

- Formulation and implementation of policies that protect women from structural inequalities that make them more vulnerable to HIV transmission

Other factors include (UN Women, 2020):

- Creation of a safe environment in which survivors are listened to and believed in. This may help them get help faster even when they are in high risk of HIV prevention
- Provide essential services for survivors of GBV such as hotlines, counselling and reporting channels to help improve them lead improved and safer lives
- Creation of awareness on the forms of abuse, their various signs and how support can be offered to such an individual. This involves sharing a helpline for those in need to access help and demonstrating how this can be used (a local organization dealing with this, a social worker or facilitator can share a local helpline with his/her audience during this presentation)
- Standing up against rape culture that normalizes sexual violence by fuelling gender inequality and attitudes on gender and sexuality
- Women empowerment programs that help them gain financial independence and enable them to make better and informed decisions

A combination of prevention methods involving many sectors (such as health and education) and many approaches (such as behavioural and structural changes) would be required to prevent GBV in order to prevent HIV transmission and AIDS-related deaths (Orza, 2018).

GBV, HIV, COVID-19 and Epidemics

Activity

Case study

Upon hearing the president declare a countrywide lockdown as part of prevention measure against COVID-19, Halua thought that her husband would stop drinking and beating her whenever he came home drunk. A few months into the lockdown, she realized that things would get worse than she had imagined before. Within a few days, her organization issued layoffs and she was among the affected people. Her husband, Jusco, on the other hand, was occasionally working from home. This led to them having to stay indoors for majority of the time. At first, they thought they would get through the situation and use it to improve their marriage and improve themselves. As time went by, Jusco started drinking more and abusing her physically. One day he forced himself on her sexually and over time it became frequent. Initially she pleaded him not to sexually abuse her but reluctantly learnt to give and convinced herself that she was obligated to as his wife. One day, Halua came across an article on intimate partner violence and realized that she had been a victim of intimate partner violence.

GBV and HIV

GBV is associated with various acute health situations such as HIV/AIDS. Since women and minority groups like FSWs, transgender women and women who inject drugs are majority of victims of GBV, they are more likely to contract HIV. They are also more likely to be at risk of HIV morbidity and mortality due to their marginalization in society and challenges that they face in accessing HIV services. They are even recognized as part of the key populations by HIV organizations like the Joint United Nations Program on HIV/AIDS (UNAIDS, 2019)

Research indicates that women who experience GBV are more likely to engage in sexual behaviour that may put them at risk of contracting HIV like engaging in unprotected sex. They are also more likely to have unknowingly contracted HIV from their sexual partners. WLHIV also experience a higher risk of experiencing violence. GBV is also associated with several acute and long-lasting health consequences including HIV.

GBV may act as a barrier to:

- Access to HIV testing,
- linkages to HIV care and treatment
- Uptake of HIV treatment like PrEP and PEP
- an individual's ability to take adhere to treatment

It is therefore important for HIV prevention and management interventions to address violence against women, meet their individual healthcare needs and also achieve public health-oriented HIV epidemic goals (USAID, 2021)

COVID-19 and HIV

Note for facilitator

You may invite a health worker to act as a resource person in this exercise and share their personal encounter with HIV/AIDS and COVID-19 in their work or through their lives.

COVID-19 is a virus that has been with us for quite some time now. It has affected many people across the world, has led to death and serious illness. Just like HIV, when COVID-19 begun there was a lot of stigma attached to it. People mainly feared contracting the disease and dying of it leading to discrimination of those affected or suffering from the virus. Some experiences and techniques used in the AIDS epidemic such as working with local communities to get tailored solutions came in handy in terms of dealing with COVID-19 too. Some

of the precautions to reduce the spread of the virus include washing or sanitizing hands often, using face masks, staying at home unless it is necessary to go out, keeping a distance of at least 1.5m between persons, and isolating if infected (UNAIDS, 2021).

Activity

Group activity – How to wash hands

Ask the members present to divide themselves into pairs

Demonstrate the hand washing technique- through a video and live demonstration

Ask each pair to remind each other of the steps as they enter the next sessions or during hand washing.

COVID 19 and PLHIV

- PLWHIV like people with other chronic illnesses are at more risk of COVID-19 infection than others because of their low body immunity.
- Due to lockdowns and travel restrictions, there was a delay in delivery of ARVs during the peak of COVID. This threatened to compromise individual's viral load as it affected their adherence to ARVs.
- PLWHIV should receive COVID vaccines regardless of their CD4 cells or viral load as it is more likely to help than harm them.They should also take additional and booster shots as they keep emmerging and receive additional shots to help them gain more protection against the virus.

Key messages for about COVID-19 vaccines for PLWHIV include the following:

- Everyone above 5 years and older regardless of their HIV status can be vaccinated for Covid-19
- Those with advanced HIV and or not on medications are required to get an additional primary shot of the vaccine if they are eligible
- Everyone from 12 years and above including PLWHIV should get a booster shot if eligible

Note: It is important to observe COVID-19 guidelines and talk to a healthcare provider to get advice or know when you are eligible for a booster shot.

Note to the facilitator:

The facilitator may recap the history of HIV/AIDS transmission as explained in a previous module. They may also emphasize that since a vaccine has not yet been developed for HIV, IT IS IMPORTANT TO concentrate techniques for prevention of transmission and management of the virus.

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Church of Sweden

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COMPREHENSIVE SEXUALITY EDUCATION (CSE)

THIRD EDITION

COMPREHENSIVE SEXUALITY EDUCATION (CSE)

Session Objective:	To facilitate learning on Comprehensive Sexuality Education (CSE) as a SAFER Practice in preventing HIV (re)infections and AIDS related death.
Session Overview:	• What CSE is as a SAFER Practice • How CSE Empowers individuals against HIV infection and AIDS related deaths
Key Message:	A person's choice of action is guided by knowledge so CSE is power and therefore a SAFER Practice.
Biblical Scripture:	*Wisdom is the principal thing; Therefore, get wisdom. And in all your getting, get understanding. (Proverbs 4:7, NKJV)*
Scripture Emphasis:	Pursuit of knowledge and understanding is encouraged in the Bible. This makes it easier for one to make the right choices in life.
Islamic Scripture:	*He gives wisdom to whom He chooses, and whoever is given wisdom is blessed abundantly. But only insightful people bear this in mind. (Qur'an 2: 269).*
Islamic Emphasis:	He who does any action without knowledge is likely to do wrong things which may be a risk for self or others. Seek knowledge on any action you plan to do.
Scripture Emphasis:	Both men and women are equal in the sight of God. They are both judged by their actions
Expected Learning Outcomes:	By the end of this session, participants will have acquired: • a clear understanding of CSE as a SAFER practice • understanding the need to promote CSE in relation to HIV and AIDS for empowerment and human rights advocacy.
Toolkit References:	• Introduction to SSDDIM • Modules on Stigma, Shame, Denial, Discrimination, Inaction, Misaction

	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • PrEP • PEP • COVID-19/Ebola Epidemics • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	Flipchart paper and pens Scissors, glues, paper, paints, magazines(these are for an optional exercise)

What is CSE

Comprehensive Sexuality Education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical, and social aspects of sexuality.

Why is CSE important?

Many children and young people approach adulthood faced with negative conflicting messages about sexuality. These messages arise from misinformation from social media and peers which is exacerbated by norms, rules and taboos which discourage public discussion of sexuality. This makes many children and young people not empowered to take control and make informed decisions about their sexuality. As a consequence, many of them are not prepared for safe, productive and fulfilling life where HIV and AIDS, unwanted pregnancy, Gender Based violence and inequality do not pose serious risk to their wellbeing.

Aims of CSE

CSE aims to:

- Equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity;
- Develop respectful social and sexual relationships;
- Consider how their choices affect their own well-being and that of others; and
- Understand and ensure the protection of their rights throughout their lives.

What is included in CSE?

CSE includes scientifically accurate information about human development, anatomy and reproductive health, as well as information about contraception, childbirth and Sexually Transmitted Infections (STIs), including HIV. It also explores issues about family life, relationships, culture and gender roles, and also addresses human rights, gender equality, bodily autonomy and threats such as discrimination, sexual abuse and violence.

CSE should be informed by evidence, adapted to the local context and logically designed to measure and address factors such as beliefs, values, attitudes, and skills that may affect wellbeing in relation to sexuality. It helps children and young people develop self-esteem and life skills that encourage critical thinking, clear communication, responsible decision-making and respectful and empathetic behaviour.

CSE should be delivered by well –trained and supported personnel in school setting and efforts be made to reach out-of-school children and young people. In school settings, CSE can reach a large number of children and young people before they become sexually active. In out-of-school setting, CSE can empower children and young people who are vulnerable to misinformation, coercion and exploitation.

Key point:

CSE should be**: s**cientifically accurate, incremental, age- and developmentally-appropriate, comprehensive, based on a human rights approach, based on gender equality, culturally relevant and context appropriate, transformative and able to develop life skills needed to support healthy choices.

Learning activities

These learning activities are mutually reinforcing and should be taught alongside one another among various groups based on age.

SN	TOPIC	Learning Activities
1	Relationships	Families
		Friendship, love and romantic relationship
		Tolerance, inclusion and respect
		Long term commitment
2	Values, Rights, Culture and Sexuality	Values and Sexuality
3	Understanding Gender	Human Rights and Sexuality
		Culture, Society and Sexuality
4	Violence and Staying Safe	Violence
		Consent, Privacy and Bodily Integrity
		Safe use of Information and Communication Technologies (ICTs)
5	Skills for Health and Well-being	Norms and Peer Influence on Sexual Behaviour
		Decision-making
		Media Literacy and Sexuality
		Communication, Refusal and Negotiation Skills
6	Violence and Staying Safe	Sex, Sexuality and the Sexual Life Cycle
		Reproduction
		Puberty
		Body Image
7	Sexuality and Sexual Behaviour	Sexual Behaviour and Sexuality

Reference

UNESCO (2018): *International Technical Guidance on Sexuality Education: An Evidence-Informed Approach* (Revised edition). Paris: UNESCO

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ISSUES WITH ADOLESCENTS & CHILDREN IN RELATION TO HIV/AIDS

THIRD EDITION

Issues with adolescents & children in relation to HIV

Session Objective:	To enable learning about issues relating to adolescents and Children Living with HIV (CLWHIV) and how these adolescents and children may be supported to live healthy and normal lives.
Session Overview:	• Issues with adolescents and children and HIV/AIDS • HIV transmission among adolescents and children • Causes of HIV transmission among adolescents and children • Symptoms of HIV among adolescents and children • Treatment of HIV among adolescents and children • Side effects of ART among adolescents and children • Ways in which adolescents and children living with HIV can be supported to adhere to treatment and live normal lives • Ways to find adolescents and children who have not been tested
Key Message:	With adequate support from adults for testing and treatment adherence, HIV is manageable among adolescents and children

Biblical Scripture:	*"He took her by the hand and said to her, "Talitha koum!" (which means "Little girl, I say to you, get up" Immediately the girl stood up and began to walk around (she was twelve years old). At this they were completely astonished." (Mark 5: 41-42:!")* *"But Jesus called the children to him and said, "Let the little children come to me, and do not hinder them, for the kingdom of God belongs to such as these. (Luke 18: 16)*
Scripture Emphasis:	The early exposure to information guides enable parents and carers of children and adolescents to provide life-enhancing care and support for children and adolescents living with and affected by HIV
Islamic Scripture:	*"The Prophet, Peace Be Upon Him, said to the woman who asked him about* *how much she was entitled to take from her miser husband without his knowledge:* *"Take in a seemly manner what suffices for you and your children" (Sahih Bukhari 5364)*
Islamic Emphasis:	Islam prioritizes the health of children so much that if the father is not willing to contribute to this, the religion allows the mother to take from the father what is necessary to suffice her and the children. This is allowed even without the knowledge of the father.
Expected Learning Outcomes:	By the end of this module, participants should be able to: • Discuss issues related to adolescents and children living with HIV • Engage with and support adolescents and children living with HIV to empower them to live normal lives • Advocate for and with children and adolescents living with HIV
Toolkit References:	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	Experts in paediatric HIV; community health workers; case study

Activity

Case study

Akili is a 6-year-old girl who lives with her grandmother. She gets sick often and most people in her community think she is bewitched. Children are not allowed to play with her for fear that they will get sick too. She feels sad and unwanted. One day, she confronts her grandmother and asks her to explain her condition. Her grandmother explains that she has HIV, a condition that makes her body quite weak in terms of fighting diseases. She encourages her that taking medicine given to her by doctors can make her strong just like other children. She tells her not to let the condition to define her and she can live like other children too. She asks a lot of questions in relation to the infection. By the end of this interaction, she is satisfied to have learned more of her condition. With her grandmother's love and support, she aims at being a joyful l girl and slowly educating others about embracing those living with her condition. She says she wants to become an activist for CLWHIV even when she grows up.

Facts about children and HIV

- In 2021, approximately 3.7 million children around the globe are infected with HIV, the virus that causes AIDS.
- Paediatric TB and pneumonia are leading causes of death for children living with HIV
- In the past, 33% of HIV positive children who did not receive treatment were likely to die before their first birthday; 50% likely to die before age 2; and 80% likely to die before age 5. Yet in 2021, only 63% of HIV exposed infants were tested by two months of age as recommended.
- A significant amount of these cases are in Sub-Saharan Africa and HIV/AIDS is one the leading causes of death of children (Dunkin, 2020).
- As with adults, HIV damages a child's immune system exposing them susceptible to diseases and other infections.
- With the right type of medicine and adherence to it, children can live long and healthy lives. Children living with HIV need our love, care and support to live normal lives

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Note for Facilitator:

You can invite a healthcare worker or paediatric HIV expert to give a talk on issues related with HIV and children

HIV transmission and children

Most children living with HIV are likely to have acquired it from:

- Their mothers
    - Mothers living with HIV can pass it on during birth if mother's bodily fluids mix with the baby's fluids for example in case of injuries
    - Their mothers through breastfeeding
- Child sexual abuse
    - Children can be infected through sexual intercourse with an infected person.
    - Children can be affected by older partners that they are assigned to through early marriage.
- High-risk behaviours e.g. injecting drugs, a common practice among street children and also having sex with other minors who are living with HIV
- Blood transfusion in hospital – though this is rare because blood is always screened before transfusion

(For more information on this, see: Dunkin, 2020)

- For the women who are tested and adhere to the treatment given to them if they test positive for HIV, the chances of them infecting their children with HIV/AIDS are pretty slim.

Symptoms of HIV among children

Some common symptoms are:

- Failure to gain weight or grow as may be expected of them by a doctor
- Brain or issues with the nervous system like having trouble walking and getting seizures
- Being sick often with childhood diseases like TB, pneumonia, diarrhoea and ear infections

Note:

- Not all children will have these symptoms
- These symptoms may vary according to age
- Some children may have these symptoms when they are not living with HIV

Opportunistic diseases and infections among children living with HIV

Just like the case is in adults, when HIV gets into and advanced stage, children start getting opportunistic infections because of low body immunity. Some of these infections can be deadly. for someone with a poor immune system. Some of the common ones are outlined below:

- Pneumonia
- TB
- Cytomegalovirus (CMV)-a double-stranded DNA from the herpes family that can cause end-organ disease for PLWHIV whose immune system is extremely weak or ineffective (Krel, Thomas and Uppal, 2020)
- Oral thrush

- Severe diaper rush from a yeast infection

HIV Testing for children

- WHO's latest treatment guidelines recommend that infants, if HIV-exposed, should be tested by 4 to 6 weeks and 9 months of age using virologic assay, and when the child stops breastfeeding with a rapid antibody test. Those found positive should be started on antiretroviral therapy immediately upon diagnosis. If the result is positive for either of these tests, your baby will need to start treatment straight away.

Challenges of treatment for children

Children can get similar treatment as that of adults through anti-retroviral therapy (ART). But there are more challenges for children than for adults. The challenges include:

- Some of the drugs may not be available in syrup form for babies and small children to easily ingest.
- Some of the drugs can also lead to serious side effects for children such as:
  - Diarrhoea
  - Coughs and colds
  - Loss of appetite
- Early diagnosis and timely initiation of treatment are particularly critical in the case of infants.
- Antiretroviral Therapy' study from South Africa demonstrated a 76 per cent reduction in mortality when treatment is initiated in the first 12 weeks of life among infants who test positive for HIV.

Note:

Even with this challenge, it is best for children to take ART. If children fail to take ART, it is estimated that 50% of them do not make it to their 2nd birthday. Older children who are living with HIV but do not have any symptoms can take ART to maintain good health.

New, children-friendly drugs are now available, particularly Dolutegravir-based HIV treatment for all children and provided dosing recommendations for children over four weeks of age and more than 3 kg. This tailored paediatric HIV treatment will help meet the urgent needs of vulnerable children as it comes as a strawberry-flavoured tablet that can be dissolved in water, making it easier to give to children too young to swallow tablets.

Activity

Group work

- *Divide the participants in groups of 12 each*
- *Ask one member for each group to stand in between the rest*
- *Ask an equal number of participants to stand on opposite sides of the individual at the centre and hold either of their hands*
- *Ask them to pull the person at the centre in opposite directions as the member who could not for in either roles, sits and observes the person at the centre*
- *Do this for two minutes then ask the observer to share what they had observed about the person who was being pulled at the centre*
- *Ask them to stop the pulling after a while and instead, walk up to the person, holding them or talking to them in a friendly manner then observe their reaction at this trial.*

Answer: *Most of the observers' observation will be similar. They are expected to have seen a strain in the person at the Centre, to have seen that they seem hurt, and are trying to stand on their own feet but they are unable to. When group members start showing compassion towards the subject of this exercise, one can easily observe that they seem livelier and at peace than they were before.*

Lesson: *CLWHIV face many challenges as they try to understand their conditions. Some of them may be struggling to adhere to their medication, coping up with their side effects, to understand their condition, to fit in with other children, among others. The last thing these children need is to be attacked by the community over their status. When this stop and they feel loved and cared for, they are able to thrive and live normal lives like others.*

Important points on children growing up with HIV

- It is important for children living with HIV to be provided with friendly and age-appropriate information on their conditions. This will empower them to live positively with HIV.
- They need to be reminded that it is not their fault they got sick and that they need to have a balanced diet and to faithfully get treatment.

- For children to navigate through living with HIV, they need social, financial and emotional support from their family and society.
- Children living with HIV may face bullying and discrimination due to their status unless their teachers and fellow students are guided on the myths and misconceptions of HIV and AIDS and given the right information.
- With adequate love and support, children living with HIV can lead normal lives just like HIV negative children.

Issues with adolescents and HIV

- Adolescents, may be divided into:
  - Early adolescents (10-14 years)
  - Late adolescents (15-19)
- Adolescence is one of the most hectic periods in human development.
- Adolescents have to come to terms with physical changes, hormonal changes and other changes.
- Comprehensive Sex Education is important to empower them to achieve holistic health
- Neglect of adolescent Sexual and Reproductive Health (SRH) issues pose many challenges to adolescents. Some of the common challenges are:
  - early pregnancy
  - high rates of Sexually Transmitted Infections (STIs) including HIV
  - Stress
  - Sexual coercion, exploitation, and violence

- Neglect of ASRH issues may expose adolescents,especially girls,to the risk of HIV and STIs,may lead to sexual coercion,exploitation and violence.
- Early marriage and sexual abuse.

All these challenges affect the overall health of adolescents and that of their families.

Activity

Group discussion

- *Divide the participant in groups of 10 or 5 depending on the total number of partcipants present for this activity*
- *Ask them to have a discussion on challenges they may have faced or have heard of in terms of ASRH*
- *You can ask them to list them and share the most common ones according to their group*
- *Compare and contrast what the groups have gethered and compile a separate list on the board then concentrate on the five most common ones*
- *Tie the issues raised to your explanation in the segment below'*

Barriers and challenges

Several barriers hinder adolescents from achieving good sexual and reproductive health. Mutea et.al (2020) classify some of these as follows:

Individual level

- Poverty that hinders adolescents from accessing ASRH since they have to pay for transport to health centres, consultation and for the medication that is to be given to them during such visits
- The negative attitude of healthcare workers scares adolescents from vising the facilities even when they need help. At times they may even travel further to save themselves from this
- Fear that someone else may disclose their condition or need for SRH and they may become subject to shame and ridicule

Relationship-level

- Lack of parental advice on ASRH or a discouragement by parents on the use of SRH products may cause the adolescents to seek misinformed opinions or advise from others
- Some adolescents may fear accessing ASRH services from the opposite gender due to cultural and societal taboos, including early marriage and sexual abuse
- Other fear that due to lack of privacy in the hospital setting, their confidentiality may be breached by a medical practitioner or some may mistakenly overhear the conversation

Organizational level

- Short-staffing in hospital
- Health facility costs
- Shortage of products
- Sometimes, the healthcare workers in charge of ASRH were reported to be absent leaving a gap in service provision
- For adolescents in school, they may need to confide in a teacher to access such services and sometimes that may make them vulnerable to backlash and a possible breach of confidentiality
- Health services not being adolescent-friendly
- Health staff often judgemental of pregnant adolescent girls and young women
- Need for adolescent peer mentors who are living with HIV and support groups

Community-level

- Due to the community association of ASRH to sexual practices, adolescents are afraid to access these services as they may be stigmatized for being indiscipline
- Religious beliefs about sex that term sexual activity among adolescents as a fornication as they are required to abstain until they get married are also barriers to accessing ASRH
- Myths and misconceptions about contraceptives. Some adolescents shun away from the use of certain contraceptives like condoms due to their association with discomfort and irritation from the lubricant which they assume may put them at risk of acquiring an infection

Policy-level

- Politics that constrain adolescents from achieving their SRH by viewing it as a low priority. On that note, there are very little policies and restrictive legislation that lead to ill ASRH. Most of the time, in the event that there are existing policies on this issue, they are often under implemented
- Lack of knowledge on ASRH policies that outline ASRH services and information that is to be conveyed to adolescents
- Under implementation of ASRH policies in some areas
- Lack of resources channelled to the ASRH sector that limits the extent to which program officers can provide ASRH information to the target audience when required to.

Note to facilitator:

Give opportunity to the participants to raise some ways to promote ASRH so that your notes are complementary.

Case study

Given the rise in teenage pregnancy, unsafe abortions and prevalence of HIV in Malii Village, the area chief organized a joint meeting with adolescents, their parents, healthcare workers and other relevant parties. He said that everyone was free to share in the discussion. He noticed that the adolescents were shy in participating in the open forum but raised issues while in their peer groups. Some of the issues they raised to explain the cause of what was happening in the community was that they at times had to go far in access to ASRH for fear that someone would see them get those services in their locality and shame them for that. They also said that they feared being shouted at by healthcare workers. This discussion went on for a while and the chief resolved to help in improving the situation. He asked members present to raise some recommendations to improve the sector. Some of the recommendations, like the provision of CSE and the use of mass media and community gatherings to create awareness were raised.

Addressing the barriers to ASRH

The following message extracted from FCI Messages of Hope on strategies of addressing gaps in adolescent access to HIV provision suffices:

Strategies to effectively reach and engage older children and adolescents are different from those used to engage younger children. Proven strategies to better address adolescents' needs in HIV service provision include:

- Youth engagement in support groups;
- Address and reduce gender-based violence;
- Mobilize community for change (schools, churches, mosques, etc.)
- Education programmes for caregivers;

- Support appropriate disclosure;
- Prevention efforts to reach youth before age

Additionally, as PEPFAR observes, in addressing barriers to ARSH, there is "need adolescent peer mentors who are living with HIV and development of support groups, such as Community Adolescent Treatment Supporters (CATs) in Zimbabwe.

References

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HIV in PRISON

THIRD EDITION

HIV in PRISONS

HIV TRANSMISSION IN PRISON

Note:

Before starting this module, it may be valuable to talk to prisoners and visit a prison. There are some very good prison museums in many countries, giving people a good sense of prison life. For example, in Malawi is the Mikuyu Prison Museum near Zomba in the South of the country. Up to 3000 prisoners were kept in the prison built for 100. Visiting the prison is a stark reminder of how inhumane conditions still are in many prisons through- out the world. If you are ever in Malawi this prison is not only a tourist attraction but can be a place of prayer and meditation for all people who are incarcerated.

Session Objective:	To enable learning about sex in prison as a way of HIV transmission
Session Overview:	Facilitator lead discussions on sexual practices in prison in relation to HIV and AIDS
Key Messages:	Prisoners, whether male or female, are at high risk for HIV infection. We need to be proactive in keeping prisoners safe, both in and out of prison.
Biblical Scripture:	*"… I was in prison and you came to visit me." (Matthew 25:36, NIV)*
Scripture Emphasis:	Prisoners need care and love, including provision of HIV prevention and care services.
Islamic Scripture:	*"O Prophet! Say to the captives in your hands: 'If Allah finds any goodness in your hearts, He will give you that which is better than what has been taken away from you, and He will*

	forgive you. Allah is Ever-Forgiving, Most Merciful.'(Qur'an 8:70)
Islamic Emphasis:	God forgives all sinners except who associate God with other gods
Expected Learning Outcomes:	By the end of this session participants should be able to • Discuss the culture of violence (including sexual violence) in prison and what this does to people within the system. • Design ways of advocating for elimination of violence in prisons • Design ways of advocating and supporting prisoners and former prisoners living with HIV.
Toolkit References:	• Introduction to SSDDIM • Modules on Stigma, Shame, Denial, Discrimination, Inaction, Misaction • The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • Sexually Transmitted Infections • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	30 minutes
Resources Needed:	Flipchart, papers, markers

Discussion:

Extract taken from the "Stanford Experiment" – www.prisonexp.org.

Read the following article:

The Stanford prison experiment was a study of the psychological effects of becoming a prisoner or prison guard. The experiment was conducted from Aug. 14-20, 1971 by a team of researchers led by Psychology professor Philip Zimbardo at Stanford University. Twenty-four students were selected out of 75 to play the prisoners and live in a mock prison in the basement of the Stanford psychology building. Roles were assigned randomly. The participants adapted to their roles well beyond what even Zimbardo himself expected, leading the "Officers" to display authoritarian measures and ultimately to subject some of the prisoners to torture. In turn, many of the prisoners developed passive attitudes and accepted physical abuse, and, at the request of the guards, readily inflicted punishment on other prisoners who attempted to stop it. The experiment even affected Zimbardo himself, who, in his capacity as "Prison Superintendent," lost sight of his role as psychologist and permitted the abuse to continue as though it were a real prison. Five of the prisoners were upset enough by the process to quit the experiment early, and the entire experiment was abruptly stopped after only six days. The experimental process and the results remain controversial. Talk about how life in prison is very different from life outside bars. How does the excerpt make you feel? Do you think you would behave differently if you were a guard, if you were a prisoner?

Note to facilitator:

You need to draw the following ideas from the discussion:

- *Prison is an abnormal environment and people will do abnormal things within its walls.*
- *There is a deeply entrenched culture of violence in prisons*
- *Intravenous (needle) drug use is high in prisons when compared to the general population. This can be due to addiction when entering prison, or feelings of depression and hopelessness within prison.*
- *Unsterile implements like needles and blades are used for tattoos, scarification and the simple ritual of cutting hair.*

Discussion in pairs:

The facilitator may request the participants in work in pairs to respond to the following question. A few of the pairs may share with the whole group.

Given the culture of abnormality and violence within prisons, how do you think sex will be used?

Note to facilitator:

You will need to draw out the following points about sex in prisons:

- *Sex is used as torture and is classed as rape.*
- *Sex can be used as initiation into gang life within prisons.*
- *Sex can be transactional (e.g. sex with prison guards to gain special favours).*
- *Sex can be comforting.*

Group Work:

The facilitator may divide the participants into groups to answer the following questions. The groups may present in plenary.

How does this affect

- *The transmission of HIV?*
- Prisoners living with HIV?

Some facts about HIV within the prison population:

- In some prison populations the HIV transmission rate can be up to five times higher than that of the general population.
- Prisoners do not stay in prison: they finish their sentences and return to society and to husbands and wives and partners and lovers.

Open Discussion:

Should prisoners have access to:

- *Antiretroviral therapy?*
- *Condoms?*
- *Voluntary Counselling and Testing?*

Prisoners and ARVs:

In most developed and some developing countries prisoners are given access to ARVs. Most prison authorities closely monitor the taking of ARVs in the right quantities and at the right time. However, once prisoners return to normal life, they can no longer rely on the prison structures for this. A number of

prisoners will have difficulty accessing their ARV treatment outside of prison, and there is difficulty ensuring they take their medication as prescribed. There is an opportunity here for faith communities to assist prisoners and their families by providing the structures for newly released prisoners to access ARVs and to take ARVs as prescribed.

SSDDIM

Prison ministry: How can faith leaders and prison ministers incorporate HIV education into their visits to prisons? How can they work together to mitigate HIV in prisons? (Both transmission and living positively).

Activity:

Design a short course on HIV for your prison ministers. This will have to take into account:

- *Group contact and individual contact*
- *Limited time you are able to spend with prisoner's*
- *Limited power that many prisoners have to control their health – both sexually and otherwise*
- *Stress the importance of listening. In many places' prisoners cannot do anything about their status. They have no access to ARVs and they may be exposed to extreme suffering if they disclose their HIV status. A prison minister may be the only person to whom they will be able to talk.*

Things to think about:

Shame: Many prisoners are already ashamed about being in prison. This shame, compounded with the shame of getting HIV or developing AIDS, can lead to a deadly silence. Furthermore, given the culture of prisons there is further shame in the way prisoners have acquired HIV.

Activity: Role Play

The aim of the role play is to get participants to practice their counselling skills and help them to develop ways of responding to the inhumanity of prison culture. Get a volunteer who is willing to play the role of a prisoner who isliving with HIV. Ask that person to disclose his or her status to another member of the group and share how the HIV infection was acquired. The selected person can play the role of one of the following:

- *A prisoner who was raped*
- *A prisoner who wanted sex as a comfort*
- *A prisoner who has a steady partner inside prison but is living with HIV*
- *A prisoner who is living with HIV and is being required to rape another prisoner*
- *A prisoner who is living with HIV and is being released soon*

How the counsellor responds is important. Encourage empathy and compassion. Stress the counselling skill of eye contact. Highlight important reactions from both people. Get each person to practice how they will respond. If there are unhelpful responses or responses that entrench the shame felt by a prisoner who is living with HIV, highlight this and perhaps have a group discussion on how we can all react better to the above scenarios

Stigma: Prisoners who are living with HIV are faced with a unique set of challenges both within and outside the prison. Within prison they may be exposed to extreme forms of physical violence and even death. Outside prison they may be denied ARV treatment as well as the societal support that they will need. Stigma around how prisoners acquire HIV often forces former prisoners not to disclose their status.

Activity:

- *If there is a prison in your area find out about their HIV education programme. If there is no programme in the prison, explore the possibilities of starting one.*
- *Often other programmes in prisons can bring about a decrease in the levels of violence and intimidation within the walls of the prison. If there are such programmes attach yourself to these if you can. HIV education can start with simple acts of kindness and compassion. Furthermore, by working alongside prisoners within other programmes you gain trust and may be able to start more formal HIV education through their intervention.*

Example: Dr Kishore Chandiramani, a lecturer in psychiatry based at the Queen Elizabeth Psychiatric Hospital in Birmingham, quizzed prison staff on whether the technique (Vippasana Meditation) had proved useful. He found it helped improve inmates' discipline and their willing- ness to co-operate with prison authorities. His work also showed that inmates who studied the technique were less prone to depression, feelings of hostility and helplessness and a sense of hopelessness.

If you know that a prisoner is being released and returning home, sensitise the community in preparation for his return. Speak about the violence of prison culture and how this can change people's behaviour. Find ways to encourage a faith environment of love and tolerance so that the former prisoner can talk about the prison experience. If the former prisoner is living with HIV, this can provide a springboard to disclosure and further help.

- **Denial:** Women prisoners are often thought not to get HIV in prison because it is assumed that female prisons are less violent and intimidating. This is not the case. Women need the same HIV education and support as their male counterparts. Women do get HIV in prisons.

- **Inaction**: There is an organisation called the African Prisons Project which you can find out about on www.africanprisons.org. Their focus is on "dignity and hope for prisoners through health, education and justice." They work primarily in Uganda but are looking to spread their wings into other parts of Africa. There also may be project ideas which you could to take to prisons in your community.

Reflection and Notes

Reflection and Notes

SEXUAL REPRODUCTIVE HEALTH RIGHTS

THIRD EDITION

Sexual and Reproductive Health Rights (SRHR)

Session Objective:	To enable learning on the relationship between SRH and HIV and AIDS, and possible interventions to improve SRH while living with HIV
Session Overview:	An introduction on SRH, SRHR and HIV Examples of SRHR violations Barriers to SRH Interventions for barriers to SRH Integrated SRH and HIV services Benefits of linking HIV to SRH
Key Message:	Comprehensive SRH may act as a HIV prevention strategy
Biblical Scripture:	*"Come now, let us reason together …" Is. 1: 18*
Scripture Emphasis:	There is no issue that cannot be discussed or have a solution if opportunity for dialogue is availed and safe space is also addressed.
Islamic Scripture:	*The Prophet – Peace Be Upon Him says: "Each of you is a shepherd, and each of you is accountable for his or her flock."* *The Messenger, Peace Be Upon Him, says: "Honour your children and give them good names." He also says: "He is not one of us who does not show mercy to our youngsters."*

	He also says: "He who does not show mercy will be shown no mercy (on the Day of Judgement)."
Scripture Emphasis:	Children are gifts and awards from the Almighty Allah; they are a trust in our custody. We must therefore care well for them and preserve them. "The responsibility of caring for children and the adolescent lies on the shoulders of the parents and the society at large.
Expected Learning Outcomes:	By the end of this module, learners are expected to have learnt the following: • The intersection between SRH and human rights • How failure to address SRH issues leads to HIV transmission • The barriers to SRH • Possible interventions to counter barriers to SRH • Services that can link SRH and HIV • Benefits of linking SRH and HIV
Toolkit References:	• The Human Immunodeficiency Virus • SAFER Practices • Access to Treatment • Antiretroviral therapy • PrEP • PEP • Sexually Transmitted Infections • Cervical Cancer and HPV • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	UNDHR, Pens, markers, Flipcharts

Sexual Reproductive Health (SRH)

Good SRH is a state of good physical, mental and social wellbeing of an individual in all matters related to sexuality and reproductive health

For universal access to SRHR to be achieved, there is need for a comprehensive SRHR approach across sectors. (Stars et.al, 2018).

This will lead to accessibility and affordability of SRH services for different groups in the population. It will in turn save lives and improve the quality of life of these individuals.

AIMS of SRHR

SRHR aims at addressing:

- SRH needs of individuals in the community.
- Issues such as violence, discrimination stigma, and lack of respect for body anatomy that may affect an individual's physical, emotional and social wellbeing.

SRHR and Human Rights

SRHR is related to multiple human rights like the ones mentioned below:

- The right to life
- The right to be free from torture
- The right to privacy
- The right to education
- The right against discrimination

SRHR ensures that individuals are entitled to goods and facilities that are:

- Adequate in number
- Easily accessible and affordable
- Accessible without discrimination and,
- Of good quality

N/B: Healthcare provider, knowledge and skills are highly beneficial in improving the quality of SRHR services

Examples of SRHR violations

- Denial of access to services to certain groups like women
- Poor quality of SRH services
- Not allowing individuals to make personal decisions on SRH
- Forced sterilization, forced virginity examinations, forced abortion without the consent of the affected party
- Female Genital Mutilation (FGM)
- Early marriages that exposes young girls to sex and increases their risk of HIV infection as they are vulnerable and have less power in such relationships

SRHR and HIV

SRHR are human rights that are fundamental to human development. SRHR covers sexual health, sexual rights, reproductive health and reproductive rights.

- There is a close link between HIV and SRHR.
- Lack of information about and access to contraceptives like condoms, which may lead to HIV transmission.
- Family planning needs. Family planning aid in the prevention of vertical transmission of HIV and promotes safer pregnancy among WLWHIV (Kangudie et.al, 2019)
- Since young women and adolescents are a key population especially in terms of SRH and HIV transmission, there is need for the formulation of policies and programs that solely cater for them. Other groups that are at a higher risk of neglect in terms of SRHR include members of the LGBTQI+ community and People Living with Disability (PLWDs).

SRHR and HIV services

To reduce SSDDM and to promote access to SRHR in order to prevent HIV transmission and AIDS-related deaths, SRHR should be integrated in health care services such as:

- Antenatal care
- Family planning
- Maternal, new-born and child healthcare
- Diagnosis and treatment of HIV and STIs
- Promotion of sexual health
- Preventing and managing GBV
- Cervical cancer and diseases of the female reproductive health system

Benefits of linking SRHR to HIV prevention include the following:

- Better HIV testing outcomes
- More and consistent practice of sex through usage of condoms
- Improved quality of care for PLWHIV and those accessing SRHR
- Improved access and uptake of HIV and SRHR services
- Inclusion of the marginalized and underserved populations in SRHR
- Better understanding and protection of human rights

Important points

- SRHR enables individuals to make their own choices in regards to their sexual health and access services to help them achieve that
- Failure in provision of SRH services like condoms may lead to risk of HIV transmission
- SRHR is related to multiple human rights like the right to life and the right to privacy
- Poor quality of SRH services is a violation to SRHR
- Several barriers like culture, individual preference and beliefs may hinder the promotion of SRH
- It is important to integrate SRH and HIV as they are closely related.
- Comprehensive SRH may act as a HIV prevention strategy

References

Starrs, A., Ezeh, A, Barker, G., *et al*. (2018) Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission. The Lancet, 391, 2642-2692. https://doi.org/10.1016/S0140-6736(18)30293-9

Kangudie, D.M., Guidigbi, H., Mensah, S. *et al.* Effective integration of sexual reproductive health and HIV prevention, treatment, and care services across sub-Saharan Africa: where is the evidence for program implementation? *Reprod Health* **16,** 56 (2019). https://doi.org/10.1186/s12978-019-0709-6

Mutea L, Ontiri S, Kadiri F, Michielesen K, Gichangi P (2020) Access to information and use of adolescent sexual reproductive health services: Qualitative exploration of barriers and facilitators in Kisumu and Kakamega, Kenya. PLoS ONE 15(11): e0241985. https://doi.org/10.1371/journal.pone.0241985

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

ADVOCACY

Human rights

THIRD EDITION

Human Rights

Material in this module is adapted from HIV/AIDS and Human Rights: A training manual for NGO's, community groups and people living with HIV/AIDS. Asia Pacific Council of AIDS Service Organisations (APCASO), 2002

Session Objective:	To enable learning about human rights are and how violation of these drive HIV/and AIDS
Session Overview:	Facilitator lead discussions on human rights in relation to HIV and AIDS
Key Message:	Protecting human rights is critical in preventing HIV transmission and AIDS-related deaths.
Biblical Scripture:	*Speak up for those who cannot speak for themselves, for the rights of all who are destitute. Speak up and judge fairly; defend the rights of the poor and needy (Proverbs 31:8-9).*
Scripture Emphasis:	Defense of human rights is commanded in scripture. It is a Christian imperative
Islamic Scripture:	*The prophet SAW said "All of you are shepherds and each of you are responsible for his flock. A man is the shepherd of the people of his house and he is responsible, a woman is the shepherd of the house of her husband and she is responsible. Each of you is a shepherd and each is responsible for his flock. (Abu dawud)*
Islamic Emphasis:	Islam has laid down some universal fundamental rights for humanity as a whole," According to Mawdudi, **the right to life, security, freedom and justice** are basic Islamic rights.

Expected Learning Outcomes:	By the end of this session participants should be able to: • Outline basic human rights • Discuss how violation of human rights drive HIV and AIDS. • Design ways of advocating for human rights for all
Toolkit References:	• SAFER Practices • Access to Treatment • Voluntary Counselling and Testing (VCT) • Empowerment • HIV and Human Rights
Time:	1 hour
Resources Needed:	UNDHR, Pens, markers, Flipcharts

What are human rights?

Definition of Human right (Noun) (Plural noun: human rights)

A right which is believed to belong to every person.

"A flagrant disregard for basic human rights."

Human rights, (HR) are rights fundamental to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible.

Universal human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of inter- national law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups.

There are lots of definitions of human rights including:

- Human rights are generally accepted principles of fairness and justice.
- Human rights are universal (they apply to everyone) moral rights that belong equally to all people simply because they are human beings.
- Human rights are universal, fundamental, inalienable rights, which all human beings are entitled to regardless of their race, gender, age, social class, national origin, occupation, talent, religion, or any other personal factor. All individuals are entitled to human rights simply because they are human.

All these definitions have one thing in common – they are based on the idea that all humans have certain basic rights simply because they are human.

Human rights are important as they:

- Allow every human to reach their full potential
- Recognise that every person is entitled to be treated with respect
- Allow different countries and people to live together peacefully
- Improve human well-being, and
- Protect people from the power of the state (and sometimes from the power of other institutions or organisations).

Eight characteristics (features) of human rights:

Human rights have many special features that make them different from other rights. The table below sets out the eight key characteristics of human rights and explains what they mean.

Human	Only human beings are entitled to human rights. Other legal entities (e.g. businesses), animals or the environment are not entitled to human rights
Universal	They apply to all persons throughout the world
Fundamental	They are important basic rights and should be given special protection by law.
Treat all as equal	Human rights recognise that all humans are born free and equal in dignity and rights.
Protect individuals from the state	States can't take away these rights they must respect, protect and fulfil human rights
Inalienable	They cannot be forfeited (given up), transferred or lost.
Inter-related and inter- dependent	Human rights are linked and dependent on each other. The use and enjoyment of a human right is dependent on an individual having all other rights as well.

Recognise the principle of humanity	Certain rights are absolute, for example, the rights to life, freedom from torture and freedom from slavery cannot be limited. Other human rights can only be limited in specific circumstances.

The HIV and AIDS pandemic is a global emergency threatening human development and welfare throughout large parts of the developing world. Poverty, unemployment, lack of access to quality and affordable social and health services, a lack of political will and gender inequality all conspire to increase vulnerability to HIV and AIDS. **The rapid spread of HIV is an indicator of the worsening state of human rights violations.**

HIV and AIDS and human rights are interrelated and interdependent. While the problem of HIV and AIDS is indicative of the existence of human rights violations, it is only through the protection, promotion and respect of human rights that the prevention and control of HIV and AIDS will be successful. It is also through human rights that those infected and affected by the disease can live a life of dignity and worth in society. Human rights address the needs of AIDS care (by protecting the human rights of those infected and affected by HIV and AIDS) and HIV prevention (by working on the factors that lead towards HIV transmission).

The broadening of human rights to all aspects of the disease and its prevention and care has accompanied a growing awareness of the scope of the epidemic and the political, social and economic conditions which promote transmission of the virus.

A human rights approach points out that HIV and AIDS needs to be approached beyond the individual and the family, and that the epidemic cannot be treated separately or independently from existing socio-economic structures.

- **IMPACT – to reduce the stigma and discrimination** associated with HIV and AIDS.
- **VULNERABILITY – to address the underlying social, cultural and economic conditions** that make people vulnerable to HIV infection.
- **RESPONSE – to create a more supportive environment and encourage participation** in the development and implementation of national responses to HIV and AIDS.

Governments are obligated to protect, promote, respect and fulfil the human rights of their people, particularly to ensure a positive and effective response to HIV and AIDS. Governments are principally responsible for creating the conditions and providing the necessary resources and services that will ensure the realisation of human rights. Civil society also plays a crucial role in supporting and defending the rights of individuals and communities and holding governments responsible to their human rights obligations. The development and promotion of a human rights consciousness and culture on the part of everyone in response to the epidemic is a necessary step toward the protection of human rights and achieving HIV and AIDS related public health goals.

Questionnaire

Prior to the workshop, once confirmed, participants can be asked to respond to a questionnaire. The questionnaire is designed to provide initial information regarding organisational activities, major human rights and HIV and AIDS issues and desired workshop outcomes (see below). The questionnaire design is simple. It may need to be translated and collected from the participants via e-mail. Results can then be compiled, analysed and factored into the workshop aims and outcomes.

HIV and AIDS AND HUMAN RIGHTS PROJECT: PRE-WORKSHOP QUESTIONNAIRE

Please take some time to answer the questions below. This questionnaire is designed to help you get the most benefit from the workshop. This questionnaire will be used to find out what the major HIV and AIDS and human rights issues are for your organisation. Your responses to these questions will help the workshop facilitators design and structure the workshop so that it addresses the issues that are important to you and to your organisation. Please attach extra pages and materials if you need to.

Name: .....
Organisation: .....
Email:.....
Please describe your role in the organisation. .....
.....
Please describe the current HIV and AIDS or human rights activities of your organisation (for example, AIDS prevention education/human rights education/ which communities or groups you work with).
.....
.....
.....
Please describe the major HIV and AIDS and human rights issues you and your organisation encounter.
.....
.....
.....
How do you think the workshop, training and action plan could be developed to assist you and your organisation (for example, what outcomes would you like to see?)
.....
.....

Case Study

Please write or attach a case study based on the work you do, which illustrates and describes the major HIV and AIDS and human rights issue for you and your organisation.
The case study does not have to be a long story. It should describe a situation based on your work which you feel concerns HIV and AIDS and human rights.

Evaluation of this information will let you know who to structure your workshop, let you know what work is currently underway and how to help the participant move forward after the training.

Key topics to look out for:
Lack of information and education increases vulnerability to infection.
Harassment and stigmatisation of marginalised and vulnerable communities creates a greater risk of infection and limits harm reduction interventions.

- Non-observance of the rights of women and children increases vulnerability to HIV infection.

How human rights violations impact on HIV and AIDS prevention and care

- Reluctance to have a test because of fear of discrimination and of being found out.
- Prevention interventions are limited because of fear of association with the disease.
- Inadequate/inappropriate or no post-test counselling denies access to health services.
- Reluctance to ask for health care because of fear of discrimination or harassment.
- Compulsory testing and lack of confidentiality leads to discrimination.
- Unwillingness to disclose HIV status hides the disease and reinforces the view that only certain groups get HIV.

Testing prevention and care continuum

Prevention care, support and treatment

- Lack of information and education increases vulnerability to infection.
- Harassment and stigmatisation of marginalised and vulnerable communities create a greater risk of infection and limits harm reduction interventions.
- Non-observance of the rights of women and children increases vulnerability to HIV infection.

WHAT ARE HUMAN RIGHTS?

General Objectives:	*To raise the level of awareness and understanding of human rights and HIV and AIDS workers and advocates and people with HIV and AIDS, on basic human rights concepts, principles and issues, and their relevance to and application in, development work, in general and HIV and AIDS work, in particular.*
Special **Objectives:**	• *To define the nature of being human;* • *To establish the link between being human and human rights;* • *To define human rights; and* • *To identify the principles of human rights*.
Resources Needed	*Flip chart paper, markers*
Time:	30min

Word Association:

Divide the participants into groups of 6 to 7. Provide each group with butcher paper and markers and ask them to write down all words/answers to the question: What is it to be "human"? Opposite each answer/word, write down the requirements needed to be able to realise or satisfy our humanity. Allow each group 10 minutes for presentation to the plenary.

Discussion Points:

Process the group outputs by identifying and consolidating the common responses presented by the different groups. Highlight the following points/ concepts in the discussion/synthesis:

To be human means:

- *To be able to engage in production or work which enables one to satisfy or meet his/her basic human needs like food, clothing, shelter and at the same time grow and develop;*
- *To think and decide for oneself in a condition that is free from coercion.*
- *Humans need to acquire knowledge, process and retain ideas and concepts, reason out and make choices; and*
- *To develop one's talents and potentialities in an environment that is free from alienation.*

The essence of being human is anchored on three basic principles, namely: **life, dignity and development.** It is not enough that individuals survive in society. They must live as **human beings should in an environment where they are able to satisfy their basic human needs, are able to live with dignity and respect; and are able to develop and maximise their full human potential,** and this applies to people with HIV and AIDS and others affected by the disease.

Being human entails living with others. Individuals realise their humanity in the context of living collectively with others or as members of society. Becoming human is closely integrated with the pursuit of collective goals, and the promotion of societal interests. Concomitantly, the advancement of society is closely linked with the process of individuals realising their humanity.

Activity "The Baby in the Picture"

Resources Needed	*Materials needed: flip-chart paper, markers, picture of a baby taken from a magazine*
Time:	*30 min*

- *Paste a picture of a baby on a board/wall. Divide the participants into groups of 6–7 members per group and provide each group with strips of butcher's paper and markers. Instruct the members of each group to write down their answers on the strips of paper to the question:* ***What does the baby need to have a full life and live as a human being?*** *Every answer is to be posted on the board/wall around the picture of the baby.*

Ask the following questions to process the answers given:

- *Why do you think the baby needs all those in the strips of paper? What good will these do to the baby?*
- *Does the baby deserve all these? Why or why not?*
- *How about you? Do you deserve to have what the group thinks the baby should enjoy? Why or why not?*
- *Are there other things adults must have to have a full life? What concept/Idea do you think can be used to refer to all the things babies and adults need to have in order to lead a full life or to live as human beings?*
- *What do you think might happen if babies and adults are deprived of all these? Is such a situation acceptable to you? Why or why not?*
- *What is the acceptable situation for you? What role do human rights play in one's life? (IMPORTANT: By this time, the group must have already identified the concept of human rights.)*

Discussion Points:

- *Human rights are what make men/women human. They represent individual and group demands for the shaping and sharing of power, wealth, enlightenment and other cherished values in community processes.*
- *Human rights are a set of guarantees for a person not only to exist but also to live with all the necessary conditions, which befits a rational being. They are protective devices designed to shield individuals from random violence and neglect.*

- *Human rights are entitlements or legal claims that individuals by virtue of being human have against the State. They deal with the relationship between the State and the individual.*
- *Human rights are deemed as state obligations.*
- *Human rights are universal, inalienable, interrelated and interdependent.*

Universal *because all individuals have human rights as they are human beings: male, female, rich, poor, black and white, young and old, etc.*
Inalienable *because everyone is born with the same human rights. They cannot be taken away, lost or surrendered whatever the person does, whoever and wherever the person is.*

Interrelated and Interdependent *because the different types of human rights are co-equal and important. They are due to every individual regardless of race, colour, sex, language, religion, political belief, social origin and birth status. They ensure dignified existence of all human beings.*

IMPORTANT: **The concepts of universality, inalienability, inter-relation and interdependence are important and need careful facilitation. Participants may have not encountered these terms before and may have difficulty understanding their meanings and the relationship between needs and entitlements. One way to simplify this and establish the connection between life, dignity and development and the legal basis of human rights is to summarise the discussion points**.

- *Human rights are what make us human and encompasses individual and social needs.*
- *Human rights are a set of guarantees human rights constitute a contract between people and governments and this gives a social character to human rights.*
- *Human rights are entitlements that is, the legal development of the social contract of human rights.*

Understanding the universal declaration of human rights

Resources Needed	*Copies of the Universal Declaration of Human Rights, flip-chart paper, markers*
Time:	120min

Objectives:

- *To understand the contents of the Universal Declaration of Human Rights (UDHR); and*
- *To identify domestic laws which promote and protect human rights.*

Activities: "A Personalised UDHR"

Divide the participants into groups of 6–7 members per group. Provide each group with a copy of the Universal Declaration of Human Rights. Assign each group with 4–5 articles and instruct them to reformulate each article based on their personal understanding and using their own words. Remind the groups to avoid repeating the words used in the original version. What local/domestic laws, regulations promote and protect these rights. Provide each group 15 minutes for presentation of the group outputs.

Discussion Points:

The UDHR was formulated to prevent the recurrence of the atrocities committed during World War II. It took a little over 3 years to complete the document, which was adopted by the United Nations General Assembly in Paris on December 10, 1948. The UDHR contains 30 articles. Article 1 is a recognition that all human beings are born equal and have human rights; Article 2 is an article of general application and is true to all the succeeding articles; Articles 2–28 enumerate and describe the rights and freedoms accorded to all men and women; and Articles 29–30 deal with duties and limitations, as well as abuse. The human rights of individuals are likewise promoted and protected in existing domestic/local laws like the Constitution, labour laws, penal codes, laws against sex trafficking, child labour, violence against women, discrimination, etc. (NOTE: Elaborate contents of these laws and relate to particular cases.)

Kinds of human rights

Resources Needed	*Collect articles from local newspapers on human rights issues* *Flip chart paper* *Markers*
Time:	120min

Collect at least 7 articles from leading local newspapers containing stories reflecting issues related to different human rights contained in the UDHR. Divide the participants into groups of 6–7 members per group and give each group an article for discussion. Ask each group to answer the following guide questions:

- *What rights are tackled in the article? What kinds of rights are these?*
- *Who are the victims? Who are the violators? Is the state accountable? In what way is the state accountable?*
- *How can these rights be protected?*

Convene the groups for the plenary and give each group a 10–15-minute presentation of their outputs. It is advisable that the presentation of the outputs be in tabular form as shown below.

Discussion Points:

Highlight the following important points:

Civil and political rights are:

Embodied in the UDHR (Articles 2–18 are Civil rights, Articles 19–21 are Political Rights) and the International Covenant on Civil & Political Rights (ICCPR);
Also referred to as first generation of rights, classic rights, individual rights;
Intended to entail an obligation from the government to refrain from certain actions; and
Geared mainly to restricting the powers of the State in respect of the individual.

Examples of civil rights *are right to life, liberty, freedom from torture, to access to relevant information, to defend and be heard in person, to freedom of residence, to marry, to enter and leave a country, etc.*

Examples of political rights *are right to freedom of expression, freedom of assembly, freedom of association, to vote, to political participation, to free and periodic elections, etc.*

Specific Rights
Classification of HR
Victims
Violators
State Accountability
Ways of Protecting

Setting the scene – An overview of the epidemic

Objectives:

To provide a basic overview of the epidemic in the country in which the workshop takes place.

Facilitator: Presentation/Discussion
This should include:

- An overview of the current epidemiology;
- An overview of the government response (including national planning);
- An overview of the NGO/civil society response; and
- Major treatment, care and prevention issues.

STIGMA, DISCRIMINATION AND HIV

Resources Needed	*Flip chart paper* *markers*
Time:	60min

Objective:

- *To discuss stigmatisation and HIV and AIDS (the social dimension of the epidemic).*
- *To explain the relationship between HR and HIV and AIDS; and*
- *To identify the human rights associated with HIV and AIDS*

What is Stigma?

In a session, ask the participants to identify behaviours, attitudes, beliefs, etc. that they think carry stigma. Write these down on a white- board.

Discussion points:

Stigma is associated with attributes and behaviours, which are seen by many people to be contrary to prevailing norms or accepted ways of behaving in society (for example in many countries, sex work is a stigmatised activity). AIDS was first associated with individuals and groups who already carried the burden of stigmatised practices and behaviours. Views and responses to the disease evolved from a complex matrix of existing views on homosexuality, illegal drug use, and fears and beliefs about the disease, in particular the fatal nature of AIDS. AIDS gave renewed life to the concept of disease as punishment, historically a widespread belief and explanation as to why some people get sick and others remain well. With the advent of AIDS, metaphors of plague, contagion, pollution and otherness became significant moral readings on the meaning of the disease.

Ask participants to think about and discuss the effects of stigma.

Discussion points:

*Stigma creates **BLAME** by others of these people for the issue that stigmatises them*
*Stigma leads to **SHAME**, on the part of the person or people stigmatised*
*Stigma leads to the perception that stigmatised people are **DIFFERENT** and not as worthy as others*

Ask participants to think about why AIDS is a stigmatised disease. Write suggestions on the whiteboard.

Discussion points:

- *HIV and AIDS is the most stigmatised modern disease. HIV and AIDS carries multiple stigmas because of the way it is transmitted and the people who are perceived to be infected and affected by it.*
- *HIV and AIDS is associated with **SEX and SEXUALITY**. These are often difficult subjects to talk about because they touch on intimate and personal behaviour. AIDS has become associated with homo- sexuality in some countries and also with sex work both of which are the objects of stigma.*
- *HIV and AIDS raises deep-seated fears in many people of **DEATH.***
- *HIV and AIDS is also transmitted through the sharing of needles which may involve injecting illegal or illicit **DRUGS.***

What is the Impact of Stigma on People Living with HIV/ AIDS (PLWHA)? *Now ask participants to discuss the impact of stigma on people affected by the disease, and on prevention and care activities.*

Discussion points:

- *PLWHA and their families and partners are **ISOLATED** and shunned because of the stigma of the disease.*
- *PLWHA also experience **DISCRIMINATION AND HUMAN RIGHTS VIOLATIONS** because the stigma of the disease leads other people to think about them and act towards them as though they have lost the qualities that make them worthy of respect and dignity.*
- *Stigma creates **BARRIERS TO HIV and AIDS PREVENTION AND CARE** by creating an environment in which it is difficult to talk openly about the ways in which HIV is transmitted and how to stop it being transmitted (for example, talking about condoms and sexual behaviours). Stigma also creates the false impression that only some people (those stigmatised, e.g., sex workers, injecting drug users or homosexual men) are at risk of being infected.*

Activities: Case Study Workshop

Resources needed	• Case study • Flip chart paper • Markers
Time	2 hrs

Divide the participants into groups of 6–7 members per group. Provide each group with a case study of a person with HIV and AIDS, the circumstances of how he/she acquired the disease and experiences in the community in relation to his/her HIV status. You can use the case studies submitted by the participants prior to the workshop or construct your own. The cases could include the following:

1. *a woman involved in the sex industry;*
2. *a father in a rural community infected by his wife who is living with HIV and discriminated against by the community;*
3. *military personnel or soldier dismissed from the service because of their HIV status;*
4. *a widow shunned by her relatives and neighbours because of living with HIV;*
5. *a female school teacher whose test result was revealed by the physician to the school authorities; and*
6. *an out-of- school youth infected with HIV through injecting drug use with theirs peers.*

IMPORTANT: *It is best that the case studies for this workshop be derived from local experiences.*

Ask participants to discuss the case assigned to the group by answering the following guide questions:

- *What human rights violations (HRVs) are committed against the person/individual(s)?*
- *Where has the State failed in its obligation/duty resulting in the HRV?*
- *Who else, besides the State is failing in their human rights obligations?*
- *What articles of the UDHR and domestic laws are being violated by these acts?*
- *What concrete actions can be taken to remedy and protect the rights of the concerned individuals?*

Once participants have completed this activity, this session can be extended into a plenary dealing with the different levels of human rights response and its application to HIV and AIDS.

The following key areas should be stressed:

- *The individual level-stigma/discrimination.*
- *The social and community level, including how human rights violations create barriers to HIV and AIDS prevention as well as care.*
- *The larger structural human rights violations (for example, gender, poverty) which create the context of vulnerability.*

Ask participants to think about why AIDS is a stigmatised disease. Write suggestions on the whiteboard.

Discussion points:

- *HIV and AIDS is the most stigmatised modern disease. HIV and AIDS carries multiple stigmas because of the way it is transmitted and the people who are perceived to be infected and affected by it.*
- *HIV and AIDS is associated with **SEX and SEXUALITY**. These are often difficult subjects to talk about because they touch on intimate and personal behaviour. AIDS has become associated with homo- sexuality in some countries and also with sex work both of which are the objects of stigma.*
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- *Stigma creates **BARRIERS TO HIV and AIDS PREVENTION AND CARE** by creating an environment in which it is difficult to talk openly about the ways in which HIV is transmitted and how to stop it being transmitted (for example, talking about condoms and sexual behaviours). Stigma also creates the false impression that only some people (those stigmatised, e.g., sex workers, injecting drug users or homosexual men) are at risk of being infected.*

Activities: Case Study Workshop

Resources Needed	*Case Study* *Flip chart paper* *markers*
Time:	120min

Divide the participants into groups of 6–7 members per group. Provide each group with a case study of a person with HIV and AIDS, the circumstances of how he/she acquired the disease and experiences in the community in relation to his/her HIV status. You can use the case studies submitted by the participants prior to the workshop or construct your own. The cases could include the following:

1. *a woman involved in the sex industry;*
2. *a father in a rural community infected by his wife who is living with HIV and discriminated against by the community;*
3. *military personnel or soldier dismissed from the service because of their HIV status;*
4. *a widow shunned by her relatives and neighbours because of living with HIV;*
5. *a female school teacher whose test result was revealed by the physician to the school authorities; and*
6. *an out-of- school youth infected with HIV through injecting drug use with theirs peers.*

IMPORTANT: *It is best that the case studies for this workshop be derived from local experiences.*

Ask participants to discuss the case assigned to the group by answering the following guide questions:

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- *Where has the State failed in its obligation/duty resulting in the HRV?*
- *Who else, besides the State is failing in their human rights obligations?*
- *What articles of the UDHR and domestic laws are being violated by these acts?*
- *What concrete actions can be taken to remedy and protect the rights of the concerned individuals?*

Once participants have completed this activity, this session can be extended into a plenary dealing with the different levels of human rights response and its application to HIV and AIDS.

The following key areas should be stressed:

- *The individual level-stigma/discrimination.*
- *The social and community level, including how human rights violations create barriers to HIV and AIDS prevention as well as care.*
- *The larger structural human rights violations (for example, gender, poverty) which create the context of vulnerability.*

Discussion Points:

The promotion and protection of human rights constitute an essential component in preventing transmission of HIV and reducing the impact of HIV/ AIDS. Adopting a human rights approach ensures people who are most vulnerable to the infection and at the same time, disadvantaged, to have access to the necessary information and services to protect themselves. This includes securing correct information, affordable health care, appropriate social support, and protection against violence and discrimination.

The protection and promotion of human rights are necessary both to the protection of the inherent dignity of persons affected by HIV and AIDS and the achievement of the public health goals of reducing vulnerability to HIV infection, lessening the adverse impact of HIV and AIDS on those affected and empowering individuals and communities to respond to HIV and AIDS (UNAIDS, 1998). Adopting a human rights approach helps to create the supportive atmosphere that is necessary to encourage people to come forward, to help them benefit from HIV and AIDS education and services, and to enable them to change their behaviour.

The HIV and AIDS problem extends beyond the physical health of the individual and finds its sustenance and impact in the social, economic, and political conditions in which individuals live. Adopting a human rights approach enables states, communities, groups and organisations to address the problem in a comprehensive and multi-sectoral manner. The human rights framework emphasises that the effective response to the HIV and AIDS pandemic should be viewed in the context of the realisation and promotion of people's civil and political rights, as well as their economic, social and cultural rights.

The 2nd International Consultation on HIV and AIDS and Human Rights in September 1996, identified 17 key human rights principles underlying a positive response to the pandemic.

These include the following:

1. The right to non-discrimination, equal protection and equality before the law
2. The human rights of women
3. The human rights of children
4. The right to marry and found a family
5. The right to privacy
6. The right to enjoy the benefits of scientific progress and its applications
7. The right to liberty of movement
8. The right to seek and enjoy asylum
9. The right to liberty and security of the person
10. The right to education
11. The right of freedom of expression and information
12. The right of freedom of assembly and association
13. The right to participation in political and cultural life
14. The right to the highest attainable standard of physical and mental health
15. The right to an adequate standard of living and social security services
16. The right to work
17. The right to freedom from cruel, inhuman or degrading treatment or punishment.

Documentation by the Asia Pacific Network of People Living with HIV (APN+) has reported that among the prevalent forms of human rights violations committed against people with HIV and AIDS are the following:

Health Institutions/Workers

- Little or no access to quality treatment/health care.
- Antibody testing of people without their knowledge and/or consent.
- People whose HIV status is known are turned away from health centres and denied the necessary services.
- Hospital wards are overcrowded, unventilated and dirty.
- People with HIV and AIDS and people with tuberculosis are sometimes mixed in the same ward.
- Diet of persons living with HIV is largely neglected by hospital personnel.
- Health workers breach the confidentiality of Persons Living with HIV and AIDS.
- Health workers inform media of details of persons diagnosed with HIV.
- Bodies of Persons Living with HIV are rroutinely cremated within hours of their death.

Women

- Women forcibly sterilised because of their HIV status.
- HIV+ women are separated from their children or loose custody of their children.

- Women who are critical and who exposed the injustices they experienced as a consequence of their HIV status have been sent to mental institutions.
- Women are being thrown out of their homes and/or abandoned by their husbands/ partners because of their HIV status.

Family/Community

- People diagnosed with HIV are shunned by family and/or neighbours.
- Relatives burn all the personal things of a person whose death is AIDS- related.
- Persons Living with HIV positive and their family members are banned from places of worship like Temples, churches.
- Children whose parents are known to have HIV and AIDS in the community suffer discrimination in school.
- Many people with the disease have lost their jobs because of their HIV status.

Way forward

STRATEGIES TO STRENGTHEN HIV & AIDS and HUMAN RIGHTS

Group Discussion, Brainstorming

Objectives:

- To identify specific State obligations and duties in the protection and promotion of human rights in the field of HIV and AIDS; and
- To identify the gaps and weaknesses in the national response to AIDS.

Activities: Case Study Workshop

Resources Needed	*Case Study* *Flip chart paper* *markers*
Time:	60min

Divide the participants into groups of 6–7 members per group. Provide each group with a case study of a person with HIV and AIDS, the circumstances of how he/she acquired the disease and experiences in the community in relation to his/her HIV status. You can use the case studies submitted by the participants prior to the workshop or construct your own. The cases could include the following:

1. *a woman involved in the sex industry;*
2. *a father in a rural community infected by his wife who is living with HIV and discriminated against by the community;*
3. *military personnel or soldier dismissed from the service because of their HIV status;*
4. *a widow shunned by her relatives and neighbours because of living with HIV;*
5. *a female school teacher whose test result was revealed by the physician to the school authorities; and*
6. *an out-of- school youth infected with HIV through injecting drug use with theirs peers.*

IMPORTANT: *It is best that the case studies for this workshop be derived from local experiences.*

Ask participants to discuss the case assigned to the group by answering the following guide questions:

- *What human rights violations (HRVs) are committed against the person/individual(s)?*
- *Where has the State failed in its obligation/duty resulting in the HRV?*
- *Who else, besides the State is failing in their human rights obligations?*
- *What articles of the UDHR and domestic laws are being violated by these acts?*
- *What concrete actions can be taken to remedy and protect the rights of the concerned individuals?*

Discussion, Brainstorming

Objectives:

- To identify specific State obligations and duties in the protection and promotion of human rights in the field of HIV and AIDS; and
- To identify the gaps and weaknesses in the national response to AIDS.

Activities: Case Study Workshop

Resources Needed	*Case Study* *Flip chart paper* *markers*
Time:	120min

Divide the participants into groups of 6–7 members per group. Pro- vide each group with a case study of a person with HIV and AIDS, the circumstances of how he/she acquired the disease and experiences in the community in relation to his/her HIV status. You can use the case studies submitted by the participants prior to the workshop or construct your own. The cases could include the following:

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- *Who else, besides the State is failing in their human rights obligations?*
- *What articles of the UDHR and domestic laws are being violated by these acts?*
- *What concrete actions can be taken to remedy and protect the rights of the concerned individuals?*

Plan of action

Discussion, Brainstorming

Objectives:

- To formulate concrete plans on how to popularise the human rights approach in HIV and AIDS work; and
- To form a steering committee or human rights and HIV and AIDS network.

Activities: Workshop

Resources needed:	*Flip chart paper* *Markers*
Time:	*60 min*

Divide the participants into groups of 6–7 members per group or by their organisational affiliations. Assign each group to design a simple and realistic plan of action on the popularisation of human rights and HIV and AIDS, which their organisation can adopt and implement. Instruct the participants to indicate the specific target audience(s) and requirements of their plan.
Remind the participants that the framework of HIV and AIDS and human rights is broad and encompasses a range of activities that includes educational and capacity-building activities, as well as responses to human rights violations.

Process the proposed plans in the plenary with the aim of arriving at a consolidated and achievable educational plan of action, which the group/ organisation(s) can implement, if possible.

Network Formation

After the plan of action has been finalised, ask the participants what are the requirements to ensure the implementation of the plan. In order to implement and monitor the plan of action, the participants may wish to form a network which will co-ordinate activities.

In a plenary session, participants should discuss and agree on the following issues:

- *Network mandate, that is, what the network will do, how often it will meet etc.*
- *Identifying roles and responsibilities, for example a chairperson and secretary.*
- *Identifying and committing organisational resources.*

Reflection and Notes

SAVE

TOOLKIT

A Practice Guide to the SAVE Prevention Methodology

Church of Sweden

INERELA+

EXTRAS

Universal Declaration of Human Rights

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world, whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people,

Whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law, Whereas it is essential to promote the development of friendly relations between nations, Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of universal respect for and observance of human rights and fundamental freedoms, Whereas a common understanding of these rights and freedoms is of the greatest importance for the full realization of this pledge, Now, therefore, The General Assembly, proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article I

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self-governing or

under any other limitation of sovereignty.

Article 3

Everyone has the right to life, liberty and security of person.

Article 4

No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms.

Article 5

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 6

Everyone has the right to recognition everywhere as a person before the law.

Article 7

All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8

Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 9

No one shall be subjected to arbitrary arrest, detention or exile.

Article 10

Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 11

1. Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence.
2. No one shall be held guilty of any penal offence on account of any actor omission which did not constitute a penal offence, under national or international law, at the time when it was committed. Nor shall a heavier penalty be imposed than the one that was applicable at the time the penal offence was committed.

Article 12

No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 13

1. Everyone has the right to freedom of movement and residence within the borders of each State.
2. Everyone has the right to leave any country, including his own, and to return to his country.

Article 14

1. Everyone has the right to seek and to enjoy in other countries asylum from persecution.
2. This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations.

Article 15

1. Everyone has the right to a nationality.
2. No one shall be arbitrarily deprived of his nationality nor denied the right to change his nationality.

Article 16

1. Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.
2. Marriage shall be entered into only with the free and full consent of the intending spouses.
3. The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Article 17

1. Everyone has the right to own property alone as well as in association with others.
2. No one shall be arbitrarily deprived of his property.

Article 18

Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

Article 19

Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 20

1. Everyone has the right to freedom of peaceful assembly and association.
2. No one may be compelled to belong to an association.

Article 21

1. Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.
2. Everyone has the right to equal access to public service in his country.
3. The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures.

Article 22

Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment.
2. Everyone, without any discrimination, has the right to equal pay for equal work.
3. Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.
4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and well-being of him- self and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widow- hood, old age or other lack of livelihood in circumstances beyond his control.
2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.
2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace.
3. Parents have a prior right to choose the kind of education that shall be given to their children.

Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible
2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.
3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

Article 30

Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein

Pre-Workshop Evaluation Form

Note: This knowledge, attitudes and values evaluation is confidential and ANONYMOUS. Do NOT write your name anywhere on this We would like you to complete it honestly. We need your honest views to assess the impact of the workshop in order to improve the Toolkit and deliver better services. Please do not leave any questions blank.

Age	Sex	Type of community
		(Insert a number (1-4) as indicated below)

1. Urban – I live in a large city
2. Peri-urban – I live outside the city on a plot of land
3. Small town – I live in a small town
4. Village – I live in the rural areas

Please circle YES or NO

1.	There is no need for me to know about HIV because I am not at risk.	**Yes**	No
2.	I think women with many sexual partners are loose women.	**Yes**	No
3.	I think men with many sexual partners are loose men.	**Yes**	No
4.	I believe that Persons Living with HIV bring contamination into my community.	**Yes**	No
5.	I believe that Persons who are Living with HIV should not have sex.	**Yes**	No
6.	I think AIDS is God's way of punishing homosexuals.	**Yes**	No
7.	I think AIDS is God's way of punishing sexually immoral people.	**Yes**	No
8.	I believe good sex education for children and teens is essential in reducing HIV transmission.	**Yes**	No
9.	I think that masturbation is a SAFER sex practice.	**Yes**	No
10	I know that women can transmit HIV to men.	**Yes**	No
11	I know that men can transmit HIV to women.	**Yes**	No
12	I think that a woman who asks for a condom to be used during sex must have many partners.	**Yes**	No
13	I think that a man who uses a condom during sex with his partner is not man enough.	**Yes**	No
14	If my partner is living with HIV, I would drive them out or leave myself.	**Yes**	No
15	I think that circumcision ensures that a man is not at risk of HIV transmission.	**Yes**	No

16	I believe that governments need to develop laws that punish people who transmit HIV.	**Yes**	No
17	I think that lesbians (women who have sexual relationships with women) should be made to have sex with men.	**Yes**	No
18	I know that anti-retroviral therapy (ART) cures HIV.	**Yes**	No
19	I would not allow my children to play with children who are living with HIV.	**Yes**	No
20	If I test positive for HIV, I will not be able to care for my children.	**Yes**	No
21	I think that a Person Living with HIV should not be allowed to have children.	**Yes**	No
22	I know that using a condom during sex is 100% safe in preventing HIV transmission.	**Yes**	No
23	I think that sex workers who are living with HIV should not have access to HIV treatment such as ART.	**Yes**	No
24	I think that persons living with HIV should not be allowed to have formal employment.	**Yes**	No
25	I know that good nutrition supports the immune system of Persons Living with HIV.	**Yes**	No
26	I know that having multiple sexual partners does not lead to HIV transmission.	**Yes**	No

Post-Workshop Evaluation Form

Note: This knowledge, attitudes and values evaluation is confidential and ANONYMOUS. Do NOT write your name anywhere on this We would like you to complete it honestly. We need your honest views to assess the impact of the workshop in order to improve the Toolkit and deliver better services. Please do not leave any questions blank. This form is 4 pages long. Be sure to complete all questions.

Age	Sex	Type of community
		(Insert a number (1-4) as indicated below)

1. Urban – I live in a large city
2. Peri-urban – I live outside the city on a plot of land
3. Small town – I live in a small town
4. Village – I live in the rural areas

Please circle YES or NO

Please circle YES or NO

27	There is no need for me to know about HIV because I am not at risk.	**Yes**	No
28	I think women with many sexual partners are loose women.	**Yes**	No
29	I think men with many sexual partners are loose men.	**Yes**	No
30	I believe that Persons Living with HIV bring contamination into my community.	**Yes**	No
31	I believe that persons who are living with HIV should not have sex.	**Yes**	No
32	I think AIDS is God's way of punishing homosexuals.	**Yes**	No
33	I think AIDS is God's way of punishing sexually immoral people.	**Yes**	No
34	I believe good sex education for children and teens is essential in reducing HIV transmission.	**Yes**	No
35	I think that masturbation is a SAFER sex practice.	**Yes**	No
36	I know that women can transmit HIV to men.	**Yes**	No
37	I know that men can transmit HIV to women.	**Yes**	No
38	I think that a woman who asks for a condom to be used during sex must have many partners.	**Yes**	No
39	I think that a man who uses a condom during sex with his partner is not man enough.	**Yes**	No
40	If my partner is living with HIV, I would drive them out or leave myself.	**Yes**	No

41	I think that circumcision ensures that a man is not at risk of HIV transmission.	**Yes**	No
42	I believe that governments need to develop laws that punish people who transmit HIV	**Yes**	No
43	I think that lesbians (women who have sexual relationships with women) should be made to have sex with men.	**Yes**	No
44	I know that anti-retroviral therapy (ART) cures HIV.	**Yes**	No
45	I would not allow my children to play with children who are living with HIV.	**Yes**	No
46	If I test positive for HIV, I will not be able to care for my children.	**Yes**	No
47	I think that a Person Living with HIV should not be allowed to have children.	**Yes**	No
48	I know that using a condom during sex is 100% safe in preventing HIV transmission.	**Yes**	No
49	I think that sex workers who are living with HIV should not have access to HIV treatment such as ART.	**Yes**	No
50	I think that Persons Living with HIV should not be allowed to have formal employment.	**Yes**	No
51	I know that good nutrition supports the immune system of persons living with HIV.	**Yes**	No
52	I know that having multiple sexual partners does not lead to HIV transmission.	**Yes**	No

How Do You Feel About the Training?

Please comment on the training that you have attended. This is anonymous feedback to help facilitators refine and improve their own training.

13. Were your expectations of the training met?

14. Were the outcomes stated by the facilitator?

15. Were you encouraged to actively participate during the workshop?

16. Were you given opportunities to express yourself?

17. Were you given opportunities to ask questions?

18. Were all your questions answered to your satisfaction?

19. Were there areas you felt you needed more information?

20. Which sessions were most interesting for you?

21. Were there any sessions you felt were unnecessary?

22. Was there a good balance of different activities in the training?

23. Were the training materials and hand-outs useful to you?

24. How do you feel about how the facilitator managed the training?

13. Do you feel that the facilitator had adequate information and experience?

14.Would you recommend this training to others?

15.Who do you think could benefit from it?

16.How can you take the information from this training forward in your own work/life?

17.Are there any other comments you would like to add?